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Perspective Article

Presence, Witness, and Meaning: The Doctor and the Chaplain in the Therapeutic Space

Julian Ungar-Sargon

Clinical Director, Borra College of Health Sciences, Dominican University, River Forest IL, USA

*Correspondence

Julian Ungar-Sargon, MD, PhD

Clinical Director, Borra College of Health Sciences, Dominican University, River Forest IL, USA

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Abstract

This article examines the distinct but complementary roles of the physician and the chaplain within the therapeutic encounter, proposing a theoretical framework grounded in embodied theology, phenomenology of presence, and contemporary scholarship on interprofessional collaboration. While the modern healthcare environment privileges clinical interventions, efficiency, and biomedical outcomes, patients and clinicians alike frequently experience suffering that exceeds diagnostic categories and treatment protocols. Drawing upon the author's previous work on sacred space in therapeutic encounters, hermeneutic medicine, and the tzimtzum model of therapeutic presence, this article argues that the doctor and chaplain embody distinct vocational orientations that nevertheless converge in the shared practice of embodied presence. The physician integrates scientific healing with embodied witness of suffering, operating through clinical reasoning toward restoration of function and alleviation of harm. The chaplain inhabits spiritual accompaniment, drawing upon theological narratives and religious tradition to support spiritual coherence, moral integrity, and existential meaning. Rather than viewing these orientations as competing paradigms, the article proposes an integrated model wherein embodied presence creates a therapeutic space where healing and meaning co-emerge. Practical implications for interprofessional education, clinical practice, and healthcare system design are explored, with attention to barriers and facilitators of physician-chaplain collaboration.

Keywords

therapeutic presence, embodied theology, physician-chaplain collaboration, spiritual care, hermeneutic medicine, interprofessional practice, suffering, meaning-making, sacred space

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Introduction: The Crisis of Meaning in Modern Healthcare

Contemporary healthcare finds itself at a crossroads that is simultaneously technological and existential. The biomedical model that has driven extraordinary advances in diagnosis and treatment operates within a paradigm of scientific reductionism that can inadvertently reduce patients to collections of symptoms and laboratory values [1,2]. While we have developed remarkable capacities to extend life and ameliorate physical suffering, something essential seems increasingly absent from the healing encounter—the attention to meaning, purpose, and existential coherence that has historically been inseparable from the art of medicine [3].

This article situates the physician and the chaplain as distinct but interrelated vocational actors within the therapeutic space, drawing upon embodied theology to illuminate how each responds to suffering and meaning [4]. The fundamental question we address is not merely practical—how should doctors and chaplains collaborate?—but phenomenological and theological: What is the nature of healing presence, and how do different vocational orientations shape its expression? The modern healthcare environment often privileges clinical interventions, efficiency, and biomedical outcomes. Yet patients and clinicians alike frequently experience suffering that exceeds diagnostic categories and treatment protocols [5,6]. As Victor Frankl observed, humans are not destroyed by suffering but by suffering without meaning [7]. The challenge facing healthcare is to address not only physical pain but the existential and spiritual dimensions of illness that give suffering its particular character for each individual.

The Problem of Suffering and the Limits of Biomedicine

Suffering, as Cassell has definitively shown, is not reducible to physical pain [8]. Suffering occurs when the intactness of the person is threatened—when illness challenges identity, meaning, relationships, and the coherence of one's life narrative. Biomedicine, for all its power, operates primarily on the physical substrate of disease, often leaving the suffering person to manage existential dimensions of their illness with inadequate support. Research consistently demonstrates that between 14% and 54% of cancer patients report unmet

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spiritual needs, and that unaddressed spiritual distress is associated with poorer psychological adjustment, decreased quality of life, and even worse physical outcomes [9,10].

The recognition of this limitation has generated increasing attention to spirituality in healthcare. The Joint Commission now recognizes patients' rights to religious and spiritual care; the National Consensus Project for Quality Palliative Care includes spiritual care as an essential domain; most U.S. medical schools require content on spirituality and health [11,12]. Yet the implementation of these standards remains uneven, and the integration of spiritual care into clinical practice continues to challenge healthcare systems [13]. This article proposes that meaningful progress requires attending not merely to practical questions of collaboration but to the deeper phenomenological and theological dimensions that shape how different healers engage with suffering.

The Vocational Orientations of Doctor and Chaplain

Before examining how physician and chaplain might collaborate, we must understand the distinct vocational orientations that shape their respective practices. Vocation, in its original theological sense, refers not merely to occupation but to a calling—a fundamental orientation of one's life and work toward particular ends and in service of particular values [14]. The physician's vocation and the chaplain's vocation, while both directed toward the welfare of persons in distress, emerge from different sources, employ different methods, and aim at different (though complementary) goals.

The Physician's Vocation: Healing the Body, Witnessing Suffering

The physician's vocation is traditionally understood as healing the body, alleviating harm, and restoring function [15]. From Hippocrates onward, medicine has been defined by its commitment to the physical welfare of patients, guided by principles of beneficence and non-maleficence. The physician engages patients through scientific and clinical practice—applying knowledge of anatomy, physiology, pathology, and therapeutics to diagnose disease and restore health. Clinical reasoning, the systematic process of gathering data, generating hypotheses, and testing them against evidence, is the physician's distinctive intellectual practice [16].

Yet as I have argued elsewhere, the physician's vocation cannot be reduced to technical application of biomedical knowledge [17,18]. The authentic physician is also a witness to suffering—one who attends to the patient not merely as a biological system requiring repair but as a person experiencing illness within a particular life context. This witnessing function, though often unacknowledged in medical education, is essential to the healing relationship. When patients speak of feeling 'seen' or 'heard' by their physicians, they are describing an experience that transcends technical competence—an experience of being recognized in their full humanity by one who has power to help [19].

