Routledge
Taylor & Francis Group

Philosophical Psychology

ISSN: 0951-5089 (Print) 1465-394X (Online) Journal homepage: www.tandfonline.com/journals/cphp20

Understanding illness in joint attentional conversations

John Anderson P-Duarte & Estefanía Losada Nieto

To cite this article: John Anderson P-Duarte & Estefanía Losada Nieto (10 Nov 2025): Understanding illness in joint attentional conversations, Philosophical Psychology, DOI: 10.1080/09515089.2025.2570828

To link to this article: https://doi.org/10.1080/09515089.2025.2570828

Published online: 10 Nov 2025.

PHILOSOPHICAL PSYCHOLOGY
https://doi.org/10.1080/09515089.2025.2570828

Understanding illness in joint attentional conversations

John Anderson P-Duarte [a] and Estefanía Losada Nieto [b]

[a]Facultad de Educación, ciencias sociales y humanidades, Universidad de la Frontera, Temuc, Chile; [b]Facultad de filosofía y ciencias humanas, Universidad de la Sabana, Chía, Colombia

ABSTRACT

Illness is both universal and enigmatic: while it may affect anyone, its experiential dimension and underlying meanings often resist full articulation. A comprehensive understanding requires more than clinical diagnosis – it depends on the patient's narrative and subjective insight. Meaning emerges through empathetic, collaborative exchanges between healthcare providers and patients. While Evidence-Based Medicine emphasizes a reductionist, symptom-focused view, Narrative Medicine, in Rita Charon's view, offers an alternative by integrating personal experience. However, purely individual-centered approaches risk undermining shared understanding. This paper explores joint attention theory as a compelling framework for explaining successful narrative exchanges in clinical contexts, emphasizing co-constructed meaning as essential for effective, compassionate care.[1]

ARTICLE HISTORY
Received 31 March 2025
Accepted 29 September 2025

KEYWORDS
Narrative Medicine; illness comprehension; joint attention; co-construction of illness

> Medicine has never been without narrative concerns,
> because, as an enterprise in which one human being extends help to another,
> it has always been grounded in life's intersubjective domain.
> Like narrative, medical practice requires the engagement of one person with another
> and realizes that authentic engagement is transformative for all participants.
> (Charon, 2001, p. 1988).

1. Understanding how to live with this illness[2]

"It seems a bit paradoxical, and lonely, because no one understands it. Physicians believe they understand it, but they do not understand it. The only ones who really understand are the patients [. . .] physicians are like astronauts who arrive in this strange world" (Charlas con Charli, 2024, 25'), says Tatiana Andia, sociology professor, intellectual and terminal cancer patient, in expressing her reality with striking clarity. After years of living

CONTACT Estefanía Losada Nieto estefania.losada@unisabana.edu.co Facultad de filosofía y ciencias humanas, Universidad de la Sabana, KM 7, Campus Puente del Común. Edificio E2 - Segundo piso, Chía, Colombia

with the illness, she has come to understand its impact on her life – not thanks to the physicians who have treated her, but through her own effort, supported by her family. She asserts that it was a personal journey, accompanied by her loved ones, that allowed her to accept that her cancer is incurable and that she must face the end of her life "on her own terms."

Being diagnosed with a terminal or chronic illness is a devastating experience because it thrusts individuals into a state of profound *uncertainty* that undermines both personal autonomy and one's sense of meaning in life. Such diagnoses fracture the frameworks through which we make *sense* of our lives: the interpretive tools we previously relied on – our concepts, values, and priorities – often no longer serve to guide decision-making. This fracture pushes patients to inhabit an entirely different reality, as if they were citizens of another place-one in which physicians appear like astronauts. As Susan Sontag says

> Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place (Sontag, 1978, p. 3).

Speaking of another citizenship or another kingdom is a precise way to describe the confrontation with the reality of illness. In this situation, individuals often find themselves unable to make sense of what is happening to their bodies or how to live with the implications of their condition. This disorientation can erode the *capacity to act* meaningfully, leaving the person vulnerable in a distinct epistemic sense: not merely exposed to harm, but exposed precisely because *they lack an adequate understanding*. Illness interrupts their grasp of life's coherence, making it unclear how to go on living or whether doing so remains worthwhile. In this way, chronical illness induces a profound, *understanding-based vulnerability* (see. Carel, 2023)

What Tatiana Adina's testimony reveals is an unsettling reality tied to this form of vulnerability: many patients confront devastating diagnoses *alone*, without the resources to process them or the support needed to make treatment decisions (Côté, 2024, p. 456). If the idea of a new form of citizenship – or of physicians as "astronauts" in a foreign world – is correct, then there is a fracture in the physician – patient relationship. When this relationship breaks down, the task of understanding illness becomes solitary and isolated. As a result, the potential of medical treatment to restore health or relieve suffering is diminished, leading to deeper loneliness and impairing the patient's ability to make informed decisions about their own care.

Illness[3] is as commonplace as it is strange; while nearly everyone may experience it, few are able to fully articulate what it is. In everyday life, we speak of pain, discomfort, or unease, often referring to "something" whose nature "one doesn't know what it is." It would seem, then, that

making sense of illness requires the interpretive contribution of the physician. Yet this relationship is reciprocal: the physician relies on the patient's descriptions to recognize and diagnose the condition. An adequate understanding of illness is not the achievement of a single individual, but the outcome of a collaborative interaction between two agents – patient and physician – who must work together to restore health or, in cases of chronic or life-altering illness, to alleviate suffering and enhance quality of life.

This paper explores the shared construction of the understanding of illness, with particular attention to how it shapes processes of diagnosis and patient support. If understanding illness is an essential condition for its treatment, then it is crucial to analyze communicative and attentional dynamics between physicians and patients, —especially in cases where illness radically disrupts the patient's everyday life. Accordingly, this paper aims to develop a theoretical alternative in which interaction is seen as a pathway for the joint construction of illness understanding, a two-way link between physician and patient that is always *open-ended*.

This article begins by reviewing critiques of Evidence-Based Medicine (EBM) and Narrative Medicine (NM). While EBM prioritizes objective evidence and overlooks clinical intuition, NM values patient narratives but lacks clarity on how understanding is achieved, often reproducing the same limitations it aims to overcome. We then examine a biographical approach that centers on the patient's voice, yet proves insufficient in guiding treatment. To address these gaps, we propose an alternative grounded in joint narrative construction, where physicians and patients actively co-construct the meaning of illness. Drawing on the concept of Joint Attention (JA), we explore how this framework can support a more accurate and dynamic understanding. The final sections elaborate on this proposal and discuss its broader implications for clinical practice.

