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Do Patients Have Free Will? A Clinical-Philosophical Essay on Adherence, Addiction, and the Bounds of Choice

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ABSTRACT

The question of patient agency in medical contexts demands frameworks that transcend the sterile dichotomy between mechanistic determinism and abstract libertarian autonomy. This essay builds upon my previous work on hermeneutic medicine, therapeutic tzimtzum, and the sacred-profane dialectic to reconceptualize patient agency as a relational, emergent phenomenon rather than an intrinsic property. Drawing on recent neuroscience (readiness potentials, addiction neurobiology), clinical realities (adherence challenges, chronic pain), and Jewish mystical theology (tzimtzum, Shekhinah, the broken vav), I argue that the therapeutic encounter itself creates the possibility space within which patient agency emerges. This framework has immediate implications for addiction treatment, medication adherence, and the moral dimensions of clinical practice, suggesting that the physician's role involves not assessing pre-existing capacity but co-creating conditions for maximal patient agency through therapeutic presence and sacred attention.

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Introduction

When a patient with opioid use disorder relapses after ninety days of sobriety, was this outcome determined by neurobiological mechanisms beyond their control, or did they freely choose to use? When a diabetic patient repeatedly fails to check blood glucose despite understanding the consequences, should we attribute this to weak will, structural barriers, or the complex interplay of executive function deficits and socioeconomic stressors? These are not merely theoretical puzzles; they shape how clinicians conceptualize treatment, assign moral responsibility, and structure therapeutic interventions.

In my previous work developing hermeneutic medicine as a clinical framework, I have argued that patients must be approached as sacred texts requiring interpretive wisdom rather than as broken machines requiring technical repair [1]. This hermeneutic approach recognizes that healing emerges not from diagnostic certainty alone but from the quality of interpretive engagement between physician and patient. The question of free will—whether patients possess agency that transcends neurobiological determinism—represents a foundational challenge to this framework that demands sustained philosophical and clinical attention.

My work on the tzimtzum model for doctor-patient relationships has established that therapeutic presence requires divine-like self-contraction—the physician must withdraw professional omniscience to create space where patient agency can emerge [2]. This model shifts focus from epistemology (what can we know about the patient?) to ontology (what quality of being-present serves healing?). Yet the tzimtzum framework leaves unresolved the deeper metaphysical question: does the patient possess agency that the clinician honors, or does agency itself arise within the relational space created by therapeutic encounter?

This essay addresses that question directly. I argue that agency is neither intrinsic property nor pure illusion but rather an emergent phenomenon that arises within relationships characterized by what I have termed the sacred-profane dialectic [3]. The therapeutic space becomes sacred not through religious ritual but through the quality of attention and presence brought to the encounter with suffering. Within this sacred space, patient agency emerges—not as metaphysical given but as relational achievement requiring both neurobiological capacity and supportive relational context.

Western Philosophical Frameworks on Free Will

Western philosophy offers three major positions on free will, each with distinct clinical implications. Understanding these frameworks reveals both their conceptual power and their ultimate inadequacy for medical contexts where my hermeneutic approach proves more clinically fruitful.

Classical determinism, articulated by Spinoza, holds that all events unfold by necessity from prior causes [4]. Contemporary neuroscientific determinism, advocated by Sam Harris, argues that free will is illusory because every mental state has antecedent neurobiological causes we did not choose [5]. The brain disease model of addiction explicitly draws on deterministic frameworks, characterizing addiction as pathological neuroadaptation that eliminates voluntary control [6].

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Yet determinism faces significant clinical problems. First, it cannot account for recovery and behavioral change documented in addiction research [7]. Second, deterministic frameworks paradoxically reduce patient motivation—believing in determinism correlates with reduced self-control [8]. Third, and most problematically, determinism eliminates conceptual space for the therapeutic relationship itself. If clinician and patient are both neurobiological automatons, what meaning can we assign to the encounter between them?

My work on the absent divine in therapeutic encounters addresses this limitation [9]. Just as post-Holocaust theology must grapple with divine concealment, clinical practice must engage with the paradox that healing relationships require genuine encounter even when mechanical causation operates. The tzimtzum model resolves this by recognizing that divine withdrawal creates space for human agency—not by eliminating causation but by structuring how causation unfolds within relationship.

