

COMMUNICATING A DIAGNOSIS

An ethical understanding of the act of disclosing medical knowledge

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ABSTRACT: *COMMUNICATING A DIAGNOSIS: AN ETHICAL UNDERSTANDING OF THE ACT OF DISCLOSING MEDICAL KNOWLEDGE*

This article explores the philosophical and communicative dimensions of diagnosis disclosure between physicians and patients. Using the Italian healthcare system legal framework and its ongoing challenges in fostering ethical communication practices as a starting point, it continues the ongoing philosophical discussion about this interaction, considering it more than a clinical task and a profound moment of existential and narrative transformation for the patient. Drawing on theoretical frameworks from hermeneutics, narrative identity, and ethics of care, the article utilizes the well-known asymmetry of knowledge and authority between doctor and patient to emphasize the importance of treating diagnosis disclosure as a dialogical process rather than a top-down delivery of information. In analysing possible solutions to this problem without overburdening the medical worker with additional training, the article proposes the possibility of a split between the actual physician and the diagnosis communicator.

KEYWORDS: Diagnosis Communication; Ethics of Communication; Medical Hermeneutics; Epistemic Asymmetry; Communication Practices.

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Introduction

The communication of a diagnosis, from physician to patient, can be seen as a powerful lens through which to examine the broader relationship between experts and laypeople. It represents one of the most critical moments where these two worlds intersect. The participants in this exchange come from fundamentally different perspectives: they hold different roles, pursue different objectives, and operate with distinct levels of knowledge and authority. Far from being a neutral or purely clinical act, the disclosure of a diagnosis often marks a pivotal moment in a person's existential narrative. It signifies the shift from uncertainty to the naming of illness, and often from personhood to patienthood.

As Daniele Bruzzone observes «illness can upset a person's system of meanings, challenging their convictions or identity, prompting radical doubts, destabilizing their sense of control, making them more aware of their precariousness, objectively limiting their opportunities for self-realization, and ultimately making them lose confidence and hope for the future.»¹

Diagnosis communication, then, is not merely the transmission of medical information, it is an encounter charged with ethical and epistemological weight.

In the last five decades, we have witnessed a paradigm shift in science communication, particularly regarding rethinking traditional models of expert–non-expert interaction. Paternalistic or one-directional approaches are increasingly being questioned in favor of more dialogical and participatory models.² As such, we have seen a growing interest in the theorization on the direct interaction between doctor and patient, with

¹ D. Bruzzone, *Meaning-making and narrative in the illness experience: a phenomenological-existential perspective*, in «Encyclopaideia - Journal of Phenomenology and Education», 25, 59, 2021.

² For an interesting perspective on the crisis of the public understanding of science in Great Britain and the necessity of new communication models, especially regarding the active participation of citizens in scientific decisions in which they are directly involved, N. Pitrelli, *La crisi del "Public Understanding of Science" in Gran Bretagna*, in «JCOM» 2, 1, 2003.

growing attention to shared decision-making, patient autonomy, and narrative medicine.

Within clinical settings, the moment of diagnosis is especially significant due to the asymmetry between the parties involved. The physician holds epistemic authority³, the ability to define the nature of the patient's condition, while the patient occupies a position of vulnerability and emotional exposure, often lacks the tools to fully comprehend the situation. In this context, the patient must rely on the physician's knowledge and authority, accepting an external definition of their condition rooted in an epistemic gap they cannot bridge on their own.

While the ethical connotation of the communication of a diagnosis has been discussed in much detail from an ethical standpoint, the assumption that the health practitioner must take into consideration the ever-growing theoretical framework behind the ethics of care has not been challenged much. In this article, I seek to explore the communicative act of diagnosis disclosure as a moment of philosophical and ethical importance, worthy of specialised training. I begin by analysing the Italian healthcare system to demonstrate the difficulty of inserting ethical and communication training into the curricula of young health practitioners. Drawing on both normative and empirical sources, I argue that diagnosis disclosure should not be treated as a clinical procedure, but as a dialogical and ethically attentive practice, one that requires sensitivity to language, emotion, timing, and the inherent