The concept of 'hermeneutic medicine' that I have developed proposes that authentic clinical practice involves reading the patient as a sacred text—attending not merely to symptoms and signs but to the meaning of illness within the patient's life narrative [20,21]. Just as the careful reader of Scripture discovers layers of meaning invisible to casual glance, so the hermeneutic physician attends to dimensions of patient experience that purely biomedical approaches overlook. This interpretive dimension does not replace scientific medicine but enriches it, creating space for the physician to address suffering that exceeds the purely physical.

The Chaplain's Vocation: Spiritual Accompaniment and Existential Support

The chaplain's vocation emerges explicitly from religious, spiritual, and existential concerns [22]. While the physician's primary orientation is toward the body and its functions, the chaplain's orientation is toward the soul and its needs—toward meaning, purpose, connection, and transcendence. The chaplain does not primarily seek to heal the body but to support spiritual coherence, moral integrity, and religious meaning in the face of illness, suffering, and death [23].

Professional healthcare chaplaincy has evolved significantly over recent decades, developing from a largely denominational practice serving patients of particular faith traditions to a multifaith profession that serves all patients regardless of religious affiliation or its absence [24]. Contemporary chaplains are trained in clinical pastoral education, which emphasizes reflective practice, interpersonal skills, and the ability to provide spiritual care across diverse belief systems. The chaplain draws upon theological narratives and religious tradition but also upon psychology, ethics, and communication theory to address the spiritual and existential needs of patients and families [25].

Chaplains work with the deepest questions that illness provokes: Why is this happening to me? What will happen after I die? Is there meaning in my suffering? Will I be remembered? Is there a God, and if so, will God be there for me? [26]. These questions often remain unspoken in clinical encounters focused on diagnosis and treatment, yet they profoundly shape how patients experience illness and make medical decisions. Research demonstrates that spiritual care from chaplains is associated with improved quality of life, better coping, and greater satisfaction with healthcare [27,28].

Contrasting Goals, Methods, and Frameworks

The physician and chaplain approach therapeutic encounters with different primary goals. Physicians aim at healing, ameliorating symptoms, and prolonging life; their success is measured in clinical outcomes, functional status, and survival. Chaplains focus on meaning, spiritual consolation, and existential orientation; their 'outcomes' are more difficult to quantify but include peace, hope, reconciliation, and spiritual well-being [29]. Physicians operate primarily through clinical reasoning, applying scientific evidence to particular cases. Chaplains draw upon theological narratives, ritual resources, and the wisdom of religious traditions, while also employing counseling skills that are more intuitive than algorithmic [30].

These differences are not merely superficial variations in professional practice but reflect fundamentally different frameworks for understanding human beings and their needs. The biomedical model that structures physician training emphasizes objectivity, measurable outcomes, and technical intervention. The theological frameworks that inform chaplaincy emphasize subjectivity, meaning, and relational presence [31]. Yet both professions encounter the same suffering patients, and both are called to respond with whatever resources their vocations provide. The question is whether these different vocational orientations can be integrated into a coherent approach to whole-person care.

Embodied Presence: The Shared Foundation

Despite their different vocational orientations, physicians

and chaplains share a common foundation in the practice of embodied presence. Both professions attend to the human condition through proximity, witness, and empathy. Both require the practitioner to be fully present to another person in their suffering—to enter into relationship characterized by attention, receptivity, and genuine concern for the other's welfare [32]. This shared practice of presence may provide the ground upon which meaningful collaboration can be built.

The Phenomenology of Therapeutic Presence

Therapeutic presence has been extensively theorized in the psychotherapy literature, particularly in humanistic and existential traditions [33,34]. Geller and Greenberg define therapeutic presence as 'bringing one's whole self into the encounter with a client, being completely in the moment on a multiplicity of levels—physically, emotionally, cognitively, and spiritually' [35]. This presence involves three components: availability and openness to all aspects of the other's experience, openness to one's own experience in being with the other, and capacity to respond from this experience [36].

Carl Rogers, the founder of person-centered therapy, came to view presence as foundational to the therapeutic relationship—the precondition that enables empathy, unconditional positive regard, and congruence to be effectively communicated [37]. Presence, in this understanding, is not merely being physically present but being fully available—receptive, attentive, and engaged with the totality of one's being. Research demonstrates that clients perceive therapist presence and that higher levels of perceived presence are associated with better therapeutic outcomes [38].

The phenomenological tradition provides further resources for understanding presence. Merleau-Ponty's work on embodiment suggests that presence is fundamentally bodily—we are present to others through our bodies, and our embodied being-in-the-world shapes how we perceive and respond to others [39]. Presence thus involves not merely mental attention but physical availability—the way we orient our bodies, make eye contact, modulate our voices, and create space for the other's expression. This embodied dimension of presence is particularly important in healthcare, where physical examination, touch, and bodily proximity are essential elements of practice.

Presence in Medical Practice

The application of presence to medical practice has been increasingly recognized, though it remains undertheorized in medical education [40]. Physicians who demonstrate presence—who give patients their full attention, who listen without rushing, who convey genuine concern—are perceived as more competent and trustworthy by patients [41]. Presence may be particularly important in difficult clinical situations: delivering bad news, discussing end-of-life care, or accompanying patients through serious illness where cure is impossible but care remains essential [42].

In my previous work on the tzimtzum model of therapeutic presence, I proposed that authentic presence requires a kind of contraction or withdrawal of the healer's ego, expertise, and authority to create space for the patient's own experience to emerge [43]. Just as the kabbalistic concept of tzimtzum describes God's contraction to allow creation to exist, so the physician's therapeutic tzimtzum involves setting aside the impulse to diagnose, categorize, and fix in order to be fully present to the patient as a suffering person. This is not abandonment of clinical competence but its enrichment—the physician remains available to act but first takes time to be with.