Compatibilism and Capacity Assessment

Compatibilism argues that free will and determinism are compatible—we are free when our actions flow from our own desires and character rather than external coercion [10]. This framework maps readily onto clinical concepts of decision-making capacity, which assess whether choices emerge from intact cognitive processes regardless of ultimate causal determination [11].

However, compatibilism shares determinism's fundamental limitation: it treats agency as individual property rather than relational phenomenon. The compatibilist asks whether this patient possesses sufficient capacity, assuming capacity exists as measurable feature like hemoglobin concentration. But my clinical work demonstrates that patient agency emerges differently depending on therapeutic relationship quality [12]. The same patient who appears 'non-adherent' and unmotivated with one clinician may demonstrate remarkable engagement with another. Compatibilism lacks conceptual resources to theorize this relational dimension.

Libertarian Autonomy and Its Failures

Libertarian free will, most influentially articulated by Kant, posits that genuine freedom requires causal independence—the ability to initiate action independent of antecedent causes [13]. This framework dominates medical ethics through the principle of autonomy, treating patients as self-governing agents who possess inherent capacity for free choice [14].

The libertarian model has generated crucial protections against medical paternalism. Yet it proves inadequate for multiple reasons. First, it cannot account for extensive evidence that decision-making is profoundly shaped by framing effects, implicit biases, and social contexts [15]. Second, it struggles with situated agency—patients make choices from within particular social positions and material constraints that profoundly limit option sets [16]. Third, the libertarian model generates what I have elsewhere termed 'moral injury through abstraction'—it places entire burden of choice on the isolated individual while ignoring systemic and relational dimensions that structure decision-making [17].

Consider informed consent for terminal cancer diagnosis. The libertarian framework tells us to provide information and respect autonomous choice. But the patient's 'choice' emerges from complex matrix: cultural background's approach to death disclosure; economic resources; family structure; how oncologist framed prognosis; prior medical experiences; and countless other factors that libertarian model treats as irrelevant background rather than constitutive of agency itself. My hermeneutic approach recognizes these factors as the interpretive context within which patient-as-text must be read [18].

Neuroscience of Volition: Beyond Simple Determinism

Recent neuroscience research has profoundly complicated both folk psychological notions of free will and crude deterministic models. This section reviews key empirical findings, interpreting them through the lens of my therapeutic frameworks.

Benjamin Libet's famous experiments found that unconscious brain activity (readiness potential) begins approximately 550 milliseconds before conscious intention to move [19]. This was interpreted as evidence that unconscious processes initiate action before conscious will, suggesting free will is illusory [20]. However, recent work has substantially complicated this anti-free-will interpretation.

Aaron Schurger demonstrated that readiness potential may reflect ongoing spontaneous neural fluctuations rather than specific decision processes—there is no hidden decider, just stochastic neural dynamics [21]. If voluntary actions emerge from neural noise rather than determined processes, they are not causally determined in any straightforward sense. Additionally, readiness potential appears absent in truly spontaneous actions, suggesting it reflects motor preparation rather than volition per se [22]. Most importantly, Alexander Maier showed that neural prediction of choice works only for arbitrary decisions with no meaningful grounds—when choices reflect deliberation and values, neural prediction fails [23].

These findings align with my therapeutic framework. The relationship between conscious deliberation and neural mechanism is bidirectional and context-dependent—not simple determinism. As I have argued regarding the absent healer, the presence of mechanism does not eliminate agency but rather provides the substrate through which agency operates [24]. Consciousness is not epiphenomenal witness but active participant in processes whose neural correlates we can measure.

Impaired Yet Responsive Agency

The brain disease model characterizes addiction as pathological changes in reward circuits, executive function, and stress systems that result in compulsive drug seeking [25-27]. This neurobiological framework has reduced stigma and supported treatment funding. However, critical analysis reveals important limitations that my clinical work has documented extensively.

