Science Communication and Health

Fostering Trust in Doctor-Patient Interaction

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Introduction

Health, language, and trust

This book is concerned with the interaction between doctors and patients. The goal of the book is to show that doctor–patient communication can have a positive or negative impact on the therapeutic relationship, depending on the quality of the communication. In particular, I am going to show with philosophical and linguistic tools that high-quality interactions and communication contribute to fostering trust between physicians and their patients, thus consolidating therapeutic alliances. Ultimately, patients' health benefits from high-quality communication with their doctors. This means for physicians to take care of communication in terms of explicit and implicit meanings, and of asymmetries implied in doctor-patient relationship. Physicians' awareness of the importance of effective communication and their ability to handle it would assure a patient-centered approach, in which patients and their perspectives and feelings are considered. That would be the basis of reciprocal trust, which—not only being based on trust in the authority—would gain in solidity.

The link between health and communication has historical roots that date back to the time of Ancient Greek civilization. According to humoral theory, the silence of our organs was a clear sign of a healthy body; conversely, a non-silent body was sick. Even though humoralism has long since been overtaken, it indicates a strong link between health and language that is still interesting to consider today. Figuratively speaking, the presence of a disease prompts the body to "speak" through symptoms, signaling that something is wrong. Since most of us are not experts in interpreting this language or in providing the answers a sick body seeks for relief, we rely on doctors to do that for us. Physicians act as interpreters, translating the body's distress signals into diagnoses and treatments, guiding us through the complex language of illness and healing. "We put our bodily safety into the hands of […] doctors, with scarcely any sense of recklessness," writes Baier

(1986, p. 234). That is why "trust is important, but it is also dangerous" (McLeod 2021). Even though we still entrust our health to physicians, blind trust in doctors is no longer typical in modern medicine. With the advent of the Internet, self-diagnosis has become more common (Ryan and Wilson 2008), and many patients believe they can interpret their symptoms independently. This shift makes effective communication even more crucial for establishing a therapeutic relationship grounded in trust, which is essential for achieving the desired health outcomes. By addressing patient concerns and ensuring clear, empathetic dialogue, doctors can strengthen the trust needed for effective treatment.

"Trust, the phenomenon we are so familiar with that we scarcely notice its presence and its variety, is shown by us and responded to by us not only with intimates but with strangers" says Baier (1986); such is the case with the doctor–patient relationship. When people ask for medical advice, they become patients; in Sokolowski's words, they "submit themselves to be determined in their future condition by the one they consult" (Sokolowski 1991, p. 28), i.e., the physician. This marks the beginning of the relationship and the moment the doctor-patient interaction starts. Patients depend on physicians to restore their health, placing their trust in the doctor's ability to interpret the meaning behind their symptoms and provide the best possible treatment for their illnesses. This trust forms the foundation of the therapeutic relationship, guiding the way toward effective care and recovery. Along with Clark, "as patients […] we trust physicians to keep our health concerns first and foremost" (2002, p. 11). Patients trust physicians to the point of getting naked in front of them (what Sokolowski call "the phenomenon of nakedness," 1991, p. 28)—both literally, by getting undressed, and metaphorically, by sharing intimate information and relying almost completely on their expertise.

Birkhäuer et al. (2017) conducted a meta-analysis to demonstrate that, despite smaller correlations "with health behaviors, quality of life and symptom severity" (p. 1), there is a direct correlation between patients' trust in healthcare professionals and their level of satisfaction with the care they receive (on this topic, see also Lipkin et al. 1995). Rhodes goes

beyond noting this positive correlation, claiming that "the first duty of medical ethics is to seek trust and be deserving of it" (2020, p. 51), and at the same time remarking on the strong link between trust and trustworthiness that we already find in Hardin (1992; 2002). Rhodes asserts that this duty is "the source from which all of the other more specific duties are derived" (2020, p. 53), considering trust and trustworthiness to be the basis of good medical practice and a strong doctor–patient relationship.

As patients, we rely on physicians to interpret what our bodies are telling us in situations where the "outcomes are unknown" (Robbins 2016), such as during illness. Conversely, when physicians trust their patients, it boosts their own well-being and satisfaction, fostering a positive feedback loop. This mutual trust strengthens the bond between doctors and patients, enhancing trust on both sides. (Pellegrini 2017; Sousa-Duarte et al. 2020). In this work I argue that trust must be reciprocal to be a strong basis for therapeutic alliances: doctors must be trusted by their patients and trust them, too. Meeting this requirement would strengthen their relationship. The doctor–patient relationship is considered "a keystone of care" and is primarily developed through medical interviews, which are described as "the major medium of health care" and the key space for building trust. Interestingly, despite the fact that much of the medical interview involves "discussion" (Dorr Goold 1999), patients seldom have the opportunity to engage directly with the experts they rely on for their health. Throughout medical tests, treatments, and surgeries, interactions between doctors and patients are limited. This makes it crucial for both doctors and patients to understand and effectively manage communication dynamics within these medical encounters.

Trust is "just one way in which a trust relationship may be begun" (Baier 2013, p. 10). The relationship can sometimes start with a distrustful patient, which may stem from past negative experiences with the healthcare system, emotional instability, or the physician's poor reputation. Alternatively, it might begin with a skeptical physician, perhaps due to reports of low compliance from a referring colleague, unfamiliarity with the patient's condition, or discomfort arising from a familial connection

with the patient. Additionally, both the patient and doctor might simply be having a bad day, hindering the establishment of a new relationship. The reasons for beginning without trust are numerous and varied. Consequently, trust needs to be cultivated—often from the ground up or under challenging circumstances—to foster that invaluable connection between patient and physician known as the therapeutic alliance.