2. Evidence-based medicine and Narrative Medicine (NM)

Evidence-Based Medicine (EBM) is an approach to clinical *practice* that emphasizes the use of rigorously gathered and critically appraised empirical evidence – primarily from population-based studies – to guide medical decision-making. Rather than relying on laboratory-based biomedical theories or unsystematic clinical intuition, EBM, grounded in the field of Clinical Epidemiology, prioritizes data-driven methods – particularly randomized controlled trials (RCTs) – to determine what works for the *average patient*. The aim of EBM is to transform a medical model rooted in unsystematic clinical expertise (i.e., physicians' intuitive knowledge) into a "new paradigm" in which clinical care is guided by reproducible, generalizable knowledge derived from group-based trials: the best available

empirical evidence. While clinical experience is acknowledged as necessary, it is considered insufficient without the addition of critical appraisal skills. Based on explicit rules of evidence and training in data analysis, EBM seeks to equip physicians to formulate precise clinical questions and apply research findings appropriately to *individual* patients.

One major critique of EBM centers on the risk of losing a nuanced understanding of particular illnesses by dismissing expert intuition in diagnostic scenarios. While early versions of EBM were criticized for sidelining clinical expertise, its revised formulation – famously articulated by Sackett et al. (1996)—redefined it as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (p. 71). However, according to Bluhm and Borgerson (2011), this shift is largely superficial. They reported that EBM risks becoming "cookbook medicine," reducing physicians to mere executors of protocols designed by "infostat technicians" – statisticians who shape countless consultations without bearing clinical responsibility; only applying a rigid and *decontextualized* guideline (Bluhm & Borgerson, 2011).

In EBM, patient narratives, values, and lived experiences expose tensions between standardized evidence and individualized care. Critics argue EBM, by dismissing unsystematic expertise, neglects the value-laden nature of illness, overlooking how patients with the same diagnosis may choose different treatments based on unique goals, beliefs, or life contexts.

> No matter how strong the evidence is, without patient input there is no clear best decision. Furthermore, the patient's subjective experience of illness is an important part of the clinical encounter (and the source of his or her desire for treatment) and so should form the basis for discussion about treatment and for the evaluation of objectives and desired outcomes of treatment (Bluhm & Borgerson, 2011, p. 219).

The problem lies in how EBM privileges quantifiable data over qualitative and narrative-based knowledge. Patient preferences, anecdotal experiences, and contextual factors are often excluded from clinical trials due to strict inclusion and exclusion criteria. Yet, these are precisely the factors that shape how patients understand their illness and what matters to them in treatment. When EBM treats such knowledge as secondary or irrelevant, it undermines the principle of autonomy of patience and restricts the scope of shared decision-making, letting it to the physician only.

Although EBM claims to integrate patient preferences, it still positions physicians – or medical boards – as the ultimate arbiters of how evidence and values are balanced. This reinforces an *asymmetry of authority* and risks reducing shared decision-making to a formality. Without rethinking its epistemological foundations, EBM may marginalize the very narratives and values that make care humane, limiting the possibilities for genuine patient-centered practice.

One clinical practice model that seeks to address the challenge of connecting medical knowledge with patients' qualitative knowledge of illness is NM (Charon, 2012). This narrative-based medical approach emerges in response to the limitations of Evidence-Based Medicine, which has shown notable shortcomings in accounting for patients' lived experiences and values, and their role in the diagnostic process.

NM seeks to offer an alternative model for clinical practice, one that proposes an ideal of care while also providing the conceptual and practical tools necessary to achieve it (Charon, 2001, p. 1897). It does so by drawing on a broad theoretical medical corpus and by examining and elucidating narrative acts through the lens of the humanities – particularly literature. This model equips physicians with tools to understand the stories patients tell, enabling them to integrate the lived facts of a patient's life with medical knowledge; these tools are referred to as *narrative competencies*. As such, NM simultaneously offers physicians the means to improve their relationships with patients, with themselves and with colleagues fulfilling one of its primary goals: reducing physician fatigue and occupational stress (Charon, 2001, p. 1898). According to this approach, these skills integrate both affective and cognitive responses, enabling the physician to grasp not only what the other person feels but also to *infer* their thoughts based on observable and verbal information (Charon, 2012). In this way, within the framework of the physician – patient interaction, empathy emerges as a central element for representing the patient's world and facilitating interpersonal communication. Physicians must develop communicative skills grounded in their ability to "put themselves in the patient's shoes" and to understand patients' emotional states and to motivate cooperative behaviors.

Several studies are cited to show that when physicians adopt a narrative and empathetic approach, improvements are observed in treatment adherence, reduction in anxiety and in patient's perception of pain (Charon, 2001; Peña, 2018; Rosas, 2013). Those findings suggest that the integration of narrative in clinical practice not only has a humanistic impact but also tangible effects on the effectiveness of treatment (Charon, 2001). An example of this can be found in the following quote:

> The description of Ms. Lambert at the beginning of this article was written by her physician (the author) after a recent office visit and shown to her on the subsequent visit. As Ms. Lambert read the words, she realized more clearly the anguish she had been enduring. Her sisters had dismissed her concerns, saying she was imagining things about Phillip, and that had added to her own suffering. She felt relieved that her physician seemed to understand her pain, and she told the physician what her sisters had said. (Charon, 2001, 1987)

This quote illustrates the benefits of NM by exposing the experience of a patient, Ms. Lambert. She felt acknowledged and comforted after reading the account written by her doctor, which described her most recent visit. This relief stemmed from the physician's ability to clearly recognize the source of her anguish: her concern for the future of her son Phillip – something her sisters had not understood. Listening to illness narratives and accepting that there are sometimes no answers to patients' deepest questions requires generous empathy. In this approach, empathy is the cornerstone, as it underlies "attention," "affiliation," and "reflection"-three narrative skills that physicians must cultivate. These skills aim, respectively, to ensure that: (i) the patient is fully seen and heard; (ii) their suffering is understood; and (iii) they are able to ask questions that help make sense of their illness, such as: What is happening to me? Why did this happen? What will become of me? (Charon, 2001, p. 1899)

With these skills, the physician can construct a narrative framework that gives structure and meaning to the patient's suffering. As a result, the physician may cultivate values such as acceptance, generosity, and resilience, while also finding deeper meaning in their professional practice (Charon, 2001, p. 1900) and strengthening bonds with colleagues. All of this is *expected to contribute to* improved patient care, resulting in more accurate diagnoses and more effective therapeutic support.

The narrative is written by the physician from their own perspective, and the patient's voice is mainly mediated by what the physician understands. If the physician lacks robust empathic skills, the entire process risks falling apart. For instance, the degree of empathy exercised by the physician will determine how well they can understand the patient's narrative: the less empathy is exercised, the weaker the comprehension process becomes. This highlights empathy as a fundamental component in the process of understanding. Therefore, a proper account of how empathy operates in these contexts may help us assess the effectiveness of the narrative approach in medicine. This is precisely what Eugenia Stefanello (2024) insightfully observed. For her, narrative competence relies on cognitive empathy, which limits the physician's ability to fully grasp the patient's experience from within the concrete reality of illness. We will analyze this critique as follows.