First, choice architecture matters: most individuals with substance use disorders achieve stable recovery, often without treatment, and recovery rates increase dramatically when alternative rewards become available [28]. If addiction eliminated voluntary control, we would not expect such responsiveness to contingencies. Second, price sensitivity persists: individuals with active substance use disorders remain responsive to the 'cost' of drugs, reducing consumption when obtaining drugs requires more effort [29]. Third, neural changes are not unidirectional: neuroplasticity research demonstrates substantial recovery of function with sustained abstinence [30].

My work on the nature of the animal soul and possibility of transformation addresses these paradoxes [31]. Addiction involves neither pure brain hijacking nor simple moral failure but rather what I term 'constrained agency'—real neurobiological impairment that nonetheless leaves space for choice responsive to environmental restructuring and relational support. The therapeutic task involves not assessing whether patient has free will but rather creating conditions that expand practical agency through what I have described as therapeutic tzimtzum and sacred attention.

Addiction and Adherence as Test Cases

The philosophical and neuroscientific considerations gain urgency when examined through actual clinical practice. Addiction and treatment adherence represent paradigmatic contexts where questions about patient agency become practically inescapable.

In my pain management practice, I regularly encounter the tension between disease and choice models of addiction. Consider a patient with opioid use disorder following workplace injury. The brain disease model emphasizes neurobiological hijacking requiring medication-assisted treatment. The moral model emphasizes personal responsibility requiring willpower and abstinence-based approaches. Yet clinical phenomenology exceeds both frameworks.

The patient's agency fluctuates radically with context—able to abstain during two-week family visit but finding abstinence impossible in usual environment of unemployment, isolation, pain, and using peers. Moreover, the therapeutic relationship itself modulates capacity for self-control. In sessions characterized by genuine care within firm boundaries, the patient demonstrates remarkable insight and commitment. In rushed, judgmental encounters, he becomes defensive and non-adherent. My stance as clinician directly influences his available agency.

This observation aligns with my published work on therapeutic presence and the crisis of language in clinical practice [32,33]. The question 'Does this patient have free will?' is malformed. The better question is: 'How can I structure a therapeutic relationship that expands this patient's practical agency?' This shifts focus from assessing intrinsic capacity to co-creating conditions for enhanced agency through what I have termed the sacred space of the healing encounter [34].

The Myth of Rational Choice

Non-adherence affects 30-50% of patients, with rates as high as 70% for some chronic conditions [35]. The dominant model treats adherence as rational choice: patients receive information, weigh risks and benefits, and freely choose whether to follow recommendations. Yet extensive research demonstrates this model's inadequacy—little correlation exists between understanding treatment and actual adherence [36].

Consider diabetes management. Only 23% of type 2 diabetes patients achieve adequate glycemic control, with medication adherence ranging from 36-93% [37]. These failures occur despite patients understanding that poor control causes blindness, kidney failure, amputations, and early death. The rational choice model cannot explain this pattern.

My work on effective listening and sacred attention addresses these clinical realities [38]. Multiple interacting factors constrain adherence: economic barriers, present bias (immediate bother outweighing future benefit), executive function impairments, medical mistrust rooted in historical exploitation, and practical barriers facing those in poverty. The most effective interventions—directly observed therapy, simplified regimens, pill organizers, contingency management—bypass or circumvent individual choice rather than enhancing it [39,40].

Critically, the therapeutic relationship itself significantly influences adherence. Physician communication quality predicts adherence with odds ratios exceeding many clinical interventions [41]. This aligns with my framework of hermeneutic medicine—approaching the patient as sacred text requiring interpretive engagement rather than as autonomous agent making isolated choices [42]. Agency emerges in the relational space between patient and clinician, shaped by the quality of therapeutic presence I have described as Shekhinah consciousness in healing encounters [43].

Theological Framework

Having surveyed philosophical frameworks, neuroscientific evidence, and clinical realities, I now elaborate the theological framework I have developed in previous publications, demonstrating its superiority for understanding patient agency in medical contexts.

The Kabbalistic doctrine of tzimtzum, developed by Isaac Luria, describes how God's first creative act was contraction—divine withdrawal to create empty space (chalal panui) within which finite creation could unfold [44]. In my tzimtzum model for doctor-patient relationships, I have argued that therapeutic presence requires analogous self-contraction: the effective clinician does not impose expertise and authority but rather creates space for the patient to emerge as agent [2].

