

# The Place for Conversational Implicature in Doctor-Patient Communication

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**ABSTRACT:** The rationality of conversational implicatures can be assessed both from the point of view of instrumental rationality and from that of argumentative rationality. However, another important element of this assessment should be the speech context in which such implicatures are used. This paper analyses the local nature of the use and the interpretation of conversational implicatures that is often omitted from the Gricean picture in which the speaker generally relies on the capacity of the hearer to work out the intended implicature. I want to propose the idea that there are contexts in which the speaker is not justified in doing so. One such context is related to doctor-patient communication. This kind of verbal interaction is pervaded by strong emotional responses that make the use and interpretation of common indirect communicational strategies a potential communicational and ethical problem.

**KEY WORDS:** Context, implicature, indirect communication, lying, medical ethics, pragmatics, rationality.

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## 1. Introduction

Conversational implicature is a pragmatic phenomenon used by speakers to communicate beyond the literal/direct meaning of the words and sentences that they use<sup>1</sup>. It is a contextual phenomenon that is generated by the speaker's utterance in a particular conversational setting, and that would be lacking in a different context. Generally, this contextual phenomenon is a rational communicational strategy whose implementation by the speaker and interpretation by the hearer are led by rationality and societal communicative norms. However, even though it is a rational phenomenon, due to its con-

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textual nature there are settings in which it is better to avoid it. In this paper I would like to explore the idea that the rational justification of the use of conversational implicatures is not universal. I will use the case of doctor-patient interaction to illustrate this idea. Additionally, the acknowledgement of the local nature of the rationality of indirect communicational strategies can provide new insights both to communicational and moral aspects of the use of language. In what follows, I will try to explicate my position.

## 2. Good communication and argumentative training

Communication between doctors and patients is one of the most important aspects of a patient-centred approach that presumes a holistic interpersonal relationship between physicians and their patients (Starfield 2011). By talking to patients doctors can gain quick access to the patient's condition and take action even before the results of clinical analysis are ready. In order to get the most out of the interaction with the patient, doctors must be aware of the peculiarities of this kind of communication.

What differentiates everyday communication between friends or family members from the communication between doctors and patients is an interplay between different factors. The relationship between doctors and patients involves individuals in a non-equal position, it is often not voluntary and since it concerns issues of vital importance it is intrinsically pervaded by emotional responses (Ong *et al.* 1995: 903).

In this interaction, the communicative style of the physician plays an important role. Ha, Anat and Longnecker (2010) report that the "medical model has more recently evolved from paternalism to individualism. Information exchange is the dominant communication model, and the health consumer movement has led to the current model of shared decision making and patient-centred communication" (Ha, Anat and Longnecker 2010: 38).

The authors acknowledge the dangers of miscommunication in that context. It is believed that in the ambit of doctor-patient communication there is no place for uncertainties. Patients should gain from the physician's precise and clear information about the situation, conveyed as objectively as possible, in order to act in the most beneficent way for their health. No miscommunication, voluntary or involuntary, should be present. The quality of the communication between doctors and patients is closely linked to the effectiveness of the recovery of the patient both in terms of health and wellbeing and in terms of cost-effectiveness (Ha, Anat and Longnecker 2010: 42). This is not to say that all the aspects of one's health and illness are always objectively definable; the important thing is that communication, even about uncertainties, should be clear and unambiguous.

However, as we know, there are differences between doctors' personal communicative skills: for some of them bonding with the patient on a personal level comes natural, as for others the position of an authoritative figure which can lead the patient with a firm hand. Since not all physicians have good communication skills, in order to provide a pleasant and fruitful experience to the patient, communication is something that they should be taught about during their education (Travaline, Ruchinskas and D'Alonzo 2005).

In addition, it has been suggested that doctors should learn argumentation in order to be able to explain the situation better to the patients and include them in the decision-making process (Zanini *et al.* 2015).

Physicians should be taught how to talk to patients, how to listen to them and pick up important pieces of evidence from their speech, how to construct a good argument and how to detect fallacies in the patient's narrative. The doctor has to be a good investigative listener, but also a professional versed in argumentation, since he has to present to the patient what he thinks are the best approaches to his condition and create good grounds for dialogue.

Here I shall not be examining the importance of general argumentation skills for doctors; I will rather explore one kind of argumentation that is often left out of theoretical discussions involving both argumentation and doctor-patient communication in general (see for example Jenicek 2013) namely, conversational implicatures.

