22 Negotiating Procedures

From Paternalism to Shared Decision Making

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> Dialogues, as opposed to monologues, are much more effective means of education and conveying vital information. A dialogue with the patient facilitates patient interaction, participation, understanding, and adherence.
>
> Benzel 2016: 190

Abstract: In a fifth conversation step of the *Cologne Manual of Medical Communication* (C-MMC), the necessary information is to be exchanged which can serve to prepare medical decision-making (§ 22.1). First of all, the patient's expectations should be clarified, which concern his or her ideas and wishes as well as his or her control beliefs, even if these may still be subject to considerable ambivalences (§ 22.2). In further patient education, monologue information "in one piece" should be avoided, which most patients can only understand and process in fragments anyway. Instead, a dialogue-based education should be practised according to the "Ask-Tell-Ask" method, with which the doctor builds on the patient's prior knowledge and inquiries about his or her need for knowledge, in order to then gradually and measuredly expand the patient's knowledge and secure it in a trusting relationship (§ 22.3).

In the further planning of diagnosis and therapy, doctor and patient can follow different relationship models, as they have already been differentiated in the theory of medical decision-making (*paternalism*, *service*, *cooperation*) (§ 10). In practice, there are often *mixed forms in* which the patient's participation is more or less pronounced (§ 22.4). While early diagnosis and therapy planning, especially in initial consultations, are often still entirely subject to the doctor's "decision-making authority", *participatory* or *shared decision-making* (SDM) can be more effective in follow-up consultations because patients have already had their first "own" experiences in the meantime, on the basis of which they can actively and in a qualified way "have their say" on the further procedure.

Patients should be able to exercise their right to have their say in a "real" conversation, which, according to Martin Buber (1954/1986), must not be "predisposed" (§ 7.5). Although the scope for negotiation in medical decision-making is limited within the framework of *evidence-based* medicine (§ 10.3), the conversations within this framework should initially be *open-ended*. On the basis of three conversations, dialogue negotiation processes from different fields of practice are to be analysed as examples, in which the focus is on different topics and objectives. While in a GP consultation a patient hopes to overcome her "fear of cancer" through a further diagnostic procedure ("magnetic resonance imaging") (§ 22.4.4), in a case from a medical polyclinic a patient with diabetes mellitus type 1 wants a change of therapy procedure ("injection" versus "pump") in order to improve his quality of life (§ 22.5). Finally, an oncology consultation deals with the specific improvement of a patient's quality of life at the end of life, to which an optimal pain therapy should contribute (§ 22.6). In all three consultations, the patients' opportunities for participation are to be reconstructed in detail, which are more or less actively promoted by the doctors, which is to be summed up in conclusion (§ 22.7).

22.1 Manual step 5: Negotiating procedures

As was stated with the discussion of the *relationship models* in decision-making, patient education is also to be regarded as a dialogue process in which the information is to be individually dosed according to the level of knowledge and need for knowledge (§ 10). Due to the complexity of dialogue-based information, we have differentiated 6 further steps in our *conversation manual* (on the reverse side), which are specifically tailored to *breaking bad news* (Köhle et al. 2010). Since these steps have been extensively documented, illustrated and commented on elsewhere (Koerfer, Obliers, Köhle 2005, Köhle, Obliers, Koerfer 2010, Köhle 2017), we will limit ourselves below (§ 22.3) to essential aspects of a dialogical education:

- Avoid educational monologues
- Dialogue pattern: "Ask-Tell-Ask"
- Exploring and communicating knowledge
- Securing trust and knowledge

For further aspects of the informed conversation, please refer to other chapters of the handbook: The problem of dealing with emotions was previously an essential topic in communicating particularly serious diagnoses (*breaking bad news*), for example, in *oncological* conversation practice (§ 16) and was then concretised as a task of *empathic* communication (§ 21) using empirical anchor examples for the conversation manual. Since specific problems of patient-oriented information transfer and risk communication are dealt with later in the *prescription talk* (§ 26) and in *specialist communication* (§ 27), we can concentrate here on selected aspects of dialogue-based information and decision-making, as they are to be presented in accordance with the 5th step of the communication manual (Fig. 22.1) and concretised with more or less successful practical examples.