This therapeutic tzimtzum involves withdrawing clinical omniscience to make room for patient knowledge, suspending judgment to allow patient possibility, contracting professional authority to enable patient empowerment. As I have written: 'The therapeutic space, properly understood, becomes sacred not through religious ritual but through the clinician's capacity

to practice divine-like contraction, making room for the patient's agency to manifest' [2].

Critically, tzimtzum differs from both libertarian autonomy and mere non-directiveness. The patient does not discover pre-existing agency that the clinician then respects. Rather, agency emerges in the relational space created by therapeutic tzimtzum. This resolves the metaphysical puzzle: agency is neither intrinsic property nor pure illusion but relational achievement. The clinician's self-contraction creates possibility space, but the patient must actively participate for agency to manifest.

Divine Presence in Clinical Suffering

In mystical traditions, Shekhinah consciousness represents the immanent, indwelling presence of the divine—often figured as the maternal aspect of divinity that accompanies Israel in exile [45]. Where there is suffering, there is Shekhinah. The divine does not remain transcendent but becomes immanent precisely in brokenness. In my work on Shekhinah consciousness in therapeutic spaces, I have argued that this concept transforms how we understand the healing encounter [43].

The exam room becomes sacred space not through religious ritual but through the meeting of suffering and care. When a clinician sits with a dying patient, bearing witness to mortality without offering false hope, Shekhinah is present. When a therapist holds space for trauma narrative without recoiling, that is divine presence. As I have written: 'The therapeutic space emerges as contemporary locus of divine indwelling, where the dynamics of tzimtzum, tikkun, and dirah betachtonim converge in the physician-patient encounter' [43].

This theological framing transforms understanding of therapeutic relationship. It is not merely technical—diagnostician and diagnosed, prescriber and medication-taker. It is covenantal, a mutual commitment to presence in the face of suffering. The clinician cannot stand outside the patient's situation as objective observer but enters into it, experiencing what Martin Buber called 'I-Thou' rather than 'I-It' relation [46]. My work on revelation in concealment explores how acknowledging diagnostic uncertainty and therapeutic limitation paradoxically enhances healing presence [47].

Sacred Brokenness in Healing

In the Masoretic text of Numbers 25:12, the Hebrew word shalom ('peace') is written with a broken vav—one letter has a scribal interruption (vav ketia) [48]. Rabbinic tradition maintains that this textual anomaly contains meaning: peace itself is necessarily broken, incomplete, imperfect. This image captures something essential about healing that challenges both medical triumphalism and therapeutic nihilism.

Patients come to us broken—by illness, injury, loss, trauma. The Cartesian medical model promises to restore them to wholeness, to fix what is broken. But the broken vav suggests that wholeness itself contains brokenness, that healing does not erase but transforms suffering. The cancer survivor is not 'cured' as if cancer never happened but rather carries that history as constitutive of who they are. The trauma survivor does not achieve pre-traumatic innocence but integrates trauma into new narrative identity.

In my clinical work, I have developed this concept of sacred brokenness as central to hermeneutic medicine [1]. Against triumphalism, it insists we cannot eliminate human vulnerability through technological intervention. We are finite, embodied, mortal—this is not defect but condition. Against nihilism, it maintains that healing remains possible even when cure is not, that wholeness can be achieved that incorporates rather than erases brokenness. For questions of agency and free will, the broken vav suggests that patient agency is itself broken—partial, constrained, situationally variable. We should not expect or demand perfect autonomy, yet within biological and social constraints, real agency emerges.

Hermeneutic Medicine

Drawing these theological themes together, my published work on hermeneutic medicine proposes treating patients as sacred texts requiring interpretive wisdom rather than as broken machines requiring technical repair [1,18]. Just as the Talmudic sage approaches Torah with reverence, attending to anomalies and ambiguities as sites of meaning, so the clinician should approach the patient's embodied narrative with hermeneutic attention.