2.1. Limits of cognitive empathy

As Eugenia Stefanello (2024, p. 167) recognizes, empathy acts as a bridge between scientific knowledge and human experience, allowing a deeper and more compassionate physician-patient relationship-one in which the patient's personal story is validated and the illness is contextualized within an emotional framework. However, the way empathy is conceptualized

within NM is not, according to Stefanello, fully adequate to meet this goal. She argues that:

All of this seems to be particularly relevant to NM: healthcare professionals should be aware that affective sharing (i.e., affective empathy) or perspective taking (i.e., cognitive empathy) does not guarantee accurate understanding or sympathetic engagement with their patients, and that empathy is always a context-specific phenomenon, since it is influenced not only by the broader context in which the relationship is situated, but also its positive or negative perception depends on the socio-cultural, historical, economic, etc. background of the subjects involved (Stefanello, 2024, p. 175). As previously noted, in NM, empathy serves as the bridge between physician and patient, enabling the physician to listen attentively, understand the patient's situation, and formulate reflective questions that contribute to the understanding of illness. However, in order to grasp the patient's experience and reframe it narratively, the physician must rely on *imagination*. This empathetic process, which Stefanello (2024, p. 172) refers to as Cognitive Empathy, has a critical limitation: the physician is never truly in a position to access "the patient's point of view" (Stefanello, 2024, p. 171).

When physicians try to put themselves in their patients' shoes, they may unintentionally project their own experience instead of capturing the patient's uniqueness, thereby hindering authentic understanding. Two problematic forms of perspective-taking emerge in this context: the self-oriented, in which the physician imagines how they would react in the patient's situation, and the other-oriented approach, which seeks to reproduce the patient's inner world. Both approaches can lead to misinterpretations and oversimplify the complexity of the patient's experience.

Consequently, the distance and asymmetry between physician and patient – already present in the EBM model – persists, and the patient's concrete experience remains subordinated to the physician's voice. This reveals a limitation in how NM is currently practiced: imagination alone cannot fully access the particularity of first-person experience, including the patient's emotions, fears, and the often-unconscious contextual factors that shape their lived reality.

For Stefanello, the solution may lie in a renewed perspective on empathy. To develop this view, she draws on the phenomenological tradition and locates empathy within the domain of the lived body (*leib*) – a body that feels and suffers. According to her, as human beings, we experience pain in similar ways. Although we do not feel exactly the same pain as another person, we are capable of understanding that the other is suffering and that such feelings must be overwhelming. The reason is that bodies resonate with one another, because of that we can feel empathy for other and comprehend their suffering. In this context,

empathy is an emotional reaction that connects us with the world of others through *resonating with* others. As Zahavi (2014) puts it: " . . . our emotional reaction is exactly that – a reaction. It might well be that the emotions we perceive in others induce emotional resonances and action tendencies in our own bodies and that these responses then feed into and influence the way we apprehend the other, but there is a decisive difference between acknowledging this and defending the view that our understanding of the other's emotion requires us to have that very emotion ourselves." (p. 132).

According to Stefanello, we can understand others' experiences through our own. In clinical settings, this suggests that an empathetic physician may grasp a patient's suffering by emotionally resonating with it. Yet this does not mean the physician truly accesses the patient's qualitative experience. While bodily similarity allows for projection, the patient's illness remains singular, shaped by unique intensities and contexts. Thus, the physician often relies on imagination to bridge this experiential gap. Phenomenological empathy, though well-intentioned, cannot fully resolve the asymmetry between physician and patient. As Stefanello (2024) notes, empathy alone cannot account for the complex power dynamics and contextual differences in clinical interactions. Ultimately, this approach risks reverting to the same cognitive limitations it aims to surpass, leaving the singularity of illness unaddressed.

Tatiana Andia's physicians did not help her gain an understanding the singular nature of her illness; they behaved like astronauts visiting the land of the sick. With this in mind, both Rita Charon's NM and Stefanello's phenomenological approach face an unresolved challenge: how can illness be understood in the concrete singularity of a patient's life? A further question must be raised: why is it necessary to understand illness from within its singularity?

In rough terms, the goal of medical treatment is to restore the patient's health. In cases of chronic or incurable conditions – the kind of illnesses this paper focuses on – the aim is to help the patient learn how to live with the illness. To achieve this, both patient and physician must understand *this* illness in its concrete and singular manifestation. A physician's limited understanding may result in inadequate treatment. Likewise, a patient's lack of understanding may prevent them from taking the necessary steps to improve their quality of life, leading to diminished autonomy and decision-making capacity. Since the patient is already vulnerable due to illness, the inability to understand how to support their own healing exacerbates this vulnerability. We may call this a form of *understanding-based vulnerability*, one that impairs the patient's capacity for decision-making and hinders their ability to pursue a better quality of life. The physician-patient relationship is a scenario where many forms of wrong may occur, as

when the patient's account is often regarded as partial, and their biographical perspective is overlooked. This existentially fragile situation leads the ailing body to a state of vulnerability (Díaz, 2022). The disregard for the subjective dimension of illness – as conveyed through the patient's voice – further compounds this wrong.

How can the risk of wrongs against the patient be mitigated? One promising approach is to empower patients to participate meaningfully in the clinical encounter. In the next section, we will develop a theoretical perspective in which the understanding of the illness is linked to its biography, to make the patient's first-person perspective relevant in their decision-making capacity.

3. Biography and the singularity of illness

As Sontag suggests, illness transforms everything: it is the night-side of life, unsettling routines and making the familiar strange, as if entering a different kingdom with unfamiliar meanings and background assumptions. One way to restore meaningful coherence is by articulating this strangeness through personal terms that reflect one's own sense-making.

An example of this kind of description is found in the book *Hoy es siempre todavía* (2018), written by Alejandro Gaviria. This book narrates, in a biographical manner, the experience Gaviria had when he was diagnosed with cancer and the therapeutic process he went through. In this book he states: "the only thing that reassured me was telling the tale, repeating the prosaic story of my illness: a pain that reveals itself like the tip of the iceberg of a biological catastrophe" (Gaviria 2020, p. 42). Articulating his illness in his own words brought him comfort in the face of the overwhelming sense of catastrophe he experienced after the diagnosis. As he states, this exercise was part of "having a story to tell" (Gaviria 2018, p. 16). The entire text highlights the need to recount one's illness from a first-person perspective – an act that is not about identifying with the illness, but rather about recognizing how it has transformed one's life, eliciting unease, despair, and anguish, while also fostering a reclaiming of life – of one's own life, one's family, and one's children. Gaviria never dismissed the doctors' diagnosis, but he needed to put his story on his own terms.

A similar case is narrated by Oliver Sacks in his book *A leg to Stand On* (2017). The book recounts, from a first-person perspective, his experience after an accident in which he fractured his leg. It is worth noting that Sacks is a doctor, and his narrative oscillates between his experience as a patient and his experience as a physician. The difficulty arose when, after the surgery, he was unable to walk again. There was no reason why he couldn't walk. At that moment, he felt that the experience of his suffering was incomprehensible to

anyone else. He realizes something relevant about his experience: "This kind of scotoma is literally impossible to imagine unless one has experienced it" (Sacks, 2017, p. 190). He discovers that there is something in the understanding of his experience that can only be expressed by him, precisely because he has lived through it.