Book structure

This book is entirely dedicated to exploring doctor–patient interactions from a philosophical and linguistic perspective; the main purpose is to show that effective communication and trust are strongly interconnected, thus affecting the course of treatments. In particular, I support the conception of performative language, according to which every time the speaker says something also does something. This perspective, that has a long tradition in the philosophy of language debate,[1] if applied to the context of doctor-patient communication is compelling in explaining the dynamics related to the construction and consolidation of trust. The book is composed of chapters—following this Introduction—that cover different areas of interest related to this major topic.

Chapter 1, "Classical advice: Galen and the *art* of medicine"[2] addresses the possibility of a broader medical education, one that includes not only scientific subjects but also humanistic ones. A broader education would also provide them with more sophisticated tools to understand the dynamics of language as performative, thus enabling them to better handle it. The chapter goes further, suggesting that a new (or maybe ancient!) idea of medicine is advisable. In particular, it explores Galen's idea of medicine. The doctor–patient interaction would benefit from a more comprehensive approach, one that encourages physicians' ability to connect with their patients and take care of them with a view to their context of belonging. This would reflect on their communicative com-

[1] On the topic, see the voice *Speech Acts* on the Stanford Encyclopedia of Philosophy.

[2] This chapter is a revised and expanded version of Consolandi and Agnelli 2024.

petences, thus—as I previously stated—fostering trust.

Chapter 2, "Implicit Assumptions and Trust within the Doctor-Patient Dynamic: A Philosophical Linguistic Examination of Preoperative Consultations"[3] examines what is understood implicitly in doctor–patient interactions. It aims to reveal hidden meanings following Grice's theory of implicature (Grice 1975). Implicatures are often misleading in doctor–patient interactions: implicit assumptions and omissions cause misunderstandings, rendering the dialogue confusing and leading the therapeutic relationship in undesirable directions. It is intuitive to imagine that the latter run counter the strengthening of a trust-based relationship. In this chapter, I suggest that it is important for physicians to be aware of this aspect of discourse, which can be dangerous if not acknowledged and fruitful if well managed. Physicians who can handle the two main levels of communication would also be able to make it work, thus fostering a trusting relationship with their patients.

Chapter 3, "Eumanipulation: From organ donation to doctor–patient communication"[4] suggests a new and positive communication tool, which offers physicians a professional way to lead the interaction that is respectful of the patient's perspective. The example of organ donation shows that manipulative techniques have already been employed in doctor–patient and doctor–family interactions in recent years. The new communication approach, eumanipulation, would reframe such techniques within the patient-centered conception of medicine. Substantial differences between eumanipulation and nudging and advertisement are set out. Eumanipulation enlists physicians' communicative skills and their efforts to involve patients in a reciprocal sharing of points of view. It has to be framed in the conception of a non-neutral language, that is indeed performative and aims to reach a specific goal (Mercier 2016). It aims to replace unethical techniques of persuasion—counterproductive in terms of reciprocal reliability—, instead nurturing sincerity and openness to foster trust in the relationship.

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[3] This chapter is a re-elaborated and expanded version of Consolandi 2023.

[4] This chapter has been published in Italian (Consolandi and Riccio 2020). In this book you can find a revised English version.

The structure of the book is characterized by a theoretical-practical approach: every hypothesis is supported by examples taken from real situations, which in turn influenced the development of the theory itself. The dialogue between theory and practice is constant. When not already provided in the chapter, the applied section follows the theoretical separately in the Annexes. According to the idea that language is performative, in the Annexes 1 and 3 I analyze what happens in the dialogue between the doctor and the patient; in particular, the consequences of what is said and of the way in which it is said. Data analyzed in these two Annexes come from the research study *COMMUNI. CARE (COMMUNIcation and patient engagement at diagnosis of PAncreatic CAncer): study protocol*.[5] In this research, doctor–patient interaction is observed during the communication of a pancreatic cancer diagnosis by the doctor; a semi-structured interview with the patient follows: they are asked for their opinion about the correlation between effective communication and trust. The ultimate goal of this pilot is to explore a possible link between patients' understanding, trust in their physicians, and their compliance. Despite the very specific context of the study protocol—the oncological setting—, data were suitable for those chapters that concern cross-cutting issues in doctor-patient communication (as said, Chapter 1 and 3). In the *Appendix*, the published version of the study protocol may be consulted.[6]

My choice was always to adhere strictly to reality and to try to answer to existing issues in medicine. This choice affected the selection of aspects of the major topic to explore, in terms both of available data and especially of what I see as the urgency of further investigations on the topic.

As a philosopher currently in a multidisciplinary research unit, I am lucky to work on current topics from various perspectives. Since we are focusing on the application of Large Language Models in health

[5] The study protocol has been published; see the Appendix.

[6] Unfortunately, the Covid-19 pandemic inevitably impacted the study protocol. Nonetheless, it gave me the opportunity to work together with excellent healthcare professionals and to be directly in contact with patients' stories. Thus, the positive effect of this work can be silently found throughout the book. Results can be read in Consolandi et al. 2024.

contexts, I have decided to expand Chapter 2 with Annex 2, which demonstrates the application of the philosophical approach to Artificial Intelligence.[7]

Even though I do believe in the power of language to overcome barriers and hindrances, I am aware that my position is privileged. As a white, Western researcher, living in a technologically advanced country where the healthcare system is mostly publicly funded, I understand the limits of my work. Nevertheless, I am committed to widening my perspective to take part in a more inclusive and just world. I hope to have the chance to broaden my research and explore some of the missing facets of this work in the near future.

