10 Dialogical Decision Making

Promoting Patient Participation

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> Shared decision-making should enable both patient and doctor to state their understanding and preferences, and to come to a decision together about how best to proceed.
>
> Frain, Wearn 2018: 19

> (...) Current physician–patient relations range from partnerships between social actors who each play critical roles in negotiating care to a more adversarial duel in which both participants advocate for goals that are not necessarily shared.
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> Stivers, Tate 2023: 233

Abstract: By way of introduction, it will be explained why greater patient participation in medical decision-making is not only to be promoted in the sense of a *democratic* development in the health care system, but can also be directly beneficial for the *doctor-patient* relationship (§ 10.1). Here, the patient's *co-determination* and *participation* can be a relief for both partners, who can make the permanent problem of demonstrably poor "adherence to therapy" of patients an issue without taboos and contribute to overcoming the reasons and motives for the possible "misbehaviour" through open communication. In this context, one of the main tasks for physicians is to prevent or at least mitigate the clash between *lifeworld* and *medicine* (§ 10.2), i.e. to reconcile *evidence-based* medicine (§ 10.3) with the *preferences* of patients motivated by *lifeworld.*

The extent to which this harmony between the patient's lifeworld and medicine can succeed will be worked out and critically compared on the basis of a pattern analysis of different basic models of relationship design and decision-making (*paternalism*, *service*, *cooperation*) and

their variants (§ 10.4). The new concept of *participatory decision making* (PDM), which has become known and discussed in the English-speaking world as *shared decision making* (SDM), also starts from an *asymmetry* of the doctor-patient relationship, which is given by the mere request for help from one partner to the other. To this end, they enter a *therapeutic alliance* in which they first overcome the knowledge gap between the two partners, each of whom is an "expert" in their own way, in the exploratory conversation through a mutual exchange of information, which only enables both of them to participate in the decision-making process in a qualified manner. (§ 10.5). Finally, within the framework of an applied *discourse* and *medical ethics,* it should be discussed (§ 10.6) to what extent the relationship between the actors as a whole is to be shaped in such a way that the doctor and the patient - despite all limitations - meet each other in the clarification and decision-making processes as *unequal,* but *equal* and *equally rational* partners. They respect each other's *autonomy* in the knowledge that they cannot be successful without the active participation and consent of the other partner.

Finally (§ 10.7), it should be summarised that the art of *flexible* medical consultation is not only to *explore* the patient's individual need for information and participation, but also to *awaken* it and, if possible, to expand it in a joint negotiation process in such a way that the decision ultimately taken is in harmony with the patient's right to self-determination.

10.1 Participation and emancipation

The development towards the "responsible" patient does not have to prevail against medicine, but can be promoted in the interest of and in harmony with medical action. The active *participation* and *involvement* of the patient in medical decision-making is not only to be seen as a *democratic* achievement, but also as a favourable prerequisite for later "*adherence*" to treatment measures. In this respect, the *emancipation* of the patient accommodates medical action, which, however, must make certain commitments to the patient regarding *transparency*, *information* and *participation.*

10.1.1 Democracy and autonomy

With the concept of the "responsible patient", which is derived from the basic idea of the "responsible citizen" in a democratic society, particular emphasis is placed on the right to *information* and *self-determination*, especially in the case of illness. The patient's *information* and *participation* in medical decision-making are no longer seen as optional but as obligatory components of the doctor-patient relationship, whose traditional, paternalistic character has become obsolete in view of social developments and advances in medicine.

Here, with Gigerenzer and Gray (2013), three development stages of the "professionalisation of medicine" with direct social effects can be distinguished: While in the 19th century the state of health of the population in the industrialised countries could be improved primarily through clean water, more hygiene and through healthier nutrition, in the 20th century the technical-scientific progress of medicine was decisive, for example through the possibilities of combating childhood leukemia or through the use of artificial hip joints. "In addition, immense resources were invested in the expansion of health care, medical professional training and the organisation of health care. This second reform created a powerful care management" (2013: 27). However, according to Gigerenzer and Gray (Box 10.1), this development did not yet per se lead to "well-educated patients", which would now require a "third health care revolution" in the 21st century.

Box 10.1 Democracy and the Third Health Revolution

The 20th century became the age of the doctor, the clinics and the industry. Well-informed patients were not the primary goal of the second revolution (...) Now we need a third health care revolution. While the first brought clear water, the third should bring clear information. It should transform the 21st century into a *century of the patient* - a truly democratic ideal. Citizens have the right to know the basic facts, and they have a responsibility to make decisions about their health based on the best available evidence. We envision a healthy health system as a democracy in which knowledge is distributed to all levels of society.

Gigerenzer, Gray 2013: 27, emphasis in original

The strengthening of patients' rights in the sense of information and participation in decision-making is a basic democratic idea that essentially aims at the *autonomy of* the patient. As will be explained (§ 10.4, 10.6), this autonomy is by no means to be confused with *self-sufficiency* of a patient who could enforce his or her decision without or even against the doctor without jeopardising the relationship.

Patients can only exercise their autonomy with the appropriate *health literacy*, which is to be conveyed by medical action in an ongoing information process (§ 10.5). Thus, by providing basic information, the patient must first be enabled to ask further questions that are relevant to him or her. By answering these questions, physicians contribute to further promoting the patient's competence in the sense of "qualified" participation (*empowerment*), which ultimately allows a "joint decision at eye level".

Precisely because it was made jointly, the decision can also be borne in joint responsibility, which is the very first prerequisite for a successful therapy. However, this can be jeopardised by a lack of *adherence* to therapy if patients are not sufficiently informed and involved in the decision-making process.

10.1.2 Relevance and consequences of (non-)adherence

The strengthening of patients' rights through information and participation in decision-making is, in the sense of the basic *democratic* idea, a general strand of justification in the direction of a reform of the health care system. Furthermore, the well-informed and involved patient is also, from a specific internal medical perspective, the best prerequisite for the success of a treatment measure that is jointly decided and supported by the doctor and patient. Conversely, a patient who is kept "immature" would soon become a "difficult" patient who is far from doing what the doctor expects of him according to his *orders* or *prescriptions.* This is where a *paternalistic* approach to treatment increasingly enters a crisis, from which both actors ultimately suffer: Although the paternalism of the patient may well be caring because it is meant as a relief, a lack of information and participation in decision-making is more likely to result in insufficient "therapy insight", which often leads to a lack of "therapy adherence".

From the perspective of internal medicine, this "misbehaviour" on the part of the patient was initially captured by the older term of *(non-)compliance*. In contrast, the term *(non-)adherence* has now become established, which is occasionally associated with a paradigm shift

(Sandman et al. 2012). In general, the term *non-adherence* is based on a less paternalistic concept of the doctor-patient relationship (Martin, DiMatteo 2014, Martin 2014, Albus, Matthes 2014, Matthes, Albus 2014). Despite all the differences, which Martin also emphasises (Box 10.2), both terms continue to be used side by side in research. Unless otherwise noted in the context, the term *non-adherence* will be preferred here because it does more justice to the concept of participatory decision-making.

Box 10.2 *Compliance* versus *Adherence*

The terms *adherence* and *compliance* are often used interchangeably, although there is steady movement towards a preference for the former. Both terms describe doing (or avoiding) behaviours that have been recommended in order to improve health (...) *Compliance*, although it also describes carrying out recommended health behaviours is subtly different in that it implies a more paternalitic interaction between clinician and patient. *Adherence* seems to do a better job of focusing necessary attention on the interactive and collaborative nature of the relationship between patients and clinicians.

Martin 2014: 9

In addition, (sub-)types of poor "adherence" (*non-adherence*) are differentiated according to whether a patient *intends* from the outset not to take the prescribed medication (*primary* non-adherence) or whether he/she later (*secondarily*) changes his/her mind and permanently discontinues the therapy (*non-persistence*) or whether he/she takes the medication irregularly (*selectively)* ("drug holidays"), whereby the patient (*non-intentionally*) can simply be "forgetful" despite "best intentions" or increasingly "confuse" the "many" medications, etc. (Martin 2014, Albus, Matthes 2014, Matthes, Albus 2014). Overall, poor adherence to therapy can thus manifest itself in very different forms, which can more or less elude conscious control by the patient.

Regardless of the specific subtypes, the de facto non-adherence of patients is associated with enormous consequences for their individual health as well as for society as a whole. The *subjective* and *objective consequences of* non-adherence in medicine are now well documented by qualitative and quantitative studies. Total estimates of the economic costs for the USA alone are well over 100 billion dollars (O'Connor 2006, Martin, DiMatteo 2014). For patients, non-compliance often means a prolongation or even aggravation of their subjective suffering: depending on the type of disease (myocardial infarction, diabetes, hypertension), a significantly increased health or mortality risk must be objectively expected (Osterberg, Blaschke 2005, Sokol et al. 2005, Munger et al. 2007, Ho et al. 2009, Tamblyn et al. 2010, Desai, Choudhry 2013, Martin 2014, Albus, Matthes 2014, Matthes, Albus 2014) (§ 5, 29). In all these cases, the physician's order or prescription fails to achieve its intended effect, which the patient undermines through non-adherence, which may also be deplored from the physician's point of view as "misconduct" with self-harming consequences for the patient.

The specific problems of the prescription discussion, especially when prescribing new medicines, will be discussed separately (§ 26). Equally counterproductive, however, may be the refusal to *undergo diagnostic* or *surgical* measures, when patients "back out" at short notice despite having made an agreement because they "suddenly had second thoughts", etc. In this case, the necessary patient information (§ 10.5, 39) was obviously not sufficient to stabilise the patient's motivation. Lack of motivation and corresponding misconduct, however, suggest disturbances in the communication between doctor and patient, without these disturbances being sufficiently analysed.

10.1.3 Concordance as dialogical understanding

As much as the extent of non-adherence and its consequences have been investigated in many ways, the causes of this "misconduct" cannot be regarded as clear. This misconduct cannot be unilaterally attributed to the mere "unreasonableness" of patients, which will certainly also exist in individual cases (§ 10.6). Rather, possible non-adherence must be blamed on the nature of the relationship between doctor and patient themselves, between whom apparently communication *before*, *during* or *after* a medical decision may have been "faulty" or "misleading" or "dysfunctional" or may simply have been "too brief" (Langewitz et al. 2002, Weiss, Britten 2003, Pollock 2005, Koerfer et al. 2005, 2008, Weber et al. 2009, Schirmer et al. 2009, Heritage 2011, Keller, Sarkar, Schillinger 2014, Richard, Lussier 2014, Koerfer, Albus 2015). In order to prevent the later misbehaviour of their patients, a specific professionalism of physicians is already required in the consultation hour, who must have cognitive, emotive and communicative competences (§ 3.2) in order to recognise, for example, forms of resistance ("resistances") of their patients against diagnostic-therapeutic measures in good time (*receptively*) and to promote (*actively*) the insight of patients into the necessity of adherence to therapy in a patient-friendly way through *explorative*, *empathic* and *informative* interventions.

Accordingly, the research focus should not only be on the non-adherence of patients *after* the medical consultation, when almost "everything is too late", but attention should be brought forward objectively, namely to the *(disruptions and deficits of) communication* between doctor and patient themselves, in which, after all, the conditions for the patients' subsequent "misbehaviour" are laid out.

The figures cited for the demonstrably continuing high level of non-adherence speak a clear language in the direction of a need for reform to improve communication between doctor and patient, especially in decision-making: Non-adherence is primarily a communication problem because the factors that are relevant to patients' subsequent misbehaviour have not been adequately communicated beforehand. The main source of causes for non-adherence is and remains the medical "consultation", in which everything relevant must be "discussed" beforehand without taboos.

With this focus on communication, a new conceptual framework has also been established, according to which sufficient agreement ("concordance") between doctor and patient is to be assumed, which is an essential prerequisite for the intended behaviour (*adherence*) of the patient (Weiss, Britten 2003, Stevenson et al. 2004, Stevenson, Scambler 2005, Pollock 2005, Bylund et al. 2011, Bezreh et al. 2012). According to this view (Box 10.3), patients can still be *non-compliant* or *non-adherent,* but they cannot be *non-concordant*. The criterion of *(non-)concordance* can only be applied to the communication between the two partners.

Box 10.3 *Non-adherence* and *non-concordance*

Concordance is fundamentally different from either compliance or adherence in two important areas: it focuses on the consultation process rather than on a specific patient behaviour, and it has an underlying ethos of a shared approach to decision making rather than paternalism. Concordance refers to a consultation process between a health care professional and a patient. Compliance refers to specific patient behaviour: did the patient take the medicine in accordance with the wishes of the health care professional? For this reason it is possible to have a non-compliant (or non-adherent) patient. It is not possible to have a non-concordant patient. Only a consultation or discussion between the two parties concerned can be non-concordant.

Weiss, Britten 2003: 493

The responsibility for later behavioural problems of the patient (in the sense of *non-adherence*) is thus no longer attributed to the patient alone, but to both partners already in the preceding communication process, in which the difficulties of the patient to also behave according to the jointly decided medical measure (diet, sport, taking medication, etc.) were obviously not sufficiently anticipated, thematised and reflected upon. However, if medical measures can also be easily corrected or modified, as in the case of the dosage of medication, they can once again become the subject of *negotiation processes* in which *controversies* can certainly be fought out between doctor and patient.

The term and concept of *concordance* (Box 10.4) assumes a *dialogical*, but by no means a merely *harmonious* process of understanding; rather, it is intended to concede conflicts that may be rooted in the different attitudes and interests of the participants, which make compromise difficult.

Box 10.4 *Concordance* as a potentially controversial negotiation process

Concordance is based on the idea that health care practitioners and patients should work towards a mutual understanding about medicine taking and the development of a therapeutic alliance. Fundamental to the concept of concordance is that there is an open exchange of beliefs about medicines upon which both prescribing and medicine-taking decisions may then be based. Thus concordance seeks to make patient participation explicit.

The exchange of beliefs and views by both health care professionals and patients may result in an agreement to differ over treatment choices but the key issue is that all the participants in the consultation are aware of differences where they exist. This awareness may then be used as the basis for joint negotiation or compromise over the final outcome. Thus concordance seeks to make apparent potential areas of disagreement and conflict.

Stevenson, Scambler 2005: 13

In the *joint negotiation* process, conflicts between doctor and patient can thus be both overcome and exacerbated, which may put the "therapeutic alliance" to a serious test. If a conflict cannot be resolved satisfactorily, the relationship can also be dissolved by mutual agreement, provided it is not an emergency care situation. A rationally justified separation then exhausts itself in a consensus on a dissent that can no longer be resolved recognisably for the participants (principled non-concordance). Sometimes conflicts also end in an abrupt termination of the relationship, which is de facto carried out by the patient with a change of doctor (§ 19.6), without this having been announced beforehand.

As experience teaches and will be shown by examples, controversies between doctor and patient are not exactly rare, even if they do not always come to light openly. The controversies are carried out in different participant roles, which are not least based on the difference between the professional, medical perspective of the doctor and the lay, lifeworld perspective of the patient. In order to avoid or at least mitigate the many variants of the described non-adherence of patients, a *dialogical* balance must be found here between *medicine* and the *lifeworld,* in which all relevant problems from both participant perspectives are made the subject of conversation and initially negotiated in an open-ended manner until a decision can be reached in a sufficiently consensual manner.

10.2 Lifeworld and Medicine

Apart from banal problems of understanding and communication, which are equally characteristic of everyday and institutional communication, there are fundamental problems of *talking past each other* between doctor and patient, which were already characterised by Balint and systematically described by Mishler following Habermas as conflicts between the *lifeworld* and *medicine.* In a first step, these conflicts can only be overcome through better *listening* and patient-oriented *information and education*, and finally through greater *participation in* decision-making.

10.2.1 Forms of "language confusion"

Even a superficial examination of art-patient conversations reveals how often both interaction partners misunderstand each other by basically *talking past each other*, and thus get into more or less conscious controversies from which they can hardly extricate themselves again. Michael Balint worked out these phenomena of *misunderstanding* in his typical style of individual case discussions in groups of doctors, in which the case analyses were intended to reveal the typical problems of everyday care (cf. for specific Balint work e.g. Rosin 1989, Koerfer et al. 2004, Cataldo et al. 2005, Adams et al. 2006, Herzog 2013). From the multitude of cases, two reports and analyses are cited as examples only in their quintessence.

In the first case, after an accident at work, which seemed to have been well overcome, a patient complains some time later "of pains in the whole chest in front, in the lower part of the back, in the right leg, and the right hand; he said the pains were getting worse and worse" (Balint 1964/1988: 42). After the doctor's own thorough examination, he sends the patient to specialists in the clinic for further examinations with the result "that nothing could be found and that they wanted to 'present the patient to a psychiatrist'" (ibid.). According to Balint, the conflict that then developed (Box 10.5) "could perhaps be prevented if the doctors were aware that the diagnosis 'nothing is wrong with you' is not an answer to the patient's burning question about a name for his illness" (47). Although the conflict is "not fully recognised by either side", however, both can "know and feel that their relationship is strained" (47f). In this case, further offers of examination by the doctor (for another clinic) did not help either, which the patient refused.

Box 10.5 *Dangerous confusion of language* (*"nothing is wrong with you"*)

(It is) clear that there is a misunderstanding between patient and doctor. The patient's burning problem remains unsolved, his request for a name for his nameless, worrying illness is not answered, i.e. his "offer" is rejected (...) Instead, he is given the questionable reassurance that nothing is wrong with him, crowned by the "counter-offer" of a second series of unpleasant examinations, as well as a vague and not entirely realistic promise that he would be helped. So there is a dangerous confusion of languages: each of the parties speaks his language, which the other does not and cannot understand. Such a situation must inevitably lead to contradiction, disappointment, and often even open rejection and fighting. So in this case it came to open controversy.

Balint 1964/1988: 48

The conflict is typical of cases in which patients are confronted with a diagnosis of this type ("there is nothing wrong with you" or "you have nothing") without the specific medical "meaning" of this type of diagnosis, which is often meant by the medical side as "without organic findings", being further "translated" and formulated in a comprehensible way in the patient's language, i.e. integrated into his everyday understanding of his illness. In particular, the example of "somatoform disorders" (§ 32) is used to deal with this problem in detail and is further elaborated with examples of the application of *tangential* conversation (§ 3, 17).

In another case (Box 10.6), Balint presents problems of understanding and communication that do not lead to an open conflict, but nevertheless put a strain on the doctor-patient relationship. Here, there is initially a "confusion of language" which can only be resolved later: The two partners have to "talk past each other" until the doctor finally realises that his patient is pursuing a different reason for the consultation than he initially assumed for a long time.

Box 10.6 *Language confusion: Talking past each other*

First there is the faithful description of the confusion of language between doctor and patient. The doctor thinks that the patient is worried about a possible cancer and tries to reassure him about it. In this case, he could do this with the best of consciences, since he did not find the slightest suspicious sign on careful examination. However, this does not affect the patient at all; he is obviously not worried about cancer and therefore cannot be reassured. Nevertheless, the doctor, because of his learned methods and preconceived ideas, cannot "hear" and continues in his reassuring speeches. A good half hour is wasted in this talking to each other (...) After the "reassurance", the doctor wanted to end the examination by prescribing the patient his usual tablets. Then, when all medical questions and reassuring speeches fell silent and a short silence fell, the patient began to say something to his doctor, whom he trusted. But the doctor was always so busy that he could not listen properly. Nevertheless, he was sensitive enough to prick up his ears so that he overheard something important (...) Now it is probably certain that the real problem that caused this man to seek medical help was his fear of ageing.

Balint 1964/1988: 179f

As we can further learn from the report, there was a history of the patient, according to which many members in his family suffered from arthritis, so that in this context the patient's 19-year-old daughter had motivated him to visit the doctor with the words: "You have to stay young, Daddy, go to the doctor!" (179). The patient was apparently only able to tell this under the conditions of the advanced consultation hour and after a "short silence" (see above), which prompted the attending doctor to give a (self-)critical summary afterwards (Box 10.7).

Box 10.7 *Narrative of* a "seemingly insignificant thing"

I think that if I had been a stranger, the man would not have told me this seemingly insignificant thing, namely that his daughter sent him. It was only because I already knew him so well that he let it slip, he could have thought it was too stupid to tell the doctor. But he couldn't tell me right at the beginning, he had to save it for the end.

Balint 1964: 181f

The case makes it clear what often remains "unspoken" in consultations because the conditions of the conversation are kept unfavourable by the doctor, either because he is a "bad" listener who overhears or ignores what is said, or because he blocks the opportunities for patient narratives by talking himself. Here, the communicative *competences of* doctors are again in demand (§ 3, 9, 17, 19), for example, to *stimulate* the patient through *active listening to narratives* that help to bring to light specific information on further treatment, the *relevance* of which arises both from a *life-world* perspective and a *medical* perspective. Balint repeatedly emphasised the necessary *art of listening* to the doctor in his case reports (§ 9), which we will also return to repeatedly with example analyses in the practical part (§ 19-22, 24-25).

10.2.2 Conflicts between lifeworld and medicine

The problems of understanding and communication between doctor and patient have been studied by Elliot G. Mishler as systemic conflicts between the life world and medicine. Referring to approaches by Alfred Schütz, a classic of understanding sociology, and the philosopher Jürgen Habermas, whose "Theory of Communicative Action" was presented in detail in advance (§ 7.3, 7.5), Mishler (1984) has described the problem of understanding between doctor and patient essentially as the problem of conflicting "voices" of the lifeworld and medicine. Here, the main line of conflict is explained from the clash of interests between patient and doctor, which results from a specific role conflict between layperson and expert: Out of a (misunderstood) medical professionalism, the doctor tries to *suppress* the patient's life-world voice as a disturbing factor in medical treatment as much as possible, using a wide variety of communication tools to upgrade and downgrade the relevance of patient concerns (cf. Koerfer et al. 1994, 2000, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2011, Barry et al. 2001). We will return to this aspect of the physician's *relevance* of verbal patient offers separately (§ 17.4) with many examples (§ 19-22, 24-25).

Here, Mishler's (1984) critique (Box 10.8) of the *dominance* and *control* of the medical "voice" over the lifeworld "voice" of patients who are continuously "interrupted" by their doctors - a factual relationship that needs to be programmatically reversed in the sense of *humane* care in analysis and practice - should be cited first:

Box 10.8 Voice of medicine versus voice of the lifeworld

Physicians' control of structure is matched by their control of content. The relevance and appropriateness of information is defined through what physicians choose to attend to ask about. This bounded domain of relevance is summarized as the voice of medicine. Occasionally, the flow of the interview is "interrupted" by the "voice of the lifeworld" when patients refer to the personal and social contexts of their problems. Physicians rapidly repair such disruptions and reassert the voice of medicine (...)

