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# *"My Heart Tells Me": " And my Heart Tells me*
## *Rashi's Intuitive Hermeneutic and the Epistemology of Clinical Intuition*

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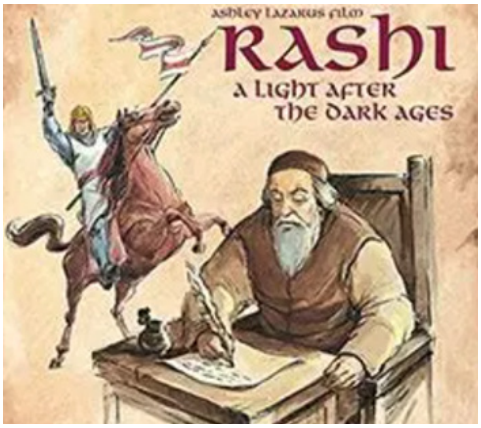


### *Abstract*

*This essay examines Rashi's hermeneutical declaration ve-libi omer li ("my heart tells me") in his commentary on the priestly ephod (Exodus 28:4) and the Lubavitcher Rebbe's theological elaboration of this moment, arguing that together they articulate an epistemology of embodied intuition directly applicable to clinical medicine.*

*Through close textual analysis of Rashi's commentary, the Rebbe's discourses in Likkutei Sichot (Volumes 26, 31) and related Hasidic sources, alongside contemporary scholarship on the ephod's material construction and cultic function, this study develops a phenomenological framework for understanding clinical intuition as sanctified knowledge. The analysis integrates classical Jewish exegetical sources with modern medical literature on diagnostic reasoning, clinical judgment, and the role of intuition in expert practice.*

*Rashi's appeal to cardiac intuition when transmitted textual sources prove insufficient establishes a paradigm wherein the "purified heart" (lev tahor)—refined through intellectual rigor, moral formation, and contemplative presence—becomes a legitimate organ of knowledge. The Rebbe's theology of the ephod as the integration of inner awareness (choshen-consciousness) with outer service (ephod-consciousness) provides a structural*

*model for the physician's dual consciousness: empathic attunement bound inseparably to technical competence. Contemporary medical literature on dual-process diagnostic reasoning, pattern recognition, and the tacit dimensions of clinical expertise converges with this theological framework, suggesting that reliable clinical intuition requires cultivation analogous to the tradition's emphasis on the lev mevin da'at ("heart that understands knowledge").*

*The recovery of ve-libi omer li as a legitimate dimension of clinical epistemology challenges medicine's residual Cartesian dualism without abandoning scientific rigor. This theological tradition offers contemporary medicine a framework for cultivating and validating intuitive judgment—recognizing that when evidence-based protocols prove insufficient, the physician's disciplined intuition, grounded in extensive knowledge and ethical formation, becomes essential for addressing the irreducible particularity of each patient's suffering. The examination room, understood through this lens, becomes a covenantal space where technical excellence and compassionate presence integrate, transforming clinical encounter into sacred work witnessed by divine presence (Shekhinah).*

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## Introduction

### When Sources Fall Silent

In his commentary on Exodus 28:4, Rashi confronts a lacuna in transmitted knowledge regarding the priestly ephod. His response—ve-libi omer li ("my heart tells me")—represents a radical epistemological shift: when textual authority proves insufficient, a sanctified intuition emerges as a legitimate source of knowledge [1]. This moment of hermeneutical courage, later elaborated by the Lubavitcher Rebbe in his interpretation of the ephod's theological significance, establishes a paradigm for understanding embodied knowledge that extends beyond biblical exegesis into the clinical encounter itself [2].

This essay argues that Rashi's appeal to cardiac intuition, as interpreted through the theology of the ephod, provides a framework for understanding the physician's intuitive knowledge— that irreducible dimension of clinical judgment that arises when empirical data proves insufficient, when the patient's suffering exceeds what laboratory values can capture, when "my heart tells me" becomes not a retreat from rigorous thinking but its apotheosis.

### Rashi's Confession: The Hermeneutics of Sacred Uncertainty

Rashi's declaration—lo shamati ve-lo matzati be-varaita perushav, ve-libi omer li—is unprecedented in its vulnerability. The great exegete openly admits the absence of transmitted authority (baraita) yet proceeds to offer an interpretation grounded not in textual precedent but in interior conviction. He describes the ephod as "fastened to him from behind, like the apron (sinar) worn by a noblewoman (isha chashuvah) when she rides a horse [1]."

The radical nature of this move cannot be overstated.