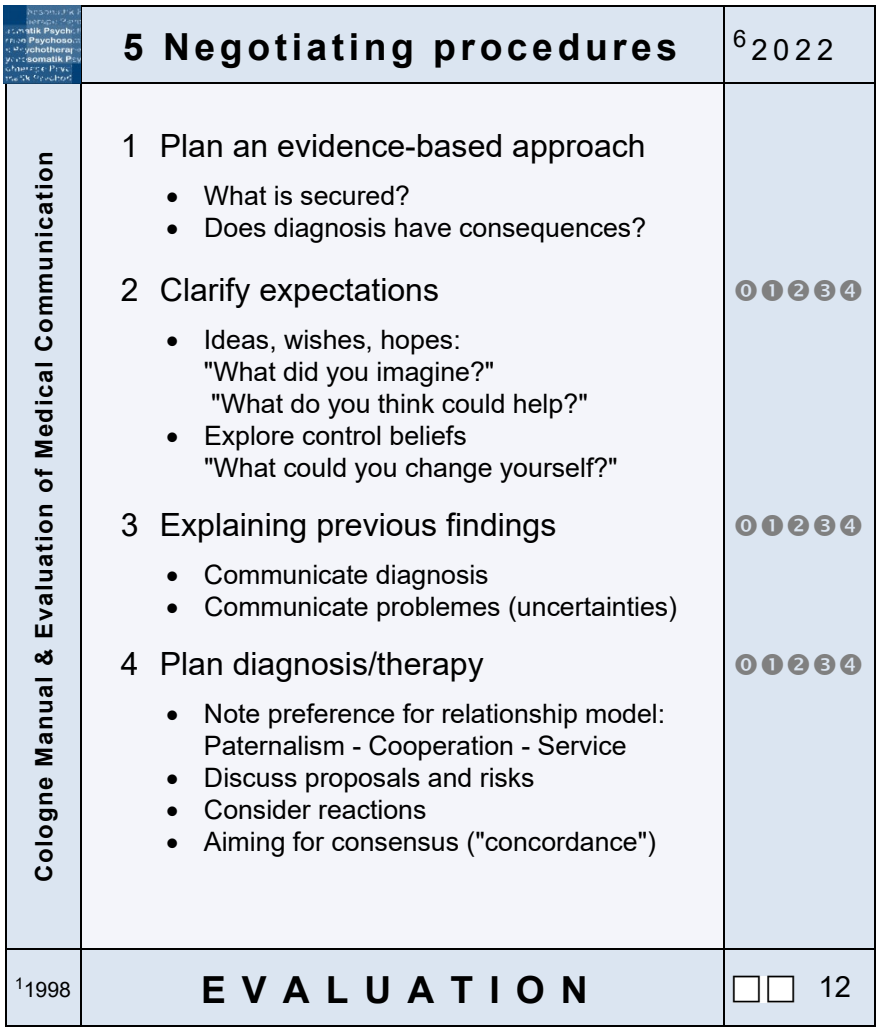

Fig. 22.1: Excerpt (Manual/Evaluation): Step/Function 5: "Negotiating procedures" (Cf. the complete Manual at the end of the chapter, Fig. 22.2)

From the practice of clarification and decision-making, shorter sequences of conversations will first be cited as anchor examples before dialogue negotiation processes are analysed in detail in longer conversation developments, which can be exemplary for *participatory decision-making* (or SDM) (§ 10).