The therapeutic alliance, patient-centered care, and time

To properly contextualize the present work, it is useful to frame the main terms related to trust in doctor-patient relationship: therapeutic alliance and patient-centered care. The alliance between doctors and their patients is called therapeutic because "the quality of these relationships can affect health outcomes" (Street et al. 2009, p. 298). Epstein and Street consider the therapeutic alliance one of the intermediate outcomes of effective communication between physicians and patients that "can contribute [to], but do not guarantee, actual improvement in patients' health or health behavior" (2017, p. 11). They stress that effective communication is a key factor in patient-centered relationships in delicate contexts, such as cancer care. This is undoubtedly true; nonetheless, doctor–patient communication must always be effective, not only when it is about a severe diagnosis and prognosis. The medical encounter is the venue for building a therapeutic relationship intended to last for a given period. Physicians and their patients discuss health topics that may include life-affecting decisions, complications, and side effects of pharmaceutical therapies. Thus, their relationship influences

[7] The topic of Artificial Intelligence in the health domain cannot be covered in just a few lines. Since this book is not the place for an in-depth discussion, I refer interested readers to Consolandi et al. (2023) for a brief overview of the ethical principles involved in this sensitive domain.

healthcare outcomes in every circumstance, not only in the case of severe conditions (Kelley et al. 2014). From a headache to lung cancer, effective physician–patient communication has a direct correlation with improved patient health outcomes (Stewart 1995; Chipidza et al. 2015).

The physician and the patient should be allies working together: they must know and trust each other to be able to face the disease, and this knowledge and trust find their development and expression during the physician–patient interaction. The medical relationship is a form of collaboration in which the two parties work together to grasp what is happening. When patients and physicians communicate, the latter are professional translators of a speaking body, i.e., of symptoms. Symptoms must be contextualized to be fully understood, as they may suggest a variety of possible explanations. Thus, patients' perspectives do count; their experience is crucial because it allows physicians to figure out what is happening and in what circumstances. Among physicians' tasks, listening to their patients' experiences is one of the most important for understanding the situation and being in contact with their patients' stories. The literature on this topic is rich. Among others, Carel (2016) suggests a methodology based on first-person reports, thus paying specific attention to the patient's point of view. Along with Sartre, she distinguishes between i) the experience of the body as objective and as subjective, ii) the body perceived as reflected in others' experience, iii) and intersubjectivity, that I here consider characterizing the communicative dimension of care. Malherbe (2007, p. 207) refers to the same distinction when talking about the "subject of life" and the "object of care," claiming that "l'enjeu fondamental de la médecine est la place qu'elle reconnaît ou qu'elle dénie à la parole".[8] Since patients are both the subject and the object of their care, it is inevitable that they are the center of care, which is primarily about them. The following real-life example shows us the power of placing patients at the center of their own care.

In a short story, Dr. Dugdale (Internal Medicine Primary Doctor and

[8] English translation: "The fundamental issue of medicine is the place that it recognizes or denies to the word."

Medical Ethicist) presents us with a "tough" patient, experienced by the medical team as difficult. One day, this patient demanded that medical students sit down and listen to his story; as the story progressed, Dr. Dugdale, who was the senior physician, found herself thinking, "*What a gift!* Through his invitation to simply sit and listen, he hadn't given us some *thing*; he had given us himself" (Dugdale 2019). The difficult patient turns out to be a person seeking doctors' attentive consideration: though physicians took care of him for years, he never felt that he was listened to. Indeed, after Dr. Dugdale gave him the article she had written about him, he started crying and said, "Thank you for noticing me." Patient-centered care (PCC) requires that physicians actively listen to their patients to treat them with true dignity. Patient-centered care has been shown to influence the process of care in multiple positive ways, including satisfaction and self-management, among others (Rathert et al. 2012). "I'll come get you where you are," says a psychologist in defining the patient-centered approach (Galvagni 2020, p. 83, my translation). This beautiful image shows us two main features of PCC.

First, it illustrates the centrality of the patient, who is indeed the focus of the relationship of care: healthcare professionals relinquish their paternalistic role in favor of a more dialogical approach in which questions like "What matters to you?" and "What is the matter?" are always at stake (Berry and Edgman-Levitan 2012). This is the bright side of PCC: clinicians are no longer "guardians" (Emanuel and Emanuel 1992) involved in a simple "father-child relationship" (De 2004) with patients but rather serve as their coaches and partners (Berry and Edgman-Levitan 2012) or their friends and teachers (Emanuel and Emanuel 1992). Patients' values and beliefs, their desires and fears are all at stake: consideration extends beyond physical health to "social and mental well-being […] as a resource which permits people to lead an individually, socially and economically productive life" (WHO 1998). In their communication, physicians and patients talk about health-related values and together try to select the available option that best suits them (Emanuel and Emanuel 1992). "You must try to understand your patients' needs," says an HIV-infected patient to medical students (Galvagni 2020, p. 75, my translation). Doctor-patient communica-

tion mirrors PCC approach, that allows the doctors to catch patients' perspectives and experiences. In this book, I will show how this can be fruitfully combined with the performative dimension of language instead of seeing it as merely descriptive. Indeed, as I already stated, every time we speak, we do something. In the delicate context of doctor-patient communication, doctors must be aware of this to properly handle the interaction with their patients and expect positive tangible outcomes.

Despite going beyond the paternalistic model, the second feature of PCC highlights the intrinsic asymmetry of the physician–patient relationship.[9] The professionals are the ones who go to "get you where you are," because they have the skills and competences to lead patients toward the best route. This kind of asymmetry is undisputed: we seek medical advice because we need doctors' expertise, which they acquire over many years of study and practice. We should consider a less obvious consequence of this asymmetry in terms of communication. This leadership role of physicians is reflected in the interaction: they engage in the conversation because patients seek relief, thus relying on physicians' help. Doctors need to be aware of their role and its implications to properly manage the interaction according to the above-mentioned definition of PCC. Otherwise, topic changes could result in "the illusion of shared understanding" (Ariss 2009): physicians must lead the conversation to prevent disagreement due to, for example, abrupt topic shift and misunderstandings.