### 3. Conversational implicature

Conversational implicatures can be defined as implicit conclusions of arguments in which some premises are explicitly stated and others are implicit and should be rationally constructed based on the linguistic and background knowledge shared by the speaker and the hearer. Here is an example, taken from Grice (1995: 32) and adapted by Sperber *et al.* (2010: 376, 377):

Andy: *Steve doesn't seem to have a girlfriend these days.*

Barbara: *He has been paying a lot of visits to New York lately.*

In this case, the hidden conclusion is that Steve does have a girlfriend in New York. Barbara does not say so explicitly, but she provides Andy with evidence for this conclusion and believes that he is capable of grasping it. Andy has just said something that leads to the conclusion that he doubts that Steve is seeing someone. Explicitly contradicting him would perhaps lead to an even stronger rejection of the idea that he indeed has a significant other. In this way he is bound to reach this conclusion himself based on Barbara's words (if he considers her a benevolent and competent testifier) and the consideration

that he would be visiting New York frequently if he had a girlfriend there. Of course, he could be visiting New York for other reasons, but they are not relevant for this conversation and Barbara is expected to be cooperative in Grice's sense (Grice 1995).

For our current purpose, we can broadly define conversational implicatures as messages conveyed indirectly through the speaker's utterance in which there is a gap between the speaker's communicative intention and the literal/direct meaning of the sentence he utters that needs to be filled in by the hearer through argumentative reasoning, explicit or not.

The gap between the uttered words and the speaker's intention generates various epistemological problems related to the phenomenon of testimony. If the speaker's words can differ from his communicative intention, how can we ever know what his real message is? How can a hearer justify the beliefs he has formed based on a conversational implicature? The answer lies in the rationality that governs all pragmatic phenomena. Conversational implicatures are the outcome of a rational conversational strategy and thus competent speakers and hearers should take them into account in any conversational situation in which is justified to do so.

Conversational implicatures require the presence of a common ground between speakers and hearers. The speaker's communicative intention in saying *p* is to communicate something different from *p*, namely *q*. It is generally held that in order to successfully communicate *q*, the speaker must rely on the hearer's capacity of working out the conversational implicature and recognize his real message. The speaker relies, consciously or unconsciously, on the argumentative ability of the hearer, who should grasp, consciously or unconsciously, the hidden conclusion of this semi-implicit argument (Grice 1995). I would like to suggest that even for otherwise competent language users there are particularly delicate situations in which the speaker is making a communicational mistake if he relies on the hearer's ability to work out the implicature.

Sbisà (2006) explains two possible views of the rationality of conversational implicatures. According to her, the rationality of conversational implicatures can be made sense of by using the notions of instrumental and argumentative rationality. Conversational implicatures can be considered instrumentally rational when they lead to the desired communicational outcome. In such cases conversational implicatures are treated as a successful communicational means. Argumentative rationality comes into play when a person needs to justify a specific communicative choice and this is the preferred way for Sbisà to link implicatures with rationality. However, there are reasons to believe that both general notions of rationality are helpful tools for the analysis of conversational implicatures. The instrumental rationality

of conversational implicatures is related primarily to the speaker as he is in the position to actively choose his preferred communicational strategy. The argumentatively rational aspect of conversational implicatures is related both to the speaker and to the hearer. If the speaker is asked why he choose this kind of communicational strategy to convey his message, he can turn to argumentative rationality to provide a justification for his choice. The hearer can use argumentative rationality in the same way to justify the belief he formed by interpreting the implicature. In doing so he will unconsciously rely on the idea that the speaker is instrumentally rational. In most cases, both instrumental and argumentative rationality will be used implicitly, but it is important that a justification can be provided, since one of the crucial characteristics of conversational implicatures identified by Grice is their calculability (Grice 1995: 39).

At the end of this brief discussion of the rationality of conversational implicatures it is important to notice that their rationality is not universal. As Audi (2001:172) states there are kinds of beliefs and desires that rational humans should have, as well as desires and beliefs they should not have. This rational body of beliefs and desires must be appropriately related to experience, and human experience is varied. When Audi talks about the relativity of rationality he introduces the notion of temporal relativity (175) which is present in those cases in which the grounds for an attitude change, making it so for the person to be rational at one time but not at another. "The rationality of a particular attitude, then, is not in general fixed by its content, any more than that of an action is generally fixed by its abstract type. In each case, the actual sustaining grounds are crucial, and these can change with time. Here its rationality is not intrinsic, but relative to its grounds" (175).

This idea can be used in order to clarify the rationality of implicatures. Here I do not want to talk about differences in how implicatures are used and interpreted by different speakers (which would constitute an instance of agent relativity, to use Audi's terminology) but about cases, or situations, in which it is not rational to use implicatures for persons who generally use and interpret them correctly.