As in the preceding steps of the manual, we limit ourselves to *observable* interview behaviour in this 5th interview step, for which a total of 12 out of 50 points can be awarded in the evaluation according to C-EMC (see Appendix § 44) (Fig. 22.2). In addition, the question of the extent to which criteria of evidence-based medicine were fulfilled in the diagnostic and therapeutic procedures "negotiated" in the interview can certainly be made a separate topic in the debriefings, for example in OSCE procedures (§ 13, 41). However, the evaluation is essentially about the medical dialogue, which is to be "measured" at this stage of the consultation by the extent to which participatory decision-making (or SDM) (§ 10) is promoted.

22.2 Clarify expectations and motivation

Sometimes patients come with a pre-determined request for a certain diagnostic or therapeutic procedure, which they explicitly demand right at the beginning of the consultation, even before they have communicated their complaints (§ 22.4.1). In many of these cases, the doctor is being approached as a service provider who is supposed to provide a certain service. Here, the doctor may have to take countermeasures and first insist on an anamnesis conversation, from which the meaning and purpose of the further procedure can be derived and diagnostic and therapeutic measures can be justified in an evidence-based manner. In order to arrive at shared decision-making (SDM) (§ 10), a change from the service model to the cooperation model must be made in these cases (§ 19.8, 22.4.1, 22.5), in which *patient preferences* must be reconciled with the requirements of *evidence-based* medicine (§ 10.3), in which the life-world-oriented interests of patients should be sufficiently taken into account, but must also be rejected if necessary.

On the other hand, patients often hold back their own ideas on how to proceed and, with a paternalistic attitude, leave the initiative to the doctor to present a treatment option, which they then apparently agree to without expressing possible reservations. In order to counteract later

non-adherence, the patient's ideas, wishes and options should be sufficiently known even before the doctor discusses further options with the patient. In this way, the doctor still receives "uninfluenced" information that a patient may not dare to express later, when only the options authorised by the doctor are still available. Encouragement to disclose ideas and wishes on how to proceed is also necessary here, as was already required in the exploration of patients' "subjective theories of illness" (§ 21.5).

22.2.1 Ideas, wishes and hopes

The patient's ideas, wishes and possibilities of behaviour must be sufficiently known in order to be able to recognise resistance to medical measures in good time, which could later lead to non-adherence. The simplest way to explore subjective ideas about further action is to ask patients directly about their expectations. However, when giving topic initiatives, one must occasionally expect *defensive reactions,* especially from patients who follow a *paternalistic* relationship model in which they want to give the initiative back to the doctor. In the following example (E 22.1a), where the doctor refers to his limited possibilities at the end of the day, the patient undermines the doctor's offer by insisting on the traditional distribution of roles, which he also justifies with his lack of knowledge.

E 22.1a		"What can I concretely do for you" - "You are the Doc".
01	D	(...) I don't have many possibilities now ... to research further . what can I concretely do for you now? .
02	P	you are the doc ...
03	D	that is, of course, the right answer.
04	P	yes, that is/ you are the doc, I don't know .
05	D	after the examination, shall I give you a injection? .
06	P	if that helps yes .

In this case, it remains unclear what was finally decided after the announced examination in the examination room. In other cases, too, questions about expectations are occasionally dismissed as "role rever-

sal", as in the following example (E 22.1b), in which the patient refers with humour to the profession of the doctor qua training.

E 22.1b		"What do you want me to advise you?" - "You are the doctor"
01	D	yes... in eh... what should we do? what should I advise you?...
02	P	Doctor ... You are the doctor. You have studied ... good eh? ... [laughs]
03	D	How important is the examination for you?
04	P	I think just to reassure myself very much.

As we will work out in detail in this example (§ 22.4.4), the patient has quite clear wishes and ideas for a further examination because of her persistent abdominal complaints, from which she expects clarity and ultimately reassurance. Most of the conversation with the doctor revolves around this request, whom she meets here laughing coquettishly after she has verbally challenged his professional authority. As the doctor's repeated enquiries reveal, she is trying to win the doctor over to her request for another "MRI" examination without directly presenting this request. Rather, indirect hints (*cues*) (§ 20) are given with the more or less conscious intention that the doctor may adopt her request. With his question (01), the doctor gives her the opportunity for clarification, which she, however, avoids precisely by invoking the doctor's authority, so that both interlocutors must once again enter into a process of negotiation (§ 22.4.4), at the end of which a joint decision is reached.