Given the type of illness under analysis, the patient's subjective experience becomes essential for deeper understanding, as shown by Gaviria and Sacks. As recognized in both EBM and NM, these illnesses cannot be adequately diagnosed from the physician's standpoint alone. What becomes crucial, however, is *how* the patient's personal experience is conceptualized and integrated into clinical reasoning. One way to express this is by acknowledging that the patient's subjective experience is so singular that certain aspects remain obscure to the physician and *hidden* from empirical evidence; nevertheless, these aspects can be articulated through the patient's personal *biography* (Von Weizsäcker, 2005, pp. 188–192).

Viktor von Weizsäcker developed a medical anthropology rooted in what he called *special pathology* (Von Weizsäcker, 2005, p. 187), which contrasts with general pathology by emphasizing the singular, symbolic nature of illness. From this perspective, illness cannot be understood in general terms but only as it manifests in individual lives. One may fall ill not only in the body, but also in the spirit. He says "1- that not only the human body falls ill but any sphere of life, and 2- that each illness is a case-specific originality" (Von Weizsäcker, 2005, p. 187).

Following von Weizsäcker's claims, we can affirm that human corporeality cannot be reduced to physiological processes alone; it also carries symbolic, spiritual, and existential meaning. My leg, for instance, is not merely a limb – it is part of a lived body inscribed with personal history and embedded in a horizon of meaning. Understanding body and illness in these terms situates them within this broader context, revealing its complex singular nature. The explanation of why *this* particular illness occurs cannot be fully captured by natural science alone. Understanding illness requires attending to its biographical dimension, which resists any full reproducible and generalizable grasp. As Von Weizsäcker (2005, p. 192) cautions, even when illness is medically controlled, "that does not mean we will know more about what is truly hidden behind it."

Inspired by von Weizsäcker's connection between illness understanding and biography, we may sketch a biographical approach, according to which making a biography aims to frame illness in the middle ground between objectivity (factual events) and subjectivity (symbolic meaning), revealing it as a *singular* and situated phenomenon that resists to receive a generalizable diagnostic. In this biographical approach, patients understand and explain their illness through a personally meaningful order – highlighting certain facts, relationships, and moments. Illness becomes something they

recognize as part of their life. This perspective expands the understanding of illness to include the patient's lived experience enabling them to take ownership and make informed decisions about treatment and life.[4]

We can ask. How different is this approach to NM. If it is different, is the biographical path sufficient to adequately understand the illness? This approach is compatible with NM in its emphasis on narration as a means of understanding illness, but it differs in focus. For NM, the narrative is constructed by the physician to offer the patient a better understanding of their condition. In the biographical approach, by contrast, illness can only be fully understood from the first-person perspective, because it is only from this vantage point that its singularity becomes evident. Now, is this first-person perspective sufficient for an adequate understanding illness? We argue not.

The cases of Andia, Gaviria, and Sacks show how patients seek to understand their illness through a horizon rooted in their own lives. However, to do so, they must turn to medical concepts, research, and expert opinions. Sacks, being a physician, had easier access to this knowledge, while Andia and Gaviria faced difficulties due to a lack of support in the physician – patient relationship. Patients need both medical concepts and professional guidance to understand their condition, make sense of treatment, and make informed decisions. Without medical guidance, or worst, medical concepts, the patient is left "spinning in the void," directionless, disconnected, and even isolated. An appropriate medical guidance allows the patient to understand the mechanisms of treatment and make better decisions about their health, and their future with the illness.

This leads us to propose an alternative in which physician and patient collaborate in making sense of a particular illness – their illness. In our approach, the object of understanding in this relationship is not the patient's life story as such, but the illness itself as it manifests and is interpreted within that life. Accordingly, what is required is not merely empathy or narrative competence in isolation, but a specific kind of relationship that enables the shared, situated construction of meaning. We argue that this relationship takes the form of a joint narrative construction, where both physician and patient actively participate as genuine agents in articulating the nature and trajectory of the illness.

4. Toward a shared understanding of illness: a joint attentional approach

The aim is to argue that an adequate understanding of illness must integrate both the patient's individual perspective – expressed through their biography – and the physician's clinical understanding. However, clearly articulating this point has proven challenging. NM suggests that physician's

empathy can mediate between these two perspectives by imaginatively accessing the patient's experience. Yet, based on Stefanello (2024, p. 175), we argued that this model results in the physician narrating the patient's life, absorbing their voice, and thereby diminishing their agency and decision-making capacity. The biographical approach emphasizes illness understanding grounded in the patient's exercise of making his biography. While this preserves the patient's voice, it risks isolating them – leaving them "spinning in the void" without the conceptual tools necessary for understanding their condition and making informed choices. In both cases, the vulnerability introduced by illness misunderstanding is not resolved but compounded by a failure to co-construct an adequate illness understanding.

The point of our discussion is that an illness understanding shaped through dialogue directly addresses understanding-based vulnerability As Carel (2023) emphasizes, chronically ill individuals are epistemically vulnerable – their knowledge, preferences, and interpretive frameworks are frequently overlooked due to structural constraints such as time pressure, or due to biases associated with their specific condition. When patients are not recognized as epistemic agents of their own illness, this vulnerability deepens, dismissing their role in the clinical encounter. In contrast, a co-constructed understanding of illness fosters mutual engagement and affirms the patient's authority in accounting for their experience, reducing the risk of epistemic vulnerability and reinforcing shared epistemic responsibility in treatment decisions (for empirical evidence, see Pomey et al., 2019). In other words, when this vulnerability is not addressed, patients may express confusion or mistrust, saying things like: "That's what the doctor says I have, but I don't really know," "I don't believe that doctor; I'm still sick," or "Following this treatment is too difficult for me" (Budych et al., 2012). We think that such reactions emerge when physician and patient fail to articulate a shared understanding of the illness. Each is left with a *partial* view, and treatment no longer fully reflects the singular nature of the patient's condition.

The claim that a shared understanding of illness is necessary is not new; however, the central contribution of this paper lies in clarifying how such understanding is constructed and in pointing that it concerns the illness itself – rather than the patient's life or biography. The hypothesis we wish to present begins with the claim that an adequate understanding of illness is not primarily about the patient's life story, but rather about the *story of the illness itself* in its singularity – a focus inherited from the biographical model. Therefore, this understanding takes the form of a *shared understanding of that illness*—what both physician and patient are referring to, what the physician aims to explain, and what the patient seeks to communicate. The shift is subtle but significant. Illness comprises both objective and subjective dimensions, and a complete understanding must account for both. The aim of the clinical encounter, then, is to bring together the

objective features (e.g., biological mechanisms, clinical protocols) with the subjective ones (e.g., biographical and experiential dimensions) into a unified understanding of a single phenomenon: *that* illness.