³ While this has been consistently the case for the last decades, generative AI has begun to change this viewpoint and the interaction between physician and patient regarding which entity holds epistemic authority. AI changes this relationship in at least two important ways: firstly, in the case where AI models are used by experts, it often lacks the components of explainability and reliability that patients rely on from a source that they want to perceive as trusted, ethical and moral (for a more in depth look at this topic, see F. Funer, *The Deception of Certainty: how Non-Interpretable Machine Learning Outcomes Challenge the Epistemic Authority of Physicians. A deliberative-relational Approach*, in «Medicine, Health Care and Philosophy», 22, 2022, pp. 167-178. Secondly, wider access to medical information from the layperson (be it given by AI or simply by digital knowledge accessible by everyone) redesigns the relationship of epistemic authority between patient and physician by renegotiating the concept of health responsibility (for a more in depth look at this topic, see J. Kivits, *Researching the 'Informed Patient'*, in «Information, Communication & Society», 7, 2024, pp. 510-530.

asymmetry of knowledge and experience. After analysing the theoretical framework that pertains to an ethical communication of a diagnosis, I then turn my attention to challenging the assumed position in which the medical practitioner is the one who holds the role of communicator.

1. *Diagnosis Disclosure in the Italian Context*

In Italy, the communication between doctor and patient has undergone significant transformation in recent decades, transformation caused by shifts in legal norms, bioethical reflection, and patient rights movements. This section offers a critical examination of the Italian context, aiming to identify both progress and persistent challenges in how diagnoses are communicated. Historically, Italian medicine was marked by a paternalistic model, rooted in the physician's presumed moral and epistemic authority. Until the late 20th century, it was common for diagnoses, especially of serious conditions like cancer, to be withheld from patients, either partially or entirely, based on therapeutic privilege (*privilegio terapeutico*). This practice, though often motivated by compassion, reflected an asymmetry of power and a reluctance to engage with patient autonomy.

Major change came with Law 219/2017 (“Norme in materia di consenso informato e di disposizioni anticipate di trattamento”), which codified the patient's right to be fully informed about their health condition and to participate actively in medical decision-making. The law not only mandates transparency but also emphasizes relationality, recognizing the importance of a communicative alliance between physicians and patient. Article 1 specifically affirms that medical interventions require informed consent, which can only be given through adequate, comprehensible, and empathetic communication.⁴

Despite this normative shift, empirical studies indicate discrepancies between legal ideals and clinical realities. Research shows that many

⁴ M. Di Paolo *et al.*, *A review and analysis of new Italian law 219/2017: 'provisions for informed consent and advance directives treatment*, in «BMC Medical Ethics», 20, 2019, p. 17.

physicians still hesitate to fully disclose serious diagnoses, especially in geriatric or oncological contexts.⁵⁶ Factors include fear of harming the patient, lack of training in communication, and institutional pressures that limit time for dialogical encounters. Thus, while the legal framework now supports ethics of transparency and respect, cultural inertia and systemic constraints continue to shape the diagnostic conversation in practice.

These dynamics complicate the physician's ethical responsibility. On one hand, the law requires truthfulness; on the other, relational autonomy, the idea that autonomy is exercised within networks of care, suggests sensitivity to cultural and familial structures.⁷ The challenge is to navigate between individual rights and cultural responsiveness, without reducing the value of communication.

Philosophically, this tension calls for a nuanced ethics of situated disclosure: one that acknowledges both the universality of moral respect and the specificity of human contexts. Diagnosis, in this view, is not a static fact to be delivered, but a relational event, shaped by language, expectations, temporality, and cultural scripts.

Communication training remains a critical weak point in Italian medical education. While some medical schools have introduced modules on empathy, dialogue, and communication ethics, many clinicians still report feeling unprepared to handle emotionally charged diagnostic conversations.⁸ Institutional resources are limited, and physicians often face high patient volumes, bureaucratic burdens, and time constraints, all of which undermine the possibility of ethical dialogue.

⁵ R. Bongelli *et al.*, *Italian onco-haematological patients' preferences in bad news communication: a preliminary investigation*, in «BMC Cancer», 21, 2021, p. 555.

⁶ L. Grassi *et al.*, *Physicians' attitudes to and problems with truth-telling to cancer patients*, in «Support Care Cancer», 8, 2000, pp. 40-45.

⁷ M. Filomena *et al.*, *Navigating Intercultural Medical Encounters: An Examination of Patient-Centered Communication Practices with Italian and Foreign Cancer Patients Living in Italy*, in «Cancers», 15, 11, 2023, 3008.

⁸ S. Gonella *et al.*, *Staff's Knowledge and Self-Confidence in Difficult Communication: Evaluation of a Short Experiential-Based Training Program*, in «Nursing Reports», 15, 2, 2025, 60.

