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INTERSUBJECTIVITY AND LANGUAGE IN THE CLINICAL ENCOUNTER
TOWARDS A THEORY OF COMMUNICATION IN HEALTH

INTERSUBJETIVIDADE E LINGUAGEM NO ENCONTRO CLÍNICO
POR UMA TEORIA DA COMUNICAÇÃO EM SAÚDE

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Contemporary medicine grounds itself in a fundamental theoretical presupposition, namely the construction of eminently rationalist and mechanistic discourses that remain divorced from the subjective historicity inherent to humanistic approaches concerned with modes of life or the quality of existence. This disjuncture has generated, from the mid-twentieth century onward, a countercurrent seeking the "re-humanization" of medicine, primarily grounded in language. Given that the clinical encounter constitutes the pivotal point of medical activity, it becomes imperative to understand how language in its discursive operation and rational and empirical knowledge harmonize with the subject(s) participating in this dialogical relationship. We shall proceed from the critique of the Kantian model that conceives language as vehicle—undertaken particularly by Humboldt—articulating it with epistemology and recent theoretical acquisitions derived from a hermeneutic-phenomenological matrix in order to create a cartography of the medical sciences and their associated discourses. This approach will enable not only the elucidation of language's role in medicine but also the integration of other knowledge domains implicated in health practices. Ultimately, this characterization may pave the way toward a general theory of health communication with the aim of promoting deeper understanding and enhancement of interactions between health professionals and their patients, rendering them more inclusive and humane.

Keywords: Language; Medicine; Health Communication; Wilhelm von Humboldt.

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A medicina contemporânea tem como um de seus pressupostos teóricos a construção de discursos eminentemente racionalistas e mecanicistas desvinculados da historicidade subjetiva própria de abordagens humanistas que se referem ao modo de vida ou à qualidade da existência. Este descompasso gerou, a partir de meados do século XX, uma contracorrente que busca a "re-humanização" da medicina, mormente calcada na linguagem. Visto que o ponto fulcral da atividade médica é o encontro clínico, faz-se mister entender como a linguagem em sua atuação discursiva e o conhecimento racional e empírico se coadunam com o(s) sujeito(s) participante(s) dessa relação dialógica. Partiremos da crítica ao modelo kantiano que considera a linguagem como veículo, realizada especialmente por Humboldt, articulando-a à teoria do conhecimento e a aquisições teóricas recentes provenientes de uma matriz hermenêutico-fenomenológica de modo a criar uma cartografia das ciências médicas e de seus discursos associados. Essa abordagem permitirá não apenas esclarecer o papel da linguagem na medicina, mas também integrar outras áreas do conhecimento implicadas nas práticas de saúde. Em última análise, esta caracterização pode abrir caminho a uma teoria geral da comunicação em saúde no intuito de promover uma compreensão mais profunda e um aprimoramento das interações entre os profissionais de saúde e os seus pacientes, tornando-as mais inclusivas e humanas.

Palavras-chave: Linguagem; Medicina; Comunicação em Saúde; Wilhelm von Humboldt.

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The heart is that which loves; which flies toward a fellow being, as such. The sensibilities do not do this, neither do they conceive; hence they are a distinct element of the soul. In my opinion
1. The Intellect &c. or that which says I,
2. The Heart &c. or that which says THOU,
3. The Sense &c. or that which says IT,
compose the inward nature.
— Charles Sanders Peirce