Rashi, whose method typically privileges pshat (plain meaning) anchored in rabbinic tradition, here ventures into territory where intuition becomes hermeneutical authority [3]. Yet this is not arbitrary subjectivity. The Hebrew lev (heart) in rabbinic discourse signifies not mere emotion but the synthesis of intellect and moral discernment—what later Hasidic thought will call mochin (intellective consciousness) integrated with middot (character traits) [4].

The image Rashi invokes—the noblewoman's riding apron—suggests disciplined grace, the dignity of concealed service. The ephod, covering the priest's back, represents that dimension of sacred service oriented away from spectacle, toward humility. It is the hidden aspect of avodah (divine service), the posture of one who serves without seeking recognition [5].

## Archaeological and Textual Evidence for the Ephod

Modern scholarship has extensively examined the ephod's material construction and cultic function. Homan's comprehensive analysis demonstrates that the ephod represents a complex garment incorporating gold, blue, purple, and crimson yarns with fine twisted linen, constructed through sophisticated weaving techniques [6]. The biblical description in Exodus 28:6-14 specifies that it consisted of two pieces—front and back—joined at the shoulders with onyx stones set in gold filigree settings, each stone engraved with the names of six tribes of Israel [7].

Propp's philological study traces the term ephod through its various biblical usages, noting its evolution from a simple linen garment worn by Samuel (1 Samuel 2:18) to the elaborate High Priestly vestment, and even to cultic objects that appear to function as oracular devices [8]. This semantic range suggests that the ephod occupied a unique position in Israelite cult—simultaneously a garment, a symbol of priestly authority, and a medium of divine communication [9].

The archaeological record provides additional context. Excavations at various Levantine sites have uncovered votive figurines and reliefs depicting deities and priests wearing elaborate apron-like garments, suggesting that Rashi's intuition about the ephod's apron-like character may reflect broader ancient Near Eastern priestly vestimentary traditions [10]. Hurowitz notes that such garments in Mesopotamian contexts often symbolized the mediating role between divine and human realms [11].

## The Rebbe's Theology: The Ephod as Integration of Wisdom and Compassion

The Lubavitcher Rebbe, in his exposition on Parshat Tetzaveh (Likkutei Sichot, Vol. 26), transforms Rashi's hermeneutical moment into a theological principle. The Rebbe identifies the lev (heart) that speaks to Rashi not as emotional impulse but as da'at—the synthetic faculty that unifies chokhmah (wisdom) and binah (understanding) with chesed (loving-kindness) and gevurah (strength) [2].

The Rebbe draws a structural parallel between two priestly garments:

- The choshen (breastplate): worn over the heart, facing forward, representing inner awareness, compassion, and direct encounter
- The ephod (apron): fastened behind, representing external action, humility, and service concealed from view

Yet these are not separate domains. The Torah specifies that the choshen must be attached to the ephod through golden chains and rings (Exodus 28:22-28) [7]. This architectural detail becomes, for the Rebbe, a theological principle: inner awareness must remain bound to outer service, compassion must inform action, the heart's wisdom must guide the hand's work [2].

The Rebbe's reading of Rashi's noblewoman imagery is particularly instructive. The woman riding the horse represents the soul's mastery over the body, spiritual consciousness directing material power. The apron—practical, functional, dignified—suggests that true nobility lies not in ostentation but in the sanctification of ordinary service. The horse, symbol of worldly strength, is guided by one whose garment signifies both protection and humility [2].

Wolfson's phenomenological analysis of Hasidic hermeneutics illuminates the theological depth of the Rebbe's interpretation. In Hasidic thought, garments (levushim) function as mediating structures between concealed essence and revealed manifestation—the ephod thus becomes not merely a physical vestment but a symbol of the dialectical relationship between divine transcendence and immanence [12]. The priest's body, clothed in sacred vestments, becomes the site where heaven and earth meet, where the infinite contracts itself to become accessible to finite human consciousness [13].