The shared understanding arises when the physician and the patient, within a sustained verbal exchange, recognize the same objective and subjective features as referring to the same illness. An adequate shared understanding of illness cannot rely solely on the physician's empathetic narrative or the patient's unguided biography. Instead, it must emerge as a *co-constructed effort* to tell a story of that illness – a shared conversational endeavor – something inherited from NM. Building on this, our hypothesis continues: the most effective way to describe this process is through the conceptual framework of Joint Attention (JA), which captures the interactive mechanisms that support mutual understanding in clinical encounters.

The appeal to JA in our proposal addresses understanding-based vulnerability and distinguishes it from both NM and the biographical model or a mixture of both, thereby establishing it as a valuable theoretical alternative grounded in a dialogical structure. The theoretical framework is that successful physician-patient encounters resemble episodes of JA, where both parties actively coordinate their attention on the same illness. The core claim is that a proper clinical encounter involves achieving a shared understanding of the illness through a joint attentional effort. This means both physician and patient recognize the same set of features – both objective (e.g., biological markers, symptoms) and subjective (e.g., lived experience, personal meaning) – as referring to the same condition. Such is an ongoing understanding achieved through dialogue and mutual clarification, allowing both parties to know they are talking about this illness.

A key strength of this proposal is that, because it is grounded in conversational dynamics, the resulting understanding is inherently *open-ended*. That is, it does not require a final complete list of symptoms or a static diagnosis. Instead, understanding unfolds over time through the back-and-forth of clinical conversation, allowing it to evolve with the patient's condition and perspective, and physician's knowledge. Ultimately, this framework positions the effort to get a shared understanding as the effort to create a *common epistemic source* for therapeutic decisions, enhancing patient agency, and enabling more responsive, appropriated care (Pomey et al. 2019. esp. ch. 6). In this way, JA theory offers a promising framework for describing how successful clinical encounters foster emotional repair, empowering patients to make sense of their illness in a meaningful and informed way. We can claim that it is precisely this open-ended structure that effectively addresses the epistemic vulnerability discussed here. The challenge, then, is to articulate how this joint understanding of illness can be

achieved in successful clinical encounters without reinforcing understanding-based vulnerability. The JA model offers a framework for this articulation, as we now explain.

5. Description of JA

The proposal of this paper lies in how the physician – patient pair achieves a shared understanding of the singular illness (that illness) in successful clinical encounters. We argue that JA offers a fruitful conceptual framework for describing successful clinical encounters, this is true to the extent that physician-patient encounters are, under certain considerations, like episodes of JA in which both individuals seek to direct their attention to the same thing – that is, to that illness.

This section introduces the conceptual mechanisms through which JA can help explain why some successful physician – patient interactions result in an adequate shared understanding of the particular illness. To do so, we begin by clarifying how we roughly conceive of JA. As Moll (2024) notes, there is no consensus on how to adequately define it. However, it is widely agreed that JA has two fundamental aspects. On the one hand, JA often plays an explanatory role in social interaction, in phenomena such as joint cooperative actions (Fiebich & Gallagher, 2013; Wilby, 2023), language learning, reasoning, and communication (Moll, 2024; O'Madagain & Tomasello, 2021), among others. For this reason, JA is commonly defined as an *irreducibly triadic attentional phenomenon* to the extent that it cannot be explicatively dived in more basic elements (Campbell, 2011). On the other hand, two (or more) individuals participate in JA episode when they both pay attention to the same thing, and that attention is *overt* (Eilan, n.d.; Peacocke, 2005). In this discussion, we assume Campbell's irreducibility claim about JA. So that, it is precisely the overt aspect of JA that plays a role in explaining how is achieved the shared meaning in successful physician-patient encounters.

To develop our description JA and how overtness do the work, we begin by making some claims about how to describe the experience of attending to something, and then, we explain what attentional *overtness* is in order to describe how to get a shared understanding about a particular illness. Our strategy will be based on developing a contrast with Campbell's approach to JA (Campbell, 2005, 2011). This contrast is not intended to refute his view but simply to make some differences explicit to get our position clear.

Campbell's account of JA can be introduced through his example of a *coordinated attack* (Campbell, 2005, 2011), designed to highlight the distinction between non-joint and joint attention. Imagine two individuals confined in separate booths, relying solely on technological mediation to coordinate an attack on the same target at the same time. Despite their

efforts to communicate, Campbell (2005, p. 292) argues that their attentional experience remains private and *non-overt*—each cannot be sure that the other is attending to the same target simultaneously. Their attention, in this case, is parallel but not genuinely shared. What is missing, according to Campbell, is co-presence in a shared material environment. Once the booths are removed and the individuals occupy a common perceptual space, their attentional focus becomes mutually available. As Campbell puts it, according to his understanding of attention, "without booths, everything is out in the open," and thus, their attention becomes overt and genuinely shared (Campbell, 2005, pp. 292–293).

5.1. Attention in JA

Campbell's elegant explanation relies on several commitments to his theory of attention. We only want to highlight two: the first is the assumption that attention in JA is basically a matter of visual perception, and the second is the thesis that paying attention to something is fundamentally an act of selecting particular aspects of the environment – a mental act of linking an object to the mind. This second idea reflects the commitment of this approach to the *spotlight* model of attention, which has recently been called into question (D'Angelo, 2020, p. 962; León, 2022, pp. 72–73).

> According to the spotlight model, objects and events must be "out there," *always-already* completely constituted even when no one is paying them any attention. [. . .] the world out there is simply constant and does not change its shape and meaning according to whether I pay attention to it or not. (D'Angelo, 2020, p. 964. Emphasis original)

It is relatively easy to distance oneself from the first commitment. Firstly, there is an intuition that JA episodes are multimodal or involve blind individuals (Scarafone, 2024). But secondly, we have also developed more unconventional examples: considering two people listening to the same lecture (Eilan, n.d..); jointly remembering something (De Brigard, 2018; Seemann, 2019); or reasoning together about a topic (O'Madagain & Tomasello, 2021). In these cases, it is not obvious that this "something" is perceptual. Specifically, we are tempted to think that by reasoning together, the object of attention is the content of the reasoning or thought itself – that is, *what is said* (O'Madagain & Tomasello, 2021, p. 4058).