In the following example (E 22.2a), the patient accepts the opportunity offered by the doctor to present her ideas, but initially remains rather vague:

E 22.2a		"What do you expect me to do for you?"
01	D	what is your wish for me now . what do you expect from me - what can I do for you? .
02	P	yes ... I don't really have an idea myself ... I just thought, uh, it's good that you made the appointment, uh, because it's clear to me that I'll have to get help, too, which is something I didn't do in the past either. always everything for myself ...

In advance, the patient - as she herself says - had described a whole "palette" of complaints (including eating disorders, stomach pains, nausea, palpitations), before she then gradually reveals her "real" concern in this initial consultation, namely to receive long-term treatment for her "depression". This concern, which here is initially still formulated abstractly by the patient ("... also has to get help ..."), then becomes clear after further enquiries by the doctor, who then makes a second appointment with her for further clarification of a longer-term treatment. As in this case, the questions about expectations often function as "door openers" for formulations of the patient's concerns, which remained latent in the course of the conversation so far and can now become manifest and the subject of *negotiations* about the further course of action.

In addition to the complex cases in which the further procedure must be negotiated successively (§ 22.5-6), there are the numerous cases of a relatively speedy agreement between doctor and patient. Patients often accept the doctor's invitation to disclose their expectations immediately, as in the following example (E 22.2b), where doctor and patient quickly agree to continue a therapy they have started.

E 22.2b		"What did you expect me to say now?"
01	D	well, Mr S . we'll have to see ...
02	P	hm .
03	D	the ... what did you expect me to do now? . that we ...
04	P	hm . so more or less eh advice or whether I should try something eh . with some medicine / medication or (...) although I have made a lot of effort with the gymnastics I should do ....
05	D	so I would definitely suggest that you take a medication to support you, that you alleviate the pain a bit, yes . and that physiotherapy continues, yes . that there is support, but the consideration was also that you take cortisone, which is, yes, that is also something stronger .
06	P	yes .
07	D	so it must be a bit stronger in terms of the complaints, I would say, first of all, we try again with medication.
08	P	hm . hm
09	D	yes, and about physiotherapy . although you have already done a lot of it .
10	P	yes . yes.

While the doctor and the patient decide "positively" on the further course of action in this short sequence of talks, they also decide "negatively" that they will wait with a specific treatment option ("cortisone") until the complaints become stronger. With this rather "casual" decision and justification, which the patient agrees to several times, the end of the conversation is gradually approached, where further agreements ("precautions") are made.

Even if invitations to disclose patients' expectations are not always immediately "effective", they should be made as soon as possible, so that they do not break through "behind the scenes" again and again, for example through increased complaints about symptoms. In most cases, the thematising of expectations serves to clarify the further course of the conversation, because in the case of a successful agreement, both partners "know where they stand", even if this does not automatically lead to an agreement on the further course of action.

22.2.2 Explore control beliefs

Beyond patients' expectations, their *control beliefs* should be known and taken into account when planning further action. Promoting patients' health behaviours requires knowledge of their attitudes and behavioural options (Kulzer et al. 2016, Martin 2014, Harvey 2014) (§ 29). Those who agree with their patients on a diet in the case of diabetes or on participation in a cardiac sports group in the case of heart disease should know their attitudes and practical possibilities when implementing such a therapeutic measure. *Unstable* patient attitudes have to be taken into account, which have to do with *ambivalences* towards the disease itself, but also towards its treatment options, which often require active cooperation, by which patients can easily feel overwhelmed.

The ambivalences manifest themselves, for example, in an interim denial of the illness or in a fear of loss of control, which can go hand in hand with a misjudgement of one's own resources. Fears of losing control can relate to the relationship with the professional helper himself, whose help is often difficult to accept, as Wöller, Kruse (2010) (Box 22.1) have described for the psychotherapeutic relationship.

