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The Patient Who Cannot Be Discharged- Licensed Access, Retrospective Consent, and the Ethics of Release in the Clinical Encounter

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ABSTRACT

Background: *Clinical medicine licenses access to the body and the interior life that would be intolerable in any other setting. It has developed elaborate procedural safeguards around that licence, and almost no vocabulary for what the licence does to the person who holds it or for what is owed afterward.*

Approach: *This paper reads that problem through a paradox in Deuteronomic law. Two coerced women appear in consecutive chapters with inverted dispositions: the captive of war must be released — ve-shillaḥtah le-nafshah, "you shall send her away to her own soul" (Deut 21:14) — while the violated na'arah may never be released — lo yukhal shallḥah kol yamav (Deut 22:29). Both verses are marked by the same term for the harm done. I trace how the exegetical tradition handles this asymmetry: the Ramban indexing permission to the pathology it concedes; the Netziv (R. Naftali Zvi Yehuda Berlin, 1816–1893) developing an account of the temporal asymmetry of coercion and a categorical refusal of victim-blaming; and the Ra'aya Meheimna at Zohar III 277a–b converting the irrevocable bond into a theology of divine non-abandonment by means of the mashal, which it names as its own method.*

Clinical argument: *Four elements of the Deuteronomic apparatus have direct clinical analogues that are largely absent from contemporary practice: (1) interposition — a mandated interval between desire and action, against a clinical culture of eleven-second agenda-setting and pathway-determined decisions; (2) compelled witnessing — the licensed party legally obliged to be present to the grief he caused and forbidden to interrupt it; (3) temporal asymmetry of consent — the principle that an encounter beginning in coercion is not retroactively purified by subsequent endorsement, which speaks directly to the well-documented phenomenon of retrospective approval of involuntary treatment; and (4) two distinct obligations of release — one requiring discharge without residual claim, one forbidding discharge altogether. Knowing which of these two governs a given patient is, I argue, a substantial fraction of clinical ethics.*

Caution: *I argue against the temptation to attribute modern trauma theory to pre-modern exegetes, and against the parallel temptation — structurally identical — by which the clinical case report sublimates a patient into a teaching point. The paper closes by proposing the Netziv's ve-la-na'arah lo ta'aseh davar as a limit on interpretive appropriation in both domains.*

Keywords

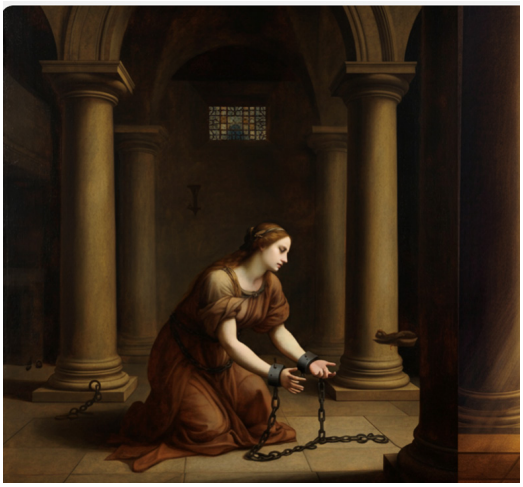
Coercion, Consent, Clinical ethics, Non-abandonment, Moral injury, Hermeneutics, Narrative medicine, Trauma-informed care, Medical humanities.

Introduction: A Clinical Problem in Search of a Text

I want to begin with a set of clinical facts that we have collectively agreed not to look at directly.

A woman under general anesthesia is examined pelvically by medical students who have not been individually named to her, for educational purposes, in a procedure she did not specifically authorize. The practice has been documented, defended, and — in a growing number of jurisdictions — legislated against, but

the ethical literature it generated is instructive precisely because the defenses were not stupid [1,2]. They turned on institutional licence: she consented to be treated at a teaching hospital; the exam is medically indistinguishable from the one already being performed; no harm results that she will ever perceive.



A man in an acute psychotic episode is held involuntarily, medicated over objection, and discharged three weeks later. At follow-up he thanks the team. The literature on this is substantial and consistent: a significant proportion of patients who experience admission as coercive later endorse it as having been necessary [3,4]. That retrospective endorsement is routinely cited — in case conferences, in teaching, in my own past practice — as evidence that the coercion was justified.

A patient with functional neurological symptoms is told, kindly and by a good clinician, what her symptoms *are*. She does not accept the formulation. Over several visits, evidence accumulates, the explanation is refined, and eventually she agrees. We record this as therapeutic alliance [5].

A patient of nineteen years is discharged from a practice for repeated no-shows.

These four situations share a structure, and medicine has no single name for it. In each, a person's body or interior life has been made available under institutional licence, in a condition of profound asymmetry, and in each the question of *what is owed afterward* is answered — when it is answered at all — by procedure rather than by ethics. We have consent forms. We have documentation standards. We have discharge criteria. What we do not have is any account of the moral position of the person who held the licence, or of the residue that remains once it is relinquished.

I have argued in previous work that the clinical encounter is an asymmetry of vulnerability redeemable only by a corresponding surrender on the physician's part [6], that the institutional costume authorizing the asymmetry deserves considerably more suspicion than it receives [7] and that the patient is best read not as a data set but as a text [8,9]. This paper takes those claims to their hardest case.

The text I want to read is the one that legislates for exactly this situation and does so without any of our euphemism. Deuteronomy 21 and 22 place two coerced women in consecutive chapters. They give them opposite endings. And the exegetical tradition that grew around that asymmetry — Ramban in the thirteenth century, the Netziv in the nineteenth, the Ra'aya Meheimna somewhere between — developed an apparatus for thinking about licensed harm that is, I will argue, more sophisticated than anything currently operating in clinical ethics.

I am aware of the risk in this move. A physician who reaches for Deuteronomy to illuminate the exam room is one step from claiming that a thirteenth-century Catalan exegete anticipated trauma-informed care, which he did not. I will try to be disciplined about that throughout, and I will argue that the discipline is itself the paper's clinical point.