It is often protested that this kind of approach requires a lot of time,[10] which physicians do not have. I suggest, rather, that it is not a matter of how long the interaction takes but of how the time is spent (see Torres et al. 2018). Custer et al. (2019) develop a list of ten fundamental communication behaviors that should occur in every interaction; even though this could lead to somewhat rote consultations, the list

[9] There is a huge literature on the topic. A great summary can be found in Pilnick and Dingwall 2011.

[10] For a detailed analysis of this claim, see Höglander et al. 2020 and Laws et al. 2011.

highlights that it is possible to optimize the time available and focus on specific tasks. It is alarming that patients are worried about wasting physicians' time because of their feeling that they are just "another one" (Llanwarne et al. 2017). Being aware of the power of their interaction with patients would allow doctors to organize the consultation time to focus on patients' experience—"to listen […] in touch with [patients'] experience of time […] that has nothing to do with the clock, or measurable time" (Borgna 2015, my translation). Physicians do not need more time to be good communicators; they need to shape the available time to be more focused on the relationship, fostering and deserving their patients' trust.

The roles of physicians and patients

At this point in the speech, it is worthy to become better acquainted with the main characters of clinical relationships: patients and doctors.

The word "patient" has a double application: it can signify a person in the medical system or anyone who has patience in dealing with something that is not easy. When we say, for example, "You're so patient with me!" we mean that the person we are talking to is able over time to accept and support us even with our difficult characteristics. These two applications have a common denominator: patients are, etymologically speaking, those who suffer (from Latin *patior*); today, this meaning is still present in the definition of patients, who are those who bear pain. Pain, discomfort, and distress are connoted in the role of the patient, who is expected to do whatever is needed to heal, following doctors' suggestions. In PCC, the latter must be aligned with patients' health-related beliefs and desires, which can be explored during the medical encounter. The time of communication thus itself becomes a time of care, as it is said to be in Italian law (n. 219/2017). Since physicians are the interpreters of the language of disease, they have responsibility to translate this language for the patient, who is personally involved. This shows a delicate aspect of the interaction: the patient is not only one of the two interlocutors but also the subject of the interaction. When phy-

sicians explain a disease and available clinical solutions, they are in fact dealing with more than that. The patient's body, quality of life, future changes, autonomy, beliefs, needs, and desires are all at stake in the physician's office. The duty physicians have as translators of symptoms is even more challenging than just interpreting the signs of a disease: they must listen carefully to their patients to be able to see the overall picture. "A way to bring the attention back to the patients and really put them at the center of care is, among other things, restoring a space for them to speak," says Galvagni (2020, p. 223, my translation). This serves, as we said, to support proper diagnosis and to guide and support patients in their decisions.

Considering the patient as the core of care is a big step forward; however, there is still something missing. Beyond (or perhaps within) the role of patient, there is a human being with a personal history, a family, cultural roots, beliefs and desires, dreams, hopes, and fears that are not necessarily health-related. When communicating with patients, doctors should always keep in mind that they are engaging with persons and that this is not secondary. As Husserl stated, the body is always both *Körper*, the objectified body, and *Leib*, the experienced body (Husserl 1961). In modern words, this reflects the difference between *disease*, the clinical perspective on patients' conditions, and *illness*, the patients' experience of their own disease, which must be contextualized in patients' lives in their entirety. If physicians consider patients only as objectified bodies, strictly or mainly treating the disease, they are cutting off an essential part of patients' experiences and realities.

In terms of communication, an example may clarify. Imagine a typical doctor–patient encounter, in which two doctors sit on a chair on one side of the desk and the patient, a male in his fifties, sits before them. While one of the doctors communicates with the patient, the other one schedules appointments and exams for him. Doctor 1 is now talking with the patient about his condition, a rare form of disease, describing the available possibilities and making clear that it is important to act quickly so as not to let the disease worsen. Meanwhile, Doctor 2 is on the phone speaking with radiology to make sure that the patient can

have X-rays taken as soon as possible; she is also printing out the schedule of other tests the patient is supposed to take in the days ahead (CBC, CMP, ECG…). The patient in the room is a father with three children and is now worried and keeps thinking about them. He is asking himself whether he will still be able to provide for them and for his wife; his family is not rich, and if he stops working, they will surely be in trouble. Furthermore, he is scared: he loves them so much and cannot stand the idea of dying and leaving them. The patient is experiencing a split in his experience: one doctor is giving him the worst-scenario diagnosis, and the other is already scheduling the necessary tests to move forward. And since Doctor 1 has just told him that it is important to move quickly, he as patient is grateful to Doctor 2. The patient is glad to be in a hospital where two doctors are taking care of him; he feels safe in their hands, and he knows that he must follow their instructions to heal if possible or at least improve his condition. But the father of three children, husband of his beloved wife, is experiencing a trauma in a confusing setting: the noise of the printer is loud and annoying; while Doctor 1 utters words such as "Your condition is severe" and "We need to move fast or there's certainly no coming back from this," Doctor 2 is chatting on the phone with the radiologist, saying, "Hi, dear, how is your niece? Did she recover from her cold? So, I have an urgent appointment to be made." The man is living this interaction from two different perspectives: his role as a patient, and his life as a human being (within which we could identify additional roles: father, husband, worker…). In the first role, he is satisfied; in the second, he is totally distressed, and there is no space in this kind of interaction to express his fears. It is evident that these two roles must be reconciled.