1. Introduction

What has gone down in history as the "philosophy of consciousness" is the idea that the apprehension of the world and the constitution of knowledge are structured from the very instance of consciousness. This paradigm dominated much of modern philosophy, especially with Descartes (see, for example, Descartes, 1999, Second Meditation, pp. 35-58), Kant (e.g. Segunda Secção, Dedução Transcendental dos Conceitos Puros do Entendimento – B, §16, B132-B133), and Husserl (see, for example, Husserl, 2001 - On intentional experience and their 'contents' - Investigation V, Volume II of the German editions, pp. 77 – 176), emphasizing the role of the thinking subject in structuring reality. However, starting in the 20th century, various philosophers questioned the centrality of consciousness as the foundation of knowledge. Broadly speaking, Nietzsche (many works, but specially Nietzsche, 1997) and Heidegger (2010, particularly in §6) rejected the idea of an autonomous subject and emphasized historicity and concrete existence; Wittgenstein demonstrated that thought is structured by language and that understanding is not merely internal to consciousness (Wittgenstein, 1958, §7, 241, 242 among others); Foucault (in particular after Foucault, 2001), Derrida (see, for example, Derrida, 1968), and Lacan (explicitly in Lacan, 1972) argued that subjectivity is an effect of social and discursive structures. The philosophy of consciousness, therefore, despite its significant influence on modern thought, was progressively replaced by approaches that emphasize language, history, and intersubjectivity.

This shift occurred across various fields of human knowledge, but medicine seems to maintain its theoretical framework primarily rooted in the paradigm of consciousness. The normalization of clinical reasoning through a scientific matrix—adopting a philosophical approach that considers consciousness as the foundation for apprehending the world—reaches its peak in Kant and depends, therefore, on creating abstract and universal principles disconnected from lived reality. It is interesting to note how medicine, ironically, seeks to reclaim what might be called a "lost humanity" without realizing that this need arises from the very empiricist scientific logic that has guided its practices over the last two centuries. Thus, it is not possible to resolve this impasse "scientifically." It is akin to chasing one's own tail: the scientific method creates a distance that it then tries to overcome.

In this context, understanding the challenges of contemporary medicine requires a thorough analysis of the interactions between language, subject, and knowledge because it is precisely at this intersection that conceptual aporias emerge within a medical practice largely supported by scientific data. It is worth remembering that for Kant, language was secondary to reason—a mere instrument for communicating thought, simply a means of expressing universal rational structures rather than an element that configures them (Lafont, 1999). Therefore, in line with Kant's critics, it is essential to insist that if we consider language as constitutive of reason, it inevitably relativizes knowledge by

challenging the notion of a universal transcendental subject (see below). And if there is no fixed transcendental subject, how can we guarantee the universality of categories of understanding? Similarly, this implies that it is impossible to ground language externally or to dispense with it altogether; i.e., any attempt to think about language must necessarily proceed through language itself, thus creating circularity. Finally, if language constitutes reason, individual subjectivity reveals itself as intrinsically dependent on a linguistic structure that is inherently shared and collective. This interdependence questions the foundations of the philosophy of consciousness, which traditionally takes the subject as a privileged starting point for constructing knowledge. In other words, it raises questions about how it is possible to reconcile a pure "transcendental self" with a language that is essentially social, historical, and marked by imprecision. Moreover, in our context here: how can these critiques be addressed considering the apparent certainty provided by techno-scientific truths—grounded in processes of universalization—and the rawness of everyday reality where individual patients indeed bleed, become infected, and die?

Given these considerations, this article aims to clarify the discursive relationships at play within medicine—particularly within its core defining element: the clinical encounter itself. We start using the critiques of Kant's model, especially those advanced by Humboldt, proceeding to articulate these critiques with epistemology and recent theoretical developments stemming from a hermeneutic-phenomenological framework in order to create a cartography of medical sciences and their associated discourses. We hope this approach not only clarifies the role of language in medicine but also integrates diverse fields of knowledge essential to health practices, paving the way for what we might envision as a utopian framework we called Theory of Communication in Health.

To achieve this goal, we will follow this path: first, we will clarify the intersubjective constitution of subjects according to Humboldt. Next, we will critically define the pathological spectrum to be addressed using Twaddle's triad (Twaddle, 1968, 1994). Finally, we will connect this theoretical framework to aspects of discourse theory and verbal persons as advanced by Havi Carel (Carel, 2016) and Tullio Viola (2011). With this framework in place, we will then integrate the triad with discourse theory and epistemology to encompass the narratives shaping clinical encounters.