Presence in Chaplaincy Practice

Chaplaincy practice has always emphasized presence as central to spiritual care. The chaplain's primary gift is not expertise or technique but availability—the willingness to be with patients in their suffering without agenda or condition [44]. Henri Nouwen's influential concept of the 'wounded healer' suggests that it is precisely the chaplain's own experience of suffering, appropriately processed and integrated, that enables authentic presence to others in their pain [45].

Chaplaincy presence is oriented not toward healing the body but toward supporting spiritual coherence. The chaplain is present to help patients make meaning, to support religious practice, to facilitate reconciliation, or simply to accompany someone through darkness without attempting to fix what may not be fixable [46]. Research on chaplaincy practice identifies 'being seen, heard, and acknowledged' as among the most valued outcomes of chaplain visits—outcomes that depend entirely on the quality of presence that chaplains bring to encounters [47].

Distinct Yet Complementary Forms of Presence

While both physicians and chaplains practice embodied presence, the form and orientation of their presence differ. The physician's presence is oriented toward diagnosis, treatment, and physical healing—it includes assessment, clinical reasoning, and preparation for intervention. Even when simply 'being with' a patient, the physician's trained awareness is alert to clinical data, to changes in condition, to opportunities for therapeutic action [48]. This clinical orientation does not negate presence but shapes it; the physician is present as healer, and this role colors every aspect of the encounter.

The chaplain's presence is oriented toward meaning, connection, and spiritual support—it includes attention to existential concerns, openness to whatever religious or spiritual resources the patient brings, and willingness to sit with unanswerable questions. The chaplain is present not primarily to act but to witness, not to fix but to accompany. This contemplative orientation shapes the chaplain's engagement; the chaplain is present as spiritual companion, and this role creates different possibilities than clinical presence affords [49].

These distinct orientations should not be viewed as competing but as complementary. The suffering patient needs both clinical presence that addresses physical dimensions of illness and spiritual presence that supports meaning-making and existential coherence. Neither alone is sufficient for whole-person care; together, they create a therapeutic space in which healing and meaning can co-emerge.

The Sacred-Profane Dialectic in Therapeutic Space

The integration of physician and chaplain presence occurs within what I have termed the 'therapeutic space'—the relational environment created when healer and patient encounter one another [50]. This space is simultaneously clinical and sacred, physical and spiritual, diagnostic and existential. Understanding its nature requires attending to what phenomenologists of religion call the 'sacred-profane dialectic' [51].

Sacred and Profane Space: Beyond Rigid Distinctions

In my essay 'Sacred and Profane Space in the Therapeutic Encounter,' I argued that the rigid distinction between sacred and profane domains creates unnecessary tensions within healthcare settings [52]. Traditional religious thinking often locates the sacred in designated spaces—temples, churches, shrines—and

regards other spaces, including clinical environments, as profane or at best neutral. This distinction can lead to the assumption that spiritual concerns belong elsewhere—in the chapel, not the ICU; with the chaplain, not the physician.

Yet the phenomenology of sacred space suggests a more complex reality. Mircea Eliade's classic analysis shows that sacred space is not a fixed property of locations but emerges through hierophany—the manifestation of the sacred within ordinary reality [53]. Any space can become sacred when it becomes the locus of encounter with transcendence, meaning, or ultimate concern. The hospital room where a dying patient reconciles with an estranged family member, the clinic where a diagnosis transforms a person's understanding of their life, the bedside where a physician's presence brings comfort in the face of mortality—these are all potential sites of sacred encounter, regardless of their apparent profane character.

The Therapeutic Space as Liminal Zone

Reconceptualizing the therapeutic encounter as a liminal zone where sacred and profane categories blend and transform provides a framework for integrating physician and chaplain presence [54]. Liminality, as Victor Turner described it, is the betwixt-and-between state where normal structures are suspended and transformation becomes possible [55]. The therapeutic space shares this liminal quality: patients are temporarily suspended from ordinary life, their usual identities disrupted by illness, their futures uncertain. In this liminal state, they may be particularly open to both clinical intervention and spiritual support.

When physician and chaplain both enter this liminal space, their distinct presences create a richer environment for healing and meaning-making. The physician's presence addresses the physical reality of illness—what is happening in the body, what treatments might help, what the prognosis is. The chaplain's presence addresses the spiritual reality of illness—what it means, how it challenges or deepens faith, what resources of meaning and hope might sustain the patient. Together, they honor the full complexity of illness as simultaneously biological event and existential crisis.

The Shekhinah Paradigm: Divine Presence in Healing

Jewish mystical tradition offers profound resources for understanding presence in healing relationships. In my essay on Shekhinah consciousness, I traced the evolution of this concept from biblical dwelling motifs to its contemporary manifestation in therapeutic encounters [56]. The Shekhinah—the indwelling presence of God—represents the divine as intimately present within creation, particularly in places of suffering and exile. The Talmudic teaching that the Shekhinah rests at the bedside of the sick suggests that healing encounters are inherently sacred—not because of any particular religious ritual but because suffering calls forth divine presence [57].

This theological framework has practical implications for physician-chaplain collaboration. If the therapeutic space is already potentially sacred—if divine presence already attends the sick—then the task of both physician and chaplain is not to make the space sacred but to recognize and honor the sacredness already present. The physician does this through the quality of clinical care and personal presence; the chaplain does this through explicit attention to spiritual dimensions. Both serve as channels for a healing presence that exceeds their individual capacities.

The Patient as Sacred Text: A Hermeneutic Framework

The metaphor of 'patient as sacred text' provides a hermeneutic framework that both physicians and chaplains can share while employing their distinct interpretive approaches [58]. Sacred texts reward careful reading; they reveal meaning gradually to those who approach with patience, humility, and genuine desire to understand. Similarly, patients are not problems to be solved but persons to be understood—their symptoms, stories, and spiritual concerns forming a complex text that invites interpretation [59].