It is important to notice that utterances can be misunderstood for a variety of reasons (syntactic complexity, lexical obscurity, poor pronunciation, obscure references, difficult argumentation and so on) but in this paper I focus on conversational implicatures due to the fact that in everyday situation their use and interpretation is not something that generally leads to misunderstanding. I use the term conversational implicature broadly to encompass every pragmatic interpretation that is not related to the non-literal/indirect meaning of particular words but of whole utterances. The use and interpretation of such pragmatic phenomena is guided by unconscious abductive reasoning, meaning that the conclusion can always be debunked with the

addition of new information to the inference. Still, abductive reasoning in the context of conversational implicatures is a sound strategy for the forming of beliefs that are usually epistemically justified. The thing we should be wary about is the emotional state of the hearer, an aspect often neglected in the analysis of implicatures.

In characterizing the notion of conversational implicature Grice writes: “A man who, by (in, when) saying (or making as if to say) that *p* has implicated that *q*, may be said to have conversationally implicated that *q*, provided that (1) he is to be presumed to be observing the conversational maxims, or at least the Cooperative Principle; (2) the supposition that he is aware that, or thinks that, *q* is required in order to make his saying or making as if to say *p* (or doing so in those terms) consistent with this presumption; and (3) the speaker thinks (and would expect the hearer to think that the speaker thinks) that it is within the competence of the hearer to work out, or grasp intuitively, that the supposition mentioned in (2) is required” (Grice 1996:30, 31). The important thing to notice is the idea underlined in (3). According to it the speaker believes that the hearer is capable of working out the implicature and relies on this presupposition to get his message across. I want to suggest that there are social environments in which this presupposition is not appropriate. The medical setting, more precisely the conversational interaction between doctors and patients, provides a good example of such environment.

#### **4. The place for indirect verbal communication in doctor-patient interaction**

At this point, it is useful to distinguish between implicatures and other communicational means that could be implemented in the context of doctor-patient interaction. We could say that in relation to the truth and the ways in which it is possible to convey information the physician has five options:

1. Tell the truth
2. Lie
3. Not say anything
4. Soften the truth
5. Implicate

Truth as an intrinsic goal in medicine is a complicated subject and I shall not discuss it here, but it should be noted that if we withhold information from the patient we are undermining his autonomy and his decision-making powers (Entwistle *et al.* 2010). We are patronizing and choosing an authoritative controlling style. Of course, the choice between telling the truth and lying to the patient is not exhausting. There are other possibilities. Besides the option of not giving any information to the patient, which I believe has the same

negative consequences as lying directly to him, the two I propose here are softening the truth and letting the patient reach the intended message with his rational capacities.

One of the many virtues a physician should have is empathy, which sometimes could be manifested in language through the preference for certain words and phrases. We can say one thing in different ways, for example, using a euphemism. Tayler and Ogden (2005) have studied the use of euphemisms and their impact on patient's beliefs about health on the example of "heart failure". They note that "[t]he term 'heart failure' may be in line with the current climate of openness, but may evoke a more negative response from the patient. In contrast, a euphemism may be less open, but more protective of the patient's experience" (Tayler and Ogden 2005: 322). In such cases, there is a clash between the need to be open with the patient and the need not to face him with an unbearable amount of negative information. That is, softening the truth in such cases can be manifested by linguistic choices that replace terms that evoke negative feelings and fear with lighter ones that provoke less negative associations or even by withholding some negative aspects of the patient's condition.

Now I turn to the fifth option, which is the central issue of this paper. Imagine the following conversation that takes place in a hospital during a consultation:

Patient: How am I doing?

Doctor: You should make good use of the next three months.

As always with conversational implicatures and indirect conversation in general the context is crucial. Let us suppose that it's the first encounter between a specialist and the patient, who came in not knowing his diagnose. The doctor's reply can be seen as problematic from two angles – the communicational and the moral point of view. The communicational one will be relevant mostly in those situations in which the implicature is accidental, that is, in those cases in which the doctor is not aware of the implicature that is carried by his utterance and picked up by the patient.<sup>2</sup>

In this example we can imagine a negative interpretation by which the patient picks up the information that he might die in the next three months. The patient might work out this message relying on what is said and the present medical context that can lead to a state of fear and anxiousness. This emotional state can encourage the patient in his negative interpretation.