Recent initiatives, such as narrative medicine programs and ethics committees, have begun to address these shortcomings.⁹ But these remain fragmented and underfunded. A more systemic approach would require integrating communication philosophy, narrative competence, and ethical literacy into the core of medical formation, not as optional extras but as essential clinical skills.

1.1 An alternative to Individual Responsibility: The Institutional Failure to Train for Narrative Diagnosis

While ethical discourse often focuses on the physician's personal responsibility in communication, this perspective risks obscuring a deeper and more systemic problem: most medical professionals are not trained, nor institutionally enabled, to engage in diagnosis as a narrative and relational act. The burden of ethical communication is disproportionately placed on the individual clinician, who must navigate complex emotional and philosophical terrain with little to no formal preparation.

Medical education in Italy, as in many countries, continues to privilege technical competence and biomedical knowledge over communicative formation. Although some curricula have begun to incorporate bioethics or narrative medicine modules, these remain marginal, often theoretical, non-assessed, or optional. As a result, the clinician is left to improvise in moments of profound ethical weight, relying on instinct rather than training.¹⁰

This institutional failure reflects a broader misunderstanding of what diagnosis communication entails. If diagnosis is, as argued, a narrative event, requiring interpretive sensitivity, dialogical skills, and emotional intelligence,

⁹ R. Berardi *et al.*, *Communication in oncology between healthcare providers, patients, the scientific community, and the media: recommendations from the Italian Association of Medical Oncology*, in «Supportive Care in Cancer», 32, 9, 2024, p. 613.

¹⁰ M. Gulino *et al.*, *Bioethics in Italian Medical and Healthcare Education. A Pilot Study*, in «Acta Biomed», 89, 4, 2018, pp. 519-531.

then communication must be taught not as etiquette, but as clinical method. The absence of such training is not a flaw in individual ethics, but a structural omission in the formation of the medical profession.

Moreover, institutional logic (short consultation times, bureaucratic overload, emphasis on legal defensibility) often discourages or punishes extended or relational communication. Physicians are caught in a paradox: legally required to inform fully, ethically urged to do so sensitively, yet structurally unprepared and unsupported.

A meaningful reform must therefore shift from individual blame to institutional responsibility. Medical faculties, health ministries, and hospital administrations must recognize that communication is not ancillary, but constitutive of care. It requires investment, training, and protected time. Until such conditions are created, the ethical ideal of dialogical diagnosis will remain unattainable for most physicians, despite their best intentions.

2. Theoretical Framework: Communicating Illness Between Knowledge and Meaning

As we have seen, medical communication cannot be seen just as an exchange of data; it is a form of relational praxis, embedded in structures of power, language, and narrative. In this section, I will try to shape the theoretical framework I will use throughout the text within the axis of medical communication, ethics, philosophy of language, and communication.

2.1 Models of Doctor–Patient Communication

Medical communication, according to Emanuel and Emanuel, can be divided into four dominant models: the paternalistic, informative, interpretive and deliberative model.¹¹ More recently, a 2007 study described physician-

¹¹ E.J. Emanuel, L.L. Emanuel, *Four Models of the Physician-Patient Relationship*, in «JAMA», 267, 16, 1992.

patient relationship models as Activity-Passivity, Guidance-Cooperation and Mutual Participation.¹² Both articles present a different degree of patient autonomy, spanning from subjugation to the doctor's decision and authority (paternalistic approach, Activity-passivity approach) to one of active decision-making featuring input from both the expert and the patient. The paternalistic model positions the physician as the sole epistemic authority, responsible for acting in the patient's best interest without full disclosure. The informative model, influenced by legal norms of informed consent, treats the patient as an autonomous agent entitled to all relevant information. While the world seems to move towards a more information-centered model for healthcare, Emanuel and Emanuel believe in something more than the simple equating of status between patient and doctor.

The informative model embodies a defective conception of patient autonomy, and it reduces the physician's role to that of a technologist. The essence of doctoring is a fabric of knowledge, understanding, teaching, and action, in which the caring physician integrates the patient's medical condition and health-related values, makes a recommendation on the appropriate course of action and tries to persuade the patient of the worthiness of this approach and the values it realizes. The physician with a caring attitude is the ideal embodied in the deliberative model.¹³

The interpretive and deliberative models represent the most dialogical and autonomy-enhancing forms of medical communication. In the interpretive model, the physician assists the patient in elucidating and clarifying their own values, helping them understand how these values inform medical decisions. Autonomy here is conceived as self-understanding, achieved through empathetic dialogue and reflective interpretation. The deliberative model, by contrast, envisions the physician as a teacher or friend who not only clarifies but also discusses and, when appropriate, advocates for health-related values

¹² B. SS. Cheng *et al.*, *A review of communication models and frameworks in a healthcare context*, in «Healthcare Dental Update», 42, 2, 2015, pp. 185-186, 189-90, 193.