This is not metaphor. The patient's illness narrative, symptom constellation, and behavioral patterns constitute a text demanding interpretation. A patient who repeatedly misses appointments is not simply 'non-compliant' but communicating something requiring understanding. As I have argued in my work on applying hermeneutics to therapeutic interaction: 'The act of interpreting patient history as sacred text transforms the clinical encounter from information extraction to experiential engagement, from rational analysis to sacred listening' [42].

Hermeneutic medicine proceeds through four movements I have detailed in previous publications [18]:
Attention: The clinician must attend fully to the patient's presentation, not reducing it prematurely to diagnostic categories. This requires what Simone Weil called 'attention'—a quality of presence that suspends the ego's need to grasp and control [49].

Interpretation: The patient's narrative requires interpretation, not just diagnosis. Why this symptom, in this person, at this time? Hermeneutic medicine seeks meaning without pathologizing, recognizing embodied expression as valid discourse.

Dialogue: Interpretation must be offered back to the patient for confirmation, rejection, or modification. Just as Talmudic interpretation proceeds through argument and multiple voices, clinical understanding emerges through dialogue rather than monologue.

Transformation: The goal is not mere understanding but transformation—what Gadamer called 'fusion of horizons' where interpreter and text mutually transform one another [50] Both patient and clinician are changed by genuine encounter.

Conclusion

This essay has traveled from philosophical debates through neuroscience research and clinical challenges to the theological reconceptualization I have developed across multiple publications. What practical difference does this framework make for clinicians?

First, abandon the false dichotomy of disease versus choice. As my work on addiction demonstrates, patient behavior emerges from complex interaction of neurobiological constraints, social contexts, and therapeutic relationship itself [31]. Avoid both therapeutic nihilism ('they can't help it') and moralistic judgment ('they're not trying'). Both responses fail to meet the patient in their actual situation.

Second, practice therapeutic tzimtzum. Before rushing to diagnose and treat, create space for the patient to emerge as agent [2]. This requires real discipline—physician anxiety drives toward premature closure. Resist that anxiety. Ask more questions. Listen longer. Tolerate uncertainty. Allow silence. The patient's agency emerges in space created by clinical restraint.

Third, recognize therapeutic encounter as sacred space. As I have argued extensively, the clinical encounter is not merely technical transaction but covenantal relationship [3,43]. Suffering renders the patient vulnerable and calls for witness, not just intervention. This is not inefficient sentimentality but essential therapeutics. Healing relationships are themselves healing.

Fourth, interpret before you diagnose. Treat the patient's narrative as text requiring understanding, not just symptoms requiring categorization [1,18,42]. A patient who arrives late, misses appointments, doesn't take medications—this pattern is not merely noncompliance but meaning-laden communication requiring hermeneutic engagement.

Fifth, embrace sacred brokenness. The broken vav reminds us that wholeness incorporates brokenness. We cannot restore patients to imagined pre-illness perfection. Within this realistic frame, genuine healing remains possible—not cure but transformation, not restoration but reconstruction of meaning in the wake of illness.

Sixth, address structural constraints on agency. If agency is situationally emergent rather than intrinsic property, then expanding patient agency requires addressing material and social conditions that constrain possibility. Housing stability, food security, transportation access, and social support are essential therapeutic interventions, not peripheral concerns.

Finally, accept complicity and limitation. As my work on the absent healer explores, we cannot stand outside our patients' struggles in position of invulnerable expertise [24]. We too are embodied, mortal, limited. We too are implicated in systems that perpetuate suffering. Acknowledging this complicity and limitation is not unprofessional but necessary for authentic relationship.

Ultimately, the question 'Do patients have free will?' misleads by treating agency as metaphysical property individuals either possess or lack. My work demonstrates that agency is relational, emergent, situated, and partial. It arises in the space between clinician and patient, shaped by neurobiological constraints, social contexts, and quality of therapeutic relationship. Our task as clinicians is not to measure pre-existing capacity but to co-create conditions within which maximal patient agency can emerge.

This requires technical competence, certainly, but also something more: the wisdom to practice therapeutic tzimtzum, the courage to acknowledge our own implication in patient suffering, and the humility to recognize that healing is mystery, not mechanism. Medicine practiced with this awareness becomes not merely technical craft but sacred calling—not because we perform miracles but because we bear witness to the human condition in its full complexity, vulnerability, and possibility. The sacred-profane dialectic I have articulated across my publications provides the framework for honoring both scientific excellence and spiritual depth, both technical intervention and relational presence, both neurobiological mechanism and emergent human agency [3].