2. The Intersubjective Constitution of the Subject in Language – Humboldt's Contribution

Wilhelm von Humboldt played a central role in transforming the understanding of language, marking a paradigmatic shift that profoundly influenced modern linguistics and philosophy. His contribution belongs to an intellectual tradition initiated by thinkers such as Johann Georg Hamann and Johann Gottfried Herder, who challenged the traditional conception of language as merely an instrument for communication or the expression of pre-existing ideas (Lafont, 1999). Following in the footsteps of his predecessors, Humboldt proposed a more sophisticated view that recognises language as a constitutive element of thought, knowledge, and human experience (Humboldt, 1990).

One of Humboldt's fundamental critiques of the traditional view of language lies in overcoming the idea that it is merely a static medium for transmitting thoughts. For him, language is a dynamic and creative activity, described by the concept of *Energeia*, as opposed to the notion of a finished product (*Ergon*) (Humboldt, 1990, p. 65). In this sense, language not only reflects the world but actively participates in constructing new concepts and content. This perspective implies that language is a condition of possibility

for both objective experience and intersubjective communication, being essential for establishing mutual understanding between individuals. Indeed, according to Humboldt, language has two essential functions that are significant for our argument. The first is its cognitive-semantic dimension, which goes beyond being a mere system of signs and becomes the very condition of possibility for thought. In this sense, language acquires an almost transcendental status, shifting the authorship of cognitive operations from the subject to its structure. With this shift, analyzing language becomes inseparable from addressing the conditions that make objective experience possible, which are derived from its function of revealing the world. Moreover, language does not merely represent reality but constructs it through a synthetic process—termed "articulation" —that combines thought objects with pre-existing words and concepts. This process enables the emergence of new empirical objectivity without negating subjectivity. As Humboldt states: "Only language can do this; and without this transformation […] the act of concept formation, and with it all true thinking, is impossible" (Humboldt, 1990, p. 77). Thus, for him, more than being a means of communication, discursive activity is a fundamental condition for thought.

The second dimension of language identified by Humboldt is its communicative-pragmatic aspect, defined by its constitutive nature as an activity—the praxis of discourse. In this sense, language not only enables communication but also fosters intersubjectivity, an essential condition for understanding between speakers. Humboldt thus anticipates a view of language that would only decades later be incorporated into philosophical discussions within the hermeneutic-phenomenological tradition interrelating thought, language, human beings, and society. To demonstrate this dynamic, he analyses personal pronouns, aligning himself with conceptions later developed by theoreticians like Émile Benveniste and Ernst Cassirer (Viola, 2011). In *Über den Dualis* (Lafont, 1999, p. 46), Humboldt argues that the "I" only fully constitutes itself in relation to a "you." Unlike "he," which merely contrasts one object with another, "you" establishes a direct connection with "I," enabling reciprocal and active interaction. Thus, language not only distinguishes subjects from objects but also founds (or creates) subjectivity through interpersonal relationships. This perspective leads Humboldt to conclude that subject-to-subject relations precede subject-to-object relations since the constitution of the first person depends on dialogue. As Lafont explains, opposing an "I" to a "he" is insufficient to establish a subject; it is through interaction with a "you" that the "I" defines itself (Lafont, 1999, p. 47). This interaction not only individualizes but also socializes, while simultaneously granting the third person their true status as a common object. In other words, it is only through the interaction between the "I" and the "you" (subjective elements) that it becomes possible to conceive the "he/she/it," understood by both parties in the dialogue as the objective element.

It's important to reiterate that Humboldt's approach also stands out for de-transcedentalising reason by recognising its concrete manifestation in particular historical languages (Segatto, 2009, p. 194). Unlike Kantian philosophy, which situates thought within universal transcendental structures, Humboldt argues that thought emerges *in* and *through* language. Thus, languages are not merely neutral vehicles for universal ideas; they shape and delimit how individuals perceive and understand the world. This cognitive-semantic dimension highlights language's role as a condition for thought.