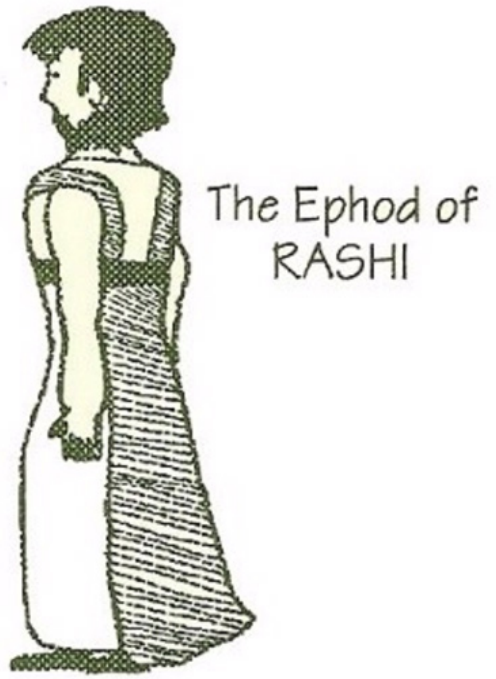



**Illustration by Channa Lockshin Bob, from the author's book "Exodus"**

## The Heart as Epistemological Organ: Beyond Cartesian Dualism

The Rebbe's interpretation of Rashi's ve-libi omer li challenges the post-Cartesian epistemology that has dominated Western medicine since the seventeenth century. Descartes' radical separation of res cogitans (thinking substance) from res extensa (extended substance) created a model of knowledge in which certainty derives solely from rational demonstration, while embodied knowing—sensation, intuition, affective attunement—becomes epistemologically suspect [14].

In contrast, the tradition flowing from Rashi through the Rebbe articulates an integrated epistemology in which the heart functions as an organ of perception. This is not anti-rational romanticism. Rather, it recognizes that certain forms of knowledge—particularly knowledge of persons, of suffering, of meaning—require faculties beyond ratiocination alone. The heart, in this framework, is lev mevin da'at—"a heart that understands knowledge" (Deuteronomy 29:3)—the synthesizing capacity that integrates data with wisdom, observation with compassion, technique with presence [4].

Elliot R. Wolfson's phenomenology of mystical hermeneutics elaborates this epistemology with philosophical precision. In Through a Speculum That Shines and Language, Eros, Being, Wolfson demonstrates that mystical interpretation is not merely cognitive but transformative—the interpreter's being becomes the medium through which revelation occurs [15,16]. The heart, as Wolfson shows in his reading of kabbalistic exegesis, is not merely the receptor of revelation but its co-creator. Torah thinking happens through the embodied, transformed self of the interpreter [16].

Contemporary phenomenological philosophy provides additional frameworks for understanding this embodied epistemology. Merleau-Ponty's concept of le corps propre (the lived body) challenges the Cartesian reduction of the body to mere mechanism, arguing instead that perception and knowledge are fundamentally embodied processes [17]. The physician's diagnostic acumen, in this framework, involves not merely cognitive processing of data but a whole-body attunement to the patient's suffering—what Merleau-Ponty calls "intercorporeality"[18].

## The Ephod in Maimonidean Halakhah: Form and Function

Maimonides provides the most systematic halakhic treatment of the priestly garments in Hilchot Klei Ha-Mikdash 9:9-11 [19]. His description emphasizes the ephod's material construction: it resembles a woman's apron (sinar), extending from below the elbows to the heels, with a cheshev (woven belt) extending from it. Two shoulder straps rise from behind, pass over the shoulders, and hang down in front over the chest, with gold settings containing onyx stones inscribed with the tribal names [19].

The Rebbe notes that Maimonides' formalism—his attention to precise measurements, materials, and construction techniques—represents one pole of understanding the ephod: its status as a material object governed by halakhic specifications [2]. Yet even Maimonides acknowledges that the priestly garments effect atonement (mechaperin), suggesting that their function transcends mere adornment [20]. The ephod specifically atones for idolatry (avodah zarah), linking the priest's garb to the people's spiritual state [21].

This dual nature—material object and spiritual instrument—reflects the ephod's liminal status. Levine's cultic analysis demonstrates that the High Priest's vestments transform him into a sacred person, marking the boundary between the profane and holy realms [22]. The ephod, bearing the names of all twelve tribes on its shoulder stones, makes the priest into a living representation of the entire community, bearing their identity and burden before God [23].

Modern scholarship on priestly vestments emphasizes their role in constructing sacred identity. Fleming notes that ancient Near Eastern priestly garments functioned as "boundary markers" that visually distinguished sacred personnel from the laity while simultaneously mediating between human and divine spheres [24]. The ephod's elaborate construction—requiring specialized artisanship in goldwork, weaving, and stone engraving—marks it as qodesh (sacred), withdrawn from ordinary use and dedicated to cultic service [25].

## The Physician's Heart: Clinical Intuition as Sacred Epistemology

The relevance of this hermeneutical tradition to clinical medicine becomes evident when we consider the structure of the diagnostic encounter. The physician approaches the patient armed with empirical tools: laboratory studies, imaging, algorithmic decision-trees derived from evidence-based protocols. Yet experienced clinicians recognize that diagnosis and therapeutic decision-making frequently exceed what empirical data alone can provide [26].