¹³ *Ibid.*, p. 185.

through moral reasoning. Autonomy in this framework is realized through moral self-development and shared deliberation on what constitutes the patient's good. Both models thus move beyond paternalistic decision-making, framing the clinical encounter as a space of cooperative reflection rather than unilateral authority. The key to a good physician-patient relationship seems to lie in acknowledging affective and existential dimensions in diagnosis disclosure. It needs to be captured how language not only conveys knowledge but also shapes experience. As such, it is necessary to incorporate hermeneutic and narrative approaches.

2.2 *Hermeneutics of Illness and the Role of Language*

The act of diagnosis can be understood as fundamentally interpretive, an event of meaning-production that extends beyond the cognitive identification of disease. As Hans-Georg Gadamer¹⁴ observed, health is not a measurable object but a *mode of being-in-the-world*: a tacit harmony between the self and its environment that is only disclosed when disrupted by illness: «Health is a condition of inner accord and of harmony with oneself that it defies measurement and standardisation.». Illness thus introduces a rupture in the horizon of everyday experience, transforming the lived body from a transparent medium of engagement into an object of concern and interpretation. The diagnostic act mediates this disruption by translating the patient's narrative and embodied suffering into the structured lexicon of biomedical discourse. This translation, however, is not neutral: it reconstitutes the patient's relationship to self, body, and world through language. To name a condition is to anchor it within a network of epistemic, institutional, and normative meanings, turning lived experience into a "case"

¹⁴ H.G. Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age* (1991), en. tr. Stanford University Press, California 1996.

legible to medicine. From a hermeneutic standpoint, diagnosis operates as an event of understanding in Gadamer's sense: it fuses the horizon of the clinician's scientific knowledge with that of the patient's existential situation, producing a world-altering interpretation.

From the perspective of linguistic philosophy, the act of diagnosis is best conceived as performative: Following J. L. Austin¹⁵, performative utterances do not merely describe reality but bring it into being; to say "You have cancer" or "You are diabetic" is to enact a transformation in the interlocutor's social and existential status. Judith Butler's reworking of performativity¹⁶ deepens this insight by emphasizing that such speech acts derive their power from their iteration within normative and institutional frameworks. The authority of diagnostic language rests upon its embeddedness in the biomedical regime of truth, which, as Michel Foucault¹⁷ famously analyzed, constitutes bodies as knowable and governable through discursive practices. The "clinical gaze" transforms subjective suffering into an object of observation, thereby situating the individual within a grid of medical intelligibility that both reveals and constrains. Diagnosis thus functions as a disciplinary speech act: it performs the subject into being as a *patient*, reconfiguring their possibilities for action and self-narration in accordance with biomedical norms. Yet, as Ian Hacking¹⁸ argued, such classificatory acts are looping kinds: once labeled, individuals internalize and respond to their classification, thereby altering both their self-conception and the social meaning of the category itself. Diagnosis, in this sense, is reflexive; it generates feedback loops between discourse and experience that reshape both personal identity and medical ontology.

¹⁵ J.L. Austin, *How to do things with words*, Clarendon Press, Oxford 1962.

¹⁶ J. Butler, *Excitable Speech: A Politics of the Performative*, Routledge, New York 1997.

¹⁷ M. Foucault, *Nascita della Clinica* (1963), tr. it. Einaudi, Torino 1998.

¹⁸ I. Hacking, *The looping effects of human kinds*, in D. Sperber, D. Premack, A.J. Premack (eds), *Causal Cognition: A Multidisciplinary Debate, Symposia of the Fyssen Foundation*, Oxford University Press, Oxford 1995.

The conceptual tension between hermeneutics and performativity turns on the locus of meaning in human action. Hermeneutics, exemplified by Ricoeur's narrative theory, conceives human practices as intelligible within a horizon of interpretation in which agents appropriate their experiences through acts of understanding and refiguration. In this view, identity emerges from the dynamic mediation between lived experience and narrative articulation. Performativity, on the other end, emphasizes the constitutive force of action itself: linguistic and bodily practices do not simply express meaning but produce social realities through iterative and norm-governed enactments. From Austin to Butler, performativity reveals how agency is both enabled and constrained by repertoires of citation that precede the subject. Consequently, while hermeneutics foregrounds the interpretive labour through which agents render their lives coherent, performativity highlights the operative dimension of practice in which subjects are continually constituted. The juxtaposition of these perspectives invites a more complex account of human action in which interpretation and enactment are intertwined, and in which narrative self-understanding must be situated within the normative and institutional matrices that shape its very possibility.