Box 22.1 Control and loss of control

The need for orientation and control is one of the basic human needs. Quite a few patients have the shameful feeling of loss of control at the beginning of treatment. The feeling of having failed in actively coping with life and now being passively dependent on outside help can have a lasting negative impact on well-being. Here, it can be important in the sense of the effective factor of resource activation to give the patient back the feeling of active shaping and participation. Involving the patient in the formulation of the goal or focus as well as providing information before the start of treatment about how the disorder is to be understood, how it is to be treated and what they themselves can contribute can help to reduce the feeling of loss of control.

Wöller, Kruse 2010: 104

Patients' need for orientation and control can be pronounced in different ways, which can make it particularly challenging to shape the relationship. Here the doctor must also be prepared for so-called "difficult" patients, among whom different groups can be distinguished, such as "dependent" patients from "reproachful-aggressive" or "devaluing" patients. Since the problems of shaping relationships in dealing with "difficult" patients will be dealt with separately (§ 34), the spectrum of control beliefs of patients will be illustrated here by way of example, which essentially relate to themselves as ill persons with their own resources in the desired change of behaviour.

In the empirical examples, only a narrow thematic focus can be considered, which is representative of other thematic areas in which patients' control beliefs play a decisive role in health promotion (Kulzer et al. 2016, Harvey 2014, Heather, Hönekopp 2014, Albus, Köhle 2017, Albus 2022). Health promotion not only extends to changes in the health or illness behaviour of adult patients, but also, in the sense of *prevention,* to the phase of *adolescence* (Schorr 2014, Wallander et al. 2014). In research on *health* belief *models, a* distinction is made between *internal* and *external* control beliefs (Box 22.2), which must be sufficiently taken into account when educating patients in the corresponding educational and motivational talks in order to be able to counteract "irrational" beliefs regarding the (causal) development of a disease and the maintenance of health-risky behaviour in good time.

Box 22.2	Health locus of control

Causal beliefs focus on the cause of past events. Locus-of-control beliefs relate to expectations for future events. Health locus of control (HLC) may be considered as internal or external. Internal refers to control by self, whereas external includes the influence of powerful others or of chance or fate.

Harvey 2014: 180

As a rule, there will be a mixture of *external* and *internal* control convictions in the conversation practice, the ratio or weighting of which must be changed in the education and motivation communication, if necessary under the active influence of the doctor. However, different hurdles and challenges to the physician's educational and motivational competence are to be expected here. Whoever as a patient is guided by the conviction that his or her illness is "fate" or even a "punishment from God" will only grant himself or herself, but also "powerful" others, limited possibilities of exerting influence. However, anyone who visits the doctor at all as a *significant* other in his or her specific *role* as a *helper* not only approves, but also hopes for and expects a more or less active influence that should contribute to the improvement of his or her general well-being and state of health.

In the following examples, it is first of all about more or less stable *control beliefs* that patients have with regard to (withdrawal from) *nicotine consumption*, which is repeatedly addressed in the consultations as one of the four central "adjusting screws" for necessary behavioural changes, along with the risk factors of *malnutrition*, *alcohol consumption* and *lack of exercise* (Albus, Hermann-Lingen 2017, Piepoli et al. 2016). In order to be able to counteract the harmful effects of such risk behaviour on other underlying diseases (*diabetes, CHD*, etc.), the promotion of health behaviour must at the same time start with the change of previous habits and attitudes, which must first be adequately explored for both conversation partners. Doctors cannot always assume that their patients have stable control beliefs, but often have to reckon with considerable ambivalences.

The first interview, the development of which will be presented in several sub-steps, is a case of *smoking cessation,* which involves, among other things, the insight, motivation and behavioural change of a pa-

tient who has been smoking since the age of 16 and now for more than 30 years. After a stay in hospital due to pneumonia, she was strongly advised to stop smoking. The detailed interview passages on insight and motivation can only be reproduced here in excerpts and abridged (E 22.3).