The Deuteronomic Paradox: Two Releases

The *eshet yefat to'ar* of Deut 21:10–14 is taken in war. The passage prescribes a month of shaving, nail-cutting, removal of the garment of captivity, and weeping for her parents, and then:

כִּי־תֵצֵא לַמִּלְחָמָה עַל־אֹיְבֶיךָ וּנְתָנוֹ יְהוָה אֱלֹהֶיךָ בְּיָדֶךָ וְשָׁבִיתָ שִׁבְיוֹ׃

When you[b] take the field against your enemies, and the ETERNAL your God delivers them into your power and you take some of them captive,

וְרָאִיתָ בַּשִּׁבְיָה אֵשֶׁת יְפַת־תֹּאַר וְחָשַׁקְתָּ בָּהּ וְלָקַחְתָּ לְךָ לְאִשָּׁה׃

and you see among the captives a beautiful woman and you desire her and would take her to wife;

וְהֵבֵאתָהּ אֶל־תּוֹךְ בֵּיתֶךָ וְגִלְּחָה אֶת־רֹאשָׁהּ וְעָשְׂתָה אֶת־צִפָּרְנֶיהָ׃

and you bring her into your household, and she trims her hair, pares her nails,

וְהֵסִירָה אֶת־שִׂמְלַת שִׁבְיָהּ מֵעָלֶיהָ וְיָשְׁבָה בְּבֵיתֶךָ וּבָכְתָה אֶת־אָבִיהָ וְאֶת־אִמָּהּ יֶרַח יָמִים וְאַחַר כֵּן תָּבוֹא אֵלֶיהָ וּבְעַלְתָּהּ וְהָיְתָה לְךָ לְאִשָּׁה׃

and discards her captive's garb; and she spends a month's time in your household lamenting her father and mother: after that you may come to her and thus become her husband, and she shall be your wife.

וְהָיָה אִם־לֹא חָפַצְתָּ בָּהּ וְשִׁלַּחְתָּהּ לְנַפְשָׁהּ וּמָכֹר לֹא־תִמְכְּרֶנָּה בַּכֶּסֶף לֹא־תִתְעַמֵּר בָּהּ תַּחַת אֲשֶׁר עִנִּיתָהּ׃ {ס}

Then, should you no longer want her, you must release her outright. You must not sell her for money: since you had your will of her, you must not enslave her.

הָתִינַע רִשְׁעָא תַּחַת קְבֵ רַמַעְתַּת־אֹל ...הְשִׁפְנֵל הָתְחַלִּשְׁוּ הְבֶ תְצַפָּח אֹל־מַא הְיָהְוּ׃

And if it should be that you do not want her, you shall send her away to her own soul... you shall not treat her as chattel, because you have afflicted her [10].

The *na'arah betulah* of Deut 22:28–29 is seized in the field:

כִּי־יִמְצָא אִישׁ נַעֲרָ בְתוּלָה אֲשֶׁר לֹא־אֹרָשָׂה וּתְפָשָׂה וְשָׁכַב עִמָּהּ וְנִמְצָאוּ׃

If a man comes upon a virgin who is not engaged and he seizes her and lies with her, and they are discovered,

וְנָתַן הָאִישׁ הַשֹּׁכֵב עִמָּהּ לַאֲבִי הַנַּעֲרָ חֲמִשִּׁים כֶּסֶף וְלוֹ־תִהְיֶה לְאִשָּׁה תַּחַת אֲשֶׁר עִנָּהּ לֹא־יוּכַל שַׁלְּחָהּ כָּל־יָמָיו׃ {ס}

the man who lay with her shall pay the young woman's father fifty [shekels of] silver, and she shall be his wife. Because he has violated her, he can never have the right to divorce her.

וּמִמַּי־לֹא תַחְלֹשׁ לַכּוּי־אֹל תְּנַע רֹאשָׁא תַּחַת תִּשְׁאַל הָיֶהת־וֹלוֹ׃

And she shall be his wife, because he afflicted her; he may not send her away all his days [11].

The verbal echo is exact. Both turn on the root הנע — *taḥat asher innitah*, *taḥat asher innah*: because you afflicted her, because he afflicted her. Both deploy the verb חלש for what happens next. And they invert: *ve-shillaḥtah* against *lo yukhal shallḥah*. Release mandated; release foreclosed.

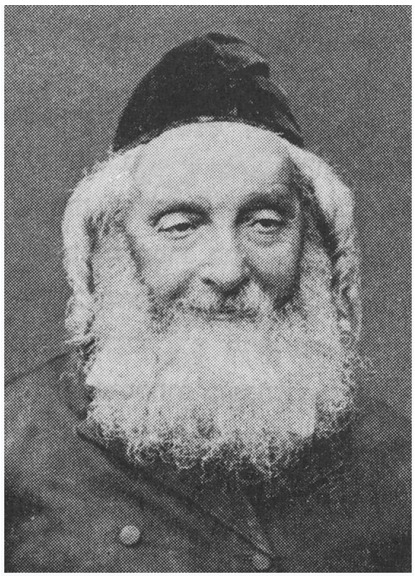
Modern biblical scholarship reads the foreclosure as economic protection in a society where a violated unmarried daughter had no marriage prospects and no independent means [12,13]. Rofé situates the law in Deuteronomy's revision of the Covenant Code, where Exod 22:15–16 treats the *seduced* virgin and Deut 22:28–29 the *seized* one [14,15]. Wells reads the Deuteronomic sexual legislation as primarily evidentiary and economic [16]; Frymer-Kensky notes that the operative category is *betulim* — virginity as social and economic status — rather than consent in any modern sense [17].

However true, none of it disposes of the difficulty. A statute binding a woman for life to the man who seized her is monstrous, and contextualization does not convert it into benevolence. What the tradition *does* with the difficulty is my subject, and the crucial observation for a clinical readership is this: **the tradition splits.**

The *peshat* commentators work predominantly on the release case and on the psychology of coercion.

The mystical tradition works on the *non*-release case and converts it into theology.

The two directions correspond, with uncomfortable precision, to the two things medicine does with patients — releases them without residue or refuses to let them go.



The Clinic as State of Exception: The Netziv's Frame

Rabbi Naftali Zvi Yehuda Berlin [18] (Netziv's) decisive move is made not in Ki Teitzei (Deut 21) but in Genesis. On *ve-akh et dimkhem le-nafshoteikhem edrosh* (Gen 9:5)

וְאַךְ־אֶת־דִּמְכֶם לְנַפְשֹׁתֵיכֶם אֶדְרֹשׁ מִיַּד כָּל־חַיָּה אֶדְרְשֶׁנּוּ וּמִיַּד הָאָדָם מִיַּד אִישׁ אָחִיו אֶדְרֹשׁ אֶת־נֶפֶשׁ הָאָדָם׃

But for your own life-blood I will require a reckoning: I will require it of every animal; of humankind, too, will I require a reckoning for human life, of everyone for each other!

he writes:

מלועה דסונ דכ יכ ,ללכ הז לע שנוע.

The Holy One explained: when is a person held to account? At a time when it is fitting to conduct oneself in brotherhood. Not so at a time of war — a time to hate — for then it is a time to kill, and there is no punishment for this at all, for so the world was founded [19].