This discursive constitution of illness is not merely theoretical but phenomenologically tangible. The language of diagnosis structures how one may speak of one's body and future, delimitating the horizon of intelligibility within which suffering can be articulated. As Havi Carel¹⁹ and Fredrik Svenaeus²⁰ have shown, illness is lived as a form of "unhomelikeness", a loss of ease in the world, whose expression depends upon the linguistic and narrative resources available to the subject. The diagnostic utterance can alleviate this estrangement by providing a shared vocabulary for meaning-making, but it can also deepen alienation when the patient's lived experience is subsumed under impersonal biomedical categories. Paul Ricoeur's hermeneutics of selfhood further clarifies this duality: the self is constituted

¹⁹ H. Carel, *The Phenomenology of Illness*, Oxford University Press, Oxford 2016.

²⁰ F. Svenaeus, *Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine*, in «Med Health Care Philos» 14, 3, 2011, pp. 333-43.

through narration, and the diagnostic label enters this narrative as a “plot event” that reconfigures the temporal and moral structure of one’s life story. To be diagnosed, therefore, is to undergo an *emplotment*, a linguistic insertion into a medical narrative that reorganizes identity and temporality.

Consequently, a hermeneutic-discursive conception of diagnosis reveals its ethical stakes. If diagnostic language both interprets and performs the patient’s world, then the responsibility of medical discourse extends beyond epistemic accuracy to the ethical shaping of subjectivity. Communicative care, in this framework, entails attentiveness to how words constitute realities: how the physician’s speech can either foreclose or expand the patient’s capacity to understand and inhabit their condition. Diagnosis should thus be reconceived not as a final determination of truth but as a provisional act of interpretation situated within an ongoing dialogue. In this dialogical space, the authority of medical language meets the agency of the suffering subject, and meaning becomes co-constructed rather than imposed. To diagnose is, therefore, to speak the world anew: a performative event where language, power, and embodiment intersect in the constitution of health, illness, and selfhood.

Ricoeur argued that personal identity is narrative: we understand ourselves in terms of an ever-evolving story. This self-knowledge is dialogical: «self-knowledge is a dialogue of the soul with itself»²¹, and «could be systematically distorted by the violence and by all the intrusions of the structures of domination into those of communication»²². Illness changes this narrative dialogue, making diagnosis a rupture or a turning point. How the diagnosis is communicated is crucial to how the patient integrates the illness into his or her life story.

It is important to note that a parallel tension emerges in the confrontation between Foucault’s notion of the clinical gaze and Ricoeur’s conception of narrative agency. For Foucault, the modern clinic inaugurates a

²¹ P. Ricoeur, *Phenomenology and Hermeneutics*, in «Noûs», 9, 1, 1975, p. 91.

²² Id., *Time and Narrative* (1983), en. tr. University of Chicago Press, Chicago 1990.

regime of visibility that objectifies the patient by translating lived suffering into a set of intelligible signs within a medical epistemic grid. This gaze, sustained by institutional practices and disciplinary norms, reconfigures the individual as a clinical case, thereby attenuating the patient's capacity for self-interpretation. Ricoeur's account of narrative agency, however, reintroduces a dimension of subjectivity that resists complete objectification: through narrative emplotment, individuals reinterpret contingency, affliction, and temporal rupture in a manner that reinstates their ability to act and to assume responsibility for their lives. The friction between these two models lies precisely in the status of the subject. Whereas the clinical gaze disaggregates the person into an observable body, narrative agency seeks to restore the unity of selfhood through interpretive practice. Yet the two are not simply opposed: a Foucauldian sensibility underscores the structural limits and power asymmetries within which narrative agency must operate, while a Ricoeurian perspective delineates the ethical and therapeutic stakes of enabling patients to reclaim their voice. Together, they reveal the necessity of a critical hermeneutics attuned both to the constitutive effects of institutional gazes and to the profound human need for narrative reappropriation.

In diagnostic disclosure, we can continue to see that the doctor's moral imperative is not merely to inform; it is to be attentive to the patient's vulnerability, to listen, and to act accordingly. The act of telling becomes a site of ethical exigency, a call to the self by the vulnerability of the other.