The Physician as Reader

When physicians approach patients as sacred texts, they move beyond the reductive reading that seeks only to identify pathology. The hermeneutic physician attends to the patient's narrative—the story of illness as experienced, not merely as documented in the medical record [60]. This involves what Rita Charon has called 'narrative competence'—the ability to recognize, absorb, metabolize, interpret, and be moved by stories of illness [61]. Through careful attention to the patient's words, silences, bodily expressions, and emotional states, the physician develops a richer understanding of what illness means to this particular person.

The hermeneutic physician also attends to context—the patient's life circumstances, relationships, cultural background, and values that shape how illness is experienced and what outcomes matter most. This contextual reading enables the physician to tailor care to the patient's particular situation rather than applying generic protocols. The patient as sacred text is always a particular text, with its own history, vocabulary, and meaning—and the skilled reader honors this particularity [62].

The Chaplain as Reader

The chaplain also reads the patient as text but with attention to different dimensions. Where the physician attends primarily to the physical and functional, the chaplain attends to the spiritual and existential. The chaplain's reading asks: What gives this person meaning? What spiritual resources sustain them? What existential questions has illness raised? What relationship with transcendence, however conceived, grounds their hope or challenges their faith? [63].

This spiritual reading often requires a different hermeneutic stance than clinical reading. While the physician often reads diagnostically—seeking to categorize and thereby to treat—the chaplain reads more contemplatively, with less urgency to reach conclusions. The chaplain may sit with ambiguity, allowing questions to remain open, making space for the patient's own meaning-making rather than imposing interpretation. This contemplative reading is itself therapeutic, creating a relational space where spiritual work can unfold at its own pace [64].

Collaborative Reading

The richest reading of the patient as sacred text occurs when physician and chaplain read together—sharing their distinct perspectives to develop a fuller understanding than either could achieve alone [65]. This collaborative reading might occur in formal settings like interdisciplinary team meetings or informally through corridor conversations and shared presence at bedside. Whatever the format, the goal is the integration of clinical and spiritual readings into a comprehensive understanding that honors the patient's full humanity.

Research on interprofessional collaboration in spiritual care suggests that such collaborative reading improves patient

outcomes and enhances the practice of all team members [66]. Physicians who work closely with chaplains report better understanding of their patients' values and greater comfort addressing spiritual concerns. Chaplains who participate in medical rounds gain clinical context that enriches their spiritual care. Together, they create a hermeneutic community capable of reading patients with greater depth and sensitivity than either profession alone.

Interprofessional Collaboration: Barriers and Bridges

Despite the theoretical complementarity of physician and chaplain roles, practical collaboration often falls short of potential [67]. Understanding the barriers that impede collaboration and the bridges that can overcome them is essential for developing models of integrated care that honor both vocational orientations.

Barriers to Collaboration

Research identifies several categories of barriers to physician-chaplain collaboration. First, there are knowledge barriers: many physicians do not understand what chaplains do, what training they have received, or how to make effective referrals [68]. Studies show that few physicians know that chaplains provide care for the healthcare team, are involved in facilitating treatment decision-making, perform spiritual assessments, and foster communication between patient, family, and team [69]. This limited understanding leads to underutilization of chaplaincy services.

Second, there are structural barriers. Chaplains are often organizationally separate from clinical teams, without presence in rounds or team meetings [70]. This physical and organizational separation limits informal contact and creates the perception that spiritual care is an add-on rather than an integral component of care. Time pressure, a universal feature of modern healthcare, further limits opportunities for the kind of extended communication that builds collaborative relationships [71].

Third, there are cultural barriers. Medicine and chaplaincy have developed different professional cultures, languages, and values [72]. Physicians are trained to value objectivity, measurable outcomes, and decisive action; chaplains are trained to value subjectivity, meaning, and contemplative presence. These cultural differences can create misunderstandings and mutual devaluation. Physicians may view chaplains as 'soft' or unscientific; chaplains may view physicians as reductionistic or spiritually insensitive [73].

Bridges to Collaboration

Research also identifies facilitators of effective collaboration. Interprofessional education—programs that bring medical trainees and chaplain trainees together for shared learning—has shown promise in improving mutual understanding and comfort with collaboration [74,75]. When residents and chaplain interns participate together in patient care, both report increased awareness of the other profession's role, greater frequency of referrals, and improved collaboration skills [76].

Structural integration—including chaplains in rounds, team meetings, and electronic health record documentation—increases visibility and creates natural opportunities for collaboration [77]. When chaplains are present where clinical decisions are made, they can contribute their unique perspective and build relationships with physicians that facilitate future collaboration. The Center for Spirituality and Health at Mount Sinai, for example, has developed multiple 'routes to partnering' that integrate chaplains into clinical workflows [78].

Shared frameworks and language can bridge cultural differences. The FICA Spiritual History Tool (Faith/belief, Importance/influence, Community, Address/Action in care) provides physicians with a structured approach to spiritual assessment that creates natural handoffs to chaplaincy [79]. Consensus definitions of spirituality and spiritual care, developed through interdisciplinary collaboration, create common ground for communication [80]. When physicians and chaplains speak a shared language, collaboration becomes more natural and effective.

Toward an Integrated Model of Therapeutic Space

Drawing together the theoretical and practical considerations explored above, I now propose an integrated model of therapeutic space in which physician and chaplain presence are understood as complementary dimensions of whole-person care [81]. This model recognizes distinct vocational orientations while creating structures for meaningful collaboration.