Additionally, Humboldt emphasizes the communicative-pragmatic dimension of language by underlining its role in ensuring intersubjectivity. Language is not merely a medium through which individuals share information; it is the foundation for social interaction and collective meaning-making. Through language, humans not only communicate their experiences but also constitute them in an ongoing process of interaction. Humboldt

therefore conceives language as an element intrinsically linked to thought and endowed with a dual status. The empirical domain corresponds to what is accessible to sensory experience and observation—encompassing facts, phenomena, and the materiality of the world as perceived by the senses and analyzed by science. In contrast, the transcendental refers to *a priori* conditions that make experience and knowledge possible—a central concept in Kantian philosophy that relates to universal cognitive structures such as space, time, and categories of understanding which underpin perception and thought but are not directly accessible through experience. For Hamann and Herder alike, language simultaneously participates in both domains: on an empirical level it manifests in discursive or written forms—perceptible and open to analysis; on a transcendental level it forms part of universal cognitive structures enabling knowledge itself. Thus understood—as both empirical *and* transcendental—language occupies a hybrid position between sensory experience and its underlying conditions for possibility (*a priori*). However, admitting such hybridity challenges Kant's critical conceptual framework since—as argued throughout "Critique of Pure Reason"—confusing these spheres risks significant epistemological errors like conflating conditions making experience possible with objects experienced themselves[*].

While our framework emphasizes the centrality of language in the clinical encounter, it is worth to note that we do not intend to reduce communication to propositional or exclusively verbal exchanges. Following Humboldt's insight that language shapes thought and intersubjective experience, we understand it in an expanded sense that includes gestures, silence, tone, and affective resonance. These dimensions become particularly significant in encounters involving patients with limited or impaired verbal capacities—such as individuals with aphasia, neurodegenerative disorders, or developmental conditions. In such contexts, the communicative act cannot rely solely on narrativity, yet remains grounded in shared meaning-making and responsiveness, often mediated by embodied and relational cues. A general theory of health communication, as we envision it, must therefore account for both the expressive power and the inherent limitations of verbal language.

3. The Twaddle Triad

Within the scope of language theories and the study of its role in understanding the phenomenon of human illness, it is important to revisit the analysis of the contribution provided by the Twaddle Triad. Although no perfect theory comprehensively describes the spectrum of human illness, the triad proposed by Andrew Twaddle, which distinguishes *disease*, *illness*, and *sickness*, is a valuable tool that allows us to analyse the biomedical, individual, and social dimensions of diseases. This distinction, recognised in theoretical medicine since the 1950s, was formalised by Twaddle in 1968 in his doctoral thesis (Twaddle, 1968) and remains widely accepted in medical sociology and anthropology, as well as among many commentators on the philosophy of medicine.

According to him, *disease* is defined as "a health problem consisting of physiological malfunction that results in an actual or potential reduction of physical capacities and/or

[*] Throughout "Critique of Pure Reason", Kant distinguishes empirical versus transcendental objects via disjunctions; in "Introduction B Part I" he says: "In the sequel therefore we will understand by a priori cognitions not those that occur independently of this or that experience, but rather those that occur absolutely independently of all experience" (B3). Another quote is "Error is only effected through the unnoticed influence of sensibility on understanding, through which it happens that the subjective grounds of the judgment join with the objective ones" (A294).