If we wish to break free of the voice of medicine, to open up new perspectives that would help us understand how to change a pattern of coercive medical care to more humane practice, then we have to begin again in a different way. In order to do this, the analysis must be inverted; the relations between the voices of medicine and the lifeworld must be reversed. In this way, the voice of medicine may be understood as an interruption of the voice of the lifeworld.

Mishler 1984: 95, 98

This methodological reversal perspective has already been demonstrated by Mishler (1984) in many empirical examples, in which he also shows how doctors should allow themselves to be "interrupted" by their patients in order to integrate their lifeworld concerns productively. Before adopting this perspective for our empirical conversation analyses, the essential theoretical provisions for an analytical consideration of the conflict between the "voices" of medicine and the lifeworld are to be compiled in a diagram (Fig. 10.1) in a didactic overview by way of *contrast.*

This simplified representation, which will be referred to here in several steps of this handbook, was also used in this or a similar way in teaching and further training (as a "blackboard picture") in our clinic, with further explanations and additions in the discussion. It should be taken into account that the communication-theoretical and philosophical approach of Jürgen Habermas (§ 7.3, 7.5) and the sociological approach to understanding and language by Elliot Mishler, which builds on it, have in the meantime been widely received with rich application variants, especially in medical research (Koerfer et al. 1994, 2000, Scambler (ed.) 2001, Barry et al. 2001, Stevenson, Scambler 2005, Sandman, Munthe 2010, Walseth, Schei 2011, Bezreh et al. 2012, Harvey, Koteyko 2013, Labrie, Schulz 2014). Compared to this diverse spectrum, the following commentary notes on the chart (Fig. 10.1) can at best be suggestions for further reading (of excerpts) of texts of the "classics", which we also include in our (advanced) courses (§ 13-14) as "theory pieces". Here we also refer back to our presentation of Habermas' "Theory of Communicative Action" (§ 7.3, 7.5).

10.2.3 Strategic versus communicative acting

Although mixed forms are always practised in medical practice, the conflicts between the lifeworld and medicine, which are possible in principle, come into view by comparing the alternative, ideal-typical extreme cases in the interaction with the patient in the sense of Habermas and Mishler (Fig. 10.1). The conflicting "voices" of medicine and the lifeworld are contrasted here in extreme-typological terms in order to be able to direct the focus beyond all possible ("milder") mixed forms in everyday practice to the essential lines of conflict in communication between doctor and patient.

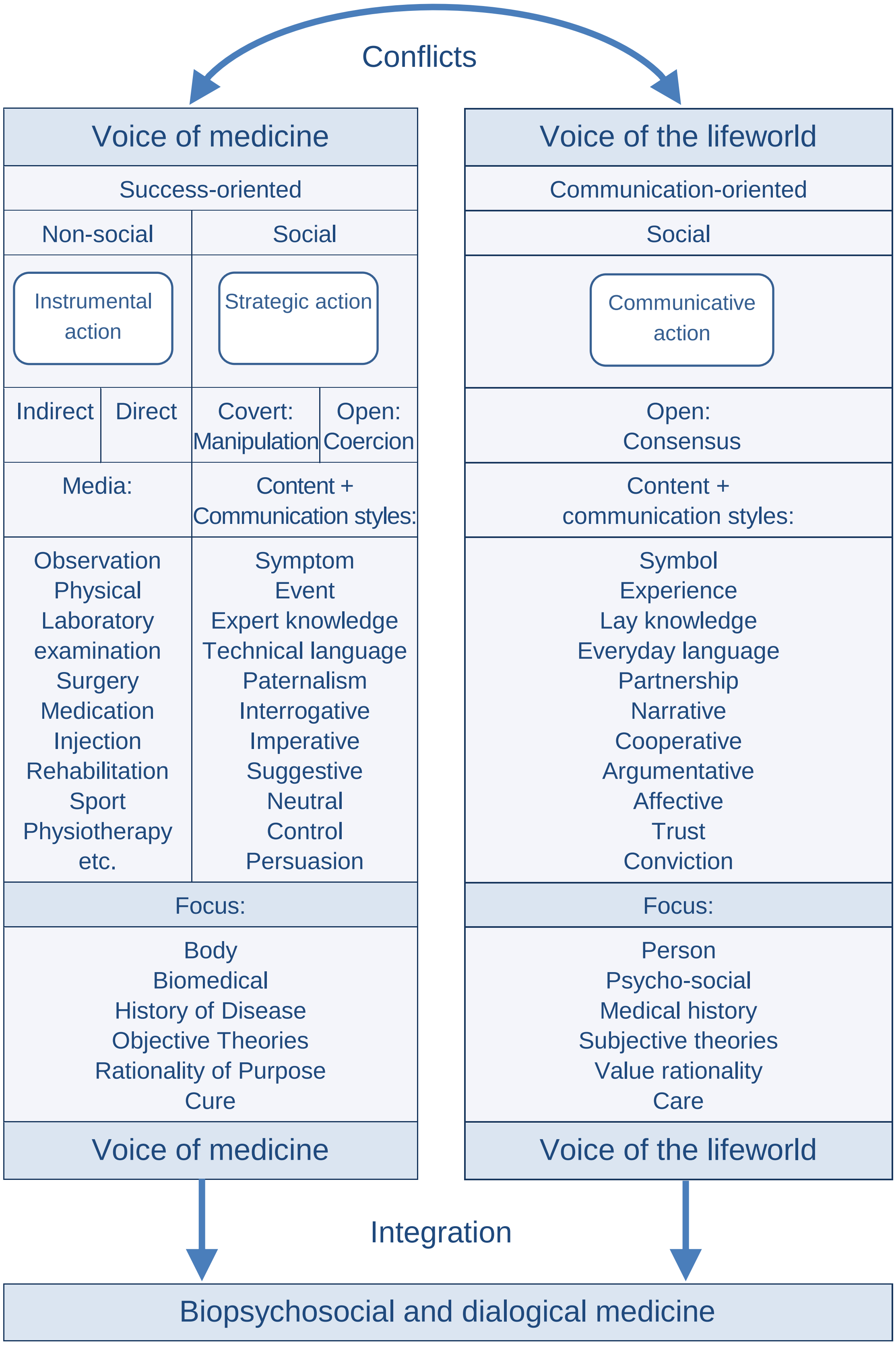


Fig. 10.1: Conflicts and integration of lifeworld and medicine

Thus Habermas himself has repeatedly (e.g. 1981: vol.1: 443, vol.2: 462) referred to the necessity of empirical studies in order to distinguish, for example, a "strategic" from a "communication-oriented use of language" with regard to their dominance in a particular type of conversation. Here, Habermas' own question about the "relative weighting" is primarily an "empirical question", which, however, must be answered in a differentiated manner for forms of institutional communication, such as in court, at school or during consultation hours (Koerfer 2013). Certain mixed forms in medical decision-making, as they are also distinguished in research, will be considered later (§ 10.4).

In contrast to the model of an essentially *communicative understanding* in which doctor and patient, despite all the asymmetry of a helper relationship, meet as *equally rational* and *entitled* partners and arrive at a decision-making process in *partnership* and with joint responsibility (§ 10.4, 10.6), in practice one must reckon with other, more or less restrictive concepts of action of medical care, which in turn can manifest themselves in two basic variants (Fig. 10.1):

- On the one hand, the *non-social* orientation of medical practice towards patients as physical *objects* can be reduced to essentially *instrumental* action. This is possible in different ways, for example, during a physical examination or a gastroscopy or an X-ray or an operation. To this end, there is often a division of labour between doctors in which one is primarily *instrumental* and the other primarily *communicative*. From the patient's point of view, it would be desirable that the information before an operation and the operation itself, as well as the debriefing, are carried out by the same doctor, but this is often not the case.

- On the other hand, medical action can be *socially* oriented towards the patient as a *person* and thus as a *subject,* with whom the doctor also exchanges verbal information during the consultation. In doing so, however, the doctor can essentially shift to *strategic* action by suppressing all of his patient's lifeworld-oriented narrative approaches through his type of *interrogative* anamnesis, which possibly leads to the perverted form of an "interrogation" (§ 9, 19). Similarly, the doctor can *ignore* or *reject* his patients' *subjective* theories of illness (in the sense of Watzlawick et al. 1967/2011) (§ 7.4) in order to then *lecture* against them with his *objective* theories. Furthermore, the doctor can then use

> his *strategic* action in decision-making, for example according to the *paternalism model* more or less *openly* on *coercion* or according to the *service model* more or less *covertly* on *manipulation* (§ 10.4.4-5). Both alternatives of strategic action seem appropriate as long as only the intended success of the treatment is achieved, which is supposed to fulfil essential functions of a mere *biomedical* care.

Disruptions in communication between doctor and patient may go unnoticed or ignored here as long as only limited *curative* purposes are pursued, such as in acute care or in emergencies, which may be essentially limited to *instrumental* action (surgery, medication, etc.) in order to achieve partial biomedical success. However, the more far-reaching objectives are pursued, which require the active cooperation of the patient in the long term in order to achieve and maintain the described *adherence* to therapy, the greater will be the impact of the disruptions.

Finally, further therapy purposes (§ 7) may have to do with the treatment of relational and communication disorders of patients themselves, which may have to be treated in *primary psychosomatic care* (§ 15, 24) or in specific *psychotherapy* (Pawelczyk 2011, Scarvaglieri 2013, Konerding 2015), etc. At the latest then, an *interrogative* interview style will have to be replaced by a *narrative* interview style (§ 9), with which not only *symptoms* and *events,* but also *symbols* and *experiences of* patients in their individual illness and life stories can be recorded.

Before we elaborate on this integration perspective, first theoretically and then also with empirical examples, we should refer back to our presentations on *biopsychosocial* medicine (§ 4): There, following Engel (1979) and von Uexküll, Wesiack (1991, 2011), an integration of the medical and lifeworld perspectives had already been striven for. The integration had been explained using the example of the obese patient whose acute attacks of respiratory distress had been placed by the doctor in the context of her separation fears, which had increased to the experience of death fears on the occasion of the social event of her son moving out of the shared flat. Here it had become clear that a purely *biomedical* approach, which would limit itself to body or organ-related treatment (for example, of obesity as well as mild hypertension, cardiac insufficiency, etc.) and neglect the events and experiences relevant to *life* - because this had already not been taken into account in the anamnesis - could hardly lead to lasting therapeutic success.

The success of therapy is endangered not only by an incomplete collection of medical history, but also by inadequate participation in therapy decision-making and planning if the preferences relevant to the *lifeworld* are not known in the first place or are insufficiently taken into account. Here, a momentous conflict between the lifeworld and medicine can arise if the *evidence-based* treatment options are not sufficiently coordinated with *patient preferences*.

The "suppression" and "interruption" of the patient's lifeworld "voice" by the doctor described by Mishler would then have a high price. This has already been shown with the subjective and objective consequences of *non-adherence*, which often results from the fact that the "best" medicine cannot have an effect if it has not first been brought into harmony with the patient's lifeworld.

10.3 Patient preferences and evidence-based medicine

A particular source of conflict arises in the consultation from the possible contrast between *preference-based* and *evidence-based* medicine, which can ideally form a unity. In case of conflict, the doctor must limit or even completely reject his patient's treatment wishes if they should not be compatible with the partially codified standards of his profession. The patient's preferences can play a supporting role in particular in complex decision-making situations characterised by *uncertainties* about the course of diseases and effects of treatment measures and where there is almost a "balance" (*equipoise*) between alternative treatment methods.

10.3.1 Institutional and individual scope for acting

A major problem in medical decision-making is first of all to clarify between the parties involved, by *means of discussion,* which treatment options can or should be chosen at all for a certain disease, or which options are not (or no longer) available for a certain course of disease, etc. (Fig. 10.2). In the practice of decision-making, the individual scope of action for both interaction partners will have to experience limitations that lie beyond the personal decision-making competence of the participants. Without this always being openly revealed in conversation, the actors' scope for decision-making is limited by *institutional* instances of a "higher order", which include, for example, medical professional organisations, specialist societies, training institutions, etc., which exercise a certain control function over medical action, which is ultimately to be carried out according to the state of the art (*lege artis*).

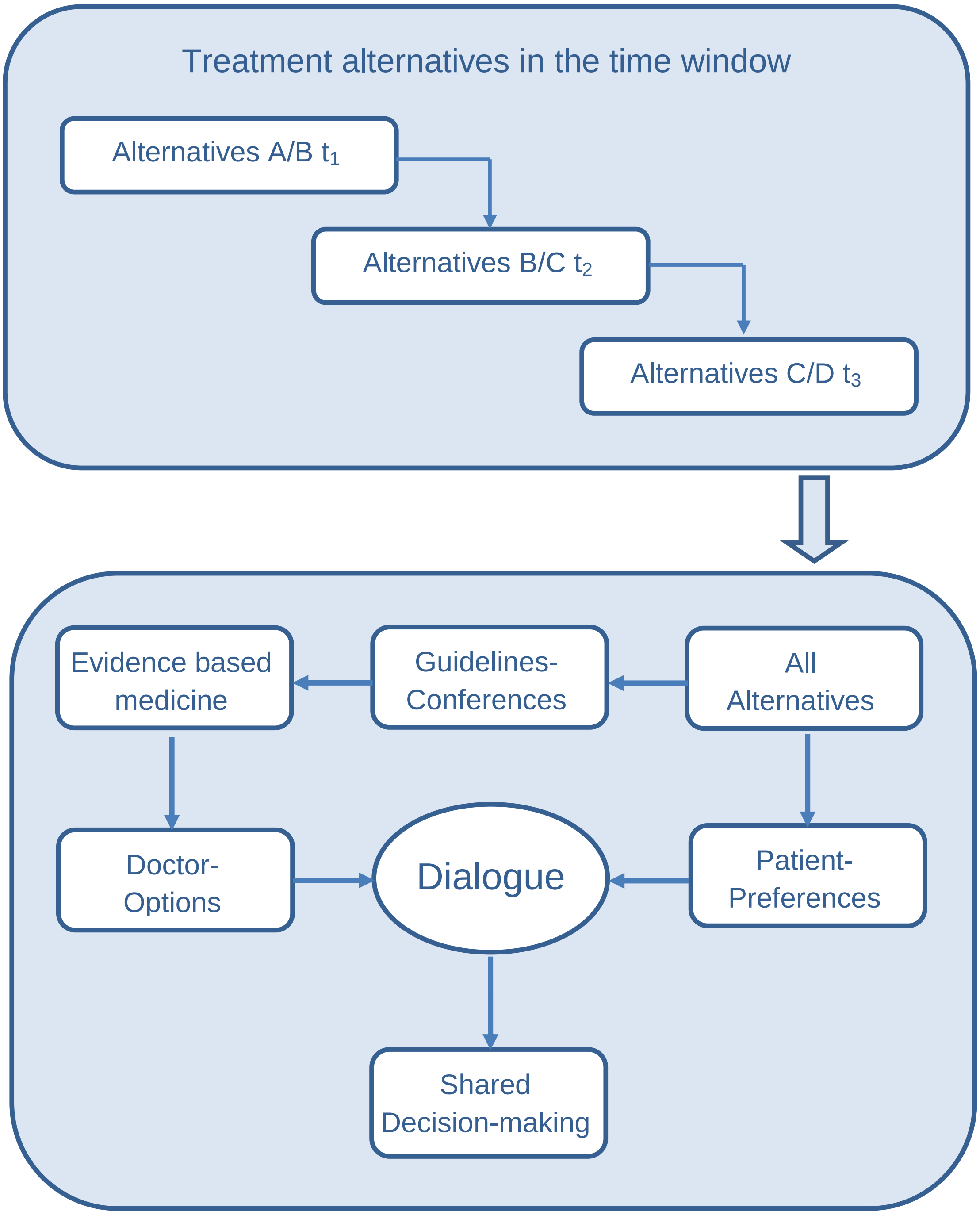


Fig. 10.2: Preference and evidence-based decision dialogue

In order to be able to guarantee this claim, guidelines for the *quality assurance of* medical action have been developed for about two decades, which should be oriented to the current state of research and treatment on the basis *of evidence*, which experts decide on in predominantly subject-specific *guideline conferences* (Lauterbach, Schrappe 2001, Sachverständigenrat 2009, Kopp 2011, Charles et al. 2011, Donner-Banzhoff et al. 2013, Smith 2013, Kulzer et al. 2016, DEGAM 2022). Accordingly, in a decision dialogue between doctor and patient, not all possible alternatives in the sense of *libertarian* ethics ("anything goes") can be freely chosen, but only treatment options that can be justified with good reasons within the *institutional* framework of evidence-based medicine.

Compared to these codified standards of the medical profession, unreasonable treatment requests from patients may then have to be rejected, for example in the case of antibiotics, antidepressants or cosmetic surgery that are not medically indicated. In case of dispute, the doctor can more or less explicitly refer to "first-order arguments", which have been developed for this purpose of justifying medical action in higher, supra-individual knowledge and decision-making bodies of his profession. However, the *individual* doctor must also be able to accept or reject their positions in a *justified manner* ("second-order arguments") in the concrete case of application qua individual competences.

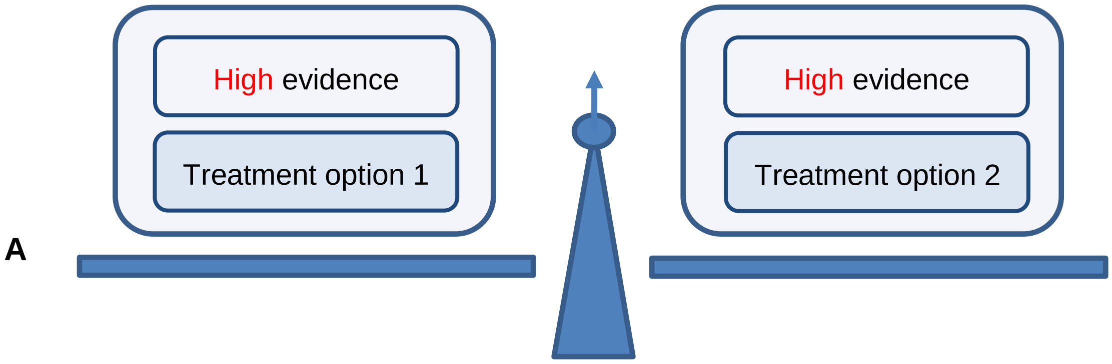
Here, the "guidelines" in no way claim to "exceed" the individual decision-making competences of a physician (Sachverständigenrat 2009, Kopp 2011) (§ 5). They understand themselves literally as *guidelines* and want to contribute with their "recommendations" to giving the physician a certain security in the process of decision-making with the patient.

10.3.2 Balance of evidence and preferences

Precisely because medical progress per se is always a process, the preconditions for decisions also remain in flux, often associated with imponderables. In a certain time window, the "agony of choice" often remains as to what the current method of choice should be, so that "decisions under uncertainty" have to be made (Murrhardter Kreis 1995, Frosch, Kaplan 1999, Klemperer 2005, Pollock 2005, Politi, Street 2011, Braddock 2012, Gigerenzer 2013). These uncertainties should not be concealed from the patient, but communicated (Politi, Street 2011, Braddock 2012, Donner-Banzhoff et al. 2013). A misunderstood sparing of the patient would be a superficial or pretextual reason here, which could only be asserted in a paternalistic relationship anyway (§ 10.4.4). This would be the first step towards the *incapacitation of the* patient, whose preference relevant to the world of life should be taken into account or even be "decisive" especially in "uncertain" decisions.

The double aspect of balance (*equipoise*)

Special problems in decision-making arise solely from the fact that the treatment options in question can often be "equivalent", so that the decision can be made in one direction or the other for *equally good reasons* (high evidence in each case) (Fig. 10.3, variant A). Thus, conservative versus non-conservative medicine, drug therapies versus surgical therapies, non-invasive versus invasive methods can often (for a certain period of time) form a *real* alternative that can remain controversial to decide even between medical experts. If the "controversial" issue cannot be resolved, this is a particularly good reason for the patient to exercise his or her rights of co-determination to a greater extent, for example by obtaining a so-called "second opinion" (see below). Obtaining this second expert opinion should not be interpreted by the attending physician as questioning his or her competence, but should even be actively supported by him or her, which we will come back to in a moment.



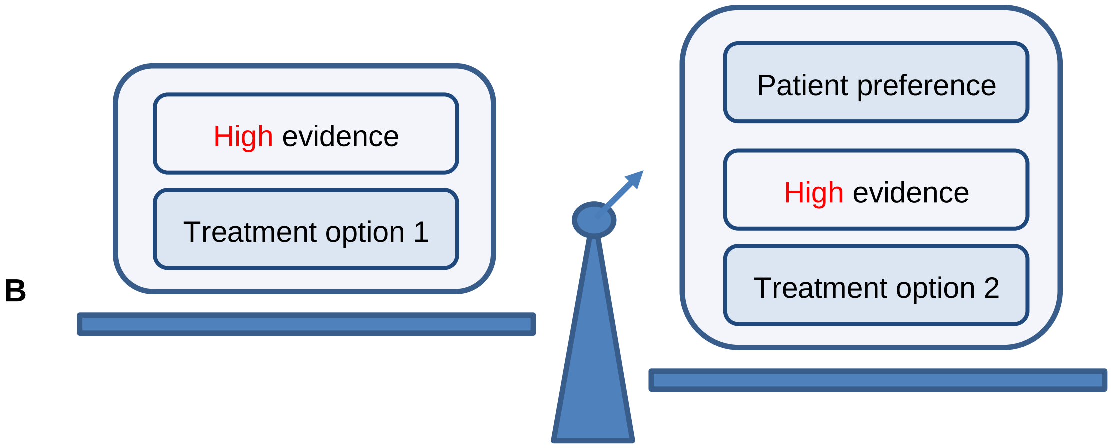


Fig. 10.3: Weighting of preferences and (equal) evidence

Especially in difficult situations that are characterised - for whatever reason - by a certain "undecidability", an equal participation of patients in decision-making is recommended. Here the concept of "balance" or "equivalence" (*equipoise*) has become established (Elwyn et al. 2005, Loh, Härter 2005, Brown, Albrecht 2011), which is used under a double aspect: Thus, especially in the case of a balance of *treatment options,* a balance of the communicative *participation roles* of doctor and patient is required, because both partners would be overburdened with a *solitary* decision on their own, i.e. without the participation of the respective other partner. In such a situation of equal treatment options, joint decision-making between equal-ranking partners is not only optional, but obligatory.

In the cooperation between doctor and patient, a number of types of decisions can be distinguished, which are determined by the *relative weighting* of evidence and preferences (Fig. 10.3). In order to overcome a "stalemate" situation with equally good/high evidence, for which the doctor must be able to "vouch", the actors must at the latest "weigh in the balance" the patient's preferences, which can or should "tip the scales" (Fig. 10.3, variant B). Here the preferences are, as it were, the "tipping point".