Core Principles

The integrated model rests on several core principles. First, embodied presence is the shared foundation of healing. Both physicians and chaplains contribute to therapeutic space through the quality of their presence—their attention, receptivity, and genuine concern for the patient's welfare. Cultivating presence should be a priority for both professions, addressed in training and supported in practice [82].

Second, the therapeutic space is simultaneously clinical and sacred. The rigid distinction between medical and spiritual domains obscures the reality that illness is both physical event and existential crisis. An integrated model honors both dimensions, creating space where physical healing and spiritual meaning-making can co-emerge [83].

Third, the patient is a sacred text requiring multiple readers. No single professional possesses all the interpretive skills needed to understand patients in their full humanity. Physicians bring clinical reading skills; chaplains bring spiritual reading skills. Collaborative reading produces richer understanding than either could achieve alone [84].

Fourth, both professions can learn from one another. Physicians can develop greater comfort with spiritual concerns and enhance their capacity for contemplative presence. Chaplains can develop greater understanding of clinical contexts and medical decision-making. Mutual learning enriches both practices and benefits patients [85].

Practical Implementation

The integrated model suggests several practical implementations. In medical education, training should include substantive content on spirituality and health, taught in collaboration with chaplaincy programs where possible. Residents should have opportunities to work alongside chaplains in clinical settings, learning to recognize spiritual distress and make appropriate referrals [86].

In clinical practice, chaplains should be integrated into interdisciplinary teams with regular presence in rounds and team meetings. Electronic health records should include spiritual assessment and chaplain notes accessible to physicians. Workflow should allow for chaplain-physician communication about shared patients, whether formally through care conferences or informally through accessible channels [87].

In organizational structure, chaplaincy departments should have adequate staffing to meet patient needs and should report to leadership committed to spiritual care as an essential component of quality. Metrics for spiritual care should be developed and tracked alongside clinical quality measures. Institutional culture should support the integration of spiritual and clinical care at all levels [88].

The Phenomenology of Witnessing Suffering

Central to both physician and chaplain vocation is the act of witnessing suffering. Yet witnessing is not passive observation but active engagement—a way of being present that acknowledges, honors, and in some mysterious way transforms the suffering it attends to [89]. Understanding the phenomenology of witnessing illuminates both the shared ground and distinct contributions of medical and spiritual care.

Witnessing as Ethical Practice

Emmanuel Levinas's philosophy of the face suggests that encountering another person's suffering places an ethical demand upon us—a demand for response that precedes and grounds all particular obligations [90]. When physician or chaplain encounters a suffering patient, they encounter not merely a clinical case or a spiritual concern but a face that calls them to responsibility. This ethical dimension of witnessing is not reducible to professional duty; it is the very ground of the healing relationship.

Witnessing suffering also has epistemological dimensions. Paul Ricoeur's work on testimony suggests that certain realities—particularly experiences of suffering and trauma—require witnesses to become knowable [91]. The suffering that remains unwitnessed is in some sense not fully real; it lacks the intersubjective validation that comes from being seen and acknowledged. When physicians and chaplains witness suffering, they contribute to its reality being recognized—and this recognition can itself be healing.

Embodied Witnessing

Recent work on 'embodied witnessing' emphasizes that authentic witnessing involves the whole person—body, mind, and spirit—not merely cognitive acknowledgment [92]. Clara Mucci's research on trauma demonstrates that healing requires 'testimony and bearing witness through mind-brain and body.' The witness must be present not merely intellectually but somatically and emotionally, allowing themselves to be affected by what they witness [93].

For physicians, embodied witnessing may involve physical examination, where touch becomes a form of acknowledgment. It includes attentive listening to the patient's story, allowing oneself to be moved by their experience. It means staying present through difficult conversations rather than rushing to the next task. For chaplains, embodied witnessing may involve sitting with patients in extended silence, holding space for emotions that cannot be articulated, or engaging in religious rituals that give bodily expression to spiritual realities [94].

The Cost of Witnessing

Authentic witnessing of suffering exacts a cost from the witness. Healthcare providers who repeatedly encounter suffering are at risk for compassion fatigue, burnout, and secondary traumatic stress [95]. This is not weakness but the inevitable consequence of genuine presence—one cannot be fully present to suffering without being affected by it. Recognition of this cost has important implications for both professions.

Interestingly, chaplains have developed particular competence in processing the emotional residue of witnessing suffering—and this competence can benefit the entire healthcare team. Research shows that chaplains often provide informal support to medical staff, helping them process difficult cases and maintain resilience [96]. In this capacity, chaplains serve not only patients but the caregiving community, creating a culture where the cost of witnessing can be shared and metabolized rather than carried alone.

Implications for Healthcare Transformation

The integration of physician and chaplain presence within therapeutic space has broader implications for healthcare transformation. As healthcare systems increasingly recognize the limitations of purely biomedical approaches, models that integrate spiritual and existential care offer pathways toward more humane and effective medicine [97].

Beyond the Biomedical Model

The biopsychosocial-spiritual model proposed by Cecily Saunders and developed in palliative care offers an alternative to biomedical reductionism [98]. This model recognizes that patients are not merely biological organisms but persons with psychological needs, social relationships, and spiritual concerns—and that effective care must address all these dimensions. The integration of chaplaincy into clinical teams represents one practical implementation of this holistic vision.

Yet the biopsychosocial-spiritual model risks becoming merely an expanded checklist unless it is grounded in a deeper understanding of presence and meaning. The theoretical framework developed here—with its attention to embodied presence, sacred space, hermeneutic reading, and witnessing—provides such grounding. It suggests that holistic care is not merely additive (addressing more domains) but transformative (approaching the whole differently) [99].

Presence-Based Healthcare

The emphasis on presence throughout this article points toward what might be called 'presence-based healthcare'—an approach that prioritizes the quality of therapeutic relationships alongside the technical quality of medical interventions [100]. This does not mean abandoning evidence-based medicine but enriching it with attention to the relational dimensions that evidence shows matter for outcomes and satisfaction.