Contemporary medical literature increasingly acknowledges the role of clinical intuition in diagnostic reasoning. Monteiro and colleagues define clinical intuition as "direct knowing of something without conscious use of reasoning," emphasizing its role in expert clinical judgment [27]. Norman and Eva's dual-process theory proposes that diagnostic reasoning involves both analytical (systematic, rule-based) and non-analytical (intuitive, pattern-recognition) processes [28]. Experienced physicians develop sophisticated pattern recognition that operates below the threshold of conscious awareness, allowing rapid integration of multiple data streams [29].

Yet medical education has historically struggled to legitimate or cultivate this intuitive dimension. Cristancho and colleagues observe that medical training emphasizes explicit, algorithmic knowledge while often failing to provide frameworks for developing or validating intuitive judgment [30]. The result is a tacit epistemological hierarchy that privileges quantifiable evidence while treating intuition as suspect—precisely the Cartesian dualism that Rashi and the Rebbe's tradition challenges [31].

**Consider the Phenomenology of Clinical Intuition The Patient Whose Laboratory Values Appear Normal, Yet Something In Their Presentation—A Subtle Affect, A Quality of Fatigue, an Inchoate Expression Of Suffering—Tells The Physician That Something Is Profoundly Wrong.** Here, ve-libi omer li becomes not caprice but attunement to dimensions of illness that resist quantification. Timmermans and Berg's ethnographic studies of clinical practice document numerous instances where experienced physicians override normal test results based on clinical gestalt, often preventing missed diagnoses [32].

**The Moment When Competing Treatment Protocols Appear Equally Justified By Evidence, Yet The Physician's Integrated Awareness of This Particular Patient's Values, Fears, Social Context, And Life Trajectory Suggests one Path Over Another.** This is not arbitrary preference but wisdom born of presence—the da'at that synthesizes knowledge with understanding. Epstein's work on mindful practice emphasizes that clinical decision-making requires not merely technical knowledge but attunement to the patient's unique narrative and circumstances [33].

The Recognition That A Patient's Physical Symptoms Encode Existential Suffering, That Their Pain Exceeds Its Physiological Substrate, That Healing Requires Addressing The Person's Narrative and Not Merely Their Pathology. This perception demands the physician's heart—the capacity to hear what is spoken beneath words, to perceive suffering that eludes algorithmic assessment. Charon's work on narrative medicine demonstrates that attending to patients' stories reveals dimensions of illness invisible to biomedical reductionism [34].

## The Ephod and the Physician's Dual Consciousness

The Rebbe's theology of the ephod as the integration of choshen (inner awareness) and outer service provides a structural model for the physician's dual consciousness. The physician must simultaneously maintain:

**The Choshen-Consciousness:** Empathic attunement, affective resonance with the patient's suffering, the capacity to perceive the patient as person rather than case. This is the forward-facing dimension of care—direct encounter, compassionate presence, the willingness to be affected by the patient's vulnerability. Halpern's research on clinical empathy demonstrates that physicians who maintain affective attunement to patients' suffering provide more effective care while experiencing less burnout [35].

**The Ephod-Consciousness:** Technical competence, diagnostic rigor, therapeutic intervention. This is the concealed dimension of service—the unglamorous

work of careful examination, methodical differential diagnosis, precise treatment execution. It lacks the dramatic visibility of emergency intervention yet constitutes the disciplined foundation of healing. Gawande's surgical writing emphasizes that technical mastery requires years of deliberate practice, attention to detail, and commitment to continuous improvement [36].

**The Torah's Architectural Specification—That Choshen and Ephod Must Remain Bound Together—Becomes A Principle of Clinical Practice:** Technical excellence without compassionate presence produces efficient but dehumanized care [37]. Empathic attunement without technical competence produces well-intentioned but ineffective intervention. The physician's vocation demands both dimensions integrated [38].

The noblewoman's riding apron, in this reading, becomes an image of the physician's disciplined authority: mastery over the powerful forces of medical knowledge (the horse) exercised with dignity, humility, and grace. The apron fastened behind suggests that the physician's deepest work—the integration of knowledge and compassion, the synthesis of technical skill and human presence—occurs in the hidden dimension, in the moment-by-moment attunement that the patient may never consciously recognize but nevertheless constitutes the substance of healing [39].

## When the Heart Speaks: The Epistemology of Clinical Presence

Rashi's confession—lo shamati ve-lo matzati—describes a recognizable clinical phenomenon: the moment when established protocols prove insufficient, when the patient's situation exceeds standard algorithms, when transmitted knowledge reaches its limit [1]. In such moments, the physician trained solely in evidence-based formulas faces paralysis. But the physician who has cultivated what the tradition calls lev tahor (a pure heart)—consciousness refined through study, experience, ethical formation, and contemplative presence—discovers another resource [40].