This last idea is relevant to distancing ourselves from the second commitment. The thesis that attention is fundamentally about selection rests on the assumption that the world available to attention is *always-ready-made*, and this assumption does not align with the broader intuition that what is said can be an object of attention (during reasoning). What is said is a feature of conversation that is not *always-ready-made* beforehand, and it changes with

the expansion of the semantic background that makes the conversation possible. Singularizing what is said during a conversational encounter requires attentional effort to transform – in the conversational experience – some meanings or contents from the background into the foreground, to say to singularize what is said. This aligns more closely with Merleau-Ponty's thesis, according to which attention is an act of creation. He states:

> [. . .] attention is the active constitution of a new object that develops and thematizes what was until then only offered as an indeterminate horizon [. . .] The object only gives rise to the "knowing event" that will transform it through the still ambiguous sense that it offers to attention as needing-to-be-determined, such that the object is the "motive" [motif] of and not the cause of this event. [. . .] The first operation of attention is, then, to create for itself a *field*, either perceptual or mental, which can be "surveyed" (überschauen), in which movements of the exploratory organ or elaborations of thought are possible. [. . .] (Merleau-Ponty et al., 2012, pp. 33–34. Emphasis original)

Although the exercise of attention may seem like an act of *creating something singular* in experience (D'Angelo, 2020, pp. 964–970), it is better interpreted as an act of reorganizing experience (León, 2022). In any case, according to this critique, attention cannot be described as a mental act of selection but rather as an act of organization. And in the context of conversational experience, this agency materializes in expressing, asking, affirming, questioning, and other exercises intrinsic to conversation itself. Paying attention to something specific consists of performing agential exercises with the purpose of singularizing that something within experience or activity (D'Angelo, 2020).[5] Based on this idea, we assert that an appropriate way to understand attention in JA is in terms of an effort to singularize something in experience through the exercise of reorganizing or prioritizing experience (León, 2022). In the clinical context that concerns us, this effort consists specifically in the singularization of what is being *said*.

5.2. Attentional overtness in JA

Attentional overtness seems to be a fundamental feature of JA, as it explains the difference between *joint exercises of attention* and (aggregates of) *individual exercises* (Seemann, 2024). In other words, it addresses the question of jointness in JA. Campbell's explanation of the booth case suggests the following: attentional overtness implies that those participating in JA are *immediately* aware (or understand) that everyone is jointly attending to the same thing; this awareness is absent in individual exercises of attention and *cannot be reduced* to them. However, not everyone agrees with this claim, partly because the concept of overtness appears to be more of a metaphorical resource for highlighting a feature of attention rather than a literal description (Scarafone 2024, pp. 5–9).

It is possible – contrary to Scarafone – to offer a description of attentional overtness as an essential aspect of JA episodes. The starting point is the notion of grounding (Clark & Brennan, 1991). In our description, attentional overtness is irreducibly collective, but it is not immediate. This follows from the notion of attention elaborated in the previous section. Let's take a closer look.

If attention is an agential exercise that consists of singularizing aspects of experience, then we can describe its overtness as a collective effort to do the same; as "something we do together" (Scarafone, 2024, p. 6). Thus, during conversational experiences (such as physician-patient narrative encounters), attentional exercise is overt (between two subjects) insofar as it is a non-individual, collective effort to singularize an aspect of the conversational experience – namely, what is said (or in Clark & Brennan's terms, what is grounded). They write: "In conversations, for example, the participants *try to establish that* 'what has been said' *has been understood*. In our terminology, they try to ground what has been said – that is, make it part of their common ground" (Clark & Brennan, 1991, p. 128, emphasis added).

Grounding is the rational exercise of establishing the background of a conversation. The fact of sharing a community or speaking the same language implies some kind of shared background. However, engaging in conversation with someone consists of creating a new background for that specific conversation – a field in which thought can move (Merleau-Ponty et al., 2012, p. 34).

This exercise of establishing a background is collective in that each intervention is nested or interwoven with those of others. A subject's intervention depends on its acceptance by their interlocutor, and in turn, that acceptance must be acknowledged by the one who intervened first. The purpose of this interweaving is *to make public* (that is, to singularize) what has been said or understood during the conversational episode (McDowell, 1998: §6). Once something has been grounded, it is considered to contribute to the conversation and can therefore be used later. For example:

T1.: **Alan**: Now, -um. Do you and your husband have [s- a car . . . ?

T2.: **Barbara**: [Do we have a car?[6]

T3.: **Alan**: Yep.

T4.: **Barbara**: No.

(Clark & Brennan, 1991, p. 227)

Alan and Barbara make different contributions to the conversation with the purpose of establishing that "Barbara (and her husband) do not have a car." That was what was said, what was singularized. In example, neither of them can, on their own, ground the fact about the car, nor can they, by their

own means, make their individual contribution. Alan asks whether Barbara has a car, but he does so over three turns (T1-T3). It is only when Barbara acknowledges the question by completing it that Alan's question can be considered fully done. Likewise, Barbara establishes that she does not have a car over three turns (T2-T4). In this sense, each turn in the conversation is interwoven with the others and, for this reason, is individuated in terms of the others. Thus, each contribution is interconnected and non-individual.

Grounding is the general task when we do some conversing with someone: establishing a shared background that constitutes each participant's understanding and, therefore, determines their agency. The effort to establish a particular fact within this background as something that has been said is also an interwoven, non-individual effort. If each instance of this effort is read as an attentional exercise aimed at singularizing an aspect of the conversational experience, then it can be said that this attentional exercise is interwoven and non-individual. This means that any singularization exercise occurring in this manner is *an overt attentional exercise* since all participants in this exercise will *experience* and then, *understand*, the singularization of the same thing in the same way: *interwoven* and non-individual.

This forms the basis for arguing that, at least in clinical encounters physician-patient, this conversational experience is a case of JA precisely for it is a type of interwoven, non-individual exercise aimed at singularizing an aspect of the experience within the conversation: *what is said* as established in the background. This implies a shared understanding of the illness to the extent that "what is being understood" – namely, the illness understanding—*has been grounded* through the active participation of all parties in the conversational exchange. In this agential approach to attention, singularizing something means bringing it from the realm of the indeterminate (within the conversation's background) into the realm of the determinate. Merleau-Ponty insists, "attention is the active constitution of a new object that develops and thematizes what was until then only offered as an indeterminate horizon" (Merleau-Ponty et al., 2012, p. 33. Emphasis added). This does not imply that the object (what is said) is exhausted once it is determined (singularized). Because of it becomes part of the background, what is understood – what is said – has an open-ended structure and is framed within the conversation. Therefore, what is said is not immediately fixed during the attentional episode, even though the entire process remains overt in the conversation. In this sense, openness is irreducibly collective, non-immediate, and the core of the explanation for the jointness in JA.

The JA framework provides a compelling explanation for what occurs in successful physician-patient encounters. When we claim that these interactions resemble episodes of JA, we are claiming that both participants make an active, coordinated effort to singularize the same illness. In this sense,

a proper clinical encounter involves a joint attentional engagement to the extent that both physician and patient work together to singularize the same set of features – both objective (biomedical) and subjective (experiential) – as referring to the same condition. As we said, a key feature of this proposal is its emphasis on the open-ended nature of illness understanding. Unlike models that aim to produce definitive symptom lists, rigid protocols, or fixed diagnostic categories (as in EBM), the JA framework conceives understanding as a dynamic, evolving process. This process emerges through *ongoing interwoven attentional interaction*, where mutual adjustments and clarifications between physician and patient co-construct a shared understanding of the illness – without relying on physician-led narration (as in NM). For grounding is a collective endeavor, the shared illness understanding outcome functions as a *common epistemic source* for decision-making, rather than as a personal isolated understanding (as in the biographical model). In this way, the JA model offers a compelling theoretical alternative: it explains why some certain ways to build understanding enhance care by deepening patient understanding and supporting agentive engagement in making sense of illness. This *open-ended understanding of that illness* fosters emotional repair and enables more informed, responsive, and collaborative therapeutic decisions.