In addition, the many cases in which there is no ("complete") balance between equally weighted treatment options, but the imbalance is nevertheless not so "serious" that the differences are already significantly "significant", must of course be further differentiated. But even in the case of "serious" imbalances in the evidence (Fig. 10.4, variant C), the question remains how "serious" the patient's preferences should "weigh", i.e. how they can "outweigh" the "imbalance" in the evidence of treatment options (Fig.10.4, variant D).

Here, the problem arises again of what weight may or should be given to the patient's preferences, i.e. the doctor can "accommodate" the patient's preferences as long as they are still justifiable within the framework of evidence-based medicine. This problem of relative weighting will occupy us throughout the empirical cases in the practice section, in which often enough there is not only a choice between two alternative treatment options, but even several options are available, the choice of which can also be bound to certain "time windows", which can also "close". In these cases, a "compromise for a limited period of time" between doctor and patient can be useful, which then has to be "reconsidered" "in due course" in an open *deliberation process* (§ 10.4.6, 10.3).

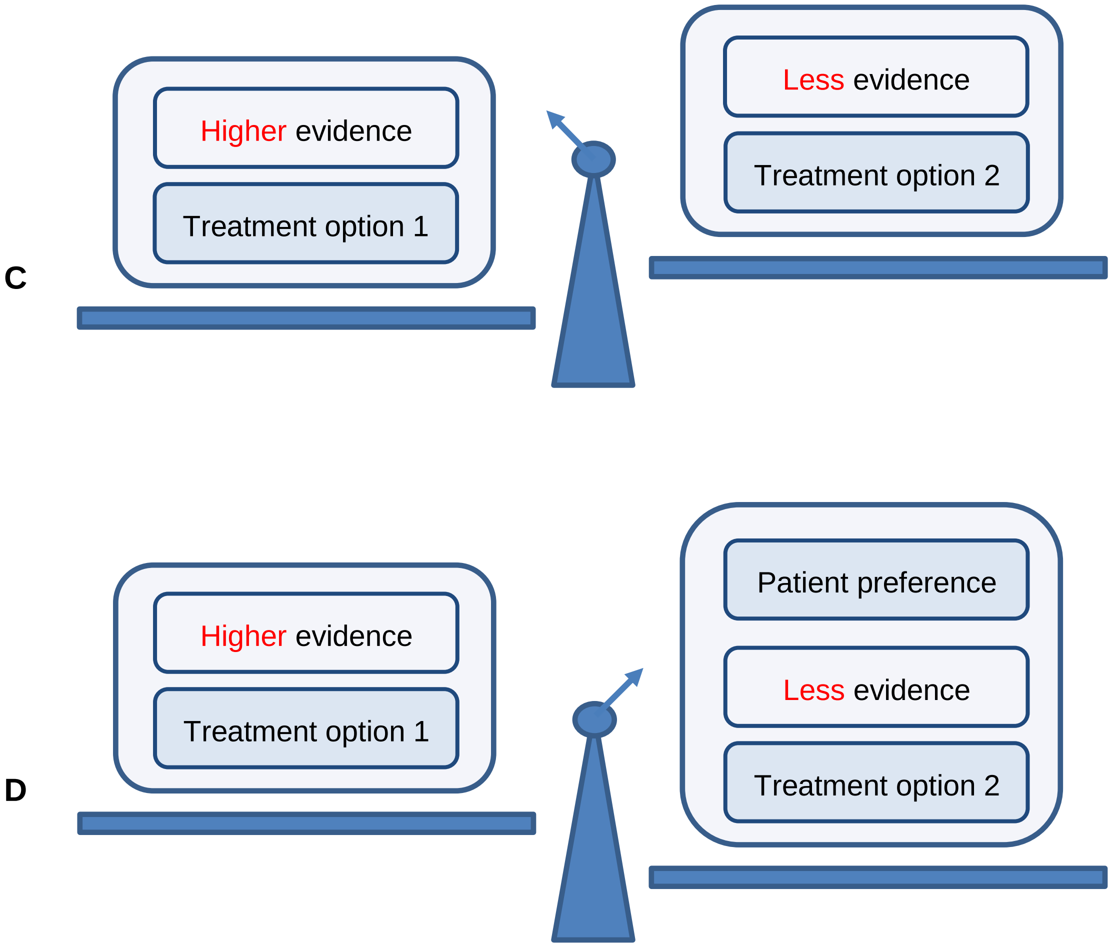


Fig. 10.4: Weighting of preferences and (unequal) evidence

For example, a doctor who considers an operation to be the "best" choice may well agree to the patient's preferred option of "watchful waiting" - provided this can still be justified within a certain time window - even if this would only be the "second-best" choice from his point of view. Whether, for example, a high patient preference for a treatment option with low evidence over another option with the highest evidence can still be "decisive" certainly requires an individual case-by-case assessment, in which the individual decision-making competence of the physician is particularly challenged. Nevertheless, individual case decisions should continue to follow criteria that can be asserted in a supra-individual typology, as will be discussed below.

Relevance and safety

Such a typology has been proposed by Whitney (2003) and differentiated with others (Whitney et al. 2004, 2008). The starting point is a series of prototypical, more or less mild to severe cases, which Whitney tries to arrange in a simple model, in which a gradual expression (*high* - *low*) in two dimensions (*importance* - *certainty) is* assumed (Fig.10.6). This model will be briefly presented here and then explained under the aspect of the individual negotiation of "relevance" (*importance)* using a hypothetical example in which the lifeworld orientation of individual patients "weighs in" to different degrees and this relative weighting can lead to compromises between doctor and patient in decision-making.

Whitney, too, in his "New Model" of decision-making, with which he wants to "explore the "limits" of shared decision-making" (SDM), starts from a contentious situation in which a certain treatment might remain controversial even between medical experts. In this, Whitney also recognises precisely a good reason for seeking a "second opinion" (Box 10.9), which can ultimately contribute to the patient's own opinion formation.

Box 10.9 Seek a second opinion in the event of controversy

Clinicians do not always agree with one another, of course, and in fact, 2 clinicians may each be quite confident that his or her own approach is superior (...) When a physician feels that one choice is better but knows that other clinicians disagree, the patient should be informed of the controversy and offered a second opinion from someone holding the other view.

Whitney 2003: 276f

It is certainly an ideal case if the doctor informs about possible controversies on *his own initiative* and offers to seek a second opinion for clarification. We will take up this aspect of the doctor's initiative again under the principle of *transparency* of medical action, which should in principle take precedence over the patient's interest (§ 7.5, 10.5.3). Even in the opposite case, if the patient wants to seek a second opinion on his own initiative, this should not be interpreted by the primary care physician as a *vote of no confidence*, but as the patient's "good right". The patient should exercise his or her right to a second opinion especially in the case of *serious* decisions, in which the patient's right to a say should be correspondingly high anyway. The priority of the decision should lie with the patient in particular when the relevance of the decision is high and the safety is low. Overall, according to Whitney (2003) (Box. 10.10), the relationship between *relevance* and *certainty* of the decision results in special constellations with different degrees of participation for the actors, to whom different priorities are attributed in the process of decision-making.

Box 10.10 Relevance and safety

A decision that is high in certainty has a widely accepted clinical response (e.g., treating neonatal sepsis with parenteral antibiotics). In contrast, a decision is low in certainty if the available interventions are very similar, if there are scant relevant data, if there is controversy over the optimal treatment, or if there is good evidence that suggests little difference in outcomes between treatments. Patients should have maximal decisional priority in situations in which medical certainty is low. When the decision is also of major importance, physicians should educate their patients to help them synthesize the available information and decide on the best course of action.

Whitney 2003: 277

According to the characteristics (*high* - *low*) in the two dimensions (*relevance* - *safety*), there are different "zones" for decision-making (Fig. 10.5), in which either the joint decision of both partners has priority, or the priority lies with the doctor if safety is high and relevance is low, or in the opposite case the priority lies with the patient. In addition, there is a "conflict zone" where both relevance and safety are high.

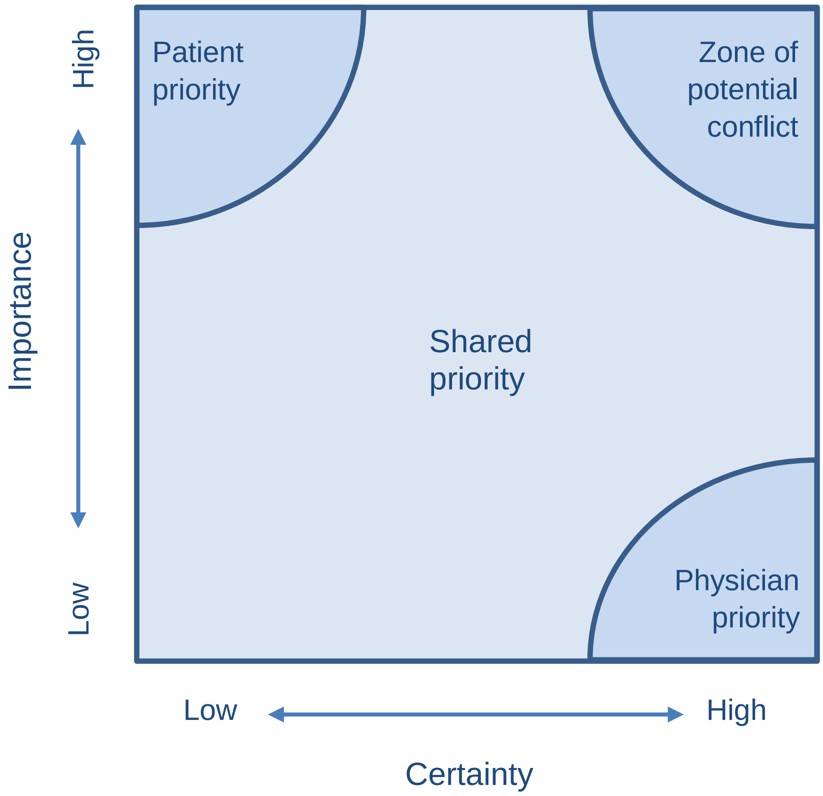


Fig. 10.5: Decision plane for medical decisions (on Whitney 2003: 278)

Due to the high relevance, the patient would have "every right" to assert himself against the doctor's strong recommendations in case of conflict, even though this is "fortunately" rather unusual: "Fortunately, the usual dynamic in this situation is for physicians to make strong recommendations and for patients to accept them" (2003: 27). However, the experience of the "usual dynamic" will not yet be able to exclude any deviation in the *individual* case, which always has to be renegotiated.[1] In this negotiation process, the problem of balance arises again, for ex-

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[1] Whitney (2003: 279) himself gives the following conflict case to consider: "Consider, for example, a pregnant woman who has 3 young children and has aggressive cervical cancer. Her physician might believe strongly that she should undergo a hysterectomy, which would maximize her chance of cure but at the cost of the fetus's life; the woman might be unwilling to terminate her pregnancy, preferring to endanger her own life rather than sacrifice that of her fetus."

ample, when a decision has to be made about the relevance of a given certainty, in which the patient finally has a "weighty say" from his or her lifeworld perspective. This will be discussed using a hypothetical case by Whitney himself, which he briefly mentions as a possible problem case at the beginning, but does not differentiate further with regard to its conflict potential.

10.3.3 Negotiating relevance and compromise

As we will discuss in detail (§ 17.4) and demonstrate in the practical part with many empirical examples, it is a constant task for both actors in the medical consultation and visit to focus and mark the *relevance of* their opinions and arguments, proposals and rejections, fears and preferences in such a way that this *relevance* is sufficiently perceived and appreciated by the other partner. The extent to which a decision-making situation can be determined by the subjective *relevance of the* patient is illustrated by an initial example by Whitney (2003) (Box 10.11), in which the patient's life-world-oriented *preferences* can obviously come into conflict with *medical necessities*, which different parties may judge and decide quite differently.

Box 10.11 Treatment of hypertension versus preservation of sexual function?

The importance of a decision reflects both medical facts and personal values and may be viewed differently by different parties. As an example, a patient and a physician may disagree about whether it is more important to treat hypertension or maintain normal sexual function. Because the patient's perspective is always at the core of good decision making, physicians are well advised to understand patients' priorities.

Whitney (2003: 276)

Obviously, this is a conflict of maxims that affects a patient's health and, moreover, his or her life in many ways. In a concrete case, many factors go into a possible decision (age, marital status, desire to have children, self-esteem, etc.). Depending on how an individual patient will decide alone or together with their doctor, it is ultimately also a question of the relationship between *quality of life* and *quantity of life* (Gustavsson, Sandman 2014). It is well known that (especially younger) patients are not always willing to limit their current "good" life for a "long" life. Under this aspect, individual patients will develop their own specific preferences based on different *relevance settings,* i.e. upgrading or downgrading, which the physician has to take into account in a joint *negotiation process in order* to reach sufficient agreement in the sense of *Concordance* (§ 10.1.3).

In this negotiation process, hierarchies of evidence, preferences, options, etc. as well as their relative weights can be "discussed" and "deliberated", which can be spontaneously combined with "thinking out loud" without taboos on both sides (§ 10.4.6, 10.6.3). Possibly "compromises" are also possible from the medical side, which the doctor can "offer" to the patient, for example in the case of "mild" hypertension (sport, diet). These compromises can possibly also be linked to a fundamental change in lifestyle, something that has been "under discussion" between doctor and patient for some time (abstinence from nicotine, alcohol, etc.).

All these options for discussion can be quite effective - at least rather than the mere directive *prescription of* a standard medication, which may then be accepted without objection and then (after reading the package insert) not taken or discontinued because of the fear of the "bad" consequences, which would be another case of *non-adherence.* We will come back to this problem in an empirical example of a conversation (§ 19.4), where a patient has already stopped taking the medication (to treat hypertension) because of a feared sexual disorder, but he can openly make this an issue with the doctor.

In the decision-making practice of concrete cases, *flexibility* is demanded of the physician overall (§ 10.7) to weigh and balance the hierarchies of evidence-based treatment options and patient preferences overall together with the patient until a joint decision becomes possible.[2] It must be taken into account that the patient's preferences may in turn themselves be subject to change, be it due to new medical information leading to a new *informed preference,* or also due to their own experiences in the case of severe courses of disease with increased

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[2] Reference can only be made here to typologies of decision-making (according to *severity*, *risk*, *uncertainty in* specific *acute* to *chronic* diseases and their specific treatment measures, etc.) (e.g. Whitney 2003, Whitney et al. 2004, Loh, Härter 2005, Whitney et al. 2008, Lussier, Richard 2008). We will come back to the problems of flexible medical competence in the face of changing information and participation needs (§ 10.7).

risks, etc., which may in any case lead to a different orientation compared to less threatening or burdensome diseases with lower (treatment) risks. Thus, in further *negotiation processes,* there may also be further tests of acceptability (§ 22.4-7), which may lead to a revision or modification until the decision valid for the time being is made again. This does not necessarily require reaching complete ("one hundred percent") agreement, but (in the above sense of *concordance*) (§ 10.1.3) a sufficiently satisfactory agreement, i.e. making a "good" choice insofar as this can also be jointly answered for and supported by both interaction partners.

10.4 Decision models and communication patterns

In research and practice on doctor-patient communication, insights can equally be gained into the connection between relationship and communication design, which are mutually dependent (§ 7.5). Thus, the choice of certain communication patterns depends on the choice of the relationship model to the patient and vice versa. Once a certain relationship model between doctor and patient has been established through the communication between them, change is difficult to achieve because both partners have already "got used to" their specific way of communicating with each other. They then repeat certain communication patterns, such as an *interrogative* pattern (question-answer) versus *narrative* pattern telling-active listening) (§ 9, 19) and thereby perpetuate their type of relationship.

The question of the origin then often turns out to be a chicken-and-egg problem, the solution to which seems idle. Nevertheless, it is usually the doctor who, right at the beginning of the relationship in the first consultation (§ 18, 19), routinely determines the direction in which both conversation partners (should) go with his professional conduct of the conversation. From the result, types of conversations can then be determined in which *power* and *control* over the conversation and the interlocutor can be exercised quite differently. Various basic models and their variants can be distinguished here, which will be discussed below from the aspect of the extent to which they tend to promote or hinder the patient's participation in decision-making.

10.4.1 Alternating models of power and control

In the practice of conversation, what has "always been" practised often prevails because it has apparently "proven" itself. A doctor who decides "a priori" in favour of the paternalistic model of the doctor-patient relationship will hardly be able to understand why verbal interventions by the doctor such as *suggestive questions* (of a certain type) or strict *instructions* or reproving *lectures* or appeasing *trivialisations* or benevolent *(emergency) lies,* which are intended to protect the patient, should be frowned upon as *strategic* action at all (§ 7.5, 10.2, 10.5). Likewise, in a certain sense, the doctor, based on his prior knowledge and experience ("a posteriori") in dealing with patients, often makes a decision in advance regarding the relationship model that should prevail overall or at least be aimed for in the sense of regulative, action-guiding *goal ideas.*

However, a change also took place in the ideas of objectives, which was justified with the social change and not least with the described practical problems of the demonstrably high non-adherence of patients (§ 10.1). In the subsequent reform debates, the pendulum swung from the one extreme of traditional, *doctor-centered* medicine, in which the patient was treated like an "immature child", to the other extreme of *patient-centered* medicine, which was to increase to a service model, in which the patient was to be treated like a "King Customer". Between these extremes, other developments have been initiated in research and practice, which we had previously characterised as *relationship-interaction-* and *dialogue-centered* medicine (§ 7.5), following and extending Beach (2013) and Koerfer, Albus (2015).

This spectrum also includes specific models of decision-making, which will be described here and further differentiated in a pattern analysis. In the pattern analysis we have to make a reduction to three basic models, with which the great variety of models, variants and mixed forms can hardly be grasped, which have determined the discussion of the last decades also specifically on medical decision-making. Thus, distinctions are also made between *four* models (Emanuel, Emanuel 1992, Peters 2015) or *six models* (Kettner, Kraska 2009) or *nine* models (Sandman, Munthe 2010, Sandman et al. 2012). In an initially open list, the following models or model variants can be distinguished:[3]

- Paternalism model
- Deliberation model
- Interpretation model
- Information model
- Business model ("service")
- Prevention model
- Agent model
- Contract model
- Cooperation model ("shared decision making")(SDM)
- Partnership model

etc.

The variety of models is difficult to classify comparatively and to evaluate critically for practice, especially since there are also subordinate and superordinate relationships and mixed forms. For example, the aspect of *deliberation is* described both as an independent model (Emanuel, Emanuel 1992, Kettner, Kraska 2009, Peters 2015) and as a sub-phase in the cooperation model (SDM), the meaning and purpose of which still need to be determined more precisely (§ 10.4.6, 10.6.3). In any case, also in the cooperation model, doctor and patient must first enter into a joint process of "thinking", "consulting" and "weighing" about the "pros and cons" of treatment options in the specific discussion phase provided for this purpose, before they can even make a joint decision in a meaningful way.

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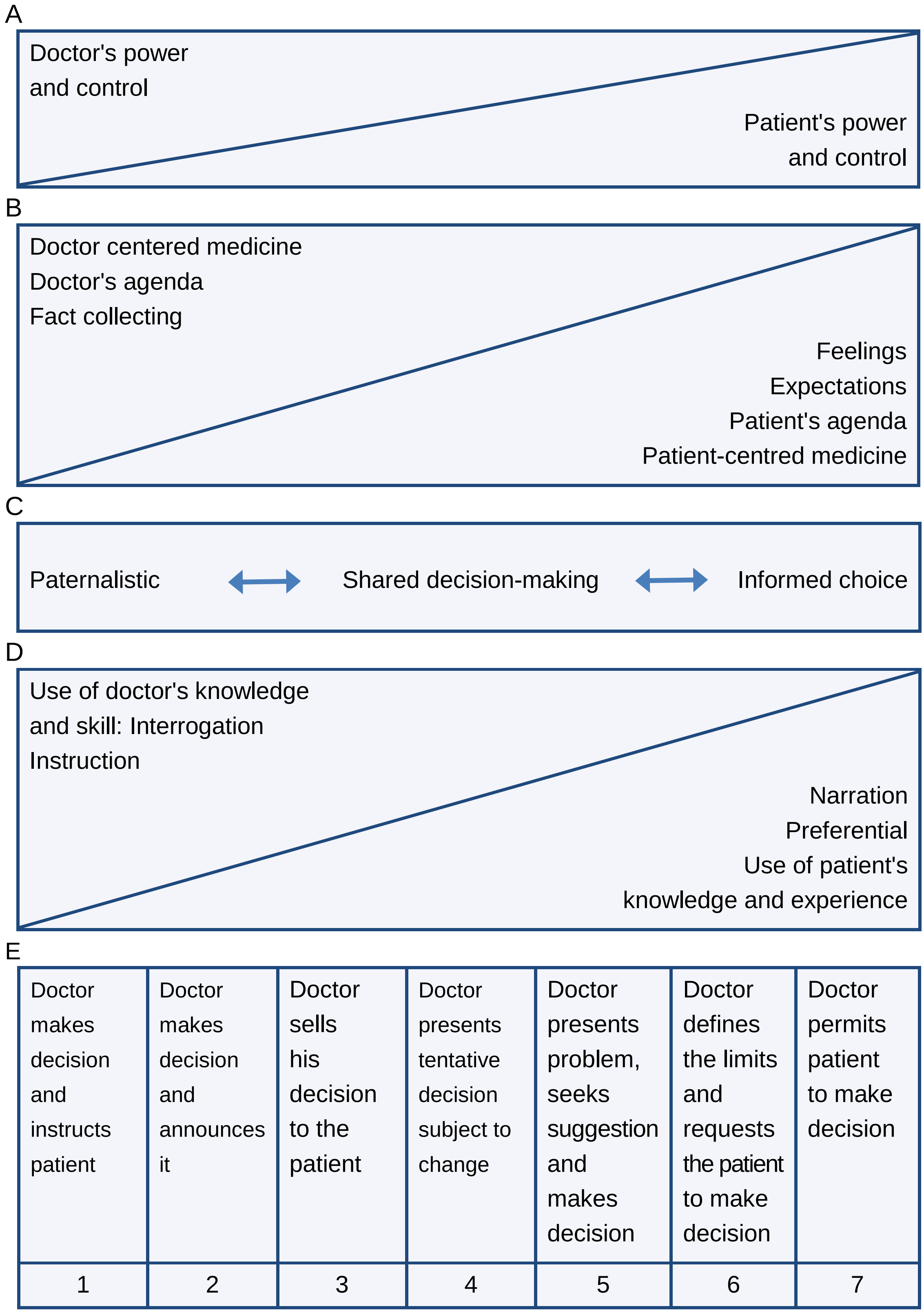
[3] Over a period of five decades, the following works may be cited as examples (sic), some of which we will return to later: Byrne, Long 1976, Pellegrino, Thomasma 1981, 1988, Charles et al. 1997, 1999, Gwyn, Elwyn 1999, Gafni et al. 1998, Guadagnoli, Ward 1998, Elwyn 2001, Scheibler 2004, Elwyn et al. 2005, Härter et al. (eds.) 2005, Makoul, Clayman 2006, Kasper et al. 2010, 2011, Légaré et al. 2014, Koerfer, Albus 2015, Peters 2015, Becker 2015, Hauser et al. 2015, Schmacke et al. 2016, Frain, Wearn 2018, Alheit, Herzberg 2018 (which particularly emphasise differences between "decision-making cultures" (Canada, USA, FRG)). More recent works include: Elwyn, Vermunt 2020, Timmermans 2020, Elwyn 2021, Waddell et al. 2021, Tidhar, Benbassat 2021, Kienlin et al. 2022, Lian et al. 2022, Leblang et al. 2022, Resnicow et al. 2022, Weber et al. 2023, Chmielowska et al. 2023, Lehane et al 2023, Stivers, Tate 2023, Zhou et al. 2023, Giorgi et al. 2024, Xiao et al. 2024.