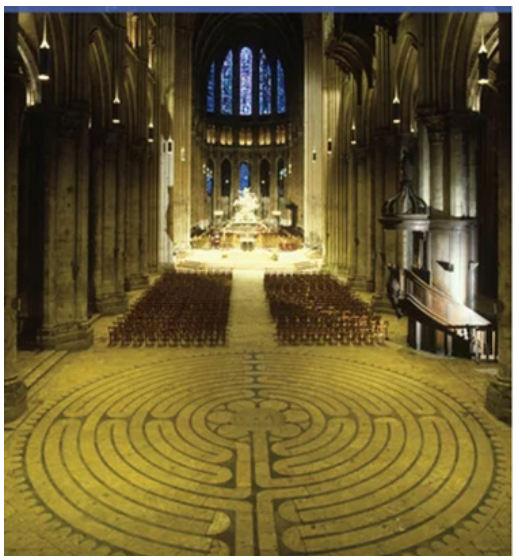
**This is not a License for Arbitrary Decision-Making or a retreat into Pre-Scientific Mysticism. Rather, it Recognizes that Medical Knowledge has Multiple Epistemological Registers:**

**Empirical Knowledge:** Derived from controlled studies, statistical analysis, reproducible observation. This constitutes the necessary foundation of scientific medicine, the inheritance (shamati) of transmitted research and clinical trials [41]. Evidence-based medicine has dramatically improved clinical outcomes by standardizing care according to best available research [42].

**Pattern Recognition:** The fruit of clinical experience, whereby the physician's perceptual apparatus becomes attuned to configurations that escape algorithmic capture. This is knowledge earned through years of attentive practice. Ericsson's research on expertise demonstrates that expert performance emerges through thousands of hours of deliberate practice with immediate feedback [43].

**Intuitive Integration:** The synthetic faculty that emerges when cognitive data, experiential wisdom, and empathic attunement converge in a moment of clarity regarding what this patient needs. This is ve-libi omer li—not groundless feeling but illuminated judgment. Kahneman and Klein's work on intuitive expertise shows that reliable intuition develops in environments with stable patterns and immediate feedback, precisely the conditions of extensive clinical practice [44].

The Rebbe's reading of Rashi establishes this intuitive knowing not as inferior to textual authority but as a legitimate, indeed necessary, complement to it [2]. Just as Rashi's heart became the organ through which understanding emerged when sources fell silent, so the physician's disciplined intuition becomes the faculty through which clinical wisdom emerges when evidence proves ambiguous or insufficient [45].



**The Purified Heart: Cultivating Clinical Intuition**

The tradition's emphasis on the lev tahor (pure heart) suggests that intuition worthy of authority requires cultivation. The heart that speaks reliably is not the heart of untutored impulse but the heart purified through:

**Intellectual Rigor:** Rashi's intuition emerges only after exhaustive search of transmitted sources [1]. The physician's intuition becomes reliable only after disciplined mastery of medical science. There is no shortcut past technical competence to intuitive wisdom. Malterud emphasizes that clinical intuition must be grounded in extensive biomedical knowledge and clinical experience to be trustworthy [46].

**Moral Formation:** The Rebbe's emphasis on da'at as the integration of intellect and character suggests that clinical intuition requires ethical refinement [2]. The physician must cultivate humility, self-awareness, and commitment to the patient's good rather than professional ego. Pellegrino and Thomasma's virtue ethics framework argues that clinical judgment is fundamentally shaped by the physician's moral character [47].

**Contemplative Presence:** The capacity to listen—to the patient's words, to their embodied expression, to the silence between symptoms—demands a quality of attention that resists the fragmentation and velocity of contemporary medical practice. This is shema (hearing) as spiritual discipline. Epstein and Krasner's research demonstrates that mindfulness training enhances physicians' capacity for attentive listening and reduces burnout [48].

Experiential Wisdom: Like Rashi's lifetime of textual study that prepared the ground for his intuitive leap, the physician's capacity for reliable intuition develops through years of attentive practice, reflection on clinical experiences, and willingness to learn from both successes and failures [49]. Schön's concept of "reflective practice" emphasizes that professional expertise develops through systematic reflection on experience, not merely accumulation of cases [50].

The Covenantal Space: Where Shekhinah Dwells

The deepest dimension of this theology emerges in the Rebbe's understanding of the priestly garments as creating a space where divine presence can dwell [2]. The physician-patient encounter, understood through this framework, becomes not merely a technical transaction but a makom kadosh (holy space)—a sanctuary where Shekhinah manifests [51].