מיד איש אחיו. פירש הקב"ה אימתי האדם נענש בשעה שראוי לנהוג באחוה. משא"כ בשעת מלחמה ועת לשנוא אז עת להרוג ואין עונש ע"ז כלל. כי כך נוסד העולם. וכדאי' בשבועות ל"ה מלכותא לקטלא חד משיתא לא מיענש ואפי' מלך ישראל מותר לעשות מלחמת הרשות אע"ג שכמה מישראל יהרגו ע"ז ועי' ס' דברים כ' ח':

War is a **state of exception**: a temporary suspension of the moral grammar governing ordinary life, grounded not in divine command but in *derekh ha-olam* [20]. Note what this costs him. Having conceded that the ordinary self is not operative in war, he acquires a problem he cannot evade: *how does the soldier get back?*

The captive-woman legislation, in this frame, is not primarily a law of sexual permission. It is a law of **re-entry** — the reconstruction of

a moral agent who has been lawfully de-moralized. Its instruments are exactly the instruments of re-entry: an interval, a domestic context, a compelled witnessing of grief, a terminal release.

The Clinical State of Exception

Medicine has its own suspended order, and we are strikingly incurious about it.

Consider what the licence authorizes. I may ask a person I met eleven minutes ago about their bowel habits, their urinary function, their suicidal ideation, their marriage. I may put my hands on and examine their body. I may, under defined conditions, hold them against their will, sedate them, restrain them, catheterize them, and examine them while they are unconscious. None of these acts is a lesser version of an ordinary social act; each is categorically outside ordinary social permission, and each is *entirely legitimate* within the clinical frame.

The frame is real, and I am not arguing against it. What I am arguing is that we have adopted the Netziv's premise without adopting his problem. We accept that clinical work suspends ordinary constraints. We have built almost nothing to handle the re-entry.

The contemporary literature closest to this is moral injury — the wound sustained not by being harmed but by perpetrating, or failing to prevent, what violates one's deepest commitments [21,22]. Dean, Talbot, and Dean's reframing of clinician distress as moral injury rather than burnout was an important corrective precisely because it relocated the wound from the clinician's stamina to the clinician's conscience [23]. But even that literature is mostly concerned with system-imposed constraint — being unable to do right by patients. It has less to say about the residue of doing something that was *permitted*, that we would do again, and that nonetheless leaves a mark: the exam that was necessary and humiliating, the hold that was correct and violent, the truth that was owed and devastating.

I have made this argument at length with respect to the militarized imagination in medicine, where the war metaphor imports the state of exception wholesale — the fight, the front line, the battle against disease — without importing any of the apparatus by which a soldier is meant to come home [24,25]. The Deuteronomic legislation supplies exactly that apparatus. The rest of this paper is an attempt to specify it.

Ḥesheq: The Clinical Drive and the Scope of Permission

Naḥmanides makes a move on Deut 21:11 that determines everything downstream:

וְרָאִיתָ֖ בַּשִּׁבְיָ֑ה אֵ֚שֶׁת יְפַת־תֹּ֣אַר וְחָשַׁקְתָּ֣ בָּ֔הּ וְלָקַחְתָּ֥ לְךָ֖ לְאִשָּֽׁה׃

and you see among the captives a beautiful woman and you desire her and would take her to wife;

וזל אשי אל — השא ול תחקל הצור אוהש אלא,

Scripture says ve-ḥashaqta bah — she is permitted to him only on account of the ḥesheq, when his drive overpowers him. But one who finds in himself no ḥesheq for her, only that he wishes to take a wife — he may not marry this one [26].

The permission is **indexed to the pathology it accommodates**. It does not generalize. A man in ordinary possession of himself, who merely finds this one convenient, falls outside the statute entirely.

The verb is precise. קשח is not בהא and not יפח. It is the verb of Shechem's soul cleaving to Dinah (Gen 34:8) and of God's inexplicable attachment to Israel (Deut 7:7). It names desire already bound to a particular object, which argument cannot unbind. And the Talmudic formula that governs the whole passage — *lo dibberah Torah ella ke-neged yetzer ha-ra* [27] — deserves closer attention than it receives. The preposition is דגנכ: over against, facing, at close quarters. Not *in service of*. The Torah takes a position opposite the drive and negotiates.

The Physician's Ḥesheq

Medicine has a *ḥesheq*, and pretending otherwise is why we handle it badly.

It is not primarily erotic, and the profession's near-exclusive focus on sexual boundary violations — necessary as that focus is — has obscured the more common form. The clinical drive is the desire *to resolve*. To have the answer. To be the one who found it. To take the interesting case. To fix the person in front of me, on my timeline, according to my formulation.

Anyone who has felt the quickening at a rare presentation knows this drive is real. It is also, in significant part, what makes good clinicians good: the diagnostic appetite is not a vice to be extirpated. But the Ramban's structure applies. A permission granted because of a drive does not extend beyond the conditions of that drive. The licence to examine, to probe, to ask, to hold, is granted for

this patient's benefit under these conditions — and the moment the licence is being exercised because the case is interesting, because the resident should see it, because I want the answer, it has exceeded its warrant.

The anesthetized pelvic exam is the pure case [1,2]. Every element of legitimate clinical licence is present. The patient consented to surgery; the surgeon is entitled to examine; the institution is a teaching hospital. What is absent is the indexing. The exam is not being performed because this patient's care requires it. It is being performed because education requires it, which is a good reason for something and not a good reason for this.

I have developed the general form of this argument in work on the disciplining rather than extinguishing of desire in halakhic culture [28] and on the structure of an economy of delight in which restraint is generative rather than merely privative [29]. The clinical translation is exact: the drive to know is not to be suppressed. It is to be indexed.

Interposition: Delay as Clinical Technology: The Month

The Torah's technique for a desire it cannot forbid is not prohibition. It is **interposition**. One cannot forbid the *ḥesheq*; one can place a month between the man and its object.

Ibn Ezra states the mechanism outright at Deut 21:13, glossing *yeraḥ yamim*: **וקשה לקי ילוא** — "perhaps his *ḥesheq* will abate" [30]. Nothing is prohibited. Time is inserted. And the interval is not empty: it is filled with shaving, nail-cutting, the removal of the garment of captivity, and the relocation of the woman *el tokh beitekha*, into the midst of the household, where the man's ordinary life continues and where he is not a soldier. The desire formed in the suspended order is dragged into the order that has not been suspended and made to survive there or not.

This is the single most transferable element of the entire apparatus, and it is the element medicine has most comprehensively abolished.

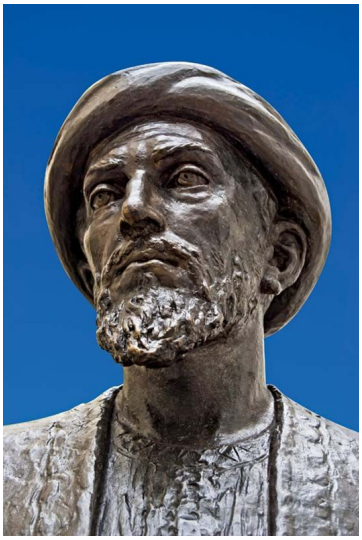
The Eleven Seconds

Consider the empirical record. In 1984 Beckman and Frankel found that physicians interrupted patients' opening statements after a median of eighteen seconds [31]. Fifteen years later Marvel and colleagues found twenty-three seconds and concluded, generously, that things had improved [32]. Two decades after that, Singh Ospina and colleagues, analyzing recorded encounters, found a median of eleven seconds before interruption, with the patient's agenda solicited in only about a third of encounters [33].