The newer models meet in the more or less strong rejection of the paternalistic model, in which the traditional, "all-powerful" doctor is allowed to decide and act over the head of his "immature" patient, as it were, for his own good. In contrast, a more or less radical reversal of power and control relationships has been demanded with different emphases, as they can be depicted with gradual characteristics in a *power/control-shift model* (Fig. 10.6, A-E), in which the different communicative forms of participation of doctor and patient can be summarised in a historical-systematic synopsis.

For the (sub-)models of decision-making that move beyond the paternalistic, doctor-centered tradition, it is constitutive that the change in power and control relations between doctor and patient must be associated with a change in both the *content of the conversation* (patient-specific agenda, topics, attitudes, etc.) and the *forms of conversation* (interrogative versus narrative) (Fig. 10.6, A-B, D). However, the extent of the changes remains controversial, even from a higher-ranking, medico-ethically relevant aspect, because, for example, in a pure service model, the patient's gain in autonomy would be "bought" with a loss of autonomy on the part of the doctor, which we will come back to separately (§ 10.6).

In research as a whole, the various possibilities of patient participation in medical decision-making continue to be discussed as competing models of relationships and decision-making. A preliminary (also didactically useful) reduction of the variety of models can initially be achieved by a graduating representation (Fig. 10.7, C, on Charles et al. 1997, 1999, Elwyn et al. 1999, 2005), in which fluid transitions between different types of conversational styles and forms of participation in decision-making can be considered at different levels.



Doctor makes decision and instructs patient	Doctor makes decision and announces it	Doctor sells his decision to the patient	Doctor presents tentative decision subject to change	Doctor presents problem, seeks suggestion and makes decision	Doctor defines the limits and requests the patient to make decision	Doctor permits patient to make decision
1	2	3	4	5	6	7

Fig. 10.6: A-E: Power/control-shift models (cf. Byrne, Long 1976, Pendleton 1983, Elwyn et al. 1999, Charles et al. 1997, 1999, Roter 2000, Tate 2004, Koerfer et al. 2008, Koerfer, Albus 2015, 2018)

According to this graduated presentation, the concept of *Participatory Decision Making* (PDM), which has been known and discussed in the English-speaking world as "shared decision making" (SDM), can be located in a middle position between the two extremes, in which the decision is not made jointly by both partners, but the decision monopoly lies either solely with the doctor ("paternalistic") or entirely with the patient ("informed choice") (Fig. 10.6, C). However, the "golden mean" does not always have to be the "royal road" that should be taken in every case. That the extreme positions ("right" and "left") are by no means obsolete was shown by the above discussion about the model of Whitney and others (§ 10.3), in which the *priority of* the decision could lie with the doctor or with the patient, depending on the degree in the dimensions of *relevance* and *safety.*

In addition, further graduations are also possible between the extreme poles (Fig. 10.6, E), as Byrne and Long (1976) already did in an extremely differentiated way long before the concept of *shared decision making* (SDM). Their early, extensive empirical studies on the conduct of medical conversations already suggest that in the practice of conversations between doctor and patient there are always changes and mixed forms with fluent transitions between different styles of conversation.

From an *evaluative point of view,* this is not only to be judged negatively, but if necessary to be evaluated as a specific competence of doctors who know how to flexibly adapt to the changing information and participation needs of their patients, which we will also deal with separately (§ 10.7).

10.4.2 Methodological problems of the evaluation

Although the concept of "SDM" has been able to establish itself in the current discussion on greater patient participation, it is still in need of clarification, even according to prominent representatives (Charles et al. 1997, 1999, Gwyn, Elwyn 1999, Gafni et al. 1998, Guadagnoli, Ward 1998, Elwyn 2001, Elwyn et al. 2005, 2014, Thomas et al. 2020, Elwyn, Vermunt 2020, Elwyn 2021, Scalia, Durand, Elwyn 2022, Galasiński, Ziółkowska, Elwyn 2023). The need for clarification extends both to *theory*, where the definitions and concepts of SDM are already very heterogeneous (Makoul, Clayman 2006), and to *practice,* where there can be "confusion" in application in everyday clinical practice (Gulbrandsen et al. 2014). The number of studies on the effects of participatory decision-making (PDM) [=SDM] on patient-relevant, disease-related outcomes is also "unsatisfactory", as Hauser et al. (2015) (Box 10.12) summarise in their review of 22 studies:

Box 10.12 Effects of PDM on disease-related outcomes

The authors summarise that the number of studies on the effect of PDM [=SDM] on patient-relevant, disease-related outcomes is unsatisfactory, both in terms of the number of available studies and the quality of the corresponding publications. Although almost half of the studies considered support an endpoint-relevant efficacy of PDM, the results do not currently allow a conclusive assessment of the endpoint relevance of PDM. The consensual standardisation of PDM-promoting measures and corresponding clinical studies is necessary and desirable.

Hauser et al. 2015: 670 (our addition: PDM=SDM)

Despite these *desiderata,* Hauser et al. (2015), in their review of studies on the *effectiveness of* SDM (or PDM), also assume that the concept is now widespread and can certainly be considered the "gold standard". It may be that this *gold standard* itself needs to be reviewed in theory and practice in terms of the extent to which a uniform application of SDM or PDM for all case types and patient groups makes sense or whether a specific, flexible fit to changing conditions and characteristics (age, gender, education, type and severity of illness, etc.) (§ 10.7) needs to be achieved.

In the everyday practice of medical decision-making, further variants and mixed forms may have to be differentiated, if the real doctor's conversation behaviour is not to be recorded as a mere deviation from an "ideal type", but as a flexible adaptation performance of the doctor towards a situational need for information and participation of patients. This individual patient need cannot be stable, but can change over time and especially in the medium of communication with the doctor's interlocutor, to which the doctor must in turn adapt with a specific *fitting competence* (§ 3.2, 10.7, 17.2).

The question of which type of decision-making doctors practise in detail with which partner and for what reasons raises methodological problems that can hardly be solved on the basis of self-reporting and by interviewing the participants alone. As useful and productive as such surveys can be, they are subject to the risk of distorting self-perception and memory, even to the point of self-deception. Here, one can hardly expect reliable answers to questions about what was practised in practice under which conditions in which variants by individual doctors towards individual patients, if *SDM* or *PDM* is claimed as a concept or is only used as a name for practised conversations. To put it bluntly, the question arises as to what is in it where SDM is written on it – or formulated in the rather philosophical title question by Thomas, Kuper, Chin-Yee, Park (2020):

> "What is "shared" in shared decision making?"

This abstract question arises in a similar way if one asks concretely whether the decision was "shared" in this specific conversation between doctor and patient or whether it came about openly through coercion or subtly through manipulation by the doctor. Because interviews and self-reporting by the doctors and patients involved quickly reach their limits here, external observations by third parties are useful (at least as a supplement), either directly from the perspective of a third participant (e.g. as a rating) or indirectly through observation on the basis of (video) recordings, which allow empirical communication analyses that refer to objectively documented, not merely subjectively remembered or reported (but "fleeting") communication. These methodological problems, which concern the data extraction and analysis of verbal and non-verbal communication in *face-to-face situations* (Winkler 1981, Edwards, Lampert 1993, Flick et al. 2000, Gee, Handford 2014) (§ 12, 18, 25), will be discussed in more detail in the evaluation section of the handbook (§ 40-43). Here, the approach of a *comparative pattern analysis* of communicative action will first be described and applied, with which the different models of decision-making can be critically compared.

10.4.3 Comparative pattern analyses

The specific differences between cooperative or partnership-based decision-making (in the sense of SDM or PDM) and alternative forms of decision-making ("paternalistic" and "informed choice") must not only be postulated at the model level, but also analysed at the communication level in order to be able to identify them in empirical decision-making. For the empirical analyses of conversations, as they will be carried out later in the practical part of the *Cologne Manual* (§ 18-23), the *comparative* aspects should be listed here in a tabular overview (Tab. 10.1), under which authentic conversations between doctor and patient can be comparatively examined in a *pattern analysis of communicative action.*[4]

In this pattern analysis, in view of the described multitude of models and their variants (for didactic and methodological reasons), a *reduction* to three basic models is made, which can also be cancelled again if necessary, if a mixture of elements from different models or their variants should emerge for certain conversations.

On this premise, three basic models of decision-making (*paternalism*, *SDM*, *service*) are first distinguished, each of which is differentiated in its *ideal-typical* course according to three communication functions (*information*, *decision*, *responsibility*). These three communication functions are usually perceived in successive conversation phases, but can also be realised circularly in feedback loops, for example when a patient asks information questions again in the decision phase of the cooperation model and thus initiates a return to the information phase that seemed to be already completed.

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[4] The pattern analysis does not happen without presuppositions, but on the one hand it follows theoretical insights (as here from medical ethics, discourse ethics or social and communication research), which on the other hand it verifies in the empirical analysis and revises if necessary. Cf. on the method of a discourse-linguistic pattern analysis Ehlich, Rehbein 1986, especially on a comparative approach in the analysis of institutional communication Koerfer 1994/2013 as well as on diagnostic communication and decision-making the preliminary work of Koerfer et al. 1996, 2005, 2008, Köhle et al. 2010, Koerfer, Albus 2015.

	Paternalism	Cooperation (shared decision)	Service (informed choice)
Ethics	Authoritative ethics	Ethics of discourse	Libertarian ethics
Relationship	doctor-centered	relationship-centered	patient-centered
Physician role	Guardian, Samaritan, Father	Partner, Consultant	Service provider, Seller
Patient role	Needy person; child	Partner, client	Consumer, customer
Topic focus	biomedical	biopsychosocial	biomedical
Strategy/ Attitude	Coercion → Obedience	Dialogue → Conviction	Manipulation → Persuasion
Direction	("one way") D → P	("two way") D ↔ P	("one way") P → D
Evidence (DC)	yes	yes	no
Preference (PZ)	no	yes	yes
Transparency	no	yes	no
Information	Monologue	Dialogue	Interrogation
	Selective mediation and reception of information	Sufficient knowledge exchange and mutual understanding	Selective knowledge acquisition through question-answer patterns
Decision	Instruction	Deliberation	Suggestion
	Order or prescription according to medical prefix	Negotiation of evidence- and preference-based options	Advertising and contracting, supply and demand of options
Responsibility	External control by D	Joint control	Self-control of P
	Tendency towards self-sufficiency of D with loss of autonomy of P	Tendency towards mutual trust with autonomy on both sides	Tendency towards self-sufficiency of P with loss of autonomy of D

Tab. 10.1: Comparative representation of three basic models of medical decision making (mod. according to Koerfer, Albus 2015: 121)

As we will see, the three communication functions (information, *decision*, *responsibility*) can be perceived quite differently in practice depending on the decision-making model, which is why a later change to another model is often made more difficult (§ 10.7). A patient who was initially only informed about the "bare essentials" according to the paternalism model would later not be sufficiently competent for qualified participation in decision-making in the cooperation model due to his lack of information.

These phase-specific differences are to be worked out in detail on the basis of the comparative *pattern analyses of communicative action*. For this purpose, the pattern analyses make use of flow charts, which can be used to depict the ideal-typical conversation processes for the basic models (paternalism, cooperation, service) (Fig. 10.7-10.9). Further model variants (contract, information, prevention, agent model, etc.) as well as mixed forms can then be derived downstream from these basic models, as can the specific cases of decision-making between doctor and patient in which a change of model is initiated by one of the two partners.

We will go into such particularly interesting cases of model change in detail in the manual-guided practical part IV (§ 18-23), in which the communicative transfer performances of medical action are to be worked out. For example, in an example documented in detail with transcripts, we will show how the doctor finally transfers a request initially presented by the patient in the service mode ("diabetes type 1 ... desired change to pump") (§ 22.5) into a cooperation model.

10.4.4 Paternalism and authoritative ethics

In the tradition of the *paternalistic* model, which is still completely committed to *Hippocratic virtue ethics*, the doctor is characterised by special functional and personal *qualities*. These include the doctor's helpfulness and altruism as well as his authority and expertise. These positive qualities are usually well accepted by the patient because they are thoroughly appreciated. The traditional role expectations correspond here with the *complementary* roles of doctor and patient, as already described by Parsons in his early writings on the doctor-patient relationship (Parsons 1951/1970, and 1964/1970). It is precisely the special characteristics of the doctor, which consist in the acquired or ascribed authority and professional competence, that entitle him to decide in the *best interests* of his patient, in the sense of a maxim that *guides* his *actions* ("doctor knows best").

As we will see in particular with examples from ward round communication (§ 25), the doctor in the paternalistic model can also make his decision "over the patient's head", which can have various reasons (§ 10.5). On the one hand, the doctor may act in this way out of convenience, assuming a supposed *economy of* sparing information; on the other hand, motives of *sparing* may play a role, which may be done with the best of intentions if the doctor seeks to relieve his patient of further information and decisions. In serious cases of illness, for example, the doctor can claim the so-called *therapeutic privilege* by withholding the full truth from the patient in need of sparing (Beauchamp 1989, Wolff 1989, Veatch 1991). The degree of information required is here determined entirely at the doctor's discretion, without the patient being able to "have a weighty say" in the dosage of information (§ 10.5).

In such cases of *strong* paternalism, characterised by an extreme *lack of transparency* (Brody 1989, Koerfer et al. 1994, Robins et al. 2011, Braddock 2012) (§ 10.5.3), communication with the patient can be quite simply structured (Fig. 10.7). The doctor shifts to the *quasi-monological* model of a "*one-way* communication" (Charles et al. 1999, Langewitz 2002, Lee, Garwin 2003, Elwyn et al. 2005). In principle, there is no room for *dialogue* communication, in which questions or objections would be commonplace. Thus, the patient's "refutations" would rather surprise and be interpreted as doubts about the medical authority of the doctor, who would have to deal with the "unreasonableness" of his interlocutor in a *lecturing manner.*

In contrast, in the expected and practised normal case of the paternalistic model, the positions of the flow pattern (Fig. 10.7, positions 1-7) can be passed through more or less *monologically-linearly*. What all the remaining communication variants have in common is that the doctor has already made a *solitary* decision beforehand qua *competence* without the patient, which now only has to be communicated more or less explicitly to his counterpart so that the latter does what he has been told.

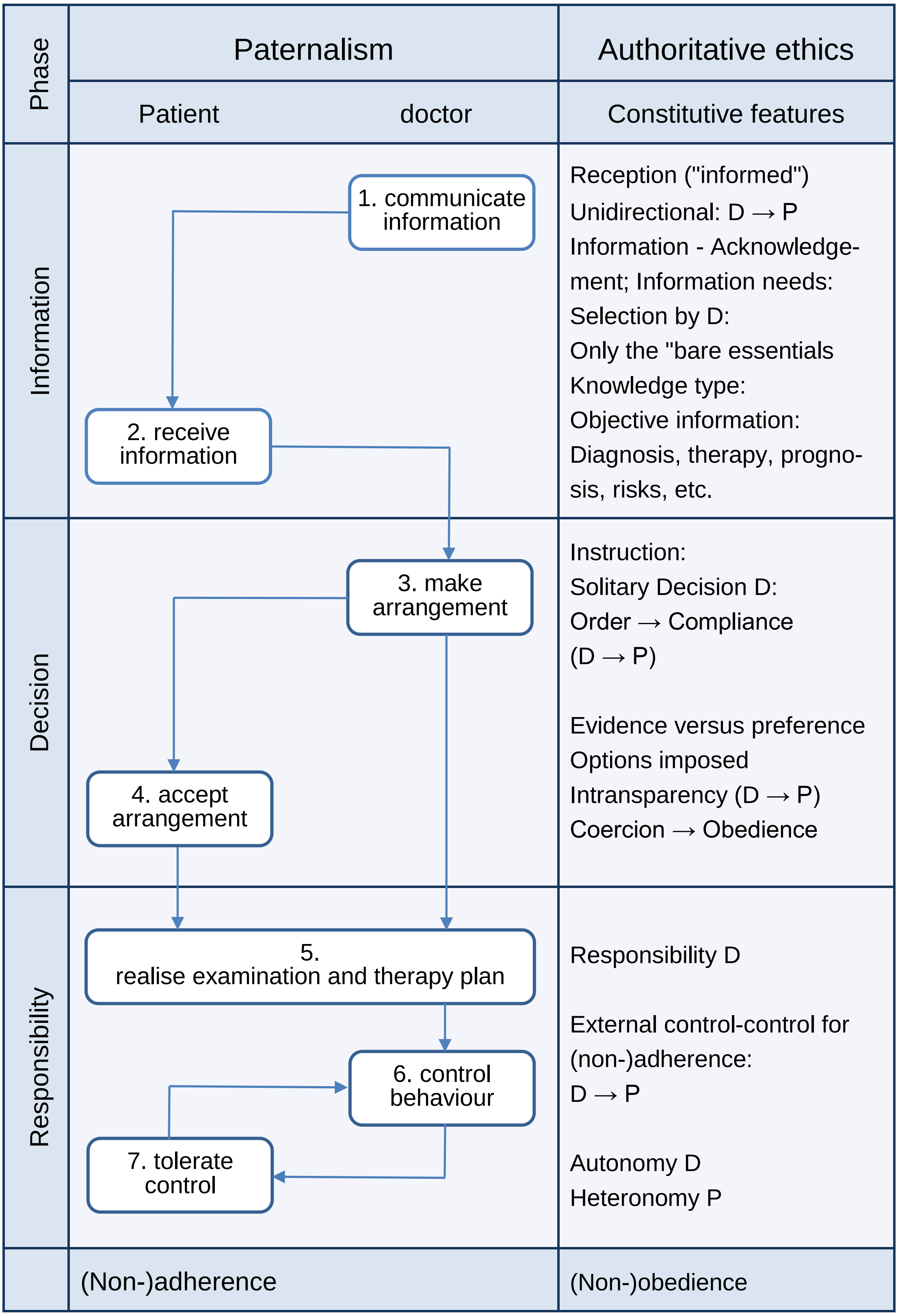


Fig. 10.7: Communication pattern for paternalism model

The predominant communication pattern in paternalism is the *instruction,* which should be followed "without ifs and buts" (position 3). The flow of information necessary for this is primarily from the doctor to the patient. Information of various kinds (diagnosis, prognosis, therapy) must only be *communicated* by the doctor (position 1) and *understood* by the patient (position 2) to the extent that this appears necessary to follow the orders and prescriptions (positions 3-4), in order to fulfil the conditions for subsequent adherence in the implementation of the further examination or therapy plan (positions 5-7). As a type of knowledge transfer, the mere knowledge of *objective, biomedical data* is often sufficient for this purpose, which in a sense of education that is only legally relevant is the prerequisite for formal consent ("informed *consent*"), which in empirical cases often turns out to be *pseudo-consent* (§ 10.7.2).

In the case of a possible *non-adherence of* the patient, the doctor would only have something to "reproach" himself with if he had obviously not "conveyed" the information in question ("sober", "3 times a day", etc.) clearly enough, which could be the only remaining "omission" from his point of view. All other motives and reasons for the patient's non-adherence would be the *responsibility* of an obviously "unreasonable" patient, who could at best be "helped" with a repeated "instruction", which would amount to a repetition of what has already been said "in clear words" - beyond all doubts and objections that the patient could assert from his lifeworld perspective (§ 10.2, 10.3.3).

In the case of *strong* paternalism, even in the case of repetition, only what the doctor considers relevant in the context of his order and prescription can be made an issue. The doctor assumes *sole responsibility* for the *order* or *prescription* itself as well as for the patient's *control,* which the patient has to *tolerate* (position 5-7). The patient may initially perceive this assumption of responsibility by the paternalistic doctor as a relief. The relationship, which is mostly characterised by a strong *dependence* of the patient on the doctor, may well develop in a *personal* and *trusting way* in the sense of the Hippocratic virtue ethics outlined above.

In any case, this relationship of trust can remain until the patient has to fear the doctor's *external control* because of his possible *non-adherence,* because he might have to break a taboo and reveal the "real" reasons for his "misbehaviour". Then the previous trust, which may only have been "blind" and not "acquired" or "*earned"* trust (Braddock 2012), could turn into mistrust, which often leads to a de facto change of doctor ("doctor shopping") on the part of the patient. This act of separation would then be the remaining activity potential of a hitherto *passive* patient who has merely endured medical control. The viability of a complementary relationship, which in the context of an *authoritative* ethic is essentially determined by the communication pattern of the doctor's *instruction,* obviously experiences its limits where the intended *obedience* of the patient as a corresponding attitude fails to materialise or is terminated.

10.4.5 Service and libertarian ethics

The extreme *opposite* of the doctor-centered paternalism model is the patient-centered *service model*, in which the patient visits the doctor as a pure service provider, possibly with the intention of being treated by him as "King Customer". Doctor and patient then meet as in a *business model* as seller and buyer for the free exchange of goods, to which the consumer attitude of the patient can invite just as appropriately as the supply behaviour of the doctor.

An extreme variant is represented by the *prevention models* in which doctor and patient do not enter into a supporting relationship. Rather, the visit to the doctor is ascribed roughly the same status as sport, with the same function of self-help (Pellegrino, Thomasma 1988). Such models can hardly be claimed for the health system as a whole, but at best can be applied to partial areas in which certain selective health services are offered as advertised health programmes (*wellness, fitness*) and consumed accordingly by healthy or sick people. This consumption is not least associated with the risks of *non-evidence-based* services (§ 10.3), as is the case with certain individual / self-paid health services offers by doctors.