E 22.3		"I've wanted to for a long time, but I can't do it on my own".
01	D	why do you come to me? .
02	P	I had a severe pneumonia and was in hospital (...) and in hospital they recommended you to me. I would like to stop smoking.
03	D	hm . since when have you been smoking? .
04	P	at the age of 16 . so over 30 years .
05	D	how much do you smoke? .
06	P	well, on average a pack . is also sometimes a bit more, but you can say . a pack .
07	D	a pack? .
08	P	yes .
09	D	why do you want to quit smoking now? .
10	P	I've wanted to for a long time, but I can't do it alone.
11	D	why? .
12	P	yes, I don't know.
13	D	have you ever tried? .
14	P	yes . either the will is really lacking . or . I know- . [shakes head]

After the first steps of the anamnesis, which serve to clarify the patient's previous smoking "career" as well as the reason and motivation for giving up smoking,[1] the patient's need for help becomes clear ("I can't do it alone"), who apparently "lacked the will" in the past. Accordingly, the doctor now follows up with a question about her previous experiences of giving up smoking, during which the patient apparently repeatedly experienced a threatening *loss of control*, which she describes to the doctor in a linguistically dramatic form (04P: "then I go crazy") (E 22.4). According to the everyday understanding of "going crazy", one loses all

[1] Smoking cessation is essentially associated by the doctor with acupuncture treatment, for which patients also visit his practice. Independent of questions about the evidence of acupuncture treatment, the following is about the specific type of doctor-patient communication on smoking cessation, in which the control beliefs are explored by the doctor and expressed by the patient.

"inner" and "outer" control, which is aptly described by the patient directly afterwards with further terms ("nervous", "aggressive").

E 22.4		"then I go crazy ... I get nervous ... aggressive ."
01	D	what happens if you don't smoke? .
02	P	if I don't smoke? .
03	D	hm .
04	P	I go crazy... (3) ... I get nervous ... aggressive.
	D	(...)
	P	(...)
05	D	I want to know: how far have you come to the realisation that smoking is bad? .
06	P	yes, first because ... in the hospital they told me ... I should try ... not to smoke any more, right .
07	D	hm .
08	P	and I know that beforehand . and you know how harmful it is . and then always the coughing (...)

Following the dramatic description of negative experiences with nicotine withdrawal, the doctor inquires several times in the conversation about the *stability* of her previously expressed *insights* and *intentions,* as he had already begun to do (05D: "I want to know: how far have you come to the realisation"). Here, on the one hand, the patient expresses her *subjective* experiences, in which the accompanying symptoms of coughing are also already assessed as disturbing in everyday life (here left out in the family, at work, etc.), on the other hand, she *objectively* quotes the urgent warnings of the medical authorities, which she makes completely her own (E 22.5). In this process, the *mental* adoption of the medical warnings goes hand in hand with an *emotional* experience of the impending physical health disorders, so that the patient has "somehow become afraid".

E 22.5		"and that's when I kind of got scared"
01	P	and can that also be a kind of circulatory disorder caused by smoking? . as I've seen in the hospital now . here the left side, no? ... the leg and the foot were ...
02	D	hm . hm .
03	P	they tested the reflexes, right? . and somehow the left one was

		completely different from the right one . and somehow I got scared [...].
04	D	[...]
05	P	and somehow I got a bit scared .
06	D	justified fear .

In the sequences omitted here, the doctor answers the patient's question (01) in the affirmative about possible circulatory disorders, which would occur more frequently in smokers, and announces his own examinations following the conversation. At the same time, he takes up the patient's *fear* by qualifying it as a "justified fear". Unlike in idiomatic expressions, according to which "fear" is often characterised as "bad advice", in this case "fear" can also function as "good advice" for an urgent change in behaviour after this upgrading of relevance ("justified fear"); at any rate, this may have been what the doctor meant and what the patient understood. After further sequences, there is an intermediate assessment in which the doctor again asks about the patient's *insight* and *will,* whereupon the patient again states her motivation (E 22.6) to give up smoking "mainly for the sake of her health".