This sacralization of the clinical encounter does not sentimentalize medicine or retreat from its scientific foundations. Rather, it recognizes that healing involves dimensions beyond physiological restoration: the restoration of meaning, the affirmation of dignity, the accompaniment of suffering, the sacred witnessing of vulnerability [52]. When the physician brings both technical excellence (ephod) and compassionate presence (choshen) into integrated awareness, the examination room becomes a threshold space—the modern equivalent of the Temple's Holy Place [53].

In this space, ve-libi omer li becomes not merely diagnostic intuition but prophetic perception—the capacity to hear what Levinas calls "the face of the Other" making its ethical demand, to perceive the patient's suffering as a call that precedes and exceeds clinical categories [54]. The physician's heart, like Rashi's, becomes the medium through which understanding emerges when protocols prove insufficient, when the patient's humanity exceeds medical taxonomy, when healing requires presence that transcends technique [55].

Kearney's work on the inner life of physicians emphasizes that sustaining this quality of presence requires the physician to acknowledge and process their own vulnerability, grief, and moral distress [56].

The physician cannot maintain choshen-consciousness—open-hearted attunement to suffering—without attending to their own need for renewal and meaning-making [57]. The Rebbe's insistence on the binding of choshen to ephod suggests that authentic service requires the integration of one's own inner work with outer action [2].

## Conclusion

Toward an Embodied Epistemology of Medicine

Rashi's confession—ve-libi omer li—and the Rebbe's theology of the ephod together articulate an epistemology urgently needed in contemporary medicine: an embodied knowing that integrates empirical rigor with intuitive wisdom, technical competence with compassionate presence, scientific method with sacred attentiveness [1,2].

This tradition challenges medicine's residual Cartesianism without abandoning its scientific foundations [58]. It calls physicians to cultivate not merely technical expertise but the purified heart—the lev mevin da'at—capable of perceiving dimensions of suffering and pathways to healing that resist algorithmic capture [59].

The physician who approaches each patient with both the choshen of empathic awareness and the ephod of disciplined service, who masters scientific knowledge yet remains open to intuitive insight, who recognizes that "my heart tells me" represents not retreat from rigor but its fulfillment in wisdom—such a physician embodies the integration Rashi modeled and the Rebbe theologized [60].

In an era of increasing medical bureaucratization, algorithmic standardization, and the reduction of healing to efficiency metrics, the recovery of ve-libi omer li as a legitimate—indeed essential—dimension of clinical knowledge becomes an act of resistance and renewal [61]. It reclaims medicine as a vocation that demands the whole person: mind, heart, and presence integrated in service of the suffering other [62].

The examination room, understood through this theological lens, becomes what it has always potentially been: a Mishkan, a dwelling place for divine presence, where healer and patient together participate in the sacred work of restoration, witnessed by the Shekhinah who dwells in spaces of compassionate attentiveness, where "my heart tells me" becomes the physician's prayer and the patient's hope [51,63].

## References


1. Rashi (1951) Commentary on Exodus 28:4, s.v. V'ephod. In: Mikraot Gedolot. Brooklyn: Otzar Hasefaria https://www.sefaria.org/Rashi_on_Exodus.28.4.5?lang=bi&with=Otzar%20La%27azei%20Rashi&lang2=bi.
2. Schneerson MM. Parshat Tetzaveh I (1958) In: Likkutei Sichot,. Brooklyn: Kehot Publication Society 26
3. Kamin S. Rashi's, Immanuel, peshat (1979) exegetical categorization in respect to the distinction between 9:16-32.
4. Loewenthal N (1997) The concept of da'at in the early Hasidic system. In: Hasidism reappraised. Littman Library 137-148.
5. Milgrom J. Leviticus (1979) a new translation with introduction and commentary. New Haven: Yale University Press 1-16.
6. Homan MM. (2002) To your tents, O Israel! The terminology, function, form, and symbolism of tents in the Hebrew Bible and the ancient Near East. Leiden: Brill 156-89.
7. Propp WH. Exodus (2006) 19-40: a new translation with introduction and commentary. New Haven: Yale University Press 431-47.
8. Propp WH (2006) The meaning of the ephod. In: Exodus 19-40: a new translation with introduction and commentary. New Haven: Yale University Press 441-44.
9. Haran M. (1954) The ephod according to biblical sources. Tarbiz 24: 380-391.
10. Mettinger TND (1995) No graven image. Israelite aniconism in its ancient Near Eastern context. Stockholm: Almqvist & Wiksell p. 185-97.
11. Hurowitz VA (1985) The priestly account of building the tabernacle. J Am Orient Soc 105: 21-30.
12. Schneerson MM, Parshat Tetzaveh (1986) In: Likkutei Sichot,. Brooklyn: Kehot Publication Society 31.
13. Schneerson MM. Parshat Tetzaveh/Zachor (1992) In: Torat Menachem 5726, Brooklyn: Kehot Publication Society 2 :234-41.
14. Schneerson MM (1987) In: Igrot Kodesh,. Brooklyn: Kehot Publication Society 2: 447-449.
15. Wolfson ER (1993) The mystical significance of Torah-study in German pietism. Jewish Q Rev 84:43-78.