Set that beside the Deuteronomic provision and the comparison is not flattering. The Torah legislates a month. We manage eleven seconds.

The point is not that clinical medicine should adopt thirty-day waiting periods. It is that **the interval is a moral technology, not an inefficiency**, and that we have systematically eliminated it under the belief that it was the latter. Michael Balint understood this better than anyone since his account of the "apostolic function" — the doctor's largely unexamined conviction about how patients ought to behave and what their illness ought to be — is a description of a *ḥesheq* operating without an interval to check it [34]. Balint's method was, in essence, the deliberate reintroduction of delay: the case discussion group as a month interposed between the clinical impression and the clinical act.

Practices that reintroduce interposition are neither exotic nor new. Watchful waiting. Delayed prescribing. The deliberate second visit before the label is affixed. Sleeping on a formulation. The diagnostic pause. What is striking is that each of these is currently justified — when it is justified at all — on grounds of diagnostic accuracy or resource stewardship. None is justified on the grounds Deuteronomy gives, which is that the clinician's own state now of decision is not to be trusted, and that time is the only reliable solvent for it.



The Compelled Witness

Maimonides adds an element the tradition has underused. At Hilkhot Melakhim 8:6 he rules that the unconverted captive dwells in the household thirty days, and then:

העגומ וניאו ,התד לע הכוב וכו.

And likewise, she weeps for her religion, and he does not

prevent her [35].
The captor is legally obliged, in his own house, for a full month, to be present to the grief he caused — and *forbidden to interrupt it*. Not permitted to be absent. Not permitted to console her out of it. Not permitted to explain to her why the grief is misplaced. He must watch, and he must not stop it.

I do not know of a modern clinical analogue that goes this far.

The Clinical Failure

Every reflex of clinical training runs against this provision. We are trained to intervene in distress: to normalize, to reassure, to redirect, to reframe, to offer the pamphlet, to name the resource, to move to the plan. The interruption data above is not fundamentally about time pressure; it is about a professional identity organized around *doing something*, for which sitting in someone's grief without acting registers as failure.

The Maimonidean provision proposes the opposite: that in a certain class of situation, **presence without intervention is the obligation**, and that the person obliged is specifically the one who caused the harm. It is not the chaplain's job, or the social workers, or the palliative teams. It is the job of the person whose licensed act produced the grief.

The trauma-informed care literature gestures at this — the SAMHSA framework's emphasis on safety, trustworthiness, and avoiding retraumatization implies a clinician who can tolerate distress without managing it away [36]. But the framework is largely procedural, and the Maimonidean formulation is sharper on the crucial point: *ve-eino mon'ah* is a prohibition on the clinician, not a service to be delivered.

Composite vignette 1

A man in his sixties, six weeks after a diagnosis carrying a poor prognosis, spends most of a follow-up visit describing his father's death from an unrelated illness forty years earlier. There is no clinical decision to be made in the visit; the imaging is unchanged. Every instinct trained into me says to acknowledge briefly and move to the plan. The Maimonidean provision says: this is the month, you caused the occasion for it, and you may not prevent it. (Details altered; composite of several encounters).

The Temporal Asymmetry of Coercion

This is the section in which the Netziv makes his most directly clinical contribution, and it is the argument I would most want a psychiatric readership to take up.

Even If Its End Was Willing

כִּי־יִמְצָא אִישׁ נַעֲרָ בְתוּלָה אֲשֶׁר לֹא־אֹרָשָׂה וּתְפָשָׂה וְשָׁכַב עִמָּהּ וְנִמְצָאוּ׃

If a man comes upon a virgin who is not engaged and he seizes her and lies with her, and they are discovered,

On *ve-shakhav immah* (Deut 22:28) the Netziv writes, with characteristic compression:

ושכב עמה. גם כאן קמ"ל אפי' סופו ברצון מ"מ הוא חייב קנס אונס מתחלה׃

"And he lay with her."

Here too Scripture teaches us: even if its end was willing, he is nonetheless liable for the fine of coercion, because of the beginning [37].

The category behind this is the Talmudic **teḥillato be-ones ve-sofo be-ratzon — "its beginning in coercion and its end in willingness"** — with the associated **yetzer albesha, "the drive clothed her"** [38,39]. What the Netziv extracts is a principle about time: **the moral character of an encounter is fixed at its origin, and subsequent conduct does not retroactively revise it.**

I want to state the methodological caution here rather than in a footnote, because it is the paper's ethical spine. Formulations like "relational autonomy", "coercive control" and "consent after coercion does not retroactively convert coercion into consent" are modern analytical constructs. They are not the Netziv's vocabulary, and they carry commitments he did not hold. The defensible claim — and the stronger one — is that *the Netziv preserves, with unusual clarity, the temporal asymmetry of coercion, and that legal insight can be placed in productive conversation with modern accounts of consent without collapsing the two.*

Retrospective Endorsement in Psychiatry

Now the clinical application, which is exact.

The MacArthur coercion studies established that perceived coercion in psychiatric admission is only loosely coupled to legal status and is driven substantially by whether the patient experienced voice, validation, and respect in the process [3]. Gardner and colleagues then documented something more unsettling: patients revise their beliefs about the need for hospitalization over time, and a substantial proportion who initially experienced the admission as unnecessary and coercive later come to endorse it [4].

That finding is used, in practice, as reassurance. I have heard it deployed in case conferences; I have deployed it myself.

The reasoning runs: he was angry at the time, but he thanked us afterward, so the coercion was justified.

The Netziv's principle says this reasoning is invalid.

Afilu sofo be-ratzon — even if its end was willing — *mi-kol makom hu ḥayyav... me-teḥillah*: the liability attaches to the beginning. The later endorsement is a real and welcome fact about the patient's recovered state. It is not evidence about the justification of the original act, because the original act is precisely what altered the conditions under which the later judgment is being formed. A person who has been medicated back into a state where he can evaluate the medication is not an independent witness to whether the medication should have been given.

This does not mean involuntary treatment is never justified. It means

the justification must be established at the time, on the grounds available at the time, and cannot be backfilled from gratitude. The clinical translation is straightforward, and I would put it in these terms: **retrospective endorsement is a good outcome and not a validation.** Documenting "patient subsequently expressed appreciation for the admission" is a clinical observation. It is not an ethical finding, and a service that treats it as one has arranged its feedback loop so that it can never learn it was wrong.

Composite vignette 2

A patient held involuntarily during an acute episode, medicated over objection, and discharged three weeks later. At six-week follow-up he says he understands why it was done and is grateful. The team records this. What the record does not contain is any independent account of whether, at the time, the threshold was met — because the gratitude has been permitted to answer the question retroactively.