Physicians may represent a great support for patients who experience this kind of existential split, which is not uncommon. Interactions with patients afford the moments when doctors can—and must—take the opportunity to build and consolidate a solid therapeutic alliance based on trust that will allow them to cooperate. It is thus fundamental to be in contact with patients in their entirety: not only as suffering beings, but first and foremost as human beings experiencing illness.

The duty of physicians to be good communicators

I have clarified that physicians must be good communicators for and with their patients. As I mentioned before, this means to be able to understand and well handle the performativity of language, thus recognizing its powerful in terms of actions. Communication in the healthcare system has many variations: it may occur on the organizational level, between healthcare professionals, or with patients' families. The doctor–patient interaction is the foundation on which every other form of healthcare communication relies. It constitutes a privileged moment in which relationships between clinicians and sick people take shape. Communication is thus not only a means but also and especially the favored moment when a trustworthy relationship can be established. According to Lazare et al. (1995), a key task of physicians is "to recognize and resolve various relational barriers to patient/clinician communication" and "elicit the patient's perspective" during the medical interview as part of developing, maintaining, and concluding the therapeutic relationship. To meet this requirement, physicians need not only to be good clinicians but also to be good communicators. Knowing and understanding language and its dynamics is essential to orienting themselves during their interactions with patients so they can "recognize and resolve various relational barriers," which are a common occurrence in doctor–patient interaction. Otherwise, poor communication may bring about the opposite scenario, i.e., misunderstandings and loss of trust, also possibly influencing patients' adherence to treatment. Eliciting the patient's perspective should not be understood from a paternalistic point of view, in which the doctor tells the patient what to do; instead, it means stimulating patients' expression of their values and asking questions to clarify their thoughts about their condition.

Doctor–patient interaction can and should be a safe space for the speakers involved, based on mutual trust. According to Chalmers, trust in physicians is "the cornerstone of an implicit contractual arrangement between society and the medical profession" (2002, p. 16). This is undoubtedly true, as Rhodes (2020, p. 48) explains in a vignette: a woman is asked to disrobe by a stranger who handles and probes her

body, touching her sexual areas and, after collecting some of her blood, decides to render her unconscious, invade her body with knives, and remove some body parts. Had this stranger not been a surgeon, this story would sound horrifying. This social contract, however, cannot be separated from a form of trust that is strictly concerned with the relationship between doctor and patient as individuals. As in Cardano et al. (2020), micro-sociological dynamics must be investigated and understood before moving to the macro-sociological. Trust between doctors and patients must be nurtured; it is not a foregone conclusion but the desired constant of the relationship and the aim of several remarkable examples of Codes of Ethics.

The language used by physicians as they lead the interaction must be chosen wisely. Physicians "should be able to convey all that their patients need to know in order to make their treatment and life decisions" (Rhodes 2020, p. 164). In line with this, the Italian law n. 219/2017 considers communication between physicians and patients an integral part of care. References to communication also appear in the Italian Code of Medical Deontology. The most interesting article is art. 20, dealing with the therapeutic relationship, here quoted in full: "The doctor–patient relationship is built on freedom of choice and the identification and sharing of reciprocal autonomies and duties. In this relationship, physicians should establish a therapeutic alliance based on reciprocal trust and reciprocal respect of values and rights, and on understandable and complete information, considering communication time as care time." This is later referred to in art. 33, where it is also said that "the physician should adapt communication to the patient's ability to understand." In the Italian professional oath, trust and understandable information are linked together in the following bullet point: "[I swear] to pursue a therapeutic relationship with the person being assisted, that is, the patient: a relationship that is based on trust and respect of values and rights and on understandable and complete information."[11]

The Australian Medical Association Code of Ethics says that "the doctor–patient relationship is a partnership based on mutual respect, col-

[11] All translations are mine.

laboration and trust" (1.5) and that physicians should "communicate effectively with the patient" (2.1.4). In the Canadian Medical Association Code of Ethics, the paragraph "Communication, Decisions Making and Consent" is entirely dedicated to this topic.

In the UK's Good Medical Practice, the first statement reads as follows: "Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law." These ideas are reinforced and clarified in the paragraphs about "Communication, partnership and teamwork" and "Maintaining trust."

This brief overview shows us that trust and communication must be considered as integral parts of medical professionalism and that they are interrelated. Furthermore, physicians have a duty to be trustworthy and good communicators, a duty that corresponds to patients' rights to be well informed, understand their own condition, and trust their doctor. It is interesting to notice that the opposite is not as obvious: it is not considered a duty of patients to be trustworthy and good communicators. This can be easily explained given that it is the physicians who play a professional role in the interaction: their role is defined by a profession characterized by deontological codes and limited by laws. It is noteworthy that physicians are in a stronger position than patients: they are the experts in the general topic they and their patients are dealing with; they are in charge of the conversations with their patients; and their patients are in a weaker position because of their health status. Consequently, it is incumbent on physicians to oversee good communication. Despite this, it is essential for both parties to be honest and trust each other to "choose between many possible worlds and decide how the world actually is and how they would like it to be," thus "creating a medical reality" (Nessa 1995). A study reveals that physicians define "bad" patients as ones with negative personality characteristics, including dishonesty (Borracci et al. 2020). Even though the role of patients is not a professional role with duties, trustworthiness and clarity in

communication should honor the therapeutic alliance patients establish with physicians; besides, the opposite would have negative repercussions for their own health outcomes.