Presence-based healthcare requires systemic changes: workflow that allows time for genuine presence, documentation that captures relational dimensions of care, metrics that value quality of experience alongside clinical outcomes, and training that develops presence as a core competency. Both physicians and chaplains have essential contributions to make to this transformation—physicians by demonstrating that presence enhances rather than impedes clinical excellence, and chaplains by offering expertise in cultivating and sustaining presence [101].

The Future of Healing

As healthcare evolves, the integration of physician and chaplain presence offers a model for the future of healing. This model honors the achievements of scientific medicine while recognizing its limitations. It takes seriously the existential and spiritual dimensions of illness without abandoning clinical rigor. It creates therapeutic spaces where both healing and meaning can emerge—spaces that honor patients in their full humanity [102].

The future envisioned here is not utopian but practical. It requires changes in education, practice, and organizational structure that are challenging but achievable. It builds on developments already underway in palliative care, integrative medicine, and person-centered care. Most fundamentally, it invites physicians and chaplains to recognize in one another not competitors for patients' attention but partners in the sacred work of caring for suffering persons [103].

Conclusion: Partners in Presence

This article has examined the distinct but complementary roles of the physician and the chaplain within the therapeutic space. Drawing upon embodied theology, phenomenology of presence, and contemporary scholarship on interprofessional collaboration, I have argued that these two vocations share a common foundation in embodied presence while maintaining distinct orientations and contributions.

The physician's vocation is oriented toward healing the body, alleviating harm, and restoring function—but it also includes witnessing suffering and, through the practice of hermeneutic medicine, reading patients as sacred texts requiring interpretation. The chaplain's vocation is oriented toward spiritual accompaniment, existential support, and meaning-making—creating space for patients to process the deepest questions that illness raises. Neither vocation alone is sufficient for whole-person care; together, they create a therapeutic space where healing and meaning can co-emerge.

The practical implications of this framework include enhanced interprofessional education, structural integration of chaplaincy into clinical teams, shared frameworks for spiritual assessment and care, and organizational cultures that value presence alongside technical excellence. These changes are not merely desirable but necessary if healthcare is to address the full range of human needs that illness reveals.

In the end, the doctor and the chaplain are partners in presence—distinct vocations united by their common attendance upon suffering humanity. By recognizing the shared importance of presence and articulating the unique contributions of each vocation, healthcare systems can foster deeper, more holistic forms of care. Patients facing illness deserve nothing less than healers who can address both their physical pain and their existential questions, who can offer both clinical competence and spiritual companionship. The integration of physician and chaplain presence in therapeutic space moves us toward this goal.

References

1. Ungar-Sargon J. Hermeneutic approaches to medicine: from objective evidence to patient as sacred text. Advanced Educational Research & Reviews 2025;2(1):40-45.
2. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977;196:129-136.
3. Cassell EJ. The nature of healing: the modern practice of medicine. New York: Oxford University Press; 2013.
4. Ungar-Sargon J. Sacred and profane space in the therapeutic encounter: moving beyond rigid distinctions. American Journal of Neurology Research 2025;4(2):1-9.
5. Boston P, Bruce A, Schreiber R. Existential suffering in the palliative care setting: an integrated literature review. J Pain Symptom Manage 2011;41(3):604-618.
6. Puchalski CM. The role of spirituality in health care. Proc (Bayl Univ Med Cent) 2001;14(4):352-357.
7. Frankl VE. Man's search for meaning. Boston: Beacon Press; 1959.
8. Cassell EJ. The nature of suffering and the goals of medicine. N Engl J Med 1982;306(11):639-645.
9. Pearce MJ, Coan AD, Herndon JE, Koenig HG, Abernethy AP. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. Support Care Cancer 2012;20(10):2269-2276.
10. Balboni TA, Vanderwerker LC, Block SD, et al. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol 2007;25(5):555-560.
11. Joint Commission. Comprehensive accreditation manual for hospitals. Oakbrook Terrace, IL: Joint Commission Resources; 2022.
12. National Consensus Project for Quality Palliative Care. Clinical practice guidelines for quality palliative care. 4th ed. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018.
13. Damen A, Exline J, Pargament K, et al. Enhancing the integration of chaplains within the healthcare team. BMJ Support Palliat Care 2023;13(e1):e1-e9.
14. Gustafson JM. Professions as 'callings.' Soc Serv Rev 1982;56(4):501-515.
15. Pellegrino ED, Thomasma DC. The virtues in medical practice. New York: Oxford University Press; 1993.
16. Kassirer JP. Teaching clinical reasoning: case-based and coached. Acad Med 2010;85(7):1118-1124.
17. Ungar-Sargon J. A new vision for the physician-patient relationship: integrating spiritual, intuitive, and holistic dimensions. Advance Medical & Clinical Research 2025;6(1):75-82.
18. Ungar-Sargon J. The sacred space of surrender: transforming physician-patient vulnerability into healing power. Journal of Behavioral Health 2025;14(1):14-26.
19. Kearney M. A place of healing: working with suffering in living and dying. New York: Oxford University Press; 2000.
20. Ungar-Sargon J. The parabolic encounter III: from ancient mashal to patient as sacred text. Journal of Behavioral Health 2025;14(3):1-7.
21. Gadamer HG. The enigma of health: the art of healing in a scientific age. Stanford: Stanford University Press; 1996.
22. VandeCreek L, Burton L. Professional chaplaincy: its role and importance in healthcare. J Pastoral Care Counsel 2001;55(1):81-97.
23. Handzo G, Koenig HG. Spiritual care: whose job is it anyway? South Med J 2004;97(12):1242-1244.
24. Fitchett G, Nolan S, eds. Spiritual care in practice: case studies in healthcare chaplaincy. London: Jessica Kingsley Publishers; 2015.
25. Association of Professional Chaplains. Standards of practice for professional chaplains. Schaumburg, IL: Association of Professional Chaplains; 2015.
26. Puchalski CM, Ferrell B, Virani R, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. J Palliat Med 2009;12(10):885-904.
27. Flannelly KJ, Emanuel LL, Handzo GF, et al. A national study of chaplaincy services and end-of-life outcomes. BMC Palliat Care 2012;11:10.
28. Balboni MJ, Sullivan A, Amobi A, et al. Why is spiritual care

infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. J Clin Oncol 2013;31(4):461-467.