The Wider Case: Consent Obtained Mid-Procedure

The same structure appears far outside psychiatry, and less examined. Consent obtained after a procedure has begun. The "while we're in there" extension. The patient who declines a treatment, is presented with the same treatment at successive visits by an increasingly concerned clinician and eventually agrees. The functional-symptoms patient whose acceptance of the formulation arrives after months of a relationship in which acceptance was visibly the price of continued engagement [5].

None of these is malpractice. Several are good medicine. But in each, the eventual *ratzon* was produced inside conditions the clinician created, and the Netziv's principle asks us to notice that a consent generated inside a coercively shaped field is not the same object as a consent formed before the field was shaped. That is a claim about the *conditions* of choosing, and it is available to us without importing a whole theory of trauma we would then have to defend.

Do Nothing Further to Her: The Refusal of Clinical Victim-Blaming

The Netziv's comment on Deut 22:26 is the more remarkable of the two, and its clinical relevance is the most immediate in the paper.

The verse declares of the woman seized in the field: *ve-la-na'arah lo ta'aseh davar* — ***"but to the young woman you shall do nothing."*** The Netziv asks why the verse is needed at all; if she was coerced, no one imagines she is liable to execution.

His answer:

> **אין לנערה חטא מות.** לא בא הכתוב לומר שלא תהרג שהרי אפילו מספק אם היה תחלה באונס או ברצון אינה נהרגת אלא מלמדנו שאפילו עונש בעלמא על שהגיע לידה בפשיעותה מה שיצאה בשדה וכדתניא בספרי לעיל ומצאה איש בעיר אלו לא יצאה בעיר לא היה מסתקף לה ומכש״כ בשדה וא״כ הגיע לה בפשיעותה חטא גדול של מות וראוי לקונסה וכדומה עונשי ב״ד. ע״ז אמר הכתוב ולנערה לא תעשה דבר שום ענין:

Scripture does not come to say she is not executed... Rather it teaches that even an ordinary penalty — for the negligence by which she came to be there, that she went out into the field — is excluded. One might think that through her own imprudence she came into proximity with a capital matter and it would be fitting to fine her or impose other court penalties.

Against this Scripture says ve-la-na'arah lo ta'aseh davar — nothing whatsoever... For she has already been penalized in that she was violated and harmed; therefore, nothing further is to be done to her [37].

The structure is worth stating plainly. The Netziv raises the victim-blaming hypothesis *explicitly* — she went out into the field; she was imprudent; some secondary liability might attach — and reports that the Torah forecloses it categorically. **אינע מוש**: nothing of any kind. And his reason is not that she was blameless. His reason is that she has *already been penalized by the harm itself.*

She Went Out into the Field

The clinical form of ***"she went out into the field"*** is everywhere, and it is almost never called what it is.

The literature on stigma among health professionals toward patients with substance use disorders is unambiguous: negative attitudes are common, they affect the care delivered, and patients perceive them [40]. The same structure operates around obesity, around type 2 diabetes, around lung cancer in smokers, around sexually transmitted infection, around injury sustained in circumstances we regard as reckless, and — with force — around "non-adherence," a word that does substantial moral work while presenting as descriptive.

In each case the reasoning is the Netziv's hypothetical exactly: she went into the field; some portion of what followed is chargeable to her; a secondary penalty is therefore appropriate. The penalty is rarely explicit. It is a shorter visit, a flatter affect, a lower index of suspicion for the next complaint, a note whose adjectives will follow the patient for a decade, a slower response to the call light.

And the Netziv's answer is the one I would want written above the workstation: **השנעג רבכ** — she has already been penalized by the thing itself. Whatever the causal contribution, the illness *is* the consequence. The clinical system has no further claim, and the instinct to add one is not justice but an unexamined transfer of our own discomfort onto the person least able to refuse it.

I have written elsewhere on the fluid and ambiguous presence of evil in spaces that understand themselves as healing [41]; this is its most banal and most common form.

The Case Report as Mashal

To follow the next movement, we need an account of the *mashal* that does not treat it as decoration. David Stern's *Parables in Midrash* remains the indispensable study [42].

Stern's central contention is that the rabbinic *mashal* is not an

illustration appended to an argument but an **exegetical narrative** — a story constructed to solve a specific difficulty in a specific verse, bound to that verse by the *nimshal*, and carrying an ideological charge that propositional exegesis could not carry. Two further features bear on the clinical case.

First, **the mashal always generates narrative surplus**. A story has characters, motives, and details that the *nimshal* cannot cash out. Stern reads this surplus as the source of the form's power — and, I would add, of its danger. What the *nimshal* fails to absorb does not disappear.

Second, Stern argued forcefully against reading midrash as radical indeterminacy [43,44]. Midrash is polysemous, but its polysemy operates inside a rhetorical and communal frame that constrains what may be said. Boyarin's account of midrashic intertextuality supplies the complementary point that midrash fills gaps with other verses rather than with invention [45].

The Clinical Nimshal

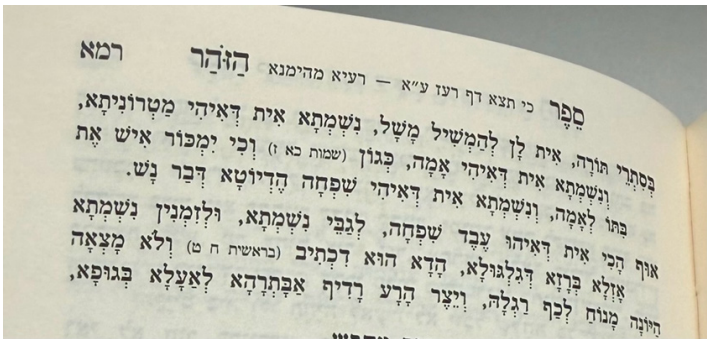
The clinical case report is a *mashal* in Stern's precise sense and recognizing that is more than an analogy.

A body presents. The body becomes a history. The history becomes a presentation, structured by convention: identifying data, chief complaint, HPI, ROS. The presentation becomes a syndrome; the syndrome becomes a case; the case becomes a teaching point, a figure in a lecture, a line in a paper. Each step is a narrative substitution that permits us to say something we could not otherwise say — which is exactly Stern's account of what a *mashal* does and why it exists.

And each step generates surplus.

The *nimshal* of a clinical case is the diagnosis, or the teaching point, or the guideline it illustrates. Everything the diagnosis does not absorb is surplus: the father who died forty years ago, the reason she went to the field, the eleven seconds she did not get, the fact that she is frightened of the machine and not of the disease. Stern's insight is that this surplus is not noise. It is where the thing continues to live.

The clinical failure mode is therefore precisely a *nimshal* failure: we mistake the interpretation for the thing interpreted. I have argued this at length under the heading of the patient as parable [9], and it is the operational core of hermeneutic medicine as I have tried to develop it [8]. What Stern adds is the recognition that the substitution is not an error to be corrected but a *form* — one with known properties, known powers, and a known characteristic failure.