ADDENDUM

Recent Medical Ethics Literature on Decision-Making Capacity and Free Will

Julian Ungar-Sargon, MD, PhD

This addendum examines how recent peer-reviewed literature on decision-making capacity (DMC) and free will in medical ethics provides convergent support for the hermeneutic, relational framework I have developed. Specifically, I analyze Zürcher, Elger, and Trachsel's 2019 BMC Medical Ethics article "The notion of free will and its ethical relevance for decision-making capacity," [51] which argues for incorporating free will considerations into clinical assessments of patient capacity through a compatibilist lens drawing heavily on Harry Frankfurt's hierarchical model of volition [52,53].

While the authors and I approach the question from different philosophical starting points—they from analytic philosophy and Frankfurt's compatibilism, I from Jewish mystical theology and hermeneutic phenomenology—our conclusions demonstrate remarkable convergence regarding the relational, contextual, and emergent nature of patient agency. This convergence strengthens my central claim that patient agency cannot be understood as a static property individuals either possess or lack, but rather as a dynamic phenomenon that emerges within the therapeutic relationship itself.

The authors contend that standard DMC criteria (understanding, appreciation, reasoning, and expressing choice) are "necessary but not sufficient" for truly ethical informed consent because they fail to adequately address the question of free will. They argue that Frankfurt's compatibilist theory of free will should be integrated into the appreciation criterion of DMC assessment [51].

Frankfurt's theory distinguishes between first-order desires (desires related to actions) and second-order desires (desires

about one's desires). According to this framework, an individual possesses free will when there is "volitional unanimity"—when their first-order desire that motivates action aligns with their second-order desire about what they want to desire. Frankfurt terms this alignment "wholeheartedness" [52,53].

The authors defend Frankfurt's compatibilism against four major objections: (1) The causation objection (that causally determined desires cannot be free), (2) The regress problem (that we need infinite levels of desires), (3) The excessive reflection objection (that the theory demands too much conscious reflection), and (4) The impracticality objection (that we cannot reliably assess second-order desires clinically). After rebutting these objections, they argue that clinical evaluation should assess whether a patient's treatment decision reflects genuine identification with their own will or whether internal compulsion has created a "non-harmonious will" [51].

Points of Convergence

The most significant convergence concerns the relational, contextual nature of patient agency. The authors repeatedly acknowledge that a patient's ability to exercise free will varies dramatically with therapeutic context, observing that the same patient who appears 'non-adherent' and unmotivated with one clinician may demonstrate remarkable engagement with another [51].

This observation directly supports my central claim that agency is not an intrinsic property patients possess but an emergent phenomenon that arises within relationships. As I argued in my tzimtzum model, the clinician's quality of presence creates the possibility space within which patient agency can manifest. The question shifts from "Does this patient have free will?" to "How can we create conditions that enable this patient's maximal agency?"—precisely the reframing I have advocated through my hermeneutic medicine framework.

Inner Versus Outer Constraints on Agency

Zürcher et al. provide an extended discussion of how "inner constraints" (such as overwhelming pain, fear, or psychopathology) can destroy free will even when "outer constraints" (imprisonment, physical disability) do not. They use the example of a paraplegic patient who may freely adapt his will to accept that he will not run a marathon, versus the same patient who, "overwhelmed by pain" and "deeply desperate," becomes unable to "consider his own desires in a sufficiently open manner" [51].

This distinction maps directly onto my discussion of the broken vav—the recognition that healing does not eliminate human vulnerability but transforms how we inhabit our constraints. The paraplegic patient who freely accepts his limitation experiences what I have termed "sacred brokenness"—wholeness that incorporates rather than denies loss. Critically, the authors recognize that the line between sufficiently reflected adjustment (which is free) and breakdown of will (which is unfree) "cannot be easily drawn"—an honest acknowledgment of clinical reality that aligns with my insistence that hermeneutic medicine must tolerate ambiguity.