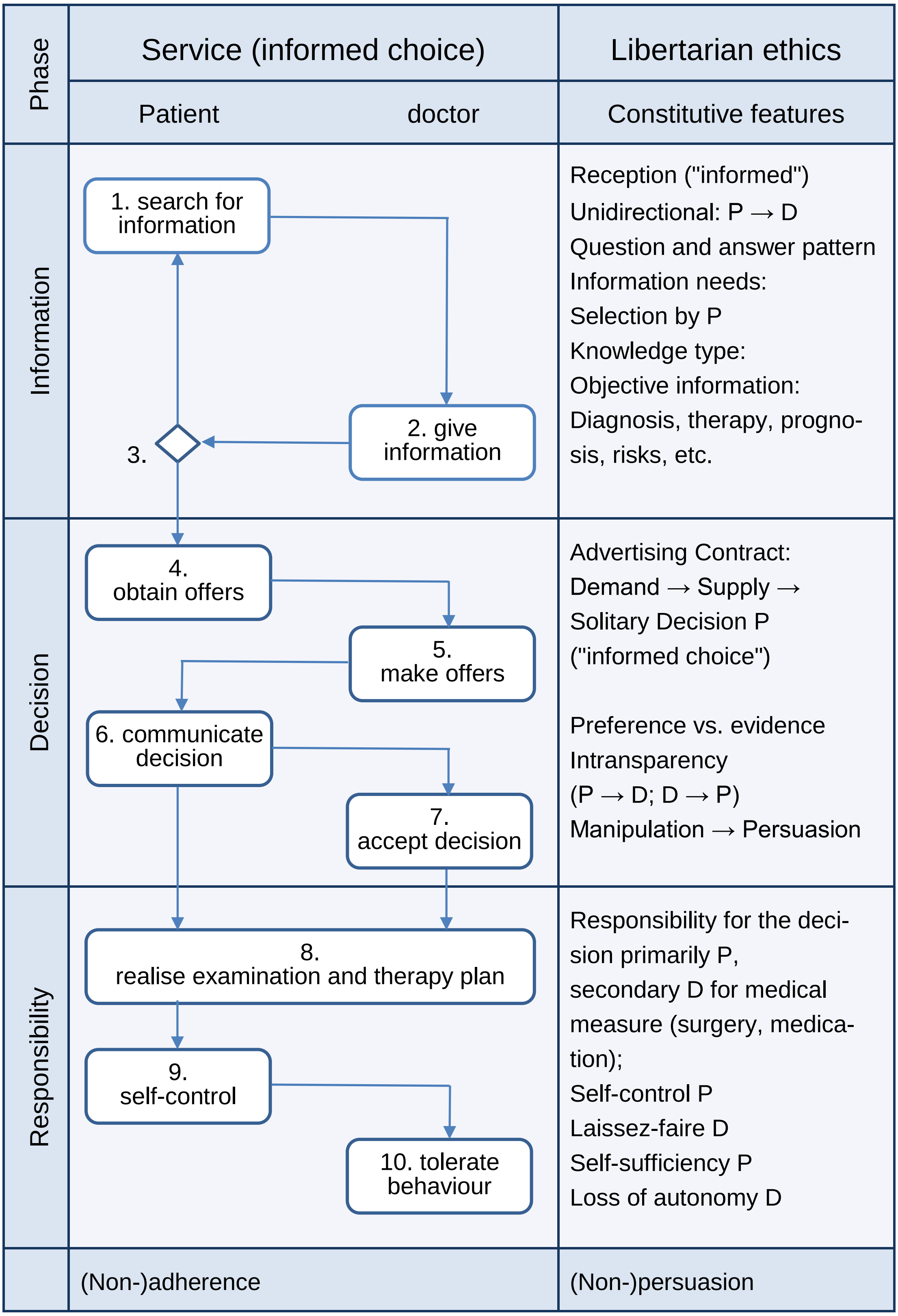
In order to avert the potentially negative consequences of a merely market-based exchange relationship between doctor and patient, which is regulated by supply and demand, protective and guarantee regulations are also made in the health sector, analogous to commercial law according to the *contract model,* with which medical encroachments, abuses, mistreatment, etc. are to be prevented.

Despite all the preceding or subsequent *advertising,* service models are ostensibly characterised by the fact that the action and topic initiatives essentially come from the patient (Fig. 10.8, position 1). The patient consults the doctor as an *expert* in order to immediately obtain the necessary information that he, as a patient, considers relevant in a preselection in order to prepare his decision, whereby he finally decides himself on the type and extent of the information that the doctor gives (position 2) (decision node in position 3). In this role as *initiator* of topics, the patient steers the interaction through the *pattern* of questioning and asking until the recurring account points, at which he ends the expert's questioning or continues in new information loops, depending on saturation or need for information.

The decision-making phase (position 4-6), in which the patient takes the initiative to obtain treatment offers with which the expert can serve, proceeds in the same way. The expert's expertise may or may not be taken into account if the patient continues the information and decision-making process outside the discussion with other experts or using other, interactive media (internet). The decision itself can in principle be made by the patient alone and merely communicated without further justification to the doctor (position 6), who has to accept it to a large extent (position 7), provided that the subsequent treatments do not substantially violate legalistic regulations in the above sense of the *contract model* or elementary *evidence-based* standards (§ 10. 3) of the medical profession.

In this entire information and decision-making process, the doctor apparently remains in a merely *responding* role without being formally and substantially involved in this process. Both directions of the interaction are determined by *intransparency*, because the two interlocutors only inform each other to a very limited extent about the "true" motives and reasons for their actions. Overall, the relationship between doctor and patient remains *impersonal* to *anonymous*. In the sense of a *libertarian* ethics ("laissez-faire"), which is only limited by *legalistic* ethics according to the contract model (Pellegrino 1989), the doctor meets the patient with *indifference* rather than with a personal commitment under high co-responsibility.

The responsibility for his *autonomously* made decision is borne solely by the patient, who can therefore not hold the doctor to account any more than for the control of his own, possibly non-adherent patient behaviour, which the doctor in turn has to accept (positions 8-10). Here, the patient's *autonomy* can be increased to the point of *self-sufficiency* by making him independent of the doctor and his influence on the decision.



Phase	Service (informed choice)		Libertarian ethics
	Patient	doctor	Constitutive features
Information	1. search for information 3.	2. give information	Reception ("informed") Unidirectional: P → D Question and answer pattern Information needs: Selection by P Knowledge type: Objective information: Diagnosis, therapy, prognosis, risks, etc.
Decision	4. obtain offers 6. communicate decision	5. make offers 7. accept decision	Advertising Contract: Demand → Supply → Solitary Decision P ("informed choice") Preference vs. evidence Intransparency (P → D; D → P) Manipulation → Persuasion
Responsibility	8. realise examination and therapy plan 9. self-control	10. tolerate behaviour	Responsibility for the decision primarily P, secondary D for medical measure (surgery, medication); Self-control P Laissez-faire D Self-sufficiency P Loss of autonomy D
	(Non-)adherence		(Non-)persuasion

Fig. 10.8: Communication pattern for service model

In doing so, the patient's interests and preferences may be hypostatised in such a way that the patient's *gain in autonomy* is "paid for" by the doctor's *loss of autonomy (*v. Uexküll 1993, Quill, Brody 1996, Sandman, Munthe 2009, Sandman et al. 2012), which will be discussed in more detail (§ 10.6.1) from the perspective of medical ethics and discourse ethics.

All in all, the *libertarian ethic*, according to which almost "anything goes" that is not explicitly "forbidden", is associated with tendencies towards a medicine *of convenience,* in which the doctor's offers of examination and treatment are oriented exclusively to the demand of patients. In this *service model of* medicine, both sides more or less consciously take the risks of mutual *manipulation*, the result of which, as in advertising, is *persuasion.*

The patient's lack of *conviction,* which is due to the lack of dialogue-based information and argumentation by the doctor (§ 10.5-7), can lead directly to the patient's *non-adherence, as in the* paternalism model and also in the service model. Here, as there, there is the *pseudo-solution of* frequent changes of doctor ("doctor shopping"), of which the *consumer-oriented* patient is likely to make even more use than the merely *obedient* patient.

10.4.6 Cooperaton (SDM) and discourse ethics

In contrast to the *authoritarian prescription practice* in the paternalistic model, in which an *obedient* patient has to follow the doctor's *instructions* without contradiction, and the *libertarian offer practice in* the service model, in which the *consumption-oriented* patient can use the medical services as he or she pleases, the cooperation model (SDM) is essentially based on the pattern of negotiation between *unequal* but *equal* and *equally rational* partners (§ 7.5, 10.6). Despite all the asymmetries inherent in the "therapeutic alliance" between unequal partners, they nevertheless meet "at eye level" in conversation in order to jointly negotiate what is *best* for the partner "in need of help".

The concept of *negotiation*, as introduced earlier as a dialogical process of understanding (*concordance)* (§ 10.1), has been systematically established in a long tradition in the social sciences (Strauss 1978), which has since been continued in medicine through multiple applications (cf. Stewart 1984, Fisher 1984, 1986, Fisher, Tod 1983, 1986, Roter, Hall 1992/2006, Lazare 1995, Gwyn, Elwyn 1999, Elwyn 2001, Pollock 2005, Stivers 2006, Sandman 2009, Sandman, Munthe 2010, Labrie, Schulz 2014, Giorgi et al. 2024). With the concept of *negotiation,* medical decision-making also always assumes the possibility of controversial initial differences resulting from the participants' different knowledge, opinions and attitudes. These initial differences can only be overcome through mutual discursive engagement of the interlocutors in order to finally arrive at a common solution to a problem that is recognised as common and which is finally to be overcome through jointly decided action.

The interlocutors in the consultation are also alternately dependent on this discursive engagement if they finally want to come to a *joint assumption of responsibility* for a *joint decision.* For this purpose, the *lifeworld* perspective must first have been successfully mediated with the *medical* perspective in a dialogue between doctor and patient (§ 10.2). In this context, the *previous history* between doctor and patient must always be taken into account, which is always already present as a common communication history and must be recalled if necessary, for example by the doctor drawing up an interim balance in the form of a résumé at the beginning of the decision-making phase (anamnesis, diagnosis, examination, therapy problem, etc.). Only on the basis of this shared knowledge can decision dialogues build up in a thematically meaningful way.

Although Elwyn et al. (1999) rightly lamented a "neglected second half of the consultation" in the context of research on decision-making, this second half always presupposes a first half, on the basis of which decision-making processes can only be meaningfully initiated in the first place. Conversely, to "neglect" this first half in decision-making would be to ignore the achievements in understanding already made by the participants in such a way that the second half would remain without sense and reason. A decision-making dialogue cannot therefore be started without preconditions, but must always be appropriately connected to known problems, tasks, goals, etc., through which the overall perspective of joint decision-making and action can only be meaningfully opened up.

Already during the first information exchange, in which the doctor inquires about the patient's *prior knowledge* if necessary (Fig. 10.9, position 1), both participants can both offer and ask for further information (positions 2-4). At the two decision nodes (diamonds) they are each able to return to the information phase as needed (positions 5, 7).

After a sufficiently saturated *exchange of information,* the *options for action (*position 6) as possible alternatives in relation to the patient's preferences (position 8) are subjected to a joint *evaluation* (positions 10) before the examination or therapy plan (position 11) can be realised by *consensus*.

Before this occurs, the decision-making phase (positions 7-10) is first determined by an open-ended process of *deliberation* (§ 10.6.3) (Charles et al. 1999, Sandman, Munthe 2010, Munthe et al. 2012, Labrie, Schulz 2014, Han et al. 2014, Elwyn et al. 2014). In this process of deliberation, which is best carried out in the form of spontaneous, "thinking aloud" (§ 10.6.3), preferences and dispreferences, arguments and counter-arguments, but also fears and hopes are exchanged in order to critically weigh the "pros and cons" of treatment alternatives from different lifeworld and medically relevant perspectives in the joint *consultation*. In the process, both partners can mutually steer the conversation via *dialogue* feedback loops at many decision nodes (diamonds), of which only a few are highlighted here as examples for reasons of reduction (diamonds 5, 7, 9).

In this way, both partners can move the conversation in one direction or the other, i.e. before a current decision is made, they can also revisit and evaluate earlier preferences of the patient that may have already been revised.

Likewise, the partners can return to the information mode if necessary because, for example, the course of the disease has changed in the meantime and a re-evaluation is therefore necessary, in which not only the *objective* "facts" but also the *subjective* experience of the disease are taken into account. As we will discuss in detail using an empirical example, uncertainty can also arise when decisions that have already been made are *put up for discussion* again. What then stands up to critical scrutiny can remain all the more certain because it was chosen again with "prudence" (§ 22.6). Under certain circumstances, decisions may have to be delayed or even "postponed", if this is possible according to the evidence-based "state of affairs", until the information and opinion-forming process has been completed to such an extent that a decision can be taken jointly and "finally" *ratified* (position 10).

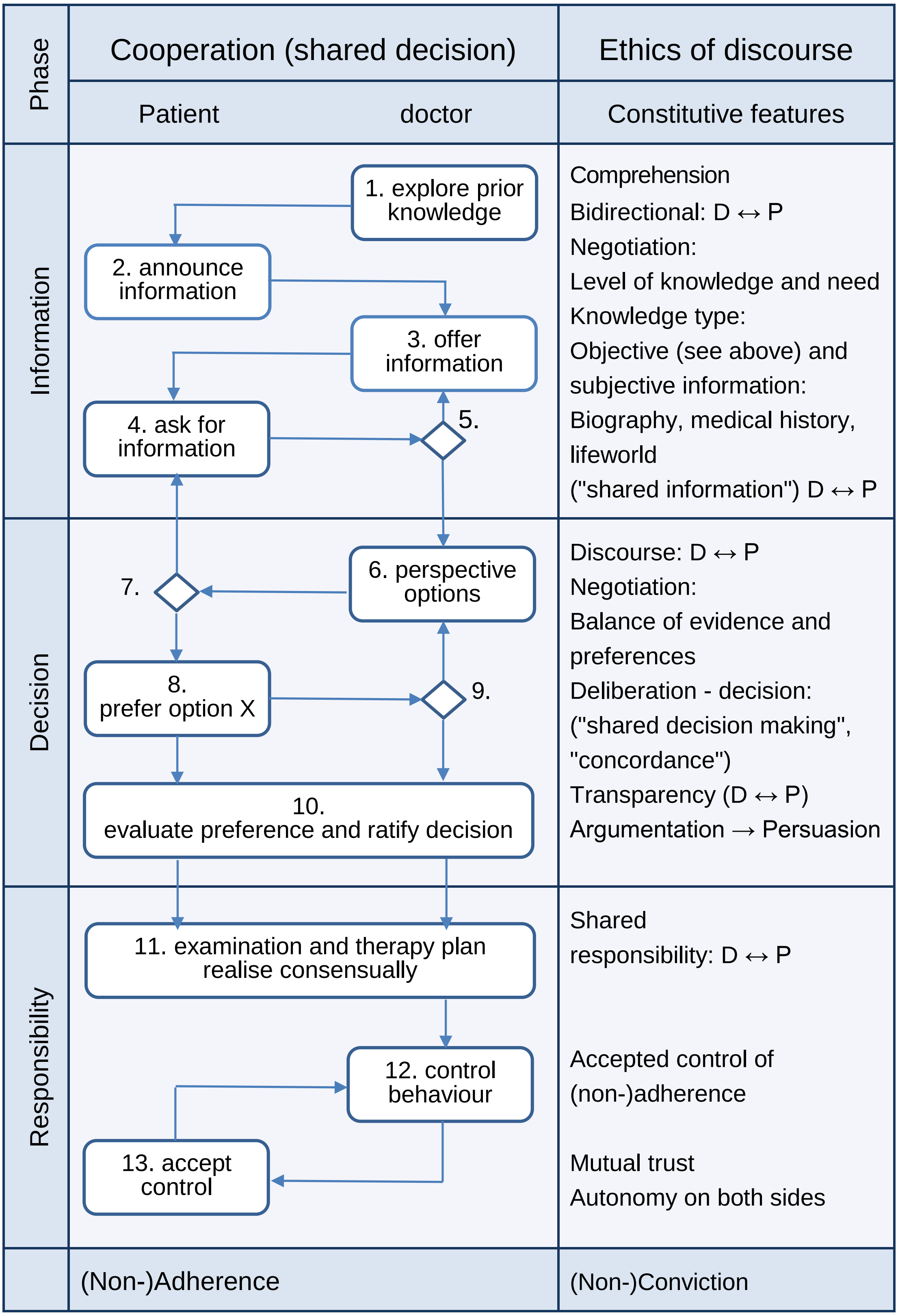


Fig. 10.9: Communication pattern for cooperation model

However, not all possible alternatives in the sense of *libertarian* ethics can be included in this decision in the cooperation model, but only those treatment options that can stand up to the standards of *evidence-based medicine*, which is a necessary condition for the simultaneous *assumption of responsibility* by the doctor (§ 10.3). Although this may rule out a number of patient preferences from the outset, the patient may nevertheless develop preferences according to his or her individual life and value history that may conflict with the doctor's "best" recommendation (*surgery*). On the other hand, the doctor may well agree to what he considers a "second-best" patient choice (*conservative treatment*) as well as a "third-best" choice such as "watchful waiting" (Elwyn et al. 2005, Epstein 2013, Hausteiner-Whiele, Henningsen 2015), provided that the patient's preferred (treatment) option can be justified within the framework of evidence-based medicine. In the end, the negotiation process in decision-making between doctor and patient does not require complete ("one hundred percent") agreement, but only a decision that is *sufficiently acceptable* to both partners.

In the cooperation model, both partners are ultimately the winners: due to the prevailing *principle of transparency*, which is constitutive for the doctor-patient relationship in the sense of *discourse ethics* (§ 7.5, 10.5), the doctor does not have to hold back with his professional knowledge as well as his personal experience and opinion, especially if he is explicitly asked about it ("Doctor, what would you do in my place?"). The discursive engagement of the doctor serves to promote patient autonomy insofar as the ultimately valid *convictions of the* patient, in the sense of an increase in competence, can only emerge and stabilise in processes of dialogue and negotiation. In this way, patient autonomy can be optimally promoted in the cooperation model without endangering the autonomy of the doctor (§ 10.6), who can continue to act in accordance with the evidence-based standards of his profession.

In the still possible case of non-adherence, the patient does not have to fear the control, but can accept it in his or her well-understood self-interest (position 12-13). According to the mutual readiness for a "real" conversation (§ 7.5), the patient can make his "misbehaviour" an issue without taboo. The open "discussion" of problems does not call the relationship into question, but only poses new challenges that require modified decisions to improve the patient's adherence.

Although this goal of adherence is pursued to a greater or lesser extent in all basic models, they differ considerably in the way in which the path to the goal can be achieved and the intended behaviour of the patient can also be perpetuated. The differences described will be summarised again in an evaluative comparison (Box 10.13) by bringing the extreme typological characteristics of the three basic models to the respective denominator.

Box 10.13 The three basic models in evaluative comparison

In the *cooperation model of* the doctor-patient relationship, both participants in the interaction meet as *partners* whose perspectives of participation, despite all their differences, are intertwined in the *reciprocity of the* insight that one partner cannot succeed without the cooperation of the other (Veatch 1991). In contrast to a merely *strategic* use of language in both the *paternalism model,* in which the patient's *obedience* is to be achieved through coercion and threat, and the *service model,* in which the patient's consent is to be obtained as *persuasion* through advertising and manipulation, the cooperation model relies exclusively on *persuasion through communicative action*, in which a joint decision is sought by virtue of *good reasons.*

Koerfer et al. 2008: 148

Although examples of extreme paternalism, for example, can certainly be found in the visit (§ 24), the three basic models can hardly be consistently realised in "pure culture" in the practice of decision-making. Rather, different variants and mixed forms are to be expected, which can be practised not only for the sake of convenience or habit, but also for *good* reasons.

10.4.7 Variants and mixed forms of decision-making

The three basic models of decision-making described above (*paternalism*, *service*, *cooperation*) represent *ideal types* that can experience many variants and mixed forms in the discussion practice of doctors in their communicative dealings with their individual patients. This is certainly also related to the changing information and participation needs of patients (§ 10.7.), to which doctors have to adapt *flexibly*.

The choice of the decision-making model ultimately practised must always be interpreted as the result of the negotiation process between doctor and patient, in which specific opportunities for participation can be opened up or blocked. The spectrum of participation opportunities can also vary between and within the basic models, as already suggested by the early differentiation of Byrne, Long (1976), according to which seven types of decision-making can be distinguished in a gradual representation (Fig. 10.6, E). As already mentioned at the beginning, beyond the three basic models, current discussions also differentiate between four, six or even nine models (Emanuel, Emanuel 1992, Kettner, Kraska 2009, Sandman, Munthe 2010, Sandman et al. 2012, Peters 2015). It is certainly debatable whether these are independent models or variants.

Thus, we can already distinguish between different forms of *weak* to *strong* paternalism, which we can encounter both in information (§ 10.5) and in decision-making (§ 10.7). *Strong paternalism* is characterised by simply being *imposed* without the patient's consent, without the patient being asked or even having to agree. There is no question of negotiation in strong paternalism. In contrast, in *weak* paternalism the authority of the doctor can be more or less explicitly requested by the patient ("You decide for me doctor", Guadagnoli, Ward 1998, Kampits 1996). Such a *declared* renunciation of communication with delegation of responsibility can more or less accommodate the *paternalistic* attitude of the doctor, so that a kind of "unholy alliance" could also arise, which should certainly be viewed critically (§ 10.7), although it can initially proceed harmoniously.

Further (sub-)types of decision-making can also be differentiated on the other side, where the service model ("informed choice") can occur in more or less *strong* forms. As already explained (§ 10.4.5), a *contract model* is required here for control in order to contain the worst consequences of a mere market orientation of both partners. In the extreme information model, the main issue is the strong perception of patient autonomy, with which the tendency towards autarky already described above can arise. Here, there is a danger that the information desired by the patient will remain inappropriate because the doctor cannot tailor it to the patient due to a lack of individual knowledge about the patient as a person.

But even if the patient were to disclose more personal information about himself for better coordination with the doctor, the following would still apply: "information sharing does not necessarily lead to a sharing of treatment decision-making process" (Charles et al. 1997: 683). A *separation of information and decision-making process* can thus be maintained here, whereby the information process, according to

Charles et al. (1997), can even be taken over by *interactive media in* extreme cases.

However, this bears the well-known risks of abbreviated patient information (§ 10.5), because even the best interactive medium cannot replace the personal conversation with the doctor, but only supplement it, which is still made a special topic in fields of action in *surgery* (§ 39). According to Frosch and Kaplan (1999), with or without media, the variant of the pure information model for the doctor runs the risk of ultimately being reduced to the role of a mere “broker of information", who thus risks losing his original medical care functions.