3. Diagnosis Disclosure as an Ethical Act

In clinical work, diagnosis is generally seen as a task-based responsibility, part of a general duty of informed consent. However, reducing this diagnostic disclosure to the act of informing misses the more important ethical thinking that it represents.

In its essence, the diagnostic interview presents a persistent epistemic asymmetry. The physician not only possesses biomedical knowledge but institutional power too: the power to name, to classify, and therefore to shape the course of the patient's experience. The patient, by contrast, at least before

the advent of the internet, enters this dialogue in a state of interpretive ignorance, perhaps sensing that something is wrong, but lacking either the words or the ability to convey their position. This imbalance is not ethically neutral. This asymmetry can be understood in two distinct ways: firstly, as a linguistic disparity; and secondly, as a divergence of communicative intentions. On the one hand, the physician is primarily concerned not only with communicating the diagnosis to the patient in the most accurate manner possible, but also with persuading the patient of the validity of the diagnosis itself. In a context where medical information is widely accessible, often without mediation, physicians are increasingly required to justify their diagnostic conclusions. Communication thus becomes not only a matter of accuracy but also of legitimacy.²³ On the other hand, patients tend to be more concerned with receiving practical advice regarding treatment and care. The physician's explanations may therefore be perceived as misaligned with the patient's immediate concerns. The foundational step toward improving such communication lies in establishing a relationship of mutual trust, which can only emerge when the physician genuinely understands the needs of the patient.²⁴ Adopting the patient's perspective enables the physician to tailor the diagnostic discourse toward what the patient truly seeks: not merely an account of the disease, but a path toward healing.

Diagnosis is not simply a knowledge event it is a biographical disruption.²⁵ For most patients, the naming of illness marks the breakdown of ordinary time, the onset of fear, and the reconstruction of identity. This emotional vulnerability places an ethical demand on the physician to attend to the patient's vulnerability, not only medically but existentially.

²³ M.G. Busà, S. Brugnerotto, *Italian doctor-patient interactions: A study of verbal and non-verbal behavior leading to miscommunication*, Conference: LREC - DIMPLE: Disaster Management and Principled Large-scale information At, Reykjavik 2014.

²⁴ F. Marino, et al., *Navigating Intercultural Medical Encounters: An Examination of Patient-Centered Communication Practices with Italian and Foreign Cancer Patients Living in Italy*, in «Cancers», 15, 11, 2023, p. 3008.

²⁵ M. Bury, *Chronic illness as biographical disruption*, in «Social Health Illness», 4, 2, 1982, pp.167-182.

Empirical studies^{26 27 28} confirm that the emotional effects of diagnosis, especially of chronic or terminal illness, can be lasting and impact the patient's trust in medicine. Yet too often the message is delivered in settings or ways that maximize emotional harm: rushed consultations, confusing language, too much jargon, or lack of empathetic engagement. Ethical communication must thus consider not only what is true, but what is bearable, without paternalism.²⁹

This balance is unstable. To communicate a devastating truth without retraumatizing the person is a subtle ethical art: a compound of veracity, empathy, timing, and contextual awareness. Diagnosis disclosure, in this sense, is a form of moral praxis, a cultivated ability to respond to another's humanity in a context of uncertainty and vulnerability.

Communication is never unidirectional. Even when the physician speaks first, the patient interprets, responds, and reframes. Thus, a more adequate ethical model of diagnosis disclosure must reject the idea of communication as transmission and embrace it as dialogue.³⁰ Building on Gadamer's and Buber's dialogical ethics, diagnosis should be approached not as a monologue of authority but as a co-created moment in which meanings are negotiated.

In this sense, the disclosure of a diagnosis is not the end of a process, but the beginning of a shared interpretive work. The physician brings biomedical expertise; the patient brings biographical context and subjective

²⁶ M. Heijmans *et al.*, *Stress in chronic disease: do the perceptions of patients and their general practitioners match?*, in «Br J Health Psychol», 6, 3, 2001, pp. 229-242.

²⁷ A.M. O'Hare *et al.*, *Emotional Impact of Illness and Care on Patients with Advanced Kidney Disease*, in «Clinical Journal of the American Society of Nephrology», 13, 7, 2018, pp. 1022-1029.

²⁸ M. Sloan *et al.*, *Is it me? The impact of patient-physician interactions on lupus patients' psychological well-being, cognition and health-care-seeking behaviour*, in «Rheumatology Advances in Practice», 2020, pp. 1-13.