Since good communication is the privileged vehicle for building and maintaining the therapeutic relationship, it must be considered an essential feature of the ideal doctor–patient relationship (Emanuel and Dubler 1995). *Through* communication as a tool, and *within* communication as a shared portion of space-time, the doctor–patient relationship flourishes. Good communication is the key to every kind of doctor–patient relationship, from cases in which the diagnosis is a simple influenza to cases leading to a poor prognosis (Fong Ha and Longnecker 2010; Honavar 2018). Tools have been developed to help doctors and patients orient themselves in their delicate relationships. The Society to Improve Diagnosis in Medicine has created the *Patient's Toolkit*[12] to help patients prepare and orient themselves before and after the visit. There, a patient can find questions to ask physicians, tables to summarize what physicians have said, and suggested ways to pay attention to themselves and their symptoms. In line with this goal, online communities such as One for All: The Connected Community of PatientsLikeMe[13] are emerging to support patients throughout their experience of various diseases. *I do not know what to say* is a pamphlet conceived by AIMAC, the Italian Association of Cancer Patients, Relatives and Friends to overcome obstacles in communication;[14] it is designed for everyone who deals with cancer patients and experiences difficulties when interacting with them in the context of their disease and condition. A disclaimer warns that the information on the website is intended to enhance the doctor–patient relationship and not as a substitute for it. In fact, these tools must be considered as complementary to the patient's interaction with the physician, which is always in first place in order of relevance.

[12] https://www.improvediagnosis.org/patients-toolkit/.

[13] https://www.patientslikeme.com/.

[14] https://www.aimac.it/libretti-tumore/parlare-malato-cancro.

The language of physicians: A taxonomy[15]

A successful doctor–patient relationship is the basis for a solid therapeutic alliance (Kaplan et al. 1989; Sledge et al. 1987; Anderson and Zimmerman 1993). Communication affects the building of this relationship, influencing aspects ranging from patient satisfaction, recall, and understanding, to coping and quality of life (Ong et al. 1995; Stewart 1995). Clinical medicine can be seen as "communication between two people … [aiming to] establish an effective working relationship in which there is mutual trust" (Irwin 1989, p. 387). When this communication is ineffective, it leads to negative outcomes (Foronda et al. 2016). In seeking to identify the ideal patient–doctor relationship, Emanuel and Emanuel (1992) compare four models of the doctor–patient interaction as a whole. In contrast, I here focus specifically on the mode of communication between physicians and patients at the moment in which the two parties come into contact to provide a general overview of communicative styles adopted by physicians with their patients. This will help clarifying what I have in mind when I stress the importance for physicians to be good communicators and what this means. I propose a taxonomy complementary to Emanuel and Emanuel's, emphasizing the different forms of communication between doctor and patient and thus restoring proper value to the linguistic dimension of this relationship. In fact, when communication with patients is effective, patients experience increased satisfaction, greater adherence to treatment, and improved health (Charlton et al. 2008). Not every form of communication is recommended and in line with the PCC approach.

The relationship begins with a patient's first conversation with the doctor. Both doctor and patient recognize each other with a simple greeting, and the doctor inquiries about the patient's specific concerns. The conversation then shifts to the patient's personal details and prob-

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lems, starting with basic information and moving to deeper questions. Doctor–patient communication explores many aspects of the patient's life, and knowing how to communicate properly is part of the doctor's responsibility (Roter and Hall 1992; Zoppi and Epstein 2002; Ha et al. 2010). The space dedicated to communication with the patient has to be as effective as possible; communication must achieve clarity in a reasonable amount of time. The more effective communication is, the more trust can flourish.

How can a successful communication be achieved? Guidelines to answer this question are numerous. The most famous philosopher who focused on communication and how to make it work is Grice; despite many things have changed since his reflections, these are undoubtedly still relevant. Grice suggests that in any kind of conversation, two or more speakers must follow four maxims to make a conversational interaction work: (i) quantity: "make your contribution as informative as is required; do not make your contribution more informative than is required"; (ii) quality: "do not say what you believe to be false; do not say that for which you lack evidence"; (iii) relevance: "be relevant"; (iv) manner: "be perspicuous," "avoid obscurity of expression; avoid ambiguity; be brief (avoid unnecessary prolixity); be orderly" (Grice 1989, p. 28). I believe that Grice's criteria can be applied to the communication between doctor and patient; nonetheless, doctor–patient communication requires much more nuance than Grice's rules suggest. It is not always possible to support all statements with evidence: medicine is not an exact science, and evidence constantly evolves. Furthermore, the appropriateness of "be brief" is controversial, since, despite time constraints in medical practice, some topics require lengthier explanations. Additionally, some conversations with patients naturally lend themselves to metaphor or joking, that are effective in lubricating conversation. Grice argues that we must consider the literal meaning of these particular linguistic phenomena and only in a second moment shift to their contextual use to fully understand the speaker's intention. Nonetheless, this point is controversial and still generates disagreement in the debate (in particular, see Carston 2010 and Sperber and Wilson 2008). In line with his original aim, I suggest that Grice's maxims can

be accepted as a general guide to improving the comprehensibility of the content of communication, knowing that the best communication exceeds them.

Grice also notes that language is not only about the *content* of communication; it has much to do with the *form* of communication as well. I support his point of view, claiming that, depending on the form of communication, physicians may or may not enhancing trust and the therapeutic alliance with their patients. I thus suggest a taxonomy of forms of doctor–patient communication based on its degree of technicality, ranked from highest to lowest: (i) technical language, (ii) descriptive language, (iii) vernacular language, and (iv) unprofessional language.

Technicality is the touchstone to highlight closeness (or distance) between physicians' and patients' worlds. Technical biomedical language is a highly specialized form of communication used by physicians to refer to patients' medical conditions. Such language is part of what constitutes the expertise of doctors, enabling them to communicate concisely. When the interlocutor is another doctor, technical language may offer the most efficient means of communication. To the patient, however, technical language may sound foreign: the terms used are not part of a common vocabulary. It is not an overstatement to say that a patient may become lost when doctors use terms like "renal failure" or "hypercholesterolemia." Technical language can even be frightening. Although very precise, its incomprehensibility to patients fails to answer their questions and relieve their doubts. Additionally, this kind of language facilitates medical paternalism because it allows the physician to retain control by establishing a hierarchy of knowledge. Technical language can make it difficult to connect meaningfully with patients, who remain distant instead of being at the center of care.