The agent model occupies a specific *hybrid position* between paternalism and the information *model.* Here, the doctor makes the sole decision on the basis of mutual information, for which he also bears sole responsibility, as in the paternalism model. However, the doctor first makes himself a personally committed agent of the patient in a special way by deciding for him as his authorised representative after an optimal exchange of information ("shared information"), i.e. behaving as if he were himself in the patient's individual decision-making situation (Gafni et al. 1998). In the case of a sufficiently empathic assumption of perspective by the doctor, the patient can expect an optimal decision for him by the doctor as a "perfect agent", which, however, he has not made himself.

In addition, variants of double-agency (Rochaix 1998) are also discussed, in which the doctor acts not only as the personal agent of the patient, but at the same time as the representative agent of public interests. Here, the doctor is guided not only by the individual interest of his individual patient, but at the same time by general criteria of *distributive justice* and *social compatibility* as well as by his specific *evidence-based* professional standards. Possible conflicts are obvious here, but cannot be avoided anyway. Here, the dangers of so-called *neopaternalism* must be reckoned with (Feuerstein, Kuhlmann 1999), in which the social or merely insurance interests of *third parties* (e.g. cost factor) can assert themselves *behind the* patient's *back* against his personal interests.

Ultimately, the doctor can only counter such a *conflict situation in the* sense of *discourse ethics by* strictly adhering to the *transparency requirement* (Brody 1989, Koerfer et al. 1994, Robins et al. 2011, Braddock 2012) (§ 7.5, 10.5). According to this, the (reasons for the) limitations of the patient's interests are not withheld *covertly-strategically* in the sense of *manipulation,* but are *recognisably* disclosed in dialogue with the patient as part of patient education. The fact that *communicative* action, which uses arguments to reach an *understanding, does* not always have to lead to the desired result, has been and continues to be a constant theme, not only in medical decision-making. As in other areas of life, there is not always just the "better" argument, which we gladly follow because we are convinced, in the sense of Habermas (§ 10.6.2), but often "equally good" arguments that make the decision so difficult for us.

10.5 The art of medical education

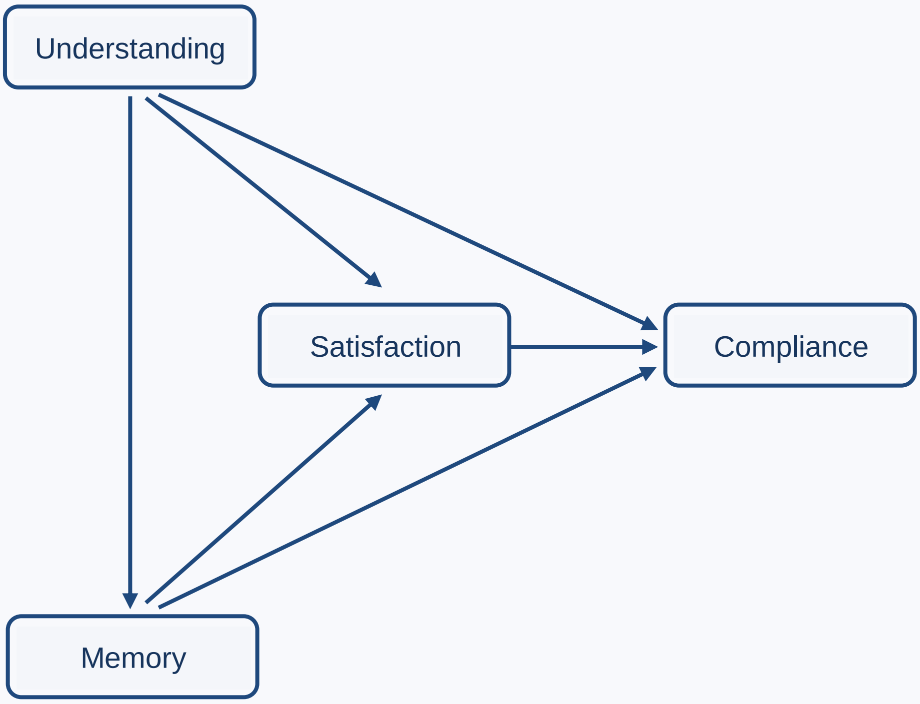
As explained above, the well-informed patient is the very first prerequisite for his or her qualified participation in medical decision-making. It is the task of the physician to qualify him sufficiently in this respect, and he must proceed in a patient-oriented manner during the *information process.* The imparting of knowledge that the patient must have in order to be able to competently "have a say" in the decision-making process must be designed in such a way that integration into the patient's previous knowledge of the world is possible, taking into account his or her personal *cognitive* and *emotional* receptiveness. To repeatedly sound out the individual limits of what is "reasonable" in conversation with the patient and, if necessary, to readjust them, is a challenge to the *art of conducting medical conversations* (§ 17), in which the doctor often has to master the cliffs between *under-* and *overtaxing the* patient. Here, the doctor should have the necessary competence to *dose* information in a similar way as he or she competently deals with the *dosage* problem with individual patients in other medical actions, while maintaining the *principle of transparency in* communicative action.

10.5.1 Understanding, remembering, satisfaction and adherence

To begin with, in order to demonstrate the immediate consequences of a lack of communication between doctor and patient, the explanatory model that one of the pioneers of doctor-patient communication, Philip Ley, presented and explained in a simple diagram (Fig.10.11) (1980, 1983, 1988) should be introduced. For the reasons given above, we stick to the term *compliance* here in the context of a quotation, which we otherwise replace with the more modern term *adherence* (§ 10.1.2). In the figure (10.11) and the accompanying explanation, the original term (*compliance*) by Ley is to be retained. Where it is possible free of context, there is nothing to prevent us from also speaking of "adherence" or "therapy compliance".

Philipp Ley's simple explanatory model, for which he has conducted many empirical studies, places four central terms and the associated concepts in a context that is important in many other sciences (psychoanalysis, psychology, neurology, computer science). There, for example, the questions are pursued as to what people learn and retain under what cognitive and emotional conditions and with what interest, or forget again or suppress because it is uninteresting or threatening to them, etc. Here, people do not behave as "patients" in a fundamentally different way than they do in their everyday lives. But because this everyday life can be severely impaired, for example in the case of a serious illness, many things are perceived and processed differently than in daily routine.

Especially when moving from the familiar environment of everyday life to the institution of hospital, our self-assurances threaten to break down and our tried and tested processing and communication routines fail. What has to be taken into account especially in the clinical visit (§ 25) also applies to the visit to the general practitioner and specialist. Here, too, it is to be expected that feelings of fear or powerlessness or dependency will impair the ability to perceive and communicate. For this reason, the necessary information should be conveyed in a particularly "simple" and "descriptive" manner or "loudly, clearly and distinctly" or "repeated" several times, not only in special circumstances vis-à-vis a child (§ 35) or elderly patient (§ 37). Also with regard to an irritated young academic, possible "concentration disorders" must be taken into account, which may also occur with him in a special situation such as the processing of information in the case of the medical "communication of a serious diagnosis" (§ 16, 22).



Whether patients will comply with advice will depend in part on whether they have understood and remembered what they have been told, and on their level of satisfaction with communications. In turn satisfaction with communication will be partly dependent on memory and understanding. Finally understanding should affect the probability of information being recalled.

Fig. 10.10:
Relationship between understanding, memory, satisfaction and compliance
(Ley 1983: 94f)

Ley's model rudimentarily showed the switching points and accumulation points where problems and disturbances are to be expected, which ultimately make adherent patient behaviour more difficult and endanger the intended therapy success. What ends in the positive case of the model with the patient's compliance ("adherence to therapy"), begins in the negative case already with a poor understanding of the patient, with corresponding cumulative effects of insufficient *memory*, lower *patient satisfaction* and greater *non-compliance.*[5]

If a patient's medical history is not sufficiently "listened to" (§ 9), he will also feel "dissatisfied" with his interests during his information, because he is "ignored" as a person, if the doctor gives a lecture *without a full stop* and without reference to him as a person. What is left *without sense and reason* here will also not be recalled later when it is important to motivate future behaviour. If knowledge is to be retrieved in an application-oriented way, it requires a different, namely *dialogical* kind of knowledge transfer, in which the problems of understanding and comprehension described below can be avoided or at least mitigated.

10.5.2 Problems and concepts of securing understanding

Doctors have an everyday and professional *double competence*, because they - like all of us - are first of all members of the lifeworld, but also at the same time agents of a specific institution. Doctors have to make systematic use of this double competence in a similar way to teachers, lawyers, judges, members of parliament, etc., who in principle also have to adjust to the lay status of their clients by changing their perspective. This is a general feature of institutional communication, whose *asymmetry,* however, often enough works to the disadvantage of the clients (Koerfer 2013) (§ 7.5, 10.6). This applies equally to students, defendants and even patients, who often fall short of the necessities and possibilities of understanding, which is a very first prerequisite for active participation in interactive events.

The first hurdle that has to be overcome between doctor and patient is *bridging* the communication problems that arise from the clash between the lifeworld and the medical world, as was previously worked out by Elliot G. Mishler (1984) from the perspective of the sociology of language and medical ethics (§ 10.2). Since the competences between doctor and patient are distributed *asymmetrically in* this respect, as ex-

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[5] Regarding the systematic relationship between *communication*, *satisfaction* and *adherence,* we refer to the comprehensive meta-study by Haskard-Zolnierek, DiMatteo (2009) as well as the commentary by Roter, Hall (2009), which we will return to in the evaluation section (§ 40).

plained above, the doctor is particularly in demand here, who as an "everyday person" and medical practitioner naturally has both types of competences and therefore bears a special responsibility for the emergence and solution of communication problems.

In order to reach a common understanding, medical competences are particularly needed to *ensure comprehension* of *orders* and *prescriptions* (§ 26), but also in the *communication of serious diagnoses* (§ 16) and *information* before operations (§ 39) (Mann 1984, Ditz 2005, Jung 2005, Bührig, Meyer 2007, Hoefert 2008, Mendick et al. 2010, 2011, Turner et al. 2011, Klüber 2015). Without a doctor's translation function from the everyday perspective, the purely (specialist) medical information will remain "without sense and understanding" for patients or may even lead to serious, momentous misunderstandings (for example in medication).

If one disregards inadequate motivation and persuasion work, which may be attributed to the famous lack of time, but also to individual resignation or disengagement of the doctor towards this individual patient, there remain easily avoidable sources of error in securing understanding. Formally, four *types* of "failures" in conveying information and their subtypes can be differentiated, which can work together individually or cumulatively, for example, already during the clarification.

These types of failures must be counteracted in good time with the appropriate counter-concepts (e.g. "unambiguously" or "translate" or "paraphrase" foreign words), which rely above all on clarification "in the language of the patient" and *dialogical* assurance of understanding (*active listening*, *questions of understanding, reassurances*, etc.).

1. Technical communication

The medical "jargon" often leads to a lack of *understanding* on the part of patients due to their lack of previous education, which they often do not dare to clarify, especially in the non-dyadic ward round (§ 25). This concerns the frequent choice of the following subtypes:

(a) uncommon *foreign words* ("ischaemia"), especially if they can be confused orally by phonetic form ("hypotension" - "hypertension", "indicated" - "induced")
(b) professional *abbreviations* ("CT", "PSA value")
(c) *Terminologised* everyday language ("dissolve water", "come off").

For example, a visiting doctor can easily communicate with the ward team over the patient's head by saying about the patient in the third person while standing at the bed: "She came because of a suspected ischaemic myocardial reaction" (§ 22.5). Doctors may (a) seldom intentionally try to achieve a patient's lack of understanding, but (b) more often accept it, e.g. because of "time constraints" (as in the ward round example) or (c) often fail to recognise it as a problem.
The problem recognition is then due to a lack of everyday perceptual competence in communication when the doctor "overlooks" the questioning look of his patient or "overhears" the mechanical or hesitant feedback. Thus, some patients will probably continue to be irritated to worried at first when they hear about "negative" findings before the possible misunderstanding clears up in the course of the conversation and the patient's facial expression may brighten up due to the "positive" news (of the "negative" findings), etc.

2. **Information deficits**

Doctors may "omit" information because, for example, the information in question is

(a) is taken for *granted* ("rectal", not "oral" application)
(b) is found to be *irrelevant* because the notifications of "risks and side effects", for example, seem dispensable (because too rare)
(c) is considered *unrealistic* from the outset because it is not "understandable" to the layperson
(d) is considered (unnecessarily) *worrying,* which is why the corresponding information is rather *concealed* for reasons of protection.

This last type of deficient "information" certainly collides with the principles of medical ethics of *transparency* in medical practice (§ 10.5.3) as well as the granting of autonomy to a "responsible" patient (§ 10.1), who has a right to information appropriate to the patient.

3. **Misinformation and falsification of information**

Misinformation and distortions can more or less "happen" for very different reasons or be deliberately "chosen" that way:

(a) Own *ignorance*, for example because a doctor is not sufficiently informed about the difference between *absolute* and *relative* risks (Steckelberg et al. 2005, Wegwarth 2013, Gigerenzer 2013, Keller et al. 2014), so that he is also unable to provide the patient with correspondingly differentiated information.

(b) The motive of *protection,* which not only leads to the *concealment of* information (see above), but can also develop into serious *falsifications of information*. This also includes the many "borderline" cases of "well-intentioned" *trivialisations, euphemisms and appeasements* ("It's not that bad", "It'll be fine", "We'll get it sorted out"), which can be inappropriate compared to the medical "state of affairs".

While the problem (a) of misinformation can be solved in the short term by increasing competence in the matter, the problem of falsification of information (b) requires a change in medical attitudes in the long term. Rhetorical *strategies* of *manipulation* (§ 10.2), which "gloss over" a serious matter, not only violate the *principle of transparency in* medical practice (§ 10.5.3, 17), but can also prove counterproductive in the long run, because they may reassure in the short term, but in the long run (also in the sense of: "Lies don't travel far") lead to irritation and thus to a strain on the doctor-patient relationship, for example when patients receive different information from other people or other sources (internet etc.).

4. Information overload

The danger of overloading with information is particularly present when doctors increasingly give it "at a stretch" or "without full stops" ("informative lecture"). This can have more or less plausible and intertwined reasons and motives:

(a) *In a* well-intentioned sense (*empowerment*), patients are to be "provided" by the doctor with information that is as "comprehensive" as possible, thereby increasing their health literacy.

(b) *Defensively,* the doctor follows a merely *legalistic* ethics of disclosure (Brody 1989, Koerfer et al. 1994, Bührig, Meyer 2007) (§ 10.7.2) in order to be able to formally dispense with all duties of disclosure in the sense that he has "done his duty" and does not have to fear any (above all legal) "hostility" later.

In both cases, there is a tendency to "overload" in the form of an explanatory lecture without inquiring about the patient's *prior knowledge* of the patient's *need for information* and engaging in a dialogical process of understanding and communication that thrives on the necessary dialogical reassurances.

> Thus, at first glance, the educational monologue seems to be "cheaper" than the seemingly "costly" form of *dialogue*, despite the relative expenditure of time. However, such balances are not to be drawn in the short term, but in the long term under both aspects of effectiveness and efficiency: If a patient is subsequently non-adherent because he or she was not able to "listen in one piece" to the "speech in one piece" and "only understood half of it", the best educational lecture has missed its target - which would also significantly increase the (time) follow-up costs.

These and other "sources of error" in communication will be differentiated in detail and substantiated with empirical examples. In particular, we will use cases from *ward round communication* (§ 25) to work out how doctors "talk over the patient's heads" in their professional language in order to achieve effective, "smooth" communication, especially between team members during rounds.

In the first place, the maxim should be followed to "speak in the language of the patient", i.e. to first use everyday language and, where it reaches its limits, to introduce *technical* terms and, if necessary, to explain them with the corresponding dialogue procedures to *ensure understanding* (*active listening*, interrogations, follow-up questions, *reassurances, summaries, etc.*) (§ 19, 27).

In this dialogical way of communication, the necessary information can gradually penetrate the patient's consciousness and be called up by him as active knowledge of the disease and treatment as needed, because it was *understood* in "his language" and can therefore be remembered more easily later.

10.5.3 Transparency and dosage of information

In order to achieve a *dialogical* communication of the necessary information with the individual information needs of the patient, the dialogical principle of *transparency* should also be applied in doctor-patient communication (Brody 1989, 2007, Koerfer et al. 1994, Robins et al. 2011, Braddock 2012) (§ 7.5.3). According to this, the doctor not only gives appropriate *answers in response* to the patient's *questions,* but in turn takes the *initiative to provide* information in order to explore and fill gaps in the patient's knowledge in *advance.*

Because of his *dual competence* as a medical doctor and everyday person, which allows him to translate between the professional and everyday world, the doctor has a special responsibility for common understanding, the problems of which he must be able to anticipate sufficiently or recognise in good time in the concrete course of the conversation. The best "prevention against lack of understanding" is to adhere to the *principle of transparency* (§ 10.5), which is to be applied both *proactively and reactively.* In both cases, it is about setting and recognising relevance (17.4), which in the case of patient education is essentially determined by an exchange of information that is usually initiated by the doctor and then reactively continued by questions from the patient and answers from the doctor.

- **Transparency initiative**
  The doctor takes the *initiative to provide* information. In doing so, he anticipates problems of understanding and comprehension that may already be caused by technical language (§ 10.5.2, 27). He *proactively* enquires about the patient's *level of knowledge* and *need for knowledge* and encourages him to ask questions, which he should then answer accordingly (see below). After a mutual exchange of information, which seems to be sufficiently saturated, the doctor again takes the initiative for further information, which is again intended to fill gaps in knowledge and understanding *in advance,* etc.

- **Reactive transparency**
  The doctor gives appropriate *answers in response* to the patient's *questions,* which may lead to further patient questions and doctor answers. Here the doctor should generally follow the maxim: "*Questions* have *priority*!" - even if they do not seem justified from the doctor's point of view because they threaten to lead away from the preferred information path. Only in exceptional cases should the doctor be allowed to explicitly defer the patient's questions and return to them with a delay, but these should generally not be overheard and ignored.

As has already become clear from the pattern analyses in decision-making, the various processes of transparent cooperation do not proceed in a linear fashion, but can also be repeated and run through in circular feedback loops. Only in this proactive and reactive interplay can the securing of understanding be controlled until the exchange of information has reached a certain saturation that is satisfactory for both sides. That doctors also answer their patients' questions appropriately is unfortunately not a matter of course, as research on visit communication has already shown (§ 2, 25), which still needs to be proven by relevant examples. In these cases, various strategic forms of *evasive*, *deflective*, *trivialising* answering behaviour on the part of the doctor have been distinguished (Bliesener 1982, Siegrist 1982, Nothdurft 1982), with which the principle of transparency is considerably violated.

On the initial information basis, argumentation processes can then follow, in which the patient arrives at initial formations of opinion and will. Once again, the various informative and argumentative processes do not proceed in a linear fashion, but can be repeated cooperatively and developed in circular feedback loops. Thus, according to the maxim: "Information questions have priority!", *intermediate questions* should always be answered immediately reactively as information questions, but also as comprehension questions from the patient, so that the dialogue flow of information remains open to both sides. Only in this reactive and initiative interplay can the securing of understanding be controlled until the exchange of information has reached a certain saturation that is satisfactory for both sides.

Certainly, the "optimal" path between the many "conversational cliffs" is not always easy for the doctor to find, which may often be experienced as an agony of choice between *Szylla* and *Charybdis*. Without concealing or glossing over essential information for well-intentioned reasons, what is needed is a patient-appropriate dosage that proves to be "tolerable".

Often enough, the doctor has to walk the tightrope between the alternatives of having provided "too much" or "too little" information when he or she seeks to fulfil his or her duty to inform, for example, during the information and risk discussion in general or specifically before a surgical intervention (Mann 1984, Jung 2005, Turner et al. 2011, Mendick et al. 2010, 2011, Hax, Hax-Schoppenhorst (eds.) 2012, Langewitz 2013). The "necessary" often does not coincide with the "golden mean". In case of doubt, the doctor may decide to give "more" information "than necessary". Especially the latter kind of *overloading* with information ("lecture") can be "well-intentioned", but it can lead to "too-much-of-the-good", which in the sense of an "overdose" can lead to a breakdown in communication (§ 17.3, cf. § 22.3 on the Ask-Tell-Ask *scheme*). The "flooding" with information can lead to counter-reactions (*defence*) in the patient, which can result in *cognitive* and *emotive* blockades, which manifest themselves, for example, in *interactive* forms of refusal ("silence" etc.).

In addition to this *direct* refusal by patients already in the conversation itself, another reaction is equally to be considered counterproductive: If patients are talked "dizzy" by their doctors with excessive information, this can lead to a non-intended result that can be characterised as *pseudo-consent* (§ 10.7.2). What is then supposedly "communicated" as consensus on the "surface of the conversation" later turns out to be *non-adherence on the part of* an "unreasonable" patient who, however, could not really be "convinced" by the doctor of the necessity of therapy at any point during the conversation.

10.5.4 Information and emotions

The possibilities of persuasion through information do not depend solely on the mere content of the information conveyed, but are determined by other cognitive, motivational, emotional and finally interactive conditions. It is well known that information from the doctor is often *worrying* or even *threatening*, which is why many a visit to the doctor is postponed or completely *suppressed.* Thus, forms of *defence* are to be expected in the ongoing consultation, especially when "bad" news is conveyed (§ 15, 16). Here, corresponding *empathic* competences are required (§ 3.2), which have to work together with the doctor's competences for a comprehensible communication of information.

Of course, large chunks of information must first be portioned into smaller "pieces" for the layperson who is not familiar with the contents in order to be "digestible". But despite all the announcement strategies ("warning shot") and portioning efforts, the communication of an inaccurate diagnosis remains in its core the "heavy chunk" that it is (Buckman, Kason 1994, Langkafel, Lüdke 2008, Köhle, Obliers, Koerfer 2010, Köhle 2011). This should also not be "talked down", even if this would be possible in the short term. The problem of dealing with emotions in doctor-patient communication will be discussed in cases of communication of serious diagnoses (§ 16, 20, 38), which cannot be reduced to an unrestricted rational exchange of information.

Although the patient's rationality in decision-making should only be questioned in exceptional cases (§ 10.6.2), the patient must nevertheless be supported by a *trusting* relationship in which the *emotional bond* can provide the security of having been "understood correctly" on the whole by the interlocutor even "without many words" under certain circumstances. The fact that misunderstandings can also creep into this kind of approximate understanding of the essentials simply because there are also self-misunderstandings is an all too human problem. As is well known, psychotherapy deals with this problem (of self-deception) in a professional form of processing. However, such "delicate" issues can be virulent in every doctor-patient relationship, which is why the family doctor, internist, surgeon etc. should also be professionally attuned to the ambivalences of his patients, for example in decision-making.