16. Magid S (2018) From theosophy to mitnagdism: the Hatam Sofer's evolving relationship with Kabbalah. In: Brown B, Gellman U, Heilman S, Sagiv G, editors. Hasidism: a new history. Princeton: Princeton University Press 449-468.
17. Leder D (1990) The absent body. Chicago: University of Chicago Press https://installations2010.wordpress.com/wp-content/uploads/2010/09/theabsentbody.pdf.
18. Wolfson ER (1994) Through a speculum that shines: vision and imagination in medieval Jewish mysticism. Princeton: Princeton University Press https://archive.org/details/throughspeculumt0000wolf.
19. Wolfson ER (2005) Language, eros, being: Kabbalistic hermeneutics and poetic imagination. New York: Fordham University Press https://www.jstor.org/stable/27564307.
20. Merleau-Ponty M (2002) Phenomenology of perception. Smith C, translator. London: Routledge https://www.taylorfrancis.com/books/mono/10.4324/9780203994610/phenomenology-perception-maurice-merleau-ponty-colin-smith .
21. Weiss G (1999) Body images: embodiment as intercorporeality. New York: Routledge https://www.routledge.com/Body-Images-Embodiment-as-Intercorporeality/Weiss/p/book/9780415918039.
22. Maimonides M, Hilchot Klei HaMikdash (2004) In: Mishneh Torah. New Haven: Yale Judaica Series 9: 9-11
23. Maimonides M. Hilchot Klei HaMikdash (2004) In: Mishneh Torah. New Haven: Yale Judaica Series 10: 4
24. Babylonian Talmud, Arachin 16 https://www.sefaria.org/Arakhin.15b.22?lang=bi .
25. Levine BA (1989) The JPS Torah Commentary: Leviticus. Philadelphia 143-152.
26. Sarna NM (1991) The JPS Torah Commentary: Exodus. Philadelphia: Jewish Publication Society 179-84
27. Fleming DE (2012) The legacy of Israel in Judah's Bible: history, politics, and the reinscribing of tradition. Cambridge: Cambridge University Press p. 267-289.
28. Jenson PP (1992) Graded holiness: a key to the priestly conception of the world. Sheffield: Sheffield Academic Press https://www.logos.com/product/10051/graded-holiness-a-key-to-the-priestly-conception-of-the-world.
29. Croskerry P (2009) A universal model of diagnostic reasoning. Acad Med 84:1022-1028.
30. Monteiro SM, Sherbino J, Sibbald M, Norman GR (2020) Critical thinking, biases and dual processing: the enduring myth of generalisable skills. Med Educ 54: 66-73.
31. Norman G, Eva K (2010) Diagnostic error and clinical reasoning. Med Educ 44: 94-100.
32. Schmidt HG, Rikers RMJP (2007) How expertise develops in medicine: knowledge encapsulation and illness script formation. Med Educ 41: 1133-1139.
33. Cristancho S, Vanstone M, Lingard L, LeBlanc C, Ott M (2013) When surgeons face intraoperative challenges: a naturalistic model of surgical decision making. Am J Surg 205:156-162.
34. Marcum JA (2004) Biomechanical and phenomenological models of the body, the meaning of illness and quality of care. Med Health Care Philos 7: 311-320.
35. Timmermans S, Berg M (2003) The gold standard: the challenge of evidence-based medicine and standardization in health care. Philadelphia: Temple University Press https://scispace.com/pdf/the-gold-standard-the-challenge-of-evidence-based-medicine-11ugepzytx.pdf.
36. Epstein RM (1999) Mindful practice. JAMA 282: 833-839.
37. Charon R (2006) Narrative medicine: honoring the stories of illness. New York: Oxford University Press https://psycnet.apa.org/record/2006-05640-000 .
38. Halpern J (2001) From detached concern to empathy: humanizing medical practice. New York: Oxford University Press https://academic.oup.com/book/5139 .
39. Gawande A (2007) Better: a surgeon's notes on performance. New York: Metropolitan Books https://www.amazon.in/Better-Surgeons-Performance-Atul-Gawande/dp/0805082115 .
40. Kleinman A (1988) The illness narratives: suffering, healing, and the human condition. New York: Basic Books
41. https://www.goodreads.com/en/book/show/312248.The_Illness_Narratives .
42. Sulmasy DP (1997) The healer's calling: a spirituality for physicians and other health care professionals. New York: Paulist Press https://archive.org/