The JA model provides tools to describe the structure of a meaningful clinical encounter without being a prescriptive framework. Based on the patient's medical history and their conversation with the patient, the physician would say:

Doctor — *This* is what you have: it is called A, it has these biological aspects, and it feels the way you describe it.

Patient — I have A, and that's why it feels this way.

Doctor — Yes, exactly. For you, the treatment is as follows. What do you think?

Patient — I understand it. Now, I know what's happening to me, but could you explain a little more?

Doctor — What else would you like to know?

Patient — What will my life be like from now on?

Doctor — I don't know for sure, but we can think about it together and figure it out little by little.

6. Concluding remarks

Illness is a phenomenon that breaks the continuity of daily life, as Andia's case suggests, for it impacts the patient's existence and requires the most exercise understanding. NM and biographical approach have underscored the role of storytelling in capturing the experience of illness, from both the physician's observational and the patient's experiential perspectives.

However, as we have pointed out, an adequate account must articulate both aspects of illness understanding. We have suggested that clinical encounters to be interpreted through the concept of JA: a collaboration between physician and patient that integrates clinical knowledge and biographical meaning within a shared effort to identify the particular illness of the patient; and then, having a shared understanding on *this* illness, allowing both physician and patient to collaboratively identify, name, and understand the illness in its singular expression.

The benefits of this approach are both epistemic and therapeutic. First, it addresses epistemic vulnerability – the uncertainty and disorientation that deepen when illness is misunderstood. By fostering a shared understanding of illness as a singular phenomenon, this model promotes a more symmetrical distribution of epistemic authority between physician and patient, particularly in decisions related to managing life with chronic illness. Such understanding enhances patient agency and engagement with treatment, as it justifies the patient's active collaboration in differential diagnoses (see Pomey et al., 2019, esp. Ch. 2, for an extended empirical discussion). Second, unlike standardized protocols or narrative templates, this framework encourages an open-ended, unscripted, and dialogical practice grounded in the concrete interaction between physician and patient. Naming, identifying symptoms, and proposing treatment guidelines are not fixed endpoints (as in EBM); rather, they emerge from a dynamic process where understanding and treatment evolve and are not readily generalizable to other patients, though potentially similar.

While reinterpreting clinical encounters as episodes of JA offers a promising avenue for enhancing the understanding of illness in its singularity, several limitations must be acknowledged. One strength of the JA model is its reliance on basic conversational abilities – speaking, listening, asking, and responding – rather than advanced narrative skills. This makes the model broadly inclusive, but it also raises questions about the role of narrative competence. Might physicians with stronger narrative abilities, as emphasized in NM, facilitate more effective attentional episodes? While an affirmative answer seems plausible, empirical evidence is still lacking to determine whether narrative skill enhances joint attentional dynamics or clinical outcomes. A second limitation involves the cognitive and communicative demands the model places on both participants. It presumes the capacity to direct attention, formulate questions, and sustain shared focus – abilities that may be limited in children, individuals with linguistic or cognitive impairments, or patients with neurodegenerative diseases such as Alzheimer's. Third, the success of this model relies on time and institutional support, often lacking in clinical settings. Systemic constraints – short consultations, heavy workloads, and bureaucracy – limit collaborative attention. Further research should explore how healthcare systems might embed this relational

model through changes in consultation time, attentional training, or dialogical practices. How can JA move from theory to institutional practice? (Budych et al., 2012).

Upon recognizing the limitations inherent in this proposal, we seek to delineate prospective lines of inquiry for which the present study may serve as foundational framework. First, in digital contexts (telemedicine or diagnostic supported by AI), it is worth exploring whether JA can be sustained – or even enhanced – in virtual settings. Can digital tools facilitate a shared attentional frame between physician and patient, or AI and patient? (Chambliss, 2024) Second, research could be done on metaphorical and non-verbal language? To broaden the model's inclusivity, future research could examine how metaphors, gestures, and embodied cues support joint understanding in patients with limited verbal capacity or non-normative communication styles. Finally, third, we believe it would be interesting to explore the link with other disciplines. Empirical validation of this model would benefit from psychology, cognitive science, and medical anthropology. Methods like ethnography, conversation analysis, or experimental simulations could assess its impact on outcomes, adherence, and patient satisfaction (*see*. Pomey *et al*. 2019).

The singular nature of illness understanding, in our suggestion, does not consist in a static outcome or a definitive answer but an open-ended understanding. In the end, the patient gradually learns to live with their illness – a hostile place – but now alongside their physician, who accompanies them and can serve as a jointly guide in their exploration.

Notes

1. This text was originally written in Spanish, and ChatGPT 4.5 was used to assist with the translation and style review in English.
2. We are grateful for the comments provided by the anonymous reviewers. Their feedback was insightful and helped us significantly improve the clarity and coherence of our argument.
3. In this research, we focus on illness that present two characteristics: those that put life at risk (such as cancer or ADIS) and/or those that significantly transform the patient's daily routine. Within this second group we find conditions such as osteoarthritis or diabetes. The reason for this selection is our intention to analyze how an illness that must be integrated into the patient's life is understood. This type of condition usually requires prolonged treatment and frequent medical consultations, which fosters a continuous physician-patient relationship, promoting a progressive understanding of the illness.
4. The biographical approach seeks to embed illness understanding within the patient's life, thereby granting meaningful space to their voice. This process may be carried out by the patient (as in the cases of Adina, Gaviria, and Sacks), the physician (as in the case of Mrs. Lambert) or both. We argue that when is physician-led exercises risk reproducing the limitations of NM. We claim that when conducted collaboratively, the JA model offers better explanatory tools – a point we develop in Sections 3 and 5.

This section, therefore, focuses on patient-led biographical exercises. We thank the reviewer for encouraging us to clarify this point.

5. D'Angelo (2020) argues that attention is inherently embodied, as it involves bodily agency – particularly with material objects. While we agree attention is agential, we set aside embodiment here; for insights on bodily presence in clinical conversations, see, among many others, Stefanello's (2024) recent contribution.
6. The symbol "[" indicates where an utterance was interrupted and marks the overlap between the two utterances.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The preparation of this article was funded by the project "Epistemic-Cognitive Aspects of Perception and Sociomaterial Mediation" (Agencia Nacional de Investigación y Desarrollo (ANID) FONDECYT 3230670, "Más allá del síntoma: Fenomenología del cuidado en la relación médico-paciente" 32641615), Universidad de La Frontera – Chile. This work was also conducted as part of the research project "Beyond the Symptom: A Phenomenology of Care in the Physician – Patient Relationship," approved by the Faculty of Philosophy at Universidad de La Sabana – Colombia.