²⁹ A.A. Rossi *et al.*, *From Fear to Hopelessness: The Buffering Effect of Patient-Centered Communication, in a Sample of Oncological Patients during COVID-19*, in «Behavioral Sciences», 11, 6, 2021.

³⁰ L. Lipari, *Listening for the Other: Ethical Implications of the Buber-Levinas Encounter*, in «Communication Theory», 2004, pp. 122-141.

meaning. The ethical responsibility of the physician is therefore twofold: to share knowledge truthfully, and to do so in a manner that welcomes the patient into the interpretive space, allowing them to reconfigure their life story in light of the diagnosis rather than having it imposed upon them.

4. Diagnosis communication as a specialised knowledge

Communicating a diagnosis is not simply the final step in a clinical workflow, nor can it be reduced to the legal duty of informing the patient. Across the analyses developed in this article, ranging from the Italian institutional context to hermeneutic, phenomenological, and performative theories of illness, it has become clear that diagnostic disclosure constitutes a moment where knowledge, power, and meaning converge. The diagnostic utterance does not merely transmit biomedical truth; it reconfigures the patient's existential horizon, inaugurating a narrative disjunction that must be interpreted, inhabited, and integrated. For this reason, diagnostic communication must be understood as an intervention into another person's life-story that demands attentiveness, dialogical openness, and a responsible use of epistemic authority. To "tell" a diagnosis is, in this sense, to participate in shaping how the patient will understand themselves, their possibilities, and their future.

This ethical charge, however, cannot be adequately met by clinicians who are neither institutionally prepared nor structurally supported to address it. The philosophical frameworks discussed, Gadamer's hermeneutics, Ricoeur's narrative agency, the Foucauldian critique of the clinical gaze, and the performative nature of medical language illuminate the practical stakes of the moment of the diagnosis: it is a place where subjectivity can be either diminished or sustained. Reconnecting these insights to the article's practical thesis makes the central point unmistakable: if diagnostic disclosure is both interpretive and constitutive, then it requires a level of communicative expertise that goes beyond the purview of biomedical training. Introducing specialized communicators, or formally distributing communicative responsibility within a clinical team, does not undermine the

physician's authority but reinforces the ethical integrity of care. It ensures that the patient receives not only factual accuracy but also interpretive guidance and emotional containment. In this light, designing institutional structures that take diagnostic communication seriously is a necessity that aligns clinical practice with the deeper ethical meaning of diagnosis as a transformative and human encounter.

A first claim is that diagnosis communication cannot be reduced to the informative model of consent, which assumes that the physician possesses knowledge, and the patient merely receives it. While transparency is crucial, a purely unidirectional notion of communication fails to recognize the patient's interpretive agency and emotional world. Instead, diagnosis disclosure should be guided by what can be termed a dialogical ethic of communication. This involves treating the patient not as a passive receiver but as an active subject in the construction of meaning, framing diagnosis not only in biomedical terms but within the patient's life narrative and recognizing that the act of disclosure is not the conclusion of a process, but the beginning of a shared journey of understanding, adaptation, and decision-making.

Having outlined the institutional problems regarding the training of physicians in the vast framework that pertains to the communication of a diagnosis, we can now advocate for the possibility of it not being in the direct purview of the health professionals. Diagnosis disclosure must be seen as ethical praxis that requires rethinking on multiple levels: linguistic, temporal, interpersonal, and institutional, and that requires expert figures trained in its communication.

4.1 Considering the possibility of a split in medical figures

In our increasingly science-oriented world, the role of the physician is gradually, yet steadily, shifting toward that of a scientist, more akin to a biologist than a provider of care. As previously noted in this article, physicians are subject to significant stress on multiple fronts: professional, bureaucratic,

and emotional. This situation raises the question of whether there is a need for the introduction of a specialized figure dedicated to the communicative dimensions of care, dimensions for which physicians are not only inadequately trained, but which are also difficult to integrate into an already demanding educational and professional trajectory.

Recent empirical studies and professional guidelines suggest an alternative: a structured division of labor between the diagnosing physician and a trained medical communicator, who may be a nurse, psychologist, or other allied professional. This shared approach does not displace the physician's epistemic authority but recognizes that the communicative act has its own disciplinary depth, requiring expertise in dialogue, empathy, and narrative framing. Science communicators already serve as intermediaries between the scientific community and the general public. In a similar vein, professionals specifically trained in care, listening, and empathy could play a crucial role in alleviating the burdens that weigh heavily on medical practitioners. At the same time, such figures could maintain a focused expertise on the patient-physician relationship, thus enhancing the quality of interaction without compromising the physician's primary clinical responsibilities.