https://archive.org/details/healerscallingsp-0000sulm.
43. Ungar-Sargon J (2025) Relational medicine, physician grief, and the sacred therapeutic space [Internet] https://jyungar.com
44. Byock I (2012) The best care possible: a physician's quest to transform care through the end of life. New York: Avery http://acdc2007.free.fr/byock2012.pdf.
45. Sackett DL (1996) Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. BMJ 312: 71-72.
46. Guyatt G, Cairns J, Churchill D, Cook D, Haynes B et al. (1992) Evidence-based medicine: a new approach to teaching the practice of medicine. JAMA 268 :2420-2425.
47. Ericsson KA (2008) Deliberate practice and acquisition of expert performance: a general overview. Acad Emerg Med 15: 988-94.
48. Kahneman D, Klein G (2009) Conditions for intuitive expertise: a failure to disagree. Am Psychol 64: 515-526.
49. Greenhalgh T (2002) Intuition and evidence—uneasy bedfellows? Br J Gen Prac 52: 395-400.
50. Malterud K (2001) The art and science of clinical knowledge: evidence beyond measures and numbers. Lancet 358: 397-400.
51. Pellegrino ED, Thomasma DC (1993) The virtues in medical practice. New York: Oxford University Press https://academic.oup.com/book/50984.
52. Epstein RM, Krasner MS (2013) Physician resilience: what it means, why it matters, and how to promote it. Acad Med 88: 301-303.
53. 53. Montgomery K (2006) How doctors think: clinical judgment and the practice of medicine. New York: Oxford University Press https://philpapers.org/rec/MONHDT.
54. Schön DA (1983) The reflective practitioner: how professionals think in action. New York: Basic Books https://raggeduniversity.co.uk/wp-content/uploads/2025/03/1_x_Donald-A.-Schon-The-Reflective-Practitioner_-How-Professionals-Think-In-Action-Basic-Books-1984_redactedaa_compressed3.pdf
55. Ungar-Sargon J (2025) Primordial silence and therapeutic presence: theodicy and the paradox of divine concealment in clinical practice. Biomed Sci Clin Res 4: 1-10.
56. Cassell EJ (2004) The nature of suffering and the goals of medicine. 2nd ed. New York: Oxford University Press https://academic.oup.com/book/6735.
57. May WF (2000) The physician's covenant: images of the healer in medical ethics. 2nd ed. Louisville: Westminster John Knox Press https://pmc.ncbi.nlm.nih.gov/
58. Levinas E (1998) Otherwise than being, or beyond essence. Lingis A, translator. Pittsburgh: Duquesne University Press https://www.dupress.duq.edu/products/philosophy6-paper.
59. Ungar-Sargon J (2025) The patient as parable: applying mystic hermeneutics to patient narratives. Advance Med Clin Res 6: 75-82.
60. Kearney M, Weininger RB, Vachon ML, Harrison RL, Mount BM (2009) Self-care of physicians caring for patients at the end of life: "being connected... a key to my survival". JAMA 301 :1155-1164.
61. Shanafelt TD, West CP, Sinsky C, Trockel M, Tutty M et al. (2022) Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2020. Mayo Clin Proc 97: 491-506.
62. Toombs SK (1992) The meaning of illness: a phenomenological account of the different perspectives of physician and patient. Dordrecht: Kluwer Academic Publishers https://pubmed.ncbi.nlm.nih.gov/3668399/.
63. Baron RJ (1985) An introduction to medical phenomenology: I can't hear you while I'm listening. Ann Intern Med 103: 606-611.
64. Berger JT (2010) The practice of medicine as being in time. Med Health Care Philos 13: 115-125.
65. Verghese A (2008) Culture shock—patient as icon, icon as patient. N Engl J Med 359: 2748-27451.
66. Branch WT Jr, Frankel RM (2016) Not all stories of professional identity formation are equal: an analysis of formation narratives of highly humanistic physicians. Patient Educ Couns 99: 1394-1399.
67. Coulehan J (1995) Tenderness and steadiness: emotions in medical practice. Lit Med 14: 222-236.