life expectancy" Twaddle, 1968, p. 8). Ontologically, *disease* is an organic phenomenon independent of subjective experience and social conventions, with its study limited to the objective measurement of its variables (Twaddle, 1968, p. 8). *Disease* is therefore the focus of medical attention. *Illness*, on the other hand, is "an undesirable health state subjectively interpreted. It consists of subjective states of feeling (e.g., pain, weakness), perceptions of the adequacy of bodily functioning, and/or feelings of competence" (Twaddle, 1994, p. 10). Ontologically, *illness* aligns in its discursive form with what medicine classifies as a symptom. Epistemically, *illness* can only be directly accessed by the individual, which allows phenomenologists of medicine like Havi Carel to refer to this ineffability of the body regarding its sensations as "first-person authority" (Carel, 2016, p. 46). Consequently, *illness* can only be indirectly accessed by a "second person" through the individual's own accounts. Finally, *sickness* is "a social identity. It refers to an individual's impaired health or health problem(s) as defined by others with reference to that individual's social activity" (Twaddle, 1994, p.11). Ontologically, it is "an event located within society... defined by participation in the social system." Epistemically, sickness is accessed through "the measurement of performance levels with reference to expected social activities when these levels fail to meet social standards" (Twaddle, 1994, p.11).
Although these definitions are open to criticism (Nordenfelt, 1994) and do not provide a definitive description of the spectrum of human suffering, Twaddle's triad is more than just a theoretical framework. It is closely related to the World Health Organisation's (WHO) definition of health as "a state of complete physical (disease), psychological (illness), and social (sickness) well-being" (Hofmann, 2002, p. 655). Furthermore, it constitutes a suitable conceptual framework for analysing and addressing controversial cases. In particular, the triad represents a structure for tackling the normative and epistemic challenges of medicine (such as autonomy, paternalism, rationing, and medicalisation) (Hofmann, 2002, p. 667). In other words, Twaddle's triad remains a functional and effective model, representing an useful approach for analyzing the full spectrum of human morbid conditions.

4. Theory of Discourses in Medical Practice

On the other hand, Havi Carel and others (Viola, 2011), in her phenomenological analysis of illness, briefly employs the notion of verbal persons in the process of illness. In her framework, *illness* can only be accessed directly in the first-person mode. However, "there is also a second-person perspective in illness" (Carel, 2016, p. 47), which involves perceiving aspects of how the ill person is feeling. "The claim that we can experience something of other people's experiences," Carel continues, "but in the second-person mode rather than the first-person mode, is made by Edith Stein" and is referred to as *empathy*. This observation is rich in implications. If we consider Twaddle's triad as an acceptable methodology for the theoretical description of human illness processes, we can combine it with Humboldt's discursive modes of intersubjective demarcation of verbal persons to achieve a comprehensive overview of all possible discourses involved in medical practice, as shown in the table below.

Table. Possible discourses in medical practice related to morbid process.

Perspective	First Person	Second Person	Third Person
Illness	Narratives Anamnesis	Empathy Phenomenology of Illness	Psychology Anthropology Humanisation Processes

Disease	Folk Wisdom "Dr. Google" Artificial Intelligence	Health Communication	Medical Science "*in toto*"
Sickness	Dispossession and Precarisation Rejection, Prejudice Fear	Psychology Existential Philosophy Psychoanalysis and other therapies	Occupational Psychology and Medicine Sociology Microeconomics Politics, Culture

This table illustrates how different discursive perspectives—first-person, second-person, and third-person—can be applied to analyze *illness*, *disease*, and *sickness*, providing a broad framework for understanding medical practice and intersubjective dynamics.

Briefly, the third-person perspective, represented by the "I-he" relationship or subject-object dynamics, brings the scientific (or, as Twaddle describes it, "epistemic") viewpoint to illness. Regarding *illness*, this perspective is represented by sciences aimed at understanding individual (*e.g.* Psychology) and collective suffering (*e.g.* Anthropology) associated with diseases, as well as care and humanisation processes designed to alleviate them. Concerning *disease*, it encompasses all scientific knowledge—whether strictly biomedical or related—produced about human pathologies. As for *sickness*, it involves a wide range of actions, from performance evaluation processes and social security to social determinants of disease as broad as Microeconomics, Politics, and cultural aspects inherent to each society.

From the first-person perspective, that is, the way the "I" relates to their illness, *illness* involves narratives and clinical histories recounted by patients themselves; *disease* represents the personal (or family-led) search for information and treatment of health problems; and *sickness* is associated with personal challenges caused by the process of illness.