The Zoharic Ascent: What Sublimation Costs

The Ra'aya Meheimna is a late Zoharic stratum with its own concerns — systematic enumeration of commandments, sharpened critique of the rabbinic establishment, heavily allegorized readings of halakhic categories [46-48]. Its treatment of our verses occurs among the *pikkudin* for Ki Tetze:

The passage is bracketed by a claim about exile:

הנמ זז אל אוה דירב אשדוק, אתולגב יהיא אתניכשד בג לע דאד

Even though the Shekhinah is in exile, the Holy One does not stir from her [49].

Then the commandment:

הסונא :וירטס וירתמ תיא הסונא יאדוד .ותסונא אשיל, אד רתב אדוקפ יהיא תמיחרד הסונא תיאו היל תמיחר אל יהיאו, הבגל היליד אתומיחרב .הכרבבו וישודק אלב הימע אגוודזאל תליחדו, היל

The commandment after this: to marry the woman one has coerced. For certainly there are coerced women of two sides: one where the love is his toward her and she does not love him; and one who does love him but fears to join with him without betrothal and blessing [49].

Then the methodological declaration:

.לשמ לישמהל ול תיא, הרות ירתסב

In the secrets of Torah, we must make a *mashal* [49].

And the resolution:

...י"דש רדהתא דש אוהה הבו ;הירבעה המא ,'י אתמשנו ,ידוהי דש והיא החלש לכוי אלו השאל היהת ולו" היב סייקתיו ...אתמשנ תויהל הל ריטנד ".וימי לכ

[The evil inclination] is a *demon*, and the soul is the *yod*, the Hebrew bondmaid; and through her that demon is transformed into *Shaddai*, who guards her so that she may live... and there is fulfilled in him: "she shall be his wife, and he may not send her away all his days" [49].

Five moves.

כִּי־יִמְצָא אִישׁ נַעֲרָ בְתוּלָה אֲשֶׁר לֹא־אֹרָשָׂה וּתְפָשָׂה וְשָׁכַב עִמָּהּ וְנִמְצָאוּ׃

If a man comes upon a virgin who is not engaged and he seizes her and lies with her, and they are discovered,

וְנָתַן הָאִישׁ הַשֹּׁכֵב עִמָּהּ לַאֲבִי הַנַּעֲרָ חֲמִשִּׁים כֶּסֶף וְלוֹ־תִהְיֶה לְאִשָּׁה תַּחַת אֲשֶׁר עִנָּהּ לֹא־יוּכַל שַׁלְּחָהּ כָּל־יָמָיו׃ {ס}

the man who lay with her shall pay the young woman's father fifty [shekels of] silver, and she shall be his wife. Because he has violated her, he can never have the right to divorce her.

It reads coercion bidirectionally. *Anusah its mi-terein sitrin.* The second category is the arresting one: a woman who *does* desire him but refuses union without *kiddushin u-verakhah*. Coercion here is constituted not by unwanted desire but by **improper sequence and framing**. The clinical resonance is immediate. A great many patients want what we are offering. What they refuse is the offering without the frame — without explanation, without the relationship, without being asked. We routinely record that refusal as non-adherence, and the Zohar would record it as *ones*.

It converts irrevocability into theology. Deuteronomy's harshest provision — a woman bound for life to the man who took her — becomes the guarantee of divine non-abandonment. *Lo yukhal shallḥah kol yamav* is transposed from constraint into promise. And note *which* chapter it builds on: not the one that releases. A God who might release Israel is not the God exile requires.

It inverts the coercer's identity. The perpetrator becomes the *yetzer ha-ra*, a *shed yehudi*, transformed through the soul into *Shaddai*, permanently bound to guard and sanctify through her. Liebes's account of the Zohar's tendency to redeem rather than annihilate the demonic is directly relevant [46].

It names its own method. *Be-sitrei Torah its lan le-hamshil mashal.* In context this introduces a specific typology rather than announcing a general manifesto, but it functions as one.

And it specifies what happens when he does not repent. The passage does not end with the transformation. It supplies the negative branch, and the branch is more interesting than the resolution. If the demon fails to return — *ve-i lo ḥazar bi-teyuvta* — the Exodus slave clause governs: *ha-ishah vi-yladeha tihyeh la-adoneha, ve-hu yetze be-gappo*, "the woman and her children shall belong to her master, and he shall go out alone". The soul is not destroyed by his refusal. She reverts to her owner, with her children. What he forfeits is the *yod* — which is to say, he forfeits *her*, and with her the only means by which דש could ever have become י״דש.

The architecture deserves to be stated precisely, because it is easy to misread. **The victim's fate is not contingent on the perpetrator's repentance; only his own is.** He cannot damage her further by failing, and he cannot redeem himself except through her. The obligation runs entirely in one direction, and the asymmetry is deliberate.

Redemption is therefore not something he achieves but something she constitutes, accessible only through the bond he is forbidden to dissolve. The right-hand branch shows the alternative: the soul reverts to her master with her children, and he leaves stripped (Exod 21:4).

The Cost

Here is the difficulty this paper exists to name, and it is a clinical difficulty as much as a theological one.

The Zoharic reading is dazzling. It takes the worst verse in Deuteronomy and extracts a theology of fidelity in exile. It takes a rapist and makes him a demon redeemed by permanent obligation to his victim.

And in doing so, it disappears the woman.

She becomes Israel. She becomes the Shekhinah. She becomes the soul, the *yod*, the *amah ivriyah*. Every transformation is an ascent, and everyone takes her further from the field where a girl was seized and where the text says, flatly, *taḥat asher innah*.

One qualification is owed here, and it cuts against my own argument. It would be easy to say that the Ra'aya Meheimna has arranged its economy around the perpetrator — that the demon's repentance is made the engine of the soul's significance, which is a structure a survivor might not recognize as good news. That reading is available, and it is not quite right.

The negative branch prevents it. If he does not repent, she is not diminished; she returns to her master with her children, and he alone is stripped. Her standing does not depend on his teshuvah. What depends on his teshuvah is *whether he obtains a yod* — whether דש ever becomes י״דש. The Zohar has built an economy in which the violated party holds the only thing the violating party needs and holds it unconditionally.

So, the critique must be sharpened rather than abandoned. The problem is not that the passage subordinates her to his redemption; on the contrary, it makes her the condition of it while leaving her fate independent of him. The problem lies at the level of the symbol rather than the plot.