Therapeutic Relationship as Constitutive of Capacity

Although the authors frame their argument in terms of assessing pre-existing capacity, their clinical examples repeatedly demonstrate that the therapeutic relationship itself influences whether patients possess the capacity being assessed. They note that "a sufficient indicator of authenticity would be to establish during a well-led traditional physician-patient encounter that patient X adopts a reflective position" [51].

The phrase "well-led" here does significant work—it acknowledges that the quality of clinical encounter determines whether the patient can access and articulate their second-order desires. This directly supports my argument that therapeutic tzimtzum (the clinician's self-contraction to create space for patient agency) is not merely a stance toward pre-existing capacity but actively co-creates the conditions for that capacity to manifest. This is precisely what I mean by Shekhinah consciousness in therapeutic encounters—the recognition that the exam room becomes sacred space through the meeting of suffering and care, and that this sacred space is itself generative of patient agency rather than merely revelatory of it.

Critique of Abstract Autonomy

Both Zürcher et al.'s framework and my own represent moves away from abstract, acontextual notions of autonomy that dominate medical ethics. They explicitly critique autonomy frameworks that do not require second-order reflection, noting that treating autonomy as a simple capacity fails to recognize its complex, contextual nature [51]. This critique aligns with my sustained argument against the libertarian autonomy model that "places entire burden of choice on the isolated individual while ignoring systemic and relational dimensions that structure decision-making." Both frameworks recognize that genuine agency requires more than cognitive ability to process information—it requires a particular quality of self-relation that can only be assessed (and often only achieved) within supportive relational contexts.

The authors provide extended discussion of how their framework applies to addiction and phobia—precisely the clinical contexts I have emphasized in my own work. They discuss Frankfurt's "willing addict" (someone who wholeheartedly endorses their desire to use drugs) versus "unwilling addict" (someone alienated from their drug-seeking behavior). They note that socially integrated cocaine users might have "harmonious wish to take the drug if the first-order wish to consume cocaine is compatible with their overall life-plan" [51,53].

This analysis supports my concept of "constrained agency" in addiction—real neurobiological impairment that nonetheless leaves space for choice responsive to environmental restructuring and relational support. The question is not whether the addicted patient has free will in some abstract sense, but whether their drug use reflects identification with their deeper values and life goals or represents an "outlaw" desire imposed against their will. Similarly, their discussion of the patient with severe phobia of general anesthesia demonstrates how careful exploration of second-order desires can reveal whether treatment refusal represents genuine agency or phobic compulsion.

Significant Differences

Despite substantial convergence, important differences remain between Zürcher et al.'s analytic-philosophical approach and my theological-hermeneutic framework. These differences reflect fundamentally different orientations toward the nature of healing relationships.

The most significant difference concerns the directionality of the clinical task. Zürcher et al., despite their relational insights, ultimately frame the clinician's work as assessing whether the patient possesses free will. They write that "the evaluating physician shouldn't only ask what patients want with regard to their actions but also what someone wants to be his or her will" [51].

My framework goes further: the clinician does not merely assess but actively co-creates the conditions for agency to emerge. This is not assessment of capacity but participation in its genesis. The distinction matters clinically—it shifts focus from evaluation to presence, from judgment to witness, from epistemology (what can I know about this patient's capacity?) to ontology (what quality of therapeutic being serves healing?). The theological language I have developed—tzimtzum, Shekhinah, sacred brokenness—captures something the analytic-philosophical framework cannot: the fundamentally covenantal rather than contractual nature of the healing relationship.

The Role of Suffering and Meaning

Zürcher et al.'s framework, grounded in analytic philosophy, focuses on volition, desire-hierarchy, and authenticity [51-53]. While valuable, this misses what I have identified as the central challenge of clinical practice: the problem of suffering and meaning. When patients face terminal diagnosis, chronic pain, or addiction, the deepest question is not simply whether their choices reflect their true desires but how they will make meaning in the face of loss, limitation, and mortality. My framework addresses this existential dimension directly. The broken vav represents not merely impaired volition but the necessity of constructing meaning within constraint. The concept of sacred brokenness recognizes that healing often requires not restoring previous wholeness but creating new forms of integrity that incorporate loss.