29. Fitchett G. Assessing spiritual needs: a guide for caregivers. Lima, OH: Academic Renewal Press; 2002.
30. Swinton J. Spirituality and mental health care: rediscovering a 'forgotten' dimension. London: Jessica Kingsley Publishers; 2001.
31. Kleinman A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books; 1988.
32. Rogers CR. On becoming a person: a therapist's view of psychotherapy. Boston: Houghton Mifflin; 1961.
33. Geller SM, Greenberg LS. Therapeutic presence: a mindful approach to effective therapy. Washington, DC: American Psychological Association; 2012.
34. Bugental JFT. The art of the psychotherapist. New York: Norton; 1987.
35. Geller SM, Porges SW. Therapeutic presence: neurophysiological mechanisms mediating feeling safe in therapeutic relationships. J Psychother Integr 2014;24(3):178-192.
36. Hycner R. Between person and person: toward a dialogical psychotherapy. Highland, NY: Gestalt Journal Press; 1993.
37. Baldwin M. Interview with Carl Rogers on the use of the self in therapy. In: Baldwin M, ed. The use of self in therapy. 2nd ed. New York: Haworth Press; 2000:29-38.
38. Geller SM, Greenberg LS, Watson JC. Therapist and client perceptions of therapeutic presence: the development of a measure. Psychother Res 2010;20(5):599-610.
39. Merleau-Ponty M. Phenomenology of perception. London: Routledge; 2012.
40. Epstein RM. Mindful practice. JAMA 1999;282(9):833-839.
41. Beach MC, Inui T, Relationship-Centered Care Research Network. Relationship-centered care: a constructive reframing. J Gen Intern Med 2006;21(S1):S3-S8.
42. Back AL, Arnold RM, Baile WF, et al. Approaching difficult communication tasks in oncology. CA Cancer J Clin 2005;55(3):164-177.
43. Ungar-Sargon J. Divine presence in healing: a kabbalistic approach to compassionate care. Journal of Behavioral Health 2025;14(2):1-4.
44. Nouwen HJM. The wounded healer: ministry in contemporary society. New York: Doubleday; 1972.
45. Remen RN. Kitchen table wisdom: stories that heal. New York: Riverhead Books; 1996.
46. Koenig HG. Spirituality in patient care: why, how, when, and what. 3rd ed. Philadelphia: Templeton Press; 2013.
47. Buis C, van de Geer J, Prins M, et al. The contribution of chaplaincy to primary and community care. Glob Adv Integr Med Health 2025;14:1-12.
48. Ungar-Sargon J. Revelation in concealment: theological reflections on the therapeutic encounter III. AJMCRR 2025;4(4):1-12.
49. Taylor JJ, Hodgson JL, Kolobova I, et al. Exploring the phenomenon of spiritual care between hospital chaplains and hospital based healthcare providers. J Health Care Chaplain 2015;21(3):91-107.
50. Ungar-Sargon J. Epistemology versus ontology in therapeutic practice: the tzimtzum model and doctor-patient relationships. Advance Medical & Clinical Research 2025;6(1):94-101.
51. Eliade M. The sacred and the profane: the nature of religion. New York: Harcourt; 1959.
52. Ungar-Sargon J. Sacred and profane space in the therapeutic encounter: moving beyond rigid distinctions. American Journal of Neurology Research 2025;4(2):1-9.
53. Eliade M. Patterns in comparative religion. Lincoln: University of Nebraska Press; 1996.
54. Turner V. The ritual process: structure and anti-structure. Chicago: Aldine Publishing; 1969.
55. Van Gennep A. The rites of passage. Chicago: University of Chicago Press; 1960.
56. Ungar-Sargon J. Shekhinah consciousness and the therapeutic encounter. Theological Essays, jyungar.com.
57. Babylonian Talmud, Shabbat 12b.
58. Ungar-Sargon J. The parabolic encounter III: from ancient mashal to patient as sacred text. Journal of Behavioral Health 2025;14(3):1-7.
59. Frank AW. The wounded storyteller: body, illness, and ethics. Chicago: University of Chicago Press; 1995.
60. Charon R. Narrative medicine: honoring the stories of illness. New York: Oxford University Press; 2006.
61. Charon R. Narrative medicine: a model for empathy, reflection, profession, and trust. JAMA 2001;286(15):1897-1902.
62. Montgomery K. How doctors think: clinical judgment and the practice of medicine. New York: Oxford University Press; 2006.
63. Pargament KI. Spiritually integrated psychotherapy: understanding and addressing the sacred. New York: Guilford Press; 2007.
64. Sulmasy DP. The healer's calling: a spirituality for physicians and other health care professionals. New York: Paulist Press; 1997.
65. Puchalski C, Ferrell B. Making health care whole: integrating spirituality into patient care. West Conshohocken, PA: Templeton Press; 2010.
66. Hemming P, Teague PJ, Cadge W, Sato M. Chaplains on the medical team: a qualitative analysis of an interprofessional curriculum. J Health Care Chaplain 2016;22(4):148-169.
67. King SDW, Jarvis D, Horan K, et al. Chaplains' collaboration and leadership in interprofessional healthcare: a scoping review part 2. J Health Care Chaplain 2025;DOI:10.1080/08854726.2025.2563474.
68. Damen A, Schuhmann C, Stifoss-Hanssen H, et al. What do healthcare chaplains do? Views of healthcare chaplains in the Netherlands. J Health Care Chaplain 2020;26(3):94-114.
69. Damen A, Exline J, Pargament K, et al. Professional self-understanding of healthcare chaplains in the Netherlands: enhancing interprofessional collaboration. BMJ Support Palliat Care 2023;13(e1):e1-e9.
70. Cadge W. Paging God: religion in the halls of medicine. Chicago: University of Chicago Press; 2012.
71. Lee BM, Curlin FA, Choi PJ. The association between clergyperson-physician collaboration and palliative care utilization. J Palliat Med 2017;20(2):177-182.
72. Best M, Butow P, Olver I. Do patients want doctors to talk about spirituality? A systematic literature review. Patient Educ Couns 2015;98(11):1320-1328.
73. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: reaching national and international consensus. J Palliat Med 2014;17(6):642-656.