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<sup>2</sup> The most common view of conversational implicature relies on the notion of speaker's intention (see for example Bach 2005 and 2012) Since this would create an unnecessary digression, I will not be discussing my own view according to which the importance of the speaker's intention is secondary to the reasons the hearer has to presuppose such intention. For a different possible approach to unintended conversational implicatures see Lassiter (2012).

As mentioned above, a feature of conversational implicatures is their cancellability, that is, such implicatures can be contextually or verbally neutralized (Grice 1995). In this case, the doctor could give a more detailed presentation of the situation and explain that the patient will start with an intense treatment in three months. However, without this additional information, which leads to a completely new informational situation, the patient could be justified, taking into account the strong emotions under the influence of which he is at the moment, in concluding that his condition is worse than it really is, and that in three months he could be dead. We can say thus that unintended conversational implicatures which lead to dangerous interpretations and the formation of false beliefs that can negatively affect the patient function as a bridge from the communicational character of conversational implicatures to their ethical status and to moral questions related to the responsibility of the physician for his words.

The moral point of view should also be considered in relation to cases in which the conversational implicature was intended. Using again the same example, the doctor could want to implicate that the treatment that will start in three months will be exhausting for the patient, leaving him little time and strength for other activities.

It is especially important in moments of crisis and physical and psychological distress to provide information that is not ambiguous so the patient can form a true justified belief based on it (Jenicek 2013). Choosing a good communicative strategy is very important and the right choice will often depend on contextual parameters. If there is a bad news to be communicated, implicatures are not a good choice, even though it could seem that not saying a bad thing but merely implicating it could soften the delivery of an unpleasant information. Nevertheless, implicatures should not be mistaken for sympathy or compassion.

It could be suggested that the positive side of an intended conversational implicature could be the fact that with its use the patient is given the relevant information and he can thus autonomously decide whether or not he is ready to accept the indirect message. If he is not ready for it yet he can postpone its acceptance while having all the premises in the back of his head. The problem with this suggestion is that it presupposes that the patient is in fact able to rationally reach the intended implied content.

Kukla (2007) writes about the importance of the availability of medical information to laymen. Her general views about the relationship between autonomy and knowledge, besides the question of general availability, could also be applied to the way doctors convey information. She notes that experts have a set of “epistemic duties” towards laypeople. She argues that clinicians have a moral and professional role in enabling the autonomous functioning



of patients as knowers and choosers (Kukla 2007: 34). In order to fulfil this role they have to provide complete and understandable information. The doctor should not presuppose that the patient is capable of forming the right implicature-based belief. It has been reported that severe illness increases anxiety in patients (Buller and Buller 1987: 377) and it is understandable that their argumentative and rational capacities could be lowered. Besides that, the use of implicatures could be interpreted by the patient as a sign of withholding information in order to create a state of submission for the patient (Buller and Buller 1987: 376).

To sum up, doctors should not use implicatures, since the understanding of information conveyed through indirect communicational means may require the hearer to be in an emotionally neutral state. His rational capacities should not be temporarily compromised by fear, anguish or other emotional states triggered by his medical condition. Conversational implicatures used by doctors can be intended or unintended. Both types can lead to misunderstanding and to negative moral consequences which manifest themselves in the form of false beliefs acquired by the patient. The doctors, as speakers, should not rely on the capacity of their patients, as hearers, to be capable of working out the intended implicature.

## 5. The benefit of familiarity with indirect communicative strategies

On the other hand, while they should avoid implicatures in order to provide the patient with unequivocal information, doctors should be acquainted with the mechanisms that govern implicature-based communication so they could be able to detect them if the patient uses them. Again, as in the case in which the doctor implicates, the implicature carried by the patient's utterance can be seen as a communicational and a moral question. Sometimes patients could turn to implicatures in order to avoid explicitly saying something that is very personal for them or, for example, admitting to do something that they know they should have been doing differently. Imagine the following dialogue:

Doctor: *Are you taking your medication regularly?*

Patient: *The last time I took my pills was this morning.*

If we suppose that the patient had to take his medication two times a day for seven days, then we should interpret him as if he wants to say that he has been taking his medication regularly. At least, this is what we would do in everyday situations if we regard the speaker as benevolent and competent. In everyday situations, especially those regarding personal states of the speaker, we should consider him benevolent and competent if our capacity for epistemic vigilance does not detect any signs that indicate otherwise (Sperber *et al.* 2010).

Who could know better if the patient took the pills regularly than the patient himself? Moreover, why would he lie about that?