Finally, from the second-person perspective—that is, how a "you" relates to the suffering of the "I" (your interlocutor)—the experience of illness translates into empathy, as previously discussed. The phenomenology of illness, particularly that developed in the late 20th and early 21st centuries, finds its place here[†]. In contrast, *sickness* brings both clinical approaches (*e.g.* Psychology and therapies) and non-clinical ones (*e.g.* Existential Philosophy and other ways of understanding humanity) to address suffering caused by illness. The second-person perspective on *disease* primarily involves healthcare professionals who produce discourses about patients, which deserves special attention here. The entirety of discourses produced in this category can be subdivided, according to Hydén & Mishler (Hydén & Mishler, 1999), into four categories:

i) Speaking *to* the patient;
ii) Speaking *with* the patient;
iii) Speaking *about* the patient;
iv) Speaking *for* the patient.

Let us briefly analyze each of these categories based on ideas developed by these authors.

[†] See, for example, works by American authors such as S. Kay Toombs, Richard Zaner, Drew Leder, and Shaun Gallagher, alongside Swedish scholar Fredrik Svenaeus and philosophers like Havi Carel and Tullio Viola, among many others.

i) **Speaking to the patient:** This addresses questions such as: How can relationships with patients be established when asking questions and explaining clinical concepts? How can different types of communication optimize patient satisfaction and adherence? Since the 1960s, research in medical communication has sought to improve doctors' communication skills to enhance anamnesis, diagnosis, and treatment. The focus has been on the doctor-patient relationship, information exchange, and its impact on patient satisfaction and adherence. One review has shown that longer consultation times and positive interactions improve these outcomes but face limitations by neglecting sociocultural contexts and treating communication in a fragmented manner (Ong, 1999). Factors such as the gender and social class of both doctors and patients have been considered for their impact on clinical interactions (Beisecker, 1990).

ii) **Speaking with the patient:** An alternative paradigm for studying medical interviews emerged in the 1980s, grounded in sociolinguistic approaches such as discourse analysis and narrative studies. This model views the doctor-patient interaction as a co-constructed communicative event, focusing on dialogue (speaking with) rather than physician control (speaking to). These models examine how doctors dominate interviews through questioning strategies that structure the conversation and suppress the patient's "lifeworld voice," imposing the "voice of medicine". Three theoretical perspectives explain this asymmetry:

iia) Structural: Reflects social inequalities, such as the higher status of doctors in terms of income and education.
iib) Conflict: Arises between the patient's lived experience and the biomedical approach, limiting opportunities for patients to narrate their stories.
iic) Shared cultural expectations: Both doctors and patients accept asymmetrical roles as part of the institutional context. Patients often preserve their lay status, reinforcing medical authority.

Although some studies (Pilnick, 2011) show that doctors can create spaces for broader responses, patients often fail to utilise them, suggesting that asymmetry is co-constructed, reflecting both institutional norms and interactional dynamics. It's interesting to note that other studies also show physicians offer opportunities for patient responses and questions, but patients don't use them (ten Have 1991, Maynard 1991). The explanation centers on a proposal that patients and physicians collaborate to maintain role boundaries - patients as laypersons seeking help, physicians as experts providing it. Patients preserve this dynamic by presenting problems acceptably and not challenging physician authority, avoiding new topics or questions even when permitted (Heath 1992). This perspective differs from power asymmetry theories and reframes physician interruptions and topic dismissals as collaborative role maintenance rather than dominance (Mishler 1984).

iii) **Speaking about the patient:** Recent research has focused on discourses *about* patients among doctors and other healthcare professionals (Carelli, 2013; Pompilio, 2016; Barreto, 2019; Pompilio, 2022). This shift broadens analysis to contexts such as clinical visits, conferences, and case presentations, highlighting how doctors synthesize information from multiple sources—patient accounts, laboratory

tests, and scientific literature—using ethnographic methods to capture these interactions. Notably, different medical specialties produce distinct discourses about the same patients, emphasising clinical elements that support their hypotheses. The careful integration of these discourses aims to improve patient care.