ORCID

John Anderson P-Duarte http://orcid.org/0000-0002-8620-8245
Estefanía Losada Nieto http://orcid.org/0000-0002-3275-3248

References

Bluhm, R., & Borgerson, K. (2011). Evidence-based medicine. In F. Gifford (Ed.), *Philosophy of medicine* (pp. 203–238). North-Holland.

Budych, K., Helms, T. M., & Schultz, C. (2012). How do patients with rare diseases experience the medical encounter? Exploring role behavior and its impact on patient-physician interaction. *Health Policy*, *105*(2–3), 154–164. https://doi.org/10.1016/j.healthpol.2012.02.018

Campbell, J. (2005). Joint attention and common knowledge. In E. N. Eilan, C. Hoerl, T. McCormack, & J. Roessler (Eds.), *Joint attention: Communication and other minds: Issues in philosophy and psychology* (pp. 287–297). Clarendon Press.

Campbell, J. (2011). An object-dependent perspective on joint attention. In A. Seemann (Ed.), *En joint attention: New developments in psychology, philosophy of mind, and social neuroscience* (p. 415). MIT Press.

Carel, H. (2023). Epistemic injustice and vulnerability. In Martin Lipscomb (Ed.), *Routledge handbook of philosophy and nursing* (pp. 460–469). Routledge. https://doi.org/10.4324/9781003427

Chambliss, B. (2024). Attending together in digital environments. *Topoi*, *43*(2), 311–322. https://doi.org/10.1007/s11245-024-10012-3

Charlas con Charli. (2024, de marzo 18). Morir en mis términos [Episodio de pódcast]. *Spotify*. https://open.spotify.com/episode/6x4Nc9HbzdJc6lcxJG6YNm

Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA*, *286*(15), 1897–1902. https://doi.org/10.1001/jama.286.15.1897

Charon, R. (2012). At the membranes of care: Stories in narrative medicine. *Academic Medicine*, *87*(3), 342–347. https://doi.org/10.1097/ACM.0b013e3182446fbb

Clark, H. H., & Brennan, S. E. (1991). Grounding in communication. In L. Resnick, R. Levine, & S. Teasley (Eds.), *Perspectives on socially shared cognition* (pp. 127–149). American Psychological Association (APA).

Côté, C. I. (2024). A critical and systematic literature review of epistemic justice applied to healthcare: Recommendations for a patient partnership approach. *Medicine, Health Care and Philosophy*, *27*(3), 455–477.

D'Angelo, D. (2020). The phenomenology of embodied attention. *Phenomenology and the Cognitive Sciences*, *19*(5), 961–978. https://doi.org/10.1007/s11097-019-09637-2

De Brigard, F. (2018). Memory, attention, and joint reminiscing. In E. K. Michaelian, D. Debus, & D. Perrin (Eds.), *New directions in the philosophy of memory* (pp. 234–250). Routledge.

Díaz, P. (2022). La mirada sobre el cuerpo y la injusticia epistémica en el marco de una fenomenología de la enfermedad. *Tópicos, Núm. 44*. https://doi.org/10.14409/topicos.2022.44.e0004

Eilan, N. (n.d.). Joint attention and the second person. Recuperado de. https://warwick.ac.uk/fac/soc/philosophy/people/eilan/jaspup.pdf

Fiebich, A., & Gallagher, S. (2013). Joint attention in joint action. *Philosophical Psychology*, *26*(4), 571–587. https://doi.org/10.1080/09515089.2012.690176

Gaviria, A. (2020). *Hoy es siempre todavía. La historia de cómo descubrí que el cáncer es como la vida*. Editorial Planeta Colombiana S.A.

León, F. (2022). *Attention in joint attention: From selection to prioritization. En* access and mediation: A new approach to attention. De Gruyter.

McDowell, J. (1998). *Meaning, communication and knowledge*. En *meaning, knowledge and reality*. Harvard University Press.

Merleau-Ponty, M., Landes, D., Carman, T., & Lefort, C. (2012). *Phenomenology of perception*. Routledge.

Moll, H. (2024). What we do and don't know about joint attention. *Topoi*, *43*(2), 247–258. https://doi.org/10.1007/s11245-023-09961-y

O'Madagain, C., & Tomasello, M. (2021). Joint attention to mental content and the social origin of reasoning. *Synthese*, *198*(5), 4057–4078. https://doi.org/10.1007/s11229-019-02327-1

Peacocke, C. (2005). Joint attention: Its nature, reflexivity, and relation to common knowledge. In N. Eilan, C. Hoerl, T. McCormack, & J. Roessler (Eds.), *En joint attention: Communication and other minds* (pp. 298–324). Oxford University Press.

Peña, A. (2018). Factores esenciales de la medicina narrativa según Rita Charon, aplicados a la consulta odontológica. (Tesis de maestría). Recuperado de 495/2381. Universidad del Bosque. https://hdl.handle.net/20.500.1

Pomey, M. P., Denis, J. L., & Dumez, V. (Eds.). (2019). *Patient engagement: How patient-provider partnerships transform healthcare organizations*. Springer Nature.

Rosas, C. A. (2013). La comprensión del dolor en la reflexión bioética: Una aproximación preliminar. *Persona. Revista Iberoamericana de Personalismo Comunitario*, *22*, 83–96. https://www.researchgate.net/publication/273257835

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence-based medicine: What it is and what it isn't. *The British Medical Journal*, *312* (7023), 71–72. https://doi.org/10.1136/bmj.312.7023.71

Sacks, O. (2017). *A leg to stand on*. (Revised text in Spanish: *Con una sola pierna* (J. Álvarez, trans.). Anagrama.

Scarafone, A. (2024). Joint attention: Normativity and sensory modalities. *Topoi*, *43*(2), 283–294.

Seemann, A. (2019). Reminiscing together: Joint experiences, epistemic groups, and sense of self. *Synthese*, *196*(12), 4813–4828. https://doi.org/10.1007/s11229-016-1156-3

Seemann, A. (2024). Joint attention as the base of common knowledge and collective intentionality. *Topoi*, *43*(2), 259–270. https://doi.org/10.1007/s11245-024-10011-4

Sontag, S. (1978). *Illness as metaphor and AIDS and its metaphors*. Farrar, Straus and Giroux.

Stefanello, E. (2024). Narrative medicine and empathy: A phenomenological perspective. *Journal of the British Society for Phenomenology*, *55*(2), 167–183. https://doi.org/10.1080/00071773.2024.2314119

Von Weizsäcker, V. (2005). *Patosofía*. Libros de Zorzal.

Wilby, M. (2023). The form and function of joint attention within joint action. *Philosophical Psychology*, *36*(1), 134–161. https://doi.org/10.1080/09515089.2022.2039384

Zahavi, D. (2014). Empathy and other-directed intentionality. *Topoi*, *33*(1), 129–142. https://doi.org/10.1007/s11245-013-9197-4