When questions arise, physicians may draw on descriptive language, translating medical jargon into language that patients can more easily understand. Here the physician unfolds and clarifies the medical world, explicating technical terms and making them accessible. The physician essentially becomes a translator for the patient. For example,

a doctor may explain "renal failure" as "kidney problems" or "worsening kidney function." Descriptive language can lead to both positive and negative outcomes. Depending on the patient's level of education, this language could still be as difficult as technical language, or it could instead be quite helpful. Nonetheless, the physician is not contending with a mere knowledge recipient but with a complex human being full of emotions such as fear, doubt, and desires for health and life. Thus, descriptive language is not the definitive way to strengthen the therapeutic alliance; a relationship that relies on reciprocity must be balanced with a more empathic form of communication that avoids lecturing.

The vernacular language is far more colloquial and spontaneous than the descriptive, even though, like the descriptive, it reflects the doctor's intention to be comprehensible to patients. Expressions like "Don't worry, it's just a cold!" or "Tell me, what's on your mind?" are more informal. Using the vernacular facilitates the building of empathy between doctor and patient. This language is more familiar. In many cases it puts patients at ease, especially when the doctor–patient relationship is long-standing. But it does not suit all patients. Some continue to prefer a more professional way of relating that relies more heavily on descriptive language.

Each of the three preceding types of language has its own place and value in the medical encounter. However, the fourth category—unprofessional language—should be avoided. When doctors become exasperated by patients, they are particularly prone to unprofessional language. A surgeon attempting to explain an operation to a patient with mental disorganization might stand up abruptly, and say, "Forget it! I'm not going to waste my time on you." Or "Fine then. If you're not going to participate in your care, fix your own problems!" Unprofessional language such as this is offensive and could severely damage the doctor–patient relationship. I mentioned above that technical language brings out the paternalistic potential in the relationship; crass language is its counterpart and equally paternalistic. A physician who speaks to a patient distastefully is not establishing empathy but minimizing the importance of the patient to the clinician. Someone might respond that

this is not always bad and that, despite all standards of decorum, some patients appear to relish crass speech. Perhaps they identify with the physician's power or find medical paternalism reassuring. Regardless, I discourage the use of unprofessional language. Language that honors patients' dignity is most befitting of medical professionals and goes in the direction of consolidating reciprocal trust.

In view of this taxonomy, an important question remains. Which is the most effective way to communicate? While I stressed the limits and potentialities of each mode of communication, the result is not a hierarchy of styles of communication but rather a Venn diagram. Styles of communication are best understood as tools; the practitioner selects the best tool for the specific situation. When it comes to communication with patients, doctors must consider factors related to *content* (e.g., routine visit for the common cold vs. end-of-life decision-making), *context* (e.g., office visit vs. hospice facility), and *circumstance* (e.g., a patient's educational status and health literacy). The most effective language is not purely technical or descriptive or vernacular, but instead a "chameleon language" that readily adapts based on content, context, and circumstance. This is indeed the best way to keep patients at the center of their own care.

Chameleon language enables physicians to select the best way of speaking. Choosing the language best tailored to the patient means having more opportunities to create a strong therapeutic relationship. A common linguistic foundation offers a fruitful way to pursue the deliberative model suggested by Emanuel and Emanuel (1992).

According to Wittgenstein (1953), all people have systems of rules they use when speaking. Wittgenstein calls these 'language-games,' which could evoke the image of a board game in which every player has a unique strategy. The goal for doctors is to create a 'third' language-game (as in Malherbe 2013) that makes the speakers' rules available to each other as they share and jointly build a new set of common rules. Chameleon language keeps both doctor and patient at the center of their relationship, encouraging the creation of this shared language-game, a set of common rules and empathy to foster reciprocal trust.

Medical humanities in medical practice

The profession of physicians should entail expertise and skills in communication to build strong therapeutic alliances with their patients. Even though many physicians can interact with patients properly and with great sensitivity, it is evident that developing communication skills from scratch is a challenge for physicians generally (Lazare et al. 1995). It is necessary to teach them how to orient themselves in the complicated world of language—meaning how to understand the dynamics of language in action, so that they can help patients not merely in clinical terms. Patients, indeed, seek a form of help that it is not purely scientific (De Sandre 1989) but also humane. This is not surprising, because the doctor–patient relationship is delicate: it must not be forgotten that this kind of communication is intertwined with existential topics, as it deals with human subjects, values, views of life, and feelings. Visibly touched, a patient said to me in an interview, "As I entered the ward, there were six or seven people, but really, with a heart, with a heart. There was a woman, and I don't know now if she was a doctor or… and she caressed my—my—my face, right? She brought me back to life. And I had never met her before. It was the first time. Never seen her before. These are things that give you—that give you something" (from interview n. 21, protocol COMMUNI.CARE, my translation; see Appendix). Similarly, a patient interviewed by Galvagni said, "Dr. B. […] talked to me as to a human being" (Galvagni 2020, p. 78, my translation). These two patients draw the focus to the cornerstone of communication in medicine: patients' intrinsic need to be treated as human beings, be seen by their caregivers, and be engaged in an informed communication.