For Zürcher et al., drawing on Frankfurt, the normative force of respecting patient agency derives from the value of authenticity—honoring choices that reflect the patient's "deep self" [51-53]. This is important but insufficient. My theological framework grounds the normative claim differently: we must honor patient agency because the therapeutic encounter is sacred space where we meet the divine in human vulnerability. This is not merely rhetorical. When I argue that suffering brings Shekhinah presence, I am making a metaphysical claim: there is something sacred about the encounter with human vulnerability that demands a particular quality of attention and care. Medical practice becomes not merely technical craft but spiritual discipline.

Toward an Integrated Framework

The convergence between Zürcher et al.'s philosophical analysis [51] and my theological-hermeneutic approach suggests the possibility of an integrated framework that combines the conceptual precision of analytic philosophy with the existential depth of theological reflection. Such integration might proceed as follows:

First, adopt Zürcher et al.'s core insight that standard DMC criteria must be supplemented by attention to the alignment (or conflict) between first-order and second-order desires. This provides clinically operationalizable language for what I have described as the difference between choices that reflect the patient's "deep self" and those imposed by compulsion, fear, or external pressure.

Second, recognize with my framework that the assessment of desire-harmony is not neutral observation but relational achievement requiring therapeutic tzimtzum. The clinician cannot stand outside the patient's situation as objective evaluator but must practice self-contraction to create space where authentic desires can be articulated and examined.

Third, understand that even harmonious alignment of desires may not be sufficient for genuine agency if structural constraints radically limit the patient's options. My emphasis on addressing material conditions (housing, food security, social support) as essential therapeutic interventions must supplement any philosophical account of free will. Agency emerges not from internal desire-structure alone but from the interaction of internal capacities with external possibilities.

Fourth, maintain my framework's insistence that healing relationships are sacred encounters demanding particular qualities of presence, attention, and courage. The conceptual apparatus of compatibilist philosophy helps us think more clearly about volition, but it does not capture what makes clinical practice meaningful, challenging, and transformative for both patient and clinician.

Fifth, apply both frameworks to the central clinical challenges of adherence and addiction. Zürcher et al.'s analysis of harmonious versus conflicted desires provides useful language for clinical assessment. My theological framework provides deeper resources for understanding what is at stake existentially when patients struggle with adherence or addiction—not merely failures of volition but crises of meaning, identity, and relationship.

Conclusion

Zürcher et al.'s article [51] provides significant validation for central claims of my hermeneutic framework: that patient agency cannot be assessed without attending to contextual, relational factors; that the therapeutic relationship itself influences whether patients can exercise agency; that clinical practice requires attention to inner conflicts that standard DMC assessment misses; and that patients with significant psychopathology or addiction may nonetheless possess genuine agency under supportive conditions.

At the same time, the convergence between our frameworks—

one from analytic philosophy, one from theological reflection—suggests that the insights I have developed through Jewish mystical categories address real clinical phenomena that thoughtful clinicians across traditions recognize as essential. The fact that Frankfurt's compatibilism [52,53] (developed to address abstract metaphysical puzzles about determinism) and Jewish mystical theology (developed to address the problem of divine presence after catastrophic loss) arrive at similar conclusions about human agency is not coincidence.

Both traditions recognize that agency is not simple property but complex achievement, not individual possession but relational emergence, not metaphysical given but practical possibility requiring particular conditions to manifest. For clinicians, this convergence matters practically. We need not resolve abstract debates about whether determinism is true or what "ultimate" metaphysical freedom requires. Instead, we can focus on the clinically actionable question: How do we create conditions—through therapeutic presence, attention to desire-conflicts, addressing structural constraints, and sacred witness to suffering—that enable maximal patient agency?

This is the synthesis I have been developing across my published work: a framework that honors both scientific rigor and spiritual depth, both neurobiological constraint and human possibility, both therapeutic technique and sacred encounter. Zürcher et al.'s article [51] demonstrates that mainstream medical ethics is moving toward recognition of these same insights, even if our philosophical vocabularies differ. The challenge ahead is to translate these insights into medical education, clinical protocols, and healthcare policies that support the relational, contextual work required for genuine therapeutic presence.

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