E 22.6		"so . I really want to stop"
01	D	well, I have treated many patients, also chain smokers (...) but the will must be independent .
02	P	yes .
03	D	you can't just try it, you have to want to . must really have come to the realisation that smoking not only uh . wastes money and uh . but also because of your health .
04	P	yes .
05	P	oh not because of money, so mainly because of health . so . I really want to stop .

The doctor's repeated appeal to the patient's "will" and "insight" is apparently understood by her without reservation and answered accordingly by her once again giving a decided explanation and justification of her intention, the *credibility* and *seriousness* of which is further reinforced ("really"). With this affirmation, the clarification and motivation conversation has reached sufficient saturation for the time being. Under many aspects of the conviction of control, both conversation partners have been able to come to an understanding in the process of a joint

decision-making, in the course of which the patient's *insight* and *will* have proven to be sufficiently sustainable. The doctor then continues taking the medical history under selected biopsychosocial aspects before proceeding to the physical examination as announced.

While a wide range of control beliefs were discussed in the previous interview, the following interview, in which the same doctor also discusses smoking cessation in detail with another patient, will only focus on the aspect of weight control, which is of particular relevance to the patient (E 22.7).

E 22.7		"so it's up to oneself?"
01	D	hm .
02	P	What do I have to do to keep my weight down if I stop smoking now?
03	D	why do you think uh . are you getting fatter? .
04	P	because it is commonly said . everyone who has quit is fatter/getting fatter .
05	D	well ... many compensate after quitting smoking by eating a little more .
06	P	aha . no .
07	D	but you, uh ...
08	P	so I do fitness training on the side ... uh . eat consciously . because I also went on a diet last year and have always been able to keep my weight down ... so it's up to oneself? .
09	D	hm .

Apparently, the patient initially fears a loss of control in which she would no longer be able to regulate her weight herself. The doctor attempts reassurance here on the premise that she would not be subject to compensation through increased eating when she quits smoking. Since weight is now solely under her control again depending on her own behaviour, the patient can express her confidence with an *internal control belief*. Due to relevant previous experiences (*fitness training*, *dieting*), she can quite confidently rely on a corresponding self-discipline in the sense of *self-efficacy,* with which she believes she can appropriately master the upcoming problems that could present themselves as temptations in eating behaviour.

In a still questioning tone of voice, the patient finally draws a conclusion as a reassurance to her doctor, according to which she herself

remains the only *responsible subject of action* ("so it's up to oneself?"). In the further course of the conversation, the healthy diet "prescribed" by the doctor (nothing "fatty" or "sweet") remains just as manageable for the patient as the "recommended" additional exercise in the "fresh air". Here, too, the patient has the stable conviction that she can follow the doctor's instructions accordingly.

22.2.3 Consider ambivalences

Depending on the type of patient and the treatment measure, not only *interindividual* but also *intraindividual* differences in patients' control beliefs must be expected, which may have an impact on their later (non-)adherence. Patients who can easily follow a diet or join a cardiac exercise group on a permanent basis may nevertheless be non-adherent when it comes to prescribing medication (§ 26). For example, patients may refuse to take certain medications because they fear certain side effects where the loss of control may be experienced as a loss of identity ("I am no longer myself"). Such a loss of control, which affects one's own self-perception, may be experienced in this way when taking painkillers (analgesics) or psychotropic drugs (including anxiolytics, antidepressants, neuroleptics), for example when coping with illness after a heart attack (Albus, Köhle 2017, Herrmann-Lingen, Albus, Titscher 2022) (§ 29). The feared or already experienced loss of control is then expressed by patients in a variety of *idiomatic expressions* ("no longer being the same person", "being beside oneself", "feeling like being controlled by others", "being wrapped in cotton wool", etc.). Independent of such specific fears of loss of control, there are still inter- and intra-individual differences according to which patients go to the doctor immediately when they have pain, for example, because they fear the "worst", but let preventive care appointments pass because the associated "inconveniences" and "worries" can rather be "suppressed".