Although physicians are "trained to see [the] human body as a wondrous machine" (Kurapati 2018), medical professionalism also entails compassion and altruism (Royal College of Physicians 2005). This contradiction inherent in a relationship based on compassion and altruism with a being seen as a machine instead of as a person has its roots in medical education, which must be revised. Chalmers (2002) suggests revising medical education to let future physicians develop the emo-

tional and psychological skills to establish trust with patients. Rhodes (2020) focuses on the communication of uncertainty when claiming that maturing communication skills should be part of physicians' training. Studies suggest that doctors who are trained in communicating about certain topics can better manage communication techniques than their colleagues (Colletti et al. 2001; Jerant et al. 2009; Feng et al. 2011). This evidence highlights the importance of teaching physicians how to interact with patients properly for the sake of both parties, i.e., both the patients and the physicians themselves. These perspectives can be incorporated into a medical training that aims not to be less scientific but more humanistic, also integrating other disciplines that have not so far been included. When in contact, the doctor and the patient together try to understand a unique situation and solve it with the available resources. The medical humanities, applied in medical contexts, help in strengthening relationships and fostering reciprocal trust because they go beyond quantitative data and merely clinical perspectives. This does not mean giving the medical humanities the role of *scientiae scientiarum* (Nonnoi 2012) but recognizing the important role that they could play in improving the art of medicine and, in particular, doctor–patient interactions. Despite its high level of specialization, medicine needs to take a step back to recover the full image and the complexity of its subject.

Philosophy can make its own contribution to improving the precious moment of sharing between physicians and patients and harmonizing these two ends of the communicative thread. The role of humanities and philosophy is explored in the first chapter of this book, "Classical advice: Galen and the *art* of medicine", where it is suggested basing medicine on a circular conception of health (Capua 2020), thus also recognizing and retrieving its roots in philosophy. Starting from a historical analysis, the chapter shows why medicine should go beyond science, regaining its humanistic theoretical foundations. Considering medicine not as a science but as based on both sciences (Whitby 1951; Cosmacini 2008; Curi 2017) and humanities allows us to reframe it and better understand its deep connections with non-clinical aspects of the therapeutic relationship. Medicine as an "art," as Galen defined it, or a "judgment," according to the Royal College of Physicians' modern concept, recovers the idea

of "a shared concern with finding a path through the 'indeterminacies' that disease can bring—in life choices as well as in clinical decisions" (Royal College of Physicians 2005, p. 17). This idea of medicine reintroduces the characteristic of uncertainty (Timmermans and Angeli 2001; Diamond-Brown 2016): medicine cannot give us absolute answers, and this must be recognized to clarify the nature of the relationship between doctor and patient and to enhance their communication.

A positive example of this approach is also provided in the fourth chapter, "Philosophy Leading the Way", where I describe the methodology that we used to structure the study protocol COMMUNI.CARE (see Appendix) stressing the leading role of philosophy.

The importance of the (un)said

Effective communication is relevant and can even be determining in building trust. Communication is two-sided: it is about what is said and what is unsaid. Communication inherently involves connecting with another speaker, fostering a dynamic and ideally ever-evolving relationship. Since medicine encompasses more than just quantitative data and medical facts, it must also integrate patients' narratives and perspectives. Therefore, an effective doctor must excel as a communicator, both by actively sharing information with patients and by passively listening to their concerns. Good communication for physicians involves allowing patients' stories to emerge (Charon 2006; Charon et al. 2016; Moia and Vegni 2000). For collaboration to be successful, both physicians and patients need to understand each other; they should ask questions to ensure they are aligned and openly share their viewpoints. This exchange enhances mutual trust and fosters a sense of security. When we communicate, we take action that shapes and influences our environment (Austin 1967); for instance, a physician's words can metaphorically wound a patient's mind (Malizia and Turi 2015, p. 27), yet in the next moment, they can serve as a healing balm for the patient's mind and body, as illustrated in the poignant poem "A fil di voce" (Malizia and Turi 2015, p. 47). Nevertheless, the silent dimension of commu-

nication has a prominent role in defining the meaning of the whole discussion, too, in terms both of implicatures (Grice 1975) and of silence. The impact of the implicit dimension of communication is as relevant as the explicit meanings in building trust.

I investigate the implicit dimension of interactions between physicians and patients in terms of implicatures in the second chapter of this book, "Implicit Assumptions and Trust within the Doctor-Patient Dynamic: A Philosophical Linguistic Examination of Preoperative Consultations", showing that part of the meaning is hidden in the unspoken dimension of speech and must be seen, recovered, and explicated. This chapter aims to show the power of the implicit and how it is intertwined with trust in the particular context of risk communication, when uncertainties affect prognosis and brings with them multiple levels of meanings and understandings. It argues that sometimes seems obvious and explicit is actually silently ambiguous. "But as to the thing to which we give the name, we may perhaps each have a conception of it in our own minds," says Plato (Soph., 218c). This is evident in the case of medical language: the doctors' dictionary is technical and thus misleading or inaccessible to the patient. This happens especially when words convey meanings in technical jargon that do not overlap with their uses in daily life. Since it does not seem realistic to completely avoid differences in vocabulary between doctors and patients (despite a beautiful little ongoing collaboration on a shared dictionary, *The meaning of words*[16]), it is easier and more productive to pay attention to this foreseeable diversity. "*Who* is telling the story?", asks Ricoeur (1990, p.95). The physician and the patient must overcome the silent barrier of meaning that divides them to be sure to safely trust one another.

As Jaspers writes, silence can be as powerful as words (1953). The physician must be able to understand patients' questions, even when they "talk and ask with their eyes" (Malizia and Turi 2015, p. 47, my translation). These two dimensions of speech each have their own dignity and are intertwined, taking part together in signifying the whole meaning. There is a moment when they are visibly connected as the silent dimen-

[16] https://www.ilsensodelleparole.it/.