The critical literature on the Shekhinah has circled this for three decades: Green situates the emergence of the feminine divine in its historical context [50]; Abrams examines the female body of God as textual artifact [51]; Wolfson argues that the kabbalistic feminine is finally reabsorbed into a male gestalt, so that the ascent of the Shekhinah is also her erasure [52,53]; Plaskow's earlier critique — that a tradition can venerate a feminine divine symbol while granting actual women no standing — remains the plainest statement [54]; Elior documents what the symbolic elevation coexisted with [55]. However well the moral accounting is arranged, by the end of the passage the *anusah* of Deuteronomy 22 has become the soul, the *yod*, the Shekhinah — and the young woman in the field, whom the Torah itself pointedly refused to sublimate, is no longer anywhere in the text.

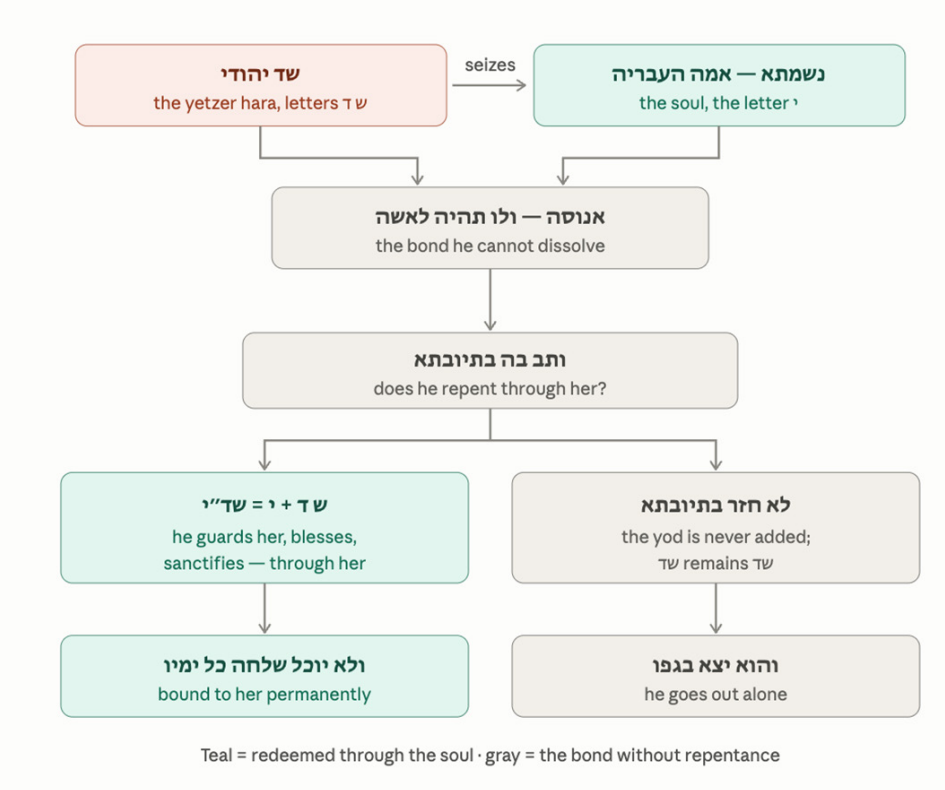


Figure 1: The transformation of shed yehudi into Shaddai in the Ra'aya Meheimna (Zohar III 277a–b). The yod added to דש is not the demon's own; it is the soul he coerced (nishmata yod, the amah ivriyah).

The sublimation is the loss, not the moral accounting

The contrast with the Zohar's other great feminine figure sharpens this. In the *Sava de-Mishpatim* passage the Torah appears as a maiden concealed in a palace who reveals her face to her lover at her own initiative and withdraws again. There, the woman's agency *is* the hermeneutic principle: the interpreter waits, and what he receives is given.

In Ki Tetze the woman has already been taken, and everything the passage achieves is achieved downstream of that. The two texts are the two halves of an ethics of reading — one describing how meaning should be approached, the other what is owed once it has been seized.

And this is exactly what the case report does

That is the paper's central claim, and I want it stated without hedging. The mechanism by which a violated woman becomes the Shekhinah is the same mechanism by which a patient becomes a teaching point. Both are *meshalim*. Both ascend. Both produce something of real value that could not have been produced otherwise. And both generate a surplus that the *nimshal* cannot absorb — and the surplus, in both cases, is the person.

A system in which a patient's suffering becomes valuable chiefly as the occasion of a publication has done something structurally identical — with this difference, which is not in medicine's favour: the Zohar at least specifies what the patient retains when the clinician fails her. I have described the specific hazard of antinomian energies that become dangerous precisely when they acquire legitimacy [56]; the licensed sublimation of a patient into a symbol is the clinical instance.

The Two Verses of Discharge

We can now state the clinical payoff of the Deuteronomic paradox. Deuteronomy gives two obligations of release, and they are opposite. Both are true of clinical practice, and the tension between them *is* the practice.

וְהָיָה֙ אִם־לֹ֣א חָפַ֔צְתָּ בָּ֖הּ וְשִׁלַּחְתָּ֣הּ לְנַפְשָׁ֑הּ וּמָכֹר֙ לֹא־תִמְכְּרֶ֣נָּה בַּכֶּ֔סֶף לֹא־
תִתְעַמֵּ֖ר בָּ֑הּ תַּ֚חַת אֲשֶׁ֣ר עִנִּיתָ֔הּ {ס}

Then, should you no longer want her, you must release her outright. You must not sell her for money: since you had your will of her, you must not enslave her.

Le-nafshah: Release Without Residue

Deut 21:14 requires that the woman be sent *le-nafshah* — to her own soul, her own selfhood, her own disposal. The halakhic tradition reads this as unconditional manumission [57]. She may not be sold; she may not be retained in service; the claim is extinguished entirely.

The clinical failure here is not discharging too readily. It is discharging while retaining the claim.

We keep patients. We keep them in our formulations, our diagnostic categories, our follow-up schedules, our sense of ownership over outcomes. We keep them in the identity we conferred — the patient told at twenty-six that she had a condition she does not have, still organizing her life around it at forty. We keep them in our narratives, which is what a case report is. The obligation of *le-nafshah* is that at a certain point the person is owed her own account of herself back, unencumbered by ours.

Kleinman's distinction between disease and illness, and Frank's account of the ill person reclaiming narrative authority from medicine, describe the same obligation from the other side [58,59]. Charon's narrative medicine supplies the method [60]. What Deuteronomy adds is that it is an *obligation*, not a courtesy, and that it is owed specifically *taḥat asher innitah* — because of what the encounter cost her.

Lo Yukhal Shallḥah: The Patient Who Cannot Be Discharged

וְנָתַן הָאִישׁ הַשֹּׁכֵב עִמָּהּ לַאֲבִי הַנַּעֲרָ חֲמִשִּׁים כֶּסֶף וְלוֹ־תִהְיֶה לְאִשָּׁה תַּחַת אֲשֶׁר עִנָּהּ לֹא־יוּכַל שַׁלְּחָהּ כָּל־יָמָיו: {ס}

the man who lay with her shall pay the young woman's father fifty [shekels of] silver, and she shall be his wife. Because he has violated her, he can never have the right to divorce her.