If the implicature is intentional and its content is not true, than we can talk about lying. There are various reasons to lie in this kind of situation, reinforced by the anxiety and stress commonly present in this kind of context. The patient could have forgotten to take his medication the evening before and, knowing that it was a bad thing for the outcome of his therapy, feared that the doctor would reprimand him. In this situation, the patient could decide to take the easy way out and implicate that he is taking the pills regularly without explicitly saying so. Since his real message is not conveyed by semantic but pragmatic means, the speaker could claim that he is not lying since the sentence he utters is in fact true and since the misleading part is merely implicated and one of the defining characteristics of implicatures is, as we have seen, their cancellability. Nevertheless, since the intentions and outcomes of explicit lying and deliberately misleading using conversational implicatures are the same I will hold that there is in fact no substantial difference between the two<sup>3</sup>.

Even if the patient is honest, there are situations in which doctors could doubt the patient's competence, for example, during an encounter with an elderly patient who has recurring memory problems. In this case the conversational implicature is unintended but it can still have negative consequences like the misinformation of the physician. Therefore, due to the specificities of patient-physician interaction, which differentiates it from everyday communication on the basis of emotional states, positions of power and authority and closeness, there are situations in which the patient could not be regarded *prima facie* competent nor benevolent. The path that the doctor should follow in this kind of situation is to ask confirmation from the patient. If the implicature of the patient's utterance is "I took the pills regularly throughout the treatment", he could ask for the explicit confirmation of this implicature: "So, you took the pills every morning and every afternoon for seven consecutive days?" This offers to the patient the possibility to alter his response or to confirm the implicature if it is true. In order for the doctor to be able to ask for clarification, he must be able to detect implicatures and calculate them correctly.

In order to be able to do that, he should take into account general communicational rules paired with the specificities of patient-physician interaction. In situations where the relevant information is already known or where the doctor has reasons to consider the patient as benevolent and competent, he can skip the additional questions and rely on the implicature. One rea-

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<sup>3</sup> See Saul (2012) for a discussion about the relation of lying and misleading.

son for that could be the importance of time in the doctor-patient interaction (Travali, Ruchinskas and D'Alonzo 2005). Implicatures can even be sought in open-ended questions posed to the patient. Once again, it is important that the doctor is able to judge whether to ask for clarification or take an implicature at face value, which is always somewhat risky. The factors he should take into account while evaluating the situation is the condition of the patient, both psychological and physical and the severity of his condition, that is, evaluate the impacts of a possible communicative misunderstanding.

## 6. Conclusion

The conversational interaction between doctors and patients is governed by peculiarities that differentiate it from everyday communication between family members and friends, but also from communicational interactions with unfamiliar persons in situations with a discrepant level of power between collocutors since the domain of personal health and wellbeing is particularly delicate.

In everyday communication, conversational implicatures are a conventionalized and rational communicational strategy that is successfully used and interpreted without much effort, but their status in the ambit of doctor-patient interaction is quite different. Implicatures are not just a means of communication that should be analysed from a linguistic perspective since their use can carry an important moral aspect, visible both in cases in which an intention to implicate is present as in those where there is no such intention. Both doctors and patients should avoid conversational implicatures, however, both parties could benefit from the ability to detect them. If a patient uses implicatures, the doctor should play the part of a lawyer analysing the witness' words in order to find contradictions, missing elements or ambiguities and ask for clarifications in order to have as much access to the patient's condition as possible. Ideally, the patient faced with conversational implicatures should employ the same strategy. The problem arises from the fact that patients are often in a state of emotional and psychological distress which makes them unfit for the rational detection of indirect argumentative strategies. Because of that, a greater responsibility for both the detection and the avoidance of conversational implicatures lies on the part of the medical professional.

The peculiarities of doctor-patient interactions prove that the rationality that should generally be associated with the use and the interpretation of conversational implicatures is not universal. There are circumstances in which the rational thing to do is to avoid the use and interpretation of implicatures, both from the point of view of instrumental rationality and from that of argumentative rationality.

The heightened stakes in many doctor-patient conversations create an extra practical reason to avoid easily misunderstood utterances. Gricean conversational implicatures can be one type of easily misunderstood utterance, but utterances can be easily misunderstood for a number of reasons. The peculiarity of implicatures is that they are generally seen a successful communicative strategy.

It might be suggested that while avoiding misunderstanding is one important goal in doctor-patient communication, it is not the only goal, and in some cases other goals (social softening of hard news, for example) may give extra reason to communicate in part through implicature. The idea of this paper was to present a social context in which the use of indirect communication should primarily be avoided since it has a higher probability to lead to misunderstanding and to ethical problems. Nevertheless, even in those situations a basic knowledge of indirect communicational strategies could be valuable for speakers as well as for hearers.

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