iv) Speaking for the patient: This dimension concerns communicative models—often developed outside strictly biomedical contexts—that aim to support both patients and healthcare professionals in making sense of illness within complex sociocultural landscapes. Such approaches foreground the patient's narrative voice, acknowledging that the lived experience of illness cannot be fully captured by clinical descriptors alone (Kleinman, 1988; Frank, 1995). By privileging first-person accounts and culturally situated interpretations of suffering, these studies extend the scope of language-and-medicine research beyond diagnostic accuracy or compliance, toward a more dialogical and interpretive engagement with the patient's world (Mishler, 1984; Charon, 2006). Although our analysis often refers to the clinical encounter as a doctor-patient dyad for clarity and conceptual focus, we recognize that medical practice frequently unfolds within more complex networks of care. Family members, informal caregivers, interpreters, and patient advocates may all participate in the communicative process, particularly when the patient cannot fully articulate their experience. In such cases, "speaking for the patient" must not be understood as a displacement of the patient's voice, but rather as an effort to co-construct and ethically mediate that voice—especially when vulnerability, dependency, or cognitive impairment are involved. By acknowledging these broader constellations of care, our model seeks to remain attentive to the plural and dynamic nature of intersubjective relations in health contexts.

These modes of discursive direction, while interdependent, constitute distinct fields of investigation and reflect systematic advancements in medicine aimed at its improvement. Together, they represent the full spectrum of discourses that emerge within the doctor-patient relationship. In this context, they enable a phenomenological and epistemological approach to clinical encounters through language.

5. Final Considerations

Generalizing the formulations of Humboldt and other theorists of language and discourse, this article argues that medicine is intrinsically linked to linguistic practices. Unraveling the structure and nuances of these practices is fundamental to understanding the subjects involved in the process of illness. Even evidence-based medicine, despite its rationalist orientation, fundamentally depends on language to structure clinical reasoning, anamnesis, diagnostic formulation, doctor-patient interaction, and therapeutic planning. The idea that the "I" is only fully constituted in relation to a "you", as argued by Humboldt, is central to grasping the dynamics of the clinical relationship. The clinical encounter, conceived here as an essentially dialogical event, relies on this intersubjective bond not only to deepen the understanding of the patient's experience but also to create a space where, as Hurwitz (2016) observes, "the patient and their account (rather than solely the disease, disease technologies and the medical case) regained the centre of attention."

The articulation of Twaddle's triad (disease, illness, and sickness) with the theory of verbal persons adds a further conceptual layer to this proposal. The authority of the first person in articulating illness resonates with the foundational role of the "I" in the

constitution of subjectivity. The second-person perspective, grounded in empathy with the suffering of the other, reflects the ethical significance of "you" in communicative and relational exchanges. Finally, the third-person stance, associated with scientific and institutional views of illness, introduces the "he/she" or "it" perspective that often contrasts with first- and second-person narratives in medical discourse.

This perspective enables two main contributions to a phenomenological characterization of language in the clinical encounter. First, it provides a conceptual map of the discursive landscape activated the moment a patient enters the healthcare system—typically through a medical consultation. From that moment on, multiple overlapping discourses emerge around the patient's clinical condition. Though initially diffuse, these discourses can be progressively structured and analyzed as a coherent narrative field. Second, this theoretical articulation lays the groundwork for a long-sought general theory of health communication—a framework capable of promoting a deeper, more inclusive, and humane understanding of the communicative dynamics that define clinical care.

That said, we recognize that one of the limitations of this study lies in its emphasis on verbal language as the primary medium through which meaning is constructed in clinical settings. While this focus is theoretically grounded and methodologically deliberate, it underrepresents the role of non-verbal communication in situations where patients may lack verbal or cognitive capacities (Cocks et al., 2011; Dipper et al., 2015). In such cases, communication is often mediated by caregivers, family members, or healthcare professionals who must 'speak for' the patient—a process that requires careful attention to the difference between the representative's narrative and the patient's own experience (Hydén & Mishler, 1999). Although this issue is briefly addressed in category (iv) of our model, we acknowledge the need for further theoretical and ethical development in this area. Future iterations of this framework will therefore seek to incorporate a broader communicative ecology—one that includes embodied, affective, and mediated modes of interaction as integral components of clinical understanding.

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