Oncology provides the richest empirical field on diagnostic communication. Nurse-led or co-delivered "bad news consultations" have been tested in various settings, showing tangible benefits for patient comprehension and emotional processing.³¹ Integrated reviews highlight that nurses frequently act as mediators and interpreters of medical information, performing emotional work that complements the physician's technical explanation.³² These studies report that when trained professionals (be it nurses, psychologists, or specialized counsellors) participate in or lead parts

³¹ E. Guerdoux *et al.*, 'Bad news consultations' with oncology nurses: Impact on perceived stress and patient experience, in «European Journal of Oncology Nursing», 56, 2022, 102085.

³² S. Khaki *et al.*, *The Role of Nurses in Delivering Bad News to the Patient and Family: An Integrated Review Study*, in «International Journal of Cancer Management», 17, 1, 2024, e145579.

of the disclosure, patients show greater understanding, reduced anxiety, and improved satisfaction. Importantly, physicians themselves report relief from emotional overload and greater confidence that the patient's needs have been met. The ethical and communicative labor of disclosure, therefore, can be effectively distributed within a clinical team without compromising truthfulness or professionalism. In dementia care, the disclosure of diagnosis involves a particularly fragile balance between honesty and protection, cognitive decline and autonomy. Research in this area increasingly advocates a staged model of communication, where the initial diagnostic statement is followed by multiple interpretive sessions involving counsellors, neuropsychologists, or dementia-specialist nurses.³³ Consensus recommendations for biomarker-based Alzheimer's diagnosis likewise prescribe multidisciplinary counselling before and after disclosure, echoing genetic testing protocols. This effectively operationalizes a split model, where the physician's role centers on accuracy and prognosis, and the communicator's role centers on meaning, adaptation, and emotional containment. The literature suggests that such a model reduces distress and facilitates more constructive planning by patients and families. Radiology offers another compelling example. For decades, radiologists rarely communicated directly with patients, relying on referring physicians to do so. Yet a growing body of research and professional advocacy now supports direct patient communication as a means of improving transparency, safety, and satisfaction^{34 35}. These discussions have led to hybrid models where communication specialists or nurse navigators bridge the gap between technical interpretation and patient understanding.

The radiology debate shows that diagnostic communication can evolve institutionally without eroding professional hierarchies. While the physician

³³ C.C. Frank *et al.*, *Disclosing a diagnosis of dementia*, in «Canadian Family Physician», 64, 7, 2018, 518.

³⁴ A.G. Rockall *et al.*, *Patient communication in radiology: Moving up the agenda*, *European Journal of Radiology*, 155, 2022, 110464.

³⁵ L. Berlin, *Communicating Results of All Radiologic Examinations Directly to Patients: Has the Time Come?*, in «The Practice of Radiology», 189, 6, 2012.

retains epistemic authority over the finding; the communicator ensures its understandability.

In this sense, the communicator's function is analogous to that of a medical interpreter or palliative counsellor: not replacing the physician but ensuring that the biomedical truth is received within the patient's interpretive horizon. The ethical act of "telling the truth" becomes a team responsibility, fulfilling both the deontological demand for honesty and the phenomenological demand for understanding.

The evidence suggests that a moderate split between diagnosing and communicating roles can be both ethically defensible and practically beneficial. Implementing this model requires institutional acknowledgment of communication as a core dimension of care, not a secondary task. Medical faculties could integrate communication philosophy, counselling, and narrative medicine into dedicated training tracks, while hospitals could establish "communication teams" akin to ethics committees. Each preserves the physician's epistemic accountability while institutionalizing communicative care. Evaluation metrics could include patient comprehension, emotional wellbeing, decisional conflict, and clinician burnout as parameters already validated in communication research.

Conclusion

Communicating a diagnosis is not only a medical duty but a specific act of communication that shapes how a patient understands their condition and their future. It involves ethical, linguistic, and psychological dimensions that go beyond the clinical moment itself. The art of disclosing a diagnosis necessitates care and study, which in turn requires a specific preparation.

Recognizing this also means rethinking who should be responsible for it. The skills required to establish a diagnosis are not the same as those needed to communicate it effectively and sensitively. A practical way to address this gap could be to separate the role of the physician from that of a trained medical communicator. The physician would remain responsible for the accuracy of the diagnosis, while the communicator would focus on helping the

patient understand and process the information. This distinction would not weaken the relationship between doctor and patient but would strengthen it, ensuring that both truth and understanding are given the attention they deserve.