Deut 22:29 requires the opposite, and it is the harder verse.
The clinical form of this obligation has a name in the medical ethics literature: non-abandonment. Quill and Cassel argued three decades ago that it is a central and undertheorized physician obligation — a commitment to continuity that persists when cure has failed, when the patient's choices are ones, we would not make, and when there is nothing further to offer but presence [61]. The literature has not developed as far as it should have.

Deuteronomy grounds the obligation somewhere unexpected. *Lo yukhal shallḥah kol yamav* — **taḥat asher innah**. He may not send her away *because he afflicted her*. The obligation of non-abandonment is generated not by benevolence, not by contract, not by professional virtue, but by **the harm the licensed act caused**.

That is a considerably sharper basis than the one we currently use, and it changes what falls under it. The patient whose treatment injured him. The patient whose diagnosis, correctly made, destroyed something. The patient we held. The patient we examined under anesthesia. The patient whose nineteen years of no-shows we terminated. In each, Deuteronomy's grounds apply with more force than our own, because the obligation attaches precisely where the licence was exercised.

The Zoharic negative branch adds a provision we lack entirely, and it is worth naming as a distinct principle. **The patient's standing does not depend on our moral recovery.** A clinician who never acknowledges the harm, never returns to it, never repairs anything, does not thereby diminish the patient's entitlement — he diminishes only himself. This matters because the reverse assumption is quietly embedded in how institutions handle adverse events: the disclosure conversation, the apology, the root-cause analysis are all structured around the institution's process of coming to terms, with the patient positioned as the audience for that process. The Zohar's arrangement is the opposite. She and her children remain with her master regardless; he goes out alone. The remedy is hers by right, not by our contrition.

Knowing Which Verse Governs

Both verses are in force and they command opposite things. The clinical skill — and I do not think we currently teach it — is knowing which one governs a given patient.

Some patients must be released entirely, with the claim extinguished, because continued clinical attention has become the injury. Some may not be released at all, whatever the pathway or the funding or the discharge criteria say, because of what was done while caring for them.

Getting this backward produces the two characteristic failures of contemporary practice. We release those we should hold — the discharge from the practice, the transition of care that never lands, the referral into a void — and we hold those we should release, in surveillance, in follow-up, in the identity we assigned. Both are failures of the same underdeveloped faculty.

Implications for Practice

I set these out as propositions rather than as a protocol, since the argument does not license a protocol.

Index the licence to the reason

Before any act that exceeds ordinary social permission, the operative question is not "am I permitted?" but "is this act being performed for this patient's benefit under *these* conditions?" The Ramban's constraint: a permission granted because of a drive does not extend beyond that drive.

Restore interposition

Treat delay as a moral instrument and a diagnostic one. Defend the second visit before the label. Defend the diagnostic pause on grounds of the clinician's state, not just the evidence base. The eleven-second finding [33] should be read as an ethical datum, not a communication-skills one.

Practise *ve-eino mon'ah*

In defined situations — after bad news, after a licensed act that

caused harm — presence without intervention is the obligation, and it belongs to the person who caused the occasion, not to a consulted service.

Do not let gratitude answer the question

Retrospective endorsement of coercive treatment is a good outcome and not an ethical validation [3,4]. Justification must be established contemporaneously, on contemporaneous grounds, and documented as such.

Apply *lo ta'aseh davar*

Where a patient's conduct contributed to their condition, the clinical system's claim is already discharged by the condition itself. Secondary penalty — in attention, in tone, in the adjectives entered into the record — is not justice [40].

Watch the nimshal

When writing a patient up, name explicitly what the formulation does not absorb. The surplus is where the patient still is [9,42].

Ask which verse governs

At every discharge: is this a *le-nafshah* release, requiring that the claim be extinguished entirely — or is this a patient I may not send away, because of what my licensed act cost them [57,61]?

Decouple the patient's remedy from the clinician's repair

What a patient is owed after harm is not contingent on whether the clinician or the institution completes a process of acknowledgement. Disclosure and root-cause analysis are obligations we hold; they are not the mechanism by which the patient's entitlement arises [61-64].

Limitations

This is a hermeneutic and conceptual paper, not an empirical one, and its clinical propositions are untested. The vignettes are composites with details altered and are illustrative rather than evidentiary.

Four further cautions. First, the analogy between the Deuteronomic captive and the contemporary patient is structural, not equivalential; a consenting adult in a consulting room is not a woman seized in war, and nothing here should be read as flattening that difference. Second, I have argued throughout against attributing modern psychological theory to pre-modern exegetes, and the same restraint applies to my own readings — the Netziv addressed *dinei knasot*, not clinical ethics, and the transfer is mine and requires its own defense.

Third, the Zoharic material is drawn from the printed Ra'aya Meheimna; the textual and authorial complexities of that stratum are substantial [47,48] and a specialist treatment would need to engage them more fully than a clinical paper permits. Fourth, and specifically: my reading of the negative branch in §10.2 takes the subject of *ve-i lo ḥazar bi-teyuvta* to be she'd rather than the soul. The classical commentary on the passage appears to assume this, and the Exodus prooftext — *ve-hu yetze be-gappo*, the departing party — supports it grammatically. But the antecedent is not stated, and a reading that assigns the failure to repent to the soul would invert the asymmetry I have built on it. Readers should verify against their own text before adopting the argument of §10.3 and §11.2.

Conclusion

Deuteronomy places two coerced women in consecutive chapters and gives them opposite endings, and every subsequent tradition had to choose which one to build on. The *peshat* commentators built on the release — and produced from it an ethics of indexed permission, of interposed delay, of compelled witness, and of the fixed moral character of an origin. The mystics built on the non-release — and produced from it a theology of a God who cannot leave, together with a provision, easily missed, that the wronged party's standing survives the wrongdoer's refusal to return.

Clinical medicine needs all this and currently theorizes none of it. We hold a licence that suspends ordinary constraint, and we have no apparatus for re-entry. We have abolished the interval that was the tradition's chief instrument for a desire it could not forbid. We interrupt at eleven seconds a grief that Deuteronomy legislated a month for. We let gratitude retroactively justify coercion in a way the Netziv would have recognized as a category error. We add penalty to patients already penalized by their illness. We make what patients are owed after harm depend on our own institutional processes of acknowledgement. And we sublimate the people in front of us into teaching points by exactly the mechanism the Zohar used to turn a violated girl into the Shekhinah — with the same brilliance, the same real gain, and the same characteristic loss.

The Netziv, working the same verses without any mystical vocabulary at all, supplies what the ascent lacks. The origin of an encounter is not purified by its ending. The person on whom the meaning was built is owed nothing further.

Be-sitrei Torah its lan le-hamshil mashal. Make the parable — the formulation, the case, the teaching point. And then go back to the field, where there is still someone standing.

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