Not infrequently, the *frightened* or even merely *irritated* reactions of patients remain below the threshold of perception of doctors who, for their part, continue talking without stopping in their explanatory monologue. Apparently, they are often unable to assess the effect of their own "shocking" words, which Bernhard Lown (2002), who invented electrode fibrillation for ventricular and atrial fibrillation, often heard in his many years of practical experience as a cardiologist and compiled in his impressive book on "The Lost Art of Healing" with many examples. Here, a recalled excerpt from a conversation with a patient is given as an example (Box 10.14), for whom the "devastating" words of various doctors obviously had a strong impact.

Box 10.14 The "devastating" effect of "thoughtless" statements

In a large hospital, it is almost impossible to prevent a patient from making inexperienced or thoughtless remarks. Inappropriate remarks can be as devastating as a physical attack. I remember a small clinical round on a patient who had by then recovered well and without incident from a heart attack (...)

"Mr. Jackson, why so sullen and depressed?" I asked.

"Anyone would be if I told you what I heard this morning," he replied.

"What was it?"

"The resident tells me that I have suffered a heart attack, the ward doctor speaks of a fresh myocardial infarction, the senior doctor calls it a coronary artery thrombosis, whereas the doctor on duty points out that I have suffered an acute ischaemic episode. How in God's name can someone survive when there is so much wrong with their heart? Worse still," he continued, "when I asked the nurse what was actually wrong, she told me I'd better not ask."

All these terms mentioned here are different paraphrases of a single con-

> dition. A patient can be driven to the deepest despair and imagine the worst when he hears an inappropriate expression or a badly chosen word.

Lown 2002: 52

This example from Bernard Lown's many years of professional experience certainly represents an extreme practice of communicative shaping of the doctor-patient relationship, in which the "devastating" effect of words is "unmistakable". According to Lown, this includes "thoughtlessly" uttered words such as: "You are living on borrowed time" or "Your next heartbeat could be your last" or "This constricted blood vessel is a widow maker" (53) etc. We will come back to such examples under the aspect of the "power of the medical word" (§ 17.1), which can have not only a "destructive" but also a "healing" effect.

In addition, conflicts of understanding and communication during consultations or rounds are often less drastic, but nevertheless fundamental problems of a lack of perspective-taking by doctors, which can be due not least to a lack of *empathic* competence. Although this may well be present as an everyday competence, it is often suppressed due to a misunderstood professional competence because, for example, dealing with the patient's emotions, i.e. his fears, worries, anxieties, hopes, etc., is not considered to be part of the doctor's *core competence* (§ 3.2, 17, 20). It is also possible that the doctor's professional routine exceeds his or her imagination as to what fears (of infections, pain, complications, incorrect treatment, etc.) patients may be plagued with when they have to visit a hospital for a "routine intervention" and are afraid not only of "hospital germs", etc., but also of general anaesthesia as the "little death" (Hempel 2010, Hontschik 2011, Kindler, Harms 2011) (§ 25). What is part of the routine of everyday work for doctors as a matter of course, often poses a threat for patients, which is already associated with the change from the familiar living environment to the foreign institution.

All in all, communicative everyday competences, which of course doctors also continue to have in principle, should not be given up with the start of the consultation or ward round, but should be *specialised*: As multifunctional "communicators" (§ 6.3), physicians must bridge the gap between the patient's *world* and the medical *profession* in order to provide the necessary translations between these often *conflicting* worlds (§ 10.2).

Preventing the types of communication problems described above as far as possible, or even counteracting them more or less successfully, is the special responsibility of doctors, because the possible problems of understanding and communication can only be anticipated with the everyday professional double competence. The better the doctor's change of perspective succeeds in *taking* the patient's everyday perspective when speaking and listening, i.e. in skillfully oscillating between everyday and professional competence, the more "trouble-free" the relationship and therapy processes based on it will be.

10.6 Applied medical and discourse ethics

As already stated at the beginning, *patient autonomy* can only be justified within the framework of a *medical ethics* that links the "responsible" patient with the basic democratic idea of the "responsible" citizen. Precisely because one's own health is about one's very own, individual interests and concerns, the patient's *right to self-determination* is a high-ranking principle that may conflict with other principles (solidarity, etc.), but cannot be fundamentally overridden. However, the right to self-determination cannot be actively exercised in a vacuum, i.e. for example as a solipsistic self-reflection process ("What would probably be best for me?"), but only in cooperation and communication with trusted doctors or other freely chosen health care experts.

Only in dialogue with a professional partner who understands how to competently assume the dialogue and argumentation roles of proponent and opponent with a well-founded "for" and "against", can individual preferences towards certain treatment options be gradually developed and examined, stabilised, modified or revised, as long as this is still only possible within a certain time window. This assessment of the time limit and validity of certain treatment options (and their risks) alone often exceeds the current *health competence* of patients, which can only be painstakingly promoted (*empowerment*) through "*information*", "*motivation*" and "*education*" (§ 8.2) in dialogue with the professional partner. The doctor and the patient should enter into a cooperative *partnership* in which they meet as *unequal* but *equal* and *equally rational* partners, in both of whose interests it is to *negotiate* "the best" for the patient together.

Insofar as *all processes* of opinion, will and decision-making are essentially *conversational* and should initially begin with an *open outcome*

(§ 7.5), a "dialogical principle" (Kampits 1996) is also applied in the doctor-patient relationship, according to which both interlocutors meet without guidelines and coercion. Here the principles of applied *medical ethics* and *discourse ethics* prove to be two sides of the same coin, which will be further elaborated in an integrative perspective in conclusion.

10.6.1 Autonomy and partnership

Especially in cases of severe illness, the process of *decision-making* for the patient is often a process of *self-discovery,* which the physician has to promote in the direction of strengthening *self-determination.* A corresponding concept and understanding of *patient autonomy* requires a principled reorientation in medical ethics (Sass 1989, Veatch 1989, Murrhardter Kreis 1995, Kampits 1996, Koerfer et al. 1996, 2005, 2008, Vollmann 2000, Geisler 2004, Ritschl 2004, Gethmann-Siefert et al. (eds.) 2005, Vollmann et al. (eds.) 2009, Kreß 2012). In contrast to traditional paternalistic ethics, which were primarily oriented towards helping the sick person ("salus aegroti suprema lex"), the autonomy of the patient is now strongly emphasised ("voluntas aegroti suprema lex"): The patient should be able to bring up his or her subjective ideas about life, expectations, wishes and values with the doctor in the decision-making process, even if there is a risk of a conflict of values (§ 5.1), without having to fear a conflict of relationship with medical sanctions because of this. The relationship is no longer "conflict-averse", but open to all problems that the patient could "cause".

Without neglecting the traditional *duty of care of the doctor* in relation to the *patient*'s *autonomy,* a different kind of *partnership-based* and nevertheless "helpful" relationship (§ 3.1) is chosen overall, in which the doctor seeks to promote the patient's autonomy in such a way that his or her *health competence* is also increased in the sense of the patient's growing *self-care.* Thus, the doctor's duty of care can correspond well with the patient's autonomy if, with and after the doctor's assistance, the patient is ultimately able to recognise for himself what is "best" for him personally, and that means that he can take qualified responsibility for a decision made and actively support it in the further course of treatment.

The medical promotion of *patient autonomy* often proves difficult in practice, without it always being possible to clearly distinguish the limitations in principle from mere institutional conditions (time pressure, etc.) or individual inadequacies of acting persons (impatience, etc.) (Brody 1989, von Uexküll 1993, Koerfer et al 1994, Borrell-Carrio et al 2004, Sandman, Munthe 2009, Sandman et al 2012). Here, the necessities, possibilities and limits of patient support are to be differentiated from a *medical-ethical* and *discourse-ethical* perspective. Autonomy, for example, should not turn into *autarky* through strategic action, in which one person (ego) asserts himself without or even against other persons (alter) even without regard to *solidarity* (also towards the community). Lack of solidarity, also on the part of patients, would be a limiting reason for excessive and that is also "unhealthy" egoism, especially in the case of "scarce" resources, which can range from limited *consultation hours* (§ 17-19, 25) to limited organ donation in the case of *transplantation* (§ 38).

Autonomy must therefore be limited when it threatens to assert itself at the expense of others (§ 10.4.5-7). Thus, according to von Uexküll, the autonomy of the patient can only be promoted insofar as the autonomy of the doctor is not endangered: "No responsible patient without a responsible doctor" (von Uexküll 1993: 62). Accordingly, an "autonomy in relation" is called for here (Borrell-Carrio et al. 2004), in which the shaping of the relationship between both partners leads to a balance between the patient's care needs and the doctor's care obligations. In this regard, the balance between *preference-based* and *evidence-based* medicine, to which both partners are committed, was already emphasised in advance (§ 10.3), so that the doctor cannot unconditionally follow the patient's preferences here. Preserving his or her medical autonomy can lead to limitations in individual cases, but these do not necessarily have to result in a loss of autonomy on the part of the patient.

Rather, autonomy is to be increased through extensive cooperation to the advantage of both partners, which in the ideal case is reflected in medical decision-making that is sustainable for both, for example, in the correspondence of greater patient satisfaction and increased professional satisfaction of the doctor. As Quill and Brody (1996) have already emphasised, the interaction between doctor and patient should not be designed as a zero-sum game in which one partner wins at the expense of the other (win/lose), but can be used as a cooperation for the benefit of both partners as winners (win/win).

In this sense, doctor and patient are not *adversaries*, but enter into a *cooperative partnership in* a "real" conversation (§ 7.5) by demonstrating their willingness to talk, conflict and compromise until proven otherwise. Even in the case of conflict, there should be no loser. In view of the *plurality* in a democratic society, a conflict of values between doctor and patient is to be regarded as both possible and justified (§ 5). In the sense of an *applied ethics of discourse,* "contentious issues" are not only permissible, but should be used constructively to further clarify the general and individual conditions for decision-making (Apel, Kettner 1992, Kettner 1991, 1998, Koerfer et al. 1994, 2005, 2008, Koerfer, Albus 2015, 2018). The "dialogue principle" must also be maintained between doctor and patient (Kampits 1996), so that the breakdown of communication in the case of dissent can only be at the end of a serious attempt at understanding. However, even the most extensive cooperation cannot prevent a possible severance of the relationship in the case of a dissent in principle, which in turn can be (mutually) recognised as a reason for separation.[6] Consensus on the dissent should then "reasonably" lead to the termination of the relationship.

10.6.2 Rationality and symmetry

The partnership of doctor and patient is indeed a partnership between *unequal* partners who should, however, meet as *equal* and *equally rational* interlocutors. To reject the assumption of sufficient *rationality on* the part of the patient would ultimately be to deny him or her the right of self-determination in decision-making. As already explained (§ 7.5.), the *asymmetry of the* doctor-patient relationship exists solely in the purpose of healing or improving the condition of one partner, who therefore seeks the professional help of the other partner.

Together they enter into a *therapeutic alliance in* which they exchange the necessary information and jointly develop ideas and concepts from their respective specific lifeworld and professional perspectives on how to help the partner in need. On the way there, both partners should in principle meet "at eye level", despite all factual re-

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[6] This applies, for example, to the "classic" cases of conflict at the beginning of life (e.g. abortion) and at the end of life (e.g. life-prolonging measures), where there are conflicts of principle between doctor and patient and where it may make sense for both sides to break off the individual relationship. As a rule, the (factually frequent) change of doctor by patients is less dramatic, which can sometimes take place with and sometimes without consensus on the dissent, because patient dissatisfaction, for example, does not require further justification to the doctor.

strictions, which should as a rule also include the *reciprocity of* the rationality assumption, which we are also guided by in our everyday actions for good reasons (Koerfer 1994/2013, Rubinelli 2013). Despite all *asymmetry,* both partners should therefore also strive for rational decision-making in the medical consultation or visit, in which they largely try to follow the "peculiarly unconstrained compulsion of the better argument" (1981, vol.1: 47, 52f.) in the sense of Habermas.[7]

A contrary insinuation of "irrationality" or even "insanity" towards interlocutors would not only in everyday life usually already initiate the end of the conversation; because with the "incapacitation" of the interlocutor, the meaningfulness of a conversation is called into doubt in the first place. In the same way, doubting a patient's ability to talk can be tantamount to "incapacitating" him or her and thus making a conversation with him or her seem "obsolete".

Of course, there are *special cases,* especially in medical action, in which the patient must be denied the necessary rationality. Rationality may be temporarily restricted in the case of a strongly *insecure, frightened* or even *shocked patient,* but it must be assumed to be sufficient again in the long term if the patient is not to be permanently incapacitated by the vicarious actions of a paternalistic doctor. What, however, in special cases or in an emergency, in which the patient cannot be "responsive" or not "fully oriented" and must nevertheless be acted upon immediately for medical reasons, should not be elevated to the status of a paternalistic *rule of* "legitimate" *incapacitation,* from which no "escape" seems possible in the further shaping of the doctor-patient relationship.

Despite all the necessity of a "helping" relationship (§ 3.1), which ultimately relies on help for self-help, a patient is only to be partially and

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[7] We had already noted in advance (§ 7.3, 7.5) that Habermas defines medical-therapeutic communication specifically in the form of *psychoanalysis* as a special type, which, however, is supported by a *specific* type of *asymmetrical argumentation* despite possible self-deceptions that are supposed to become a topic in therapy: "In the analytical conversation, the roles are distributed asymmetrically, doctor and patient do not behave like proponent and opponent. The prerequisites of a discourse can only be fulfilled after the therapy has led to success. I therefore call the form of argumentation that serves to clarify systematic self-deceptions *"therapeutic critique"* (1981, vol. 1: 42). Nevertheless, it presupposes a rational capacity for self-reflection on the part of the patient, which is at the same time promoted in therapy. Cf. on psychoanalysis as a dialogue Koerfer, Neumann 1982 and on psychoanalytic therapy Thomä, Kächele 1989 (cf. § 9 of this handbook).

temporarily released from his or her own responsibility in the circumscribed special cases of limited *accountability*. However limited in individual cases, as a rule, from the perspective of medical *ethics* and *discourse ethics,* a sufficient *rationality* of the participants ("co-construction of reasoning") must be assumed in the medical or therapeutic cooperation between doctor and patient if the interplay between help and self-help is to succeed (Koerfer 1994/2013, Koerfer et al. 2005, 2008, Sandman, Munthe 2010, Rubinelli 2013, Sandman et al. 2012, Richard, Lussier 2014). While the "helping relationship" is indeed an expression of the asymmetry between "unequal" partners, they should meet each other - apart from the special cases - as "equal" and "equally rational" partners who also follow more or less "good reasons" in medical decision-making by subjecting them to more or less rational reflection.

In this context, a "naïve" concept of symmetry is by no means to be assumed for the cooperative interplay between doctor and patient (§ 7.5), according to which both partners in fact use the same (types of) communication topics, purposes and forms with equal shares. Rather, following Habermas' conception of an *ideal* speech situation as described above (§ 7.3, 7.5), a concept of symmetry based on discourse ethics will be used (Box 10.15). According to this, only approximately symmetrical opportunities for access to communication are to be guaranteed, in which the participants can freely choose the topics, purposes and forms of communication relevant to them without coercion and fear of sanctions.

Box 10.15 Symmetry and asymmetry in doctor-patient communication

For this cooperative interplay between doctor and patient, a naïve concept of symmetry in the sense of a "halving of power" can by no means be assumed, according to which both interlocutors should have a half share in all utterances in general as well as in certain types (listener feedback, questions, answers, etc.) in particular. The fact that the patient *tells* and the doctor *listens* is a *functional* asymmetry. This is to be distinguished from a *dysfunctional* asymmetry, which is characterised by *strategic* use of language such as trivialisation, deception, intimidation or passing over (...) and should be frowned upon, especially between doctor and patient.

Rather, a *discursive* symmetry is to be assumed in the medical consultation and ward round, according to which there should be approximate *equality of opportunity for the* interlocutors both for the relevance of conversation topics and goals and for an appropriate choice of communicative means, as are relevant in communication *oriented towards under-*

> *standing* (questioning, asserting, disputing, doubting, etc.). If, in the context of a doctor's conduct of a conversation, the doctor is to be assumed to be in a position of supremacy, then this is to be used entirely in the sense of "guaranteeing" the chances of access to a dialogue-based communication.

Koerfer, Albus 2015: 131, emphasis in original

For the doctor, ensuring these chances of access to communication for the patient means above all keeping the decision-making process as a "genuine" conversation in the sense of Buber (1954/1986) (§ 7.5) essentially free of *coercion* and *manipulation* in the further course. In their negotiation process, in which information, arguments and opinions are exchanged, doctor and patient should cooperate in such a way that their joint "thinking" about the "best" treatment option remains "open-ended" for as long as possible, which should exclude any "thinking prohibitions" especially in the central phase of *deliberation.* This requires a particularly sensitive cooperation in this phase, in which the *objective* information and arguments are to be "considered" in relation to the *subjective* attitudes and values of the patients in a dialogue process.

10.6.3 Deliberation in dialogue

In the *cooperative partnership* described above, the *unequal* but *equal* and *equally rational* interlocutors take on different interaction and dialogue roles in which they occupy different positions. As explained, both partners do *not* meet as *adversaries*, but the patient needs a professional "counterpart" who can competently "play through" all relevant alternatives of treatment, their "pros" and "cons" (risks) with him. The first opinion-forming and will-forming processes may not be very stable yet, which has to be examined in conversation with the doctor, who takes on the role of the *proponent* or *opponent*, as the case may be.

This assumption of *argumentative roles* can increase to the role of the "Advocatus Diaboli", for example when a spontaneous preference of the patient is to be "put to the test" in order to "test" its stability ("Do you really mean that?"- "Have you thought through the consequences for your everyday life?"- "Do you really want to go through with the pain without medication?"). As we will see with empirical examples (§ 22), there are often good reasons to "reconsider" even decisions that have already been made together and then to ratify or modify them again if the evidence-based, medical "state of affairs" still allows this within a decision window.

In order to ensure that decisions made "hastily" do not turn out to be merely "provisional" decisions that immediately become a problem, sufficient space must be given to the process of *deliberation* in dialogue-based decision-making (Charles et al. 1999, Sandman, Munthe 2010, Munthe et al. 2012, Elwyn et al. 2012, 2014, Labrie, Schulz 2014, Han et al. 2014). In this context, the "reflection time" granted for joint "consultation" should be used in particular for "thinking aloud", where everything can be openly "discussed" *without taboo*. For the first decision can become a problem for adherence if, for example, the patient's life circumstances and habits have not been sufficiently "considered" and "advised" and the patient cannot stick to his diet or threatens to "mix up" his "many" medicines, which he did not dare to say at first.

"Thinking aloud" is to be perceived in the consultation from the respective *expert roles* (§ 7.5.) of doctor and patient in a specific way: In his role as a *professional* expert, the doctor must repeatedly issue invitations to think aloud. Conversely, he must accept the invitations to talk from the patient, who in his expert role (qua self-knowledge) can make himself and his problems the subject of discussion, for example by asking questions about compliance with the diet or taking medication, or by formulating doubts and objections.

While simple problems may be difficult to decide, we are faced with special decision-making problems in the case of a serious illness, because the consequences are often difficult to assess due to *uncertainty* (Murrhardter Kreis 1995, Frosch, Kaplan 1999, Klemperer 2005, Pollock 2005, Politi, Street 2011, Braddock 2012) (§ 10.3). Here, stable preferences of patients can hardly be expected in the first conversation. As a rule, preferences can hardly be assumed *a priori* and therefore cannot simply be *asked* by the doctor. Rather, analogous to Kleist's dictum "On the gradual production of thoughts when talking" (1878/1966), the patient's preferences often have to be developed gradually and laboriously in conversation with the doctor and checked again and again for their current validity.

Each of us can have (types of) questions put to us or also be put to us by questionnaire as to what should "apply" to us "in the event".[8] If

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[8] To avoid any misunderstanding: The following is not a plea against a written living will, which can certainly be useful after there has been sufficient

we should be able to express a certain (fixed) opinion (preferences) "here and now", we often know or suspect how unstable and fragile opinions can change under a certain pressure of experience and decision-making. Preferences are often neither fixed a priori nor do they necessarily remain stable, but have to be developed and tested. New life and illness experiences can contribute to this, but also experiences in conversations, be it with partners, friends, fellow patients or especially with the professional medical interlocutor who "knows the ropes" because his or her great experiential knowledge results not least from many patient contacts with similar problems of decision-making.

On the other hand, it will hardly be purposeful if the (even pre-informed) patient in the "quiet closet" in solipsistic self-reflection processes repeatedly presents himself with the question: "What would probably be best for me?" Such "quietly" conducted self-talk can be quite useful, but as mere "brooding" it ultimately threatens to "revolve around itself" because no new impulses come from outside. What is needed here is a process of *dialogue-based deliberation* in which one thinks "aloud" but also *answers,* and this is done by a competent, empathetic interlocutor who knows the alternatives and can formulate them concretely, i.e. can also individualise them for the patient in a way that is *tailored* to his or her personal circumstances and values.

In dialogue, the patient will then in turn express himself in (loud) self-exploration processes, in which, for example, in the case of a (life-)threatening illness or serious medical measure, he also expresses his associated *emotions* (hopes and fears). Since this is often not possible in the first conversation (e.g. after the diagnosis has been made, § 16, 22), after certain "counselling" and "thinking" pauses in which something can "sink in", it is necessary to have repeated conversations over several "speaking" hours. In these follow-up discussions, the process of "thinking aloud" must be continuously stimulated by the doctor through dialogue and kept going and strengthened through feedback procedures so that a decision can "mature" accordingly.

"reflection time" so that certain decisions could be made "after careful consideration".

10.7 Participation needs and medical flexibility

Just as patient preferences towards certain treatment options can vary, are ambivalent or remain ambivalent, patient preferences regarding (the extent of) their participation in decision-making are obviously just as heterogeneous and ambivalent. Accordingly, the doctor must be *sensitive* to unclear, changing participation preferences in perception and react *flexibly* in communication, i.e. practise the *art* of individual *dosage,* which he must also be able to master in other medical actions.

10.7.1 Patient types and individual participation needs

The fact that increased participation is also increasingly desired and, in addition, that adherence to therapy (*adherence*) and therapy success (medical *outcomes)* are favoured is now increasingly confirmed by research (Härter, Simon 2013, Martin, DiMatteo (eds.) 2014, Hauser et al. 2015). Nevertheless, one can neither take a uniform object of research as a basis, which is characterised by very different terms and conceptions of participation (SDM) (Makoul, Clayman 2006), nor assume a homogeneity of patients' participation preferences that would allow a uniform, standardised conversation practice in decision-making. Thus, Härter, Simon (2013) (Box 10.16) also emphasise in their review that preferences in participation vary depending on many factors (age, gender, education, type of illness, etc.) and may themselves be subject to change and development.