74. King SDW, Jarvis D, Horan K, et al. Chaplains' collaboration and leadership in interprofessional healthcare: a scoping review part 1. J Health Care Chaplain 2025;DOI:10.1080/08854726.2025.2563473.
75. Hemming P, Teague PJ, Cadge W, Sato M. Demystifying spiritual care: an interprofessional approach for teaching residents and hospital chaplains. Acad Med 2016;91(7):923-927.
76. Cunningham CJL, Panda M, Lambert J, Daniel G, DeMars K. Perceptions of chaplains' value and impact within hospital care teams. J Relig Health 2017;56(4):1231-1247.
77. Marin DB, Sharma V, Sosunov E, Egorova N, Goldstein R, Handzo GF. Relationship between chaplain visits and patient satisfaction. J Health Care Chaplain 2015;21(1):14-24.
78. Sharma V, Marin DB, Sosunov E, et al. The differential effects of chaplain interventions on patient satisfaction. J Health Care Chaplain 2016;22(3):85-101.
79. Puchalski C, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. J Palliat Med 2000;3(1):129-137.
80. Puchalski CM, Ferrell B, Virani R, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. J Palliat Med 2009;12(10):885-904.
81. Ungar-Sargon J. A healing space for caregiver and patient: a novel therapeutic clinic model integrating holistic healing principles. Medical and Clinical Case Reports 2025;5(1):1-11.
82. Kabat-Zinn J. Mindfulness-based interventions in context: past, present, and future. Clin Psychol Sci Pract 2003;10(2):144-156.
83. Ungar-Sargon J. Reclaiming the sacred in medicine: toward an integration of ancient wisdom and modern science in healthcare. Journal of Religion and Theology 2025;7(4):1-12.
84. Swinton J, Pattison S. Moving beyond clarity: towards a thin, vague, and useful understanding of spirituality in nursing care. Nurs Philos 2010;11(4):226-237.
85. Amonoo HL, Harris JH, Murphy WS, Abrahm JL, Peteet JR. The physician's role in responding to existential suffering: what does it mean to comfort always? J Palliat Care 2020;35(1):28-35.
86. Koenig HG, Hooten EG, Lindsay-Calkins E, Meador KG. Spirituality in medical school curricula: findings from a national survey. Int J Psychiatry Med 2010;40(4):391-398.
87. Handzo GF, Flannelly KJ, Murphy KM, et al. What do chaplains really do? II. Interventions in the New York Chaplaincy Study. J Health Care Chaplain 2008;14(1):39-56.
88. Spiritual Care Association. Consensus statement: the role of the chaplain in health care. Schaumburg, IL: HealthCare Chaplaincy Network; 2022.
89. Oliver K. Witnessing: beyond recognition. Minneapolis: University of Minnesota Press; 2001.
90. Levinas E. Totality and infinity: an essay on exteriority. Pittsburgh: Duquesne University Press; 1969.
91. Ricoeur P. Memory, history, forgetting. Chicago: University of Chicago Press; 2004.
92. Mucci C. Working with mind-body-brain in a dyadic treatment through embodied witnessing to heal trauma of human origin. Front Psychol 2024;15:1397911.
93. Mucci C. Beyond individual and collective trauma: intergenerational transmission, psychoanalytic treatment, and the dynamics of forgiveness. London: Karnac Books; 2013.
94. Ungar-Sargon J. Primordial silence and therapeutic presence: theodicy and the paradox of divine concealment in clinical practice. International Journal of Psychiatry Research 2025.
95. Figley CR, ed. Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel; 1995.
96. Cunningham CJL, Panda M, Lambert J, Daniel G, DeMars K. Chaplains as liaisons with local clergy: an underutilized resource during the COVID-19 pandemic. J Relig Health 2021;60(4):2316-2330.
97. Sulmasy DP. A biopsychosocial-spiritual model for the care of patients at the end of life. Gerontologist 2002;42(Suppl 3):24-33.
98. Saunders C. Hospice and palliative care: an interdisciplinary approach. London: Edward Arnold; 1990.
99. Ungar-Sargon J. A framework for transformative healthcare practice. Research article; 2025.
100. Epstein RM, Back AL. Responding to suffering. JAMA 2015;314(24):2623-2624.
101. Ungar-Sargon J. Insubstantial language and the space between healer and patient. Int J Psychiatr Res 2025;8(2):1-13.
102. Ungar-Sargon J. Healing as justice: clinical advocacy in therapeutic practice. Research article; 2025.
103. Ungar-Sargon J. Navigating the depths: a framework for caregiver's grief work. Journal of Behavioral Health 2025;14(2):1-9.