Box 10.16 Participation preference as a development process

Patient preferences in participation are not immutable and may vary depending on factors such as age, gender, education, experience of illness, medical care, health status, type of decision, attitude to decision-making, relationship with the doctor and information preference (...) Furthermore, qualitative studies have shown that participation in decision-making is a developmental process that is reinforced by access to information, the development of personal expertise and a good relationship with the doctor. Barriers that inhibit participation preference are a lack of understanding on the part of patients about their potential role in decision-making, as well as a lack of knowledge and understanding that there is

> not always one right decision (...) Therefore, patients fear that they lack the expertise, knowledge and clinical experience necessary to make decisions, as well as the support to identify their own preferences.

Härter, Simon 2013: 57

Of course, it makes sense and is useful to be able to start from a *typological* knowledge that enables doctors to orient their conversation practice in decision-making according to the age, gender, education or type and severity of the illness of their patients and to be able to take possible obstacles into account (Braun, Marstedt 2014). But which (type of) participation in the *individual* case exactly this patient will prefer here and now or tomorrow or later in the course of his disease, the doctor can ultimately only find out in conversation with this very patient.

Moreover, the doctor will still be able to "influence" the patient's ambivalences in the course of the treatment and in further conversations in one direction or another, which, however, is not yet "predictable" here and now for both conversation partners. Thus, the outcome of a series of conversations cannot be readily anticipated due to their individual *dialogue dynamics*. It can be a positive characteristic of "good" conversations that they can still "surprise" their participants.

10.7.2 The art of dosing information and participation

The heterogeneity and ambivalence of participation preferences can be easily understood if one first thinks of cases of *serious* illnesses or diagnoses (§ 16, 21, 38). Patients may be confronted with a complex decision-making situation that they do not feel "up to" at first due to their previous life experience. To "have" a preference for certain treatment options and then to "express" this "unambiguously" to the medical interlocutor is likely to be just as difficult as to *be* able to "articulate" adequately in advance a concrete "need for information" and "need for participation" in the information and decision-making process.

Speech comprehension and the art of dosage

Even if, as a doctor, the corresponding conceptual distinctions (*paternalism* versus *SDM* or *PDM*) had been explained colloquially and the conceptions correspondingly explained colloquially, "stringent" answers to alternative questions ("Do you (prefer) ... or ...?") are just as little to be expected as to "open", paraphrased question formulations that can also allow graduating answers ("To what extent do you want to (participate in) ...?" "How much ... do you want?"). Even if patients initially want to know "everything" or "nothing" in response to the corresponding doctor's question, or want to "participate" in the decision-making process "not at all" or "hardly at all" or as "actively" or "comprehensively" as possible (or however linguistically modified), they can nevertheless equally "fall silent" in the conversation as soon as it becomes "serious".

The first preference expressed does not necessarily have to be the ultimately "valid" one, which (in the above sense of von Kleist) can only be developed "gradually" and "while talking". The doctor must *listen* attentively and *actively to the* "talking" (§ 19) in order to understand the "nuances" which the patient can "give to understand" himself even without graduating doctor's questions.

However, even an initially "very" firmly expressed opinion on the preference can still be subject to *change,* which the doctor must take into account in the ongoing conversation in order not to "sit on" a snapshot. Rather, he must be able to assume a *stable* preference that must prove to be permanent in further discussions and treatments (similar to the distinction made in psychology between *state* and *trait*). A patient who initially wants to know as "nothing" as possible or to be informed and involved only "little" because he is perhaps still "shocked" by the first diagnosis and tries to *ward* everything *off* and deny it accordingly (§ 3.2, 29), may gradually become more and more "curious" and "active" because he realises that he cannot "get around" more information and involvement in order to be able to *cope* better with his illness himself.

It is part of the *art of* medical *conversation* (§ 17.3) to force this process of self-exploration and self-determination of the patient without *overtaxing* him. In order to strengthen the patient's *health competence* through information, motivation and education (*empowerment*), the doctor follows a kind of *reasonableness rule* (Koerfer 1994/2013). According to this rule, the doctor must test what is currently reasonable for this patient by trying to expand what is still possible step by step to an initially stable limit at which the end of what is reasonable and the beginning of what is unreasonable is reached for the patient. Here the doctor proceeds as in a *tangential* conversation (§ 3, 17, 32), in which the patient is "touched" without being "hurt". In this way, doctors must test the need for information and participation and, according to this test, make a correspondingly individual *dosage,* with which they are also otherwise very familiar in their medical practice. A special dosage problem already arises during information, which, as is well known, should be provided "gently" without leaving any significant "information gaps.

Dosed education and participation

As described at the beginning (§ 10.1), only well-informed patients can participate in decision-making in a qualified manner. In this respect, there is a connection between the need for information and the need for participation. Information and participation should go "hand in hand" and, if possible, be promoted by a "medical" hand (§ 10.5). The more a patient wants to or should participate, the more they need to be informed, and the more informed they are, the more likely they will be able (and probably willing) to participate more or less actively. The restriction stems from the fact that an *increase in knowledge* (not only in the medical consultation, but) usually leads to an *increase in interest*, and in any case the *feeling of self-efficacy* can generally be strengthened through knowledge.

The dosage of information and participation occasionally poses problems because of the possibility of *incorrect dosage* (§ 10.5). Patients may turn out to be "more difficult" than initially expected by the doctor, resulting in regressive or aggressive or devaluing reactions (§ 34). However, occasional mishandling of the conversation can be tolerated, because it can be corrected and compensated for. Other problems can arise from the fact that both parties to the conversation have both *communication rights* and *communication duties*, which can fundamentally conflict.

With the guarantee of *symmetrical access opportunities* to communication (§ 7.5, 10.6.2), the patient is initially not obliged to make full use of all opportunities. In general, communication is not an end in itself and there should be no coercion to communicate, certainly not in the medical consultation. However, the patient's right to "not know" can come into conflict with the doctor's duty to inform. For example, before an operation, the doctor is obliged to provide information, some of which is codified in written form and must be received by the patient accordingly. In addition to the familiar information sheets, which have to be signed by the patient after a discursive history (Bührig, Meyer 2007, Klüber 2015), there may be abbreviated presentation procedures in oral communication. However, these cannot be limited unilaterally by the patient, who may only want to accept the "bare minimum". Here, the distinction between the "necessary" and the "dispensable" falls solely within the competence of the doctor. Only he can decide, on the basis of his *knowledge and action competences* (§ 3.2), which (of the many) risks are to be placed in the focus of attention of the information or not, because, for example, "side effects" of medicines only have to be "touched upon" in the *prescription talk* (§ 26).

Pseudo-enlightenment and pseudo-consent

All in all, the dosage of information naturally remains a problem of balance between under- and over-dosage (§ 10.5). In order to avoid the accusation of inadequate information for legal reasons, extremes of "overloaded" information are often chosen, which already come across in the style of a more or less academic lecture and completely miss the "actual" purpose of the information. This is a matter of a lack of *fitting competence* (§ 3.2) on the part of the doctor, who fails to "translate" professional communication into comprehensible everyday communication (§ 27). Instead of formulating the information in dosed amounts of information that can be absorbed by the patient and in his or her everyday language, medical information is delivered as if before a professional audience. In this way, the conflict between medicine and the patient's life world, as described by Mishler (1984) (§ 10.2.2), is exacerbated to the point of pseudo-communication simply by the medical *jargon* and *manner of speaking.*

An "elaborate" form of clarification, which opposes a non-academic patient need, could - as already explained above - primarily be due to the fear of legal sanctions, which is only to be avoided here through *pseudo-clarification.* Nevertheless, such pseudo-information can lead to *pseudo-consent on the part of* patients, which has been characterised as "consent out of *confusion*" (von Uexküll 1987: 125, cf. Koerfer et al. 1994: 69). There is no better way of describing a tricked consensus that is not based on the patient's *conviction* but on his or her *manipulation.*

The risk of "consent out of confusion" is particularly high when doctors, in their duty to inform, retreat to a so-called *objective* standard which is, as it were, worked through mechanically (and with "text modules") vis-à-vis a patient treated as a prototype. Towards an individual patient, however, a *subjective* standard must be taken into account at the same time, which according to Veatch (1991: 84) is again most likely to be realised in a *partnership* model, in which the doctor fulfils his obligation to explicitly encourage the patient to perceive his personal attitudes and interests, a very first prerequisite for arriving at "*informed consent*". As a result, a level of agreement should be found in which the "necessities" of medicine could be sufficiently reconciled with the "possibilities" of the patient's lifeworld to the satisfaction of both partners.

10.7.3 Medical fitting competence in case of model change

As explained above, the doctor must expect very differentiated and sometimes very ambivalent participation needs in everyday decision-making practice, which can also be subject to change in the further course of conversation and treatment. Here the doctor must develop a specific *fitting competence* (§ 3.2) in order to be able to react *flexibly to* the changing demands of decision-making practice.

Since, on the whole, it can by no means be assumed that patients have a homogeneous need for *maximum* participation in decision-making, the doctor must first find out the appropriate "dosage" individually in conversation with the patient and negotiate it with him again and again. In this process, the doctor's *fitting competence* must prove itself as a *meta-competence* (§ 3.2), with which the doctor can, on the one hand, adjust *ad hoc* to the *current* needs of the patient and, at the same time, know how to awaken their *potential* needs. In the sense of v. Uexküll, Wesiack (1991), this is a *metacompetence* (§ 3.2) insofar as the doctor must be able here to decide in critical self-observation and reflection processes how far he can "go" with the patient without *overtaxing him* with a relationship model that *is unsuitable* for him.

When choosing the *appropriate* decision model, the doctor can be guided by the initial, spontaneous *relationship offers* of his patients. The practical *sustainability* of these relationship offers must then be checked again and again in further discussions and treatment processes in order to initiate a correction or modification if necessary. Instead of being subject to an early *fixation on* a *paternalistic* relationship offer in the long run, the possibilities and limits of a *change of model* should be tested interactively in time, which can lead to a renegotiation of the relationship.

Such *negotiation processes* can be elaborate and extend over several conversations, but can also be carried out in short conversation sequences. As will be shown in empirical conversation analyses (§ 19, 22), even patients who seem to *prefer* a *service relationship* with the doctor in the "first moment" of the conversation are quite willing to switch to a *cooperative partnership model* after the doctor's first verbal interventions. However, specific *fit problems* have to be taken into account when switching models at a later stage (Box 10.17), since the different phases of the models (information, decision, responsibility) cannot be interchanged at will due to their different patterns of action (cf. Fig. 10.7-9 above).

Box 10.17 Problems of fit when changing models

The art of guiding the doctor in the decision-making dialogue consists precisely in *matching* the patient's need for participation with a decision-making model that is viable for him or her. In such fitting processes, the doctor may have to readjust several times, either within the selected initial model or - if it no longer fits - by changing the model. However, restrictions resulting from the *incompatibility* of the decision models must be taken into account, so that the "rules of the game" cannot be changed arbitrarily in the middle of the "language game".

As became clear in the comparative pattern analysis of decision-making models, these models are not arbitrarily interchangeable (...) If the interaction between doctor and patient has begun in the style of paternalism, it is not possible to simply switch to the cooperation model. Rather, the change requires a return to an earlier phase. Because a "shared decision" is conditioned by "shared information", the information phase must also be gone through again with the change of model in order to compensate for the information deficits from the initially paternalistic model (...).

Koerfer et al. 2005: 151

Overall, the doctor should largely follow the maxim that more information and participation is "better" for the patient than less, but he must be able to "take" the patient along with him. The fact that a minimum level of information must not be fallen short of is often already codified in law. In no way should the doctor retreat to a paternalistic model for the sake of his own interests, because patients would then be easier to "lead". Even spontaneous patient statements of the relevant type ("You decide for me, doctor") can at best be starting points

(Guadagnoli, Ward 1998). Under no circumstances should they encourage a *fixation* that has not been adequately tested.

In this examination, forms of a more or less *weak* or strong, *authoritative* paternalism can be distinguished, for which examples are still given from ward round communication (§ 25). These examples show how doctors make serious decisions "over the heads of patients" and express them in an *authoritarian* way that does not tolerate any "back talk" for the patients. These are obviously cases of *imposed* paternalism, which is not what the patient wants.

Accordingly, from the perspective of medical ethics and discourse ethics, a distinction can be made between types of "solicited" and "unsolicited" paternalism, which, according to Kampits (1996), are characterised by a (varying) degree of *asymmetry* (Box 10.18), which can stand in the way of the patient's *autonomy.*

Box 10.18 "Solicited" and "unsolicited" paternalism

The distinction between solicited and unsolicited paternalism picks up on further problems that can collide with the patient's autonomy. While the former can be done in accordance with the patient's choices (such as therapeutic help in trying to quit smoking), thus requiring some kind of active appeal by the patient to impose treatment on him, unsolicited paternalism poses another problem, for example in the case of forced blood transfusion in Jehovah's Witnesses. In any case, a paternalistic interpretation of the doctor-patient relationship expresses a highly present asymmetry.

Kampits 1996: 16

While the criticism of a *strong*, *imposed* paternalism is generally beyond question, the problem of imposition also arises for cooperative or partnership-based decision-making models (SDM), which can also become problematic if they are not preferred by patients. Here the doctor runs the risk of being suspected of manipulation or coercion despite the best intentions. Kettner, in a comparative analysis of concepts of "autonomy-promoting counselling", concludes critically: "A non-paternalism strategically implemented for the purpose of autonomy promotion is itself paternalistic. (Box 10.19). According to this, forms of non-paternalism are not yet "self-perpetuating", which all participants could use and accept without problems.

Box 10.19 Non-paternalism in the counselling process

Moral non-paternalism, it should not be forgotten, is also an imposition for some clients, whose good sense should not simply be assumed across the board, but should be clarified in the counselling process itself. The personal agenda of clients who seek counselling in the conviction that they would be best served by the expert's good advice ("the doctor knows best") would be just as questionably manipulated by a counsellor who unaccountably imposes his non-directive agenda of denying this desire as clients who desire autonomy-promoting counselling but encounter a counsellor who unaccountably imposes a paternalistic directive agenda. Non-paternalism strategically carried out for the purpose of autonomy promotion is itself paternalistic.

Kettner 1998: 34

If the doctor does not want to get entangled in *paradoxes* under the aspect of granting autonomy in decision-making, he will not be able to simply *impose* his preferred decision-making model (e.g. SDM) on the patient, but will have to disclose the alternatives and *negotiate them* with the patient in dialogue. Again, the dialogue principle of *transparency* applies, according to which *initiative,* anticipatory information is given about what is "questionable" or even "contentious", which is then *reactively* further clarified and decided through (post) question-answer patterns.

As a rule, the decision on how to decide is less meta-communicative and explicit and is carried out in actu, especially when preferences regarding *participation roles* change during the interaction (Elwyn et al. 2005, Koerfer et al. 2005, 2008, Epstein 2013, Epstein, Gramling 2013, Koerfer, Albus 2015, 2018). In the course of negotiation processes, in which information, arguments and opinions enter, certain decision tendencies are prepared. These decision tendencies can be forced through mutual, dialogical enquiries into the position of the other partner. In the process, as a rule, the preferred or even expected *participation roles* are also increasingly negotiated, because they are *attributed* more and more clearly in the question and answer game.

Thus, in the cooperative model of decision-making (SDM), the doctor will also be able to explicitly assume an *advisory role* (§ 22.5), in which he does not have to hide his preferences, especially when asked by the patient for his *personal recommendations* ("What do you recommend?", "What would you do in my place?" etc.). But unlike in the paternalism model, where no "back talk" against *orders* and *prescriptions* is expected, the patient by no means has to follow the "best" recommendation of the doctor, who in turn may agree with what he sees as the "second best" decision or even the "third best" decision, as long as they are within the framework of evidence-based medicine (§ 10.3). Thus, the doctor will be willing to follow the option preferred by the patient (e.g. "watchful waiting"), although he prefers another measure (e.g. surgery), which he may have already recommended in the conversation in a way that is recognisable to the patient.

Thus, at the end of a negotiation process between doctor and patient, complete ("one hundred percent") agreement is not required, but merely a decision acceptable to both sides. Agreement in the sense of *concordance* (§ 10.1) consists for both partners in the certainty of having decided "what is best" for the patient with "prudence" under sufficient consideration (*deliberation*) of the relevant reasons ("for" and "against") for the time being. In this way, a sufficient consensus has been reached to implement the "decision" together and to jointly take responsibility for and bear the consequences.

10.7.4 Integration of lifeworld and medicine

In order to prevent a *pseudo-consensus in the* form of "*confused consent*" described above with von Uexküll, in which no contradiction is "audible" on the surface of the conversation, the patient must be involved in a joint decision-making process in a sufficiently qualified manner. This requires a dialogical disclosure of the individual patient's history beforehand, with which at the same time the patient's personal life situation and his or her individual attitudes and values (beliefs, hopes, wishes, preferences, etc.) can be presented in detail and sufficiently taken into account in the decision-making process.

Only with this background knowledge, on which both interlocutors must agree as essential for the development of *shared knowledge,* is a basis for decision-making given, on which the choice of an adequate treatment method can be meaningfully justified from a medical ethics perspective, which was already summarised in contrast by Pellegrino, Tomasma (1988) as follows:

Box 10.20 Examination in the context of the patient's life situation and his or her value system

A biomedically or technomedically good treatment is not automatically a good one from the patient's point of view. It must be examined in the context of the patient's life situation and his or her value system.

Pellegrino, Thomasma 1988: 79

The consequence of this is to reconstruct the patient's *medical history* from the beginning as a *life story* and a *value story* at the same time. Here, the *participatory* perspective of medicine with its *narrative* perspective should be integrated. According to this, when exchanging basic information, the patient should first have his or her say (§ 9, 19), before the doctor can meaningfully "discuss" the further perspective of life with the patient, into which certain treatment options – whether to *prolong* or *improve* life (Gustavsson, Sandman 2015) – should appropriately intervene. Since medical *interventions* always also represent "interventions" in life, they are to be evaluated and planned, as it were, in anticipation of future life, i.e. to be *integrated into* a *life plan* of the patient. These integration possibilities are to be examined jointly and self-critically in a narrative self-interpretation with the doctor, who here as an active listener assumes the role of *co-constructor* of the patient's life and medical history (§ 9, 19).

This results in a further, specific consequence for medical action that the *biographical-narrative anamnesis collection* (§ 9) is ideally integrated with the *information* and *decision-making and provided* "from one source". If this cannot always be done optimally for institutional reasons (such as the division of labour between GP and specialist or hospital), minimal standards of an integrative approach should be maintained in order not to exacerbate the conflict between *medicine* and the patients' *lifeworld* (§ 10.2). Those who oppose an integrative approach to the reality of the current care system and question its feasibility from an economic point of view should be reminded of the continuing high subjective and objective "costs" (§ 10.1), which we all have to bear due to the *non-adherence* of patients, which is essentially due to inadequate communication with the doctor.

10.8 Summary and further information

In summary, the *art* of medical conversation in decision-making consists not only in first "exploring" the patient's *current* preferences on the basis of evidence-oriented basic information about the alternative treatment options, but also in "awakening" *potential* preferences and then allowing them to "mature" sufficiently in a dialogue-based deliberation process and to *promote* this maturing process in the patient (*empowerment*) long enough for the decision finally made to withstand a *rational* test of acceptability for the time being.

This applies both to the preferences on the *factual level*, where decisions between alternative treatment options have to be made, and to the preferences on the *meta-level* ("decision, how to decide"), where more or less explicitly, but sufficiently recognisable for both participants in the conversation, their respective participation roles are negotiated in reciprocal attribution processes. Physicians should be able to *flexibly* adapt to the changing participation needs of their patients with their communicative competence (Box 10.21), which will certainly remain a challenge for all participants in everyday practice.

Box 10.21 Tailor-made decision making

The one decision model that is *universally* valid for all patients must be rejected anyway, as it is occasionally metaphorically expressed ("tailoring") and justified: "Because one shoe doesn't fit all" (Lussier, Richard 2008, Epstein, Gramling 2013, Keller, Sarkar, Schillinger 2014). For the associated *fitting problem,* doctors, who are also otherwise familiar with individual dosages, should accordingly develop a *communicative* competence (Koerfer et al. 2008) with which they can react sensitively and flexibly to different and changing patient needs in a "tailor-made" way.

Koerfer, Albus 2015: 132

Empirical examples of conversations on decision-making can be found in particular in Chapter 22 ("Negotiating procedures") and Chapter 24 ("Ward Round Communication").

From the wide range of literature on medical decision-making, which has already been mentioned, the two monographs by Scheibler (2004) and Pollock (2005) in German and English, respectively, as well as the anthologies by Härter et al. (eds.) (2005) and Martin, DiMatteo (eds.)

(2014) should be mentioned. Regarding the connection between SDM and therapy (disease-relevant "endpoints"), reference should be made to the review by Hauser et al. (2015). In addition, the work of Stivers (2006) and Toerien, Shaw, Reuber (2013), as well as that of Peters (2015) and Becker (2015), which are easily accessible as online publications and contain many empirical examples of conversations that can also be used in teaching, should be mentioned as examples.

For a systematic overview, please refer to the reviews by Dwamena et al. (2012) (on the patient-centred approach), Légaré et al. (2014) and Hauser et al. (2015) (on SDM) and Braun, Marstedt (2014) (on the "aspiration and reality" of SDM/PDM), as well as Alheit, Herzberg (2018), who particularly emphasise differences between "decision-making cultures" (in Canada, USA, FRG). Of the more recent literature on (teaching) *Shared Decision Making* (SDM), the following should be mentioned here again: Elwyn, Vermunt 2020, Timmermans 2020, Waddell et al. 2021, Tidhar, Benbassat 2021, Kienlin et al. 2022, Lian et al. 2022, Leblang et al. 2022, Resnicow et al. 2022, Weber et al. 2023, Chmielowska et al. 2023, Lehane et al 2023, Stivers, Tate 2023, Zhou et al. 2023, Giorgi et al. 2024, Xiao et al. 2024. A review of the effects of SDM on outcomes, quality, cost and consultation time is provided by Bruch et al. 2014.

Further literature on *Dialogical Medicine* and *Decision Making* can be found in chapters 3, 7 and 22 ("Negotiating procedures") and 26 ("Prescription talk"). Specific problems of "dialogical understanding" in *Specialist Medical Communication* and *Intercultural Communication* are dealt with in chapters 27 and 28, where further reading is also provided.

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Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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Citation note

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