The fact that one and the same patient cannot be assumed to have homogeneous control convictions with a correspondingly general health behaviour in all health matters becomes clear in the further course of the conversation with the preceding example of giving up smoking. Without any particular reason to talk about it, the same patient, who had just decisively explained her insights and intentions with regard to giving up smoking, makes a kind of "confession" to her doctor towards

the end of the conversation, according to which she explicitly assesses herself overall as a "bad" patient (E 22.8).

E 22.8		"I'm a bad patient, right"
01	D	hm .
02	P	I'm, I'm a bad patient, right? It takes me a long time to get up the courage to go to the doctor when I have something.
03	D	hm .
04	P	for example, next week I'm going for my first check-up in ten years.
05	D	(oh dear!) .
06	P	but right now ... I ... I don't know ... I'm on the health kick right now ... and I want this ... I've got a really stubborn head now and I want this and want that .
07	D	that is very nice .

What the patient has apparently found very difficult in general so far, seems to be particularly easy for her in the current case. All in all, her open statements are not without a certain self-contradiction, which should not have escaped the doctor's notice. On the one hand, the patient complains about her general lack of courage for visits to the doctor, of which she herself cites the long-standing avoidance of preventive care as an example, while on the other hand she *contrasts* her "current health kick" with an adversative transition ("but ..."), which she intends to pursue with a "stubborn head". Precisely because in this self-critical perspective she compares a general tendency to avoid visits to the doctor with her current "health kick", certain doubts could arise in the doctor's mind as to which behaviour will ultimately prevail in the future in view of her *cognitive dissonances*, or in other words: whether she will maintain her "stubborn head" in the current case of giving up smoking.

Even with individual patients, a general health behaviour qua *stable* control beliefs can rarely be assumed. Rather, ambivalences towards various challenges to concrete health behaviour must be taken into account, on which the doctor in his role as a *significant other* can certainly exert influence in a "positive" direction. This influence should take place in dialogue processes in which the congruence of attitudes and behaviour is sustainably ensured.

Ambivalences are rarely expressed in conversations as manifestly as in the preceding example, in which the patient openly formulates her

conflicting tendencies. In this respect, doctors should also be alert to latent ambivalences. Whether they explicitly communicate the perceived ambivalences to their patients is certainly also a question of the level of development of a trusting relationship, to which we will also return with an example of patient education (§ 22.3). If necessary, ambivalences should not be addressed *confrontationally*, but in a *tangential conversation* (§ 3, 17), which should stimulate but not force patients' reflections. In the present case, the doctor reacts to the patient's avoidance behaviour with a short feedback that sounds like an "oh dear!", but initially leaves it at that and then reinforces (07D: "that's very nice") the patient's current decision, the validity of which is precisely not questioned but recognised for her future behaviour.

Overall, doctors should not become fundamentally suspicious of patients' explicitly stated insights and intentions, but they should remain sensitive to possible ambivalences that are always to be expected in the practice of conversation. Patients themselves can suffer from these ambivalences just as much as their doctors are affected, especially if the consequences are reflected in non-adherence. Since in matters of "conviction of control" the first initiatives of exploration and declaration do not always have to be the "last word spoken" at the same time, doctors should professionally adjust to the ambivalences of their patients. As further examples show, ambivalences can still "break through" even when decisions seem to have been finally made, which then leads to renewed negotiation processes.

22.3 Explaining previous findings

While the *art of dialogical clarification* has already been discussed in detail in the theoretical part of the Handbook (§ 10.5), in the following we will present more or less successful practical cases. In doing so, we were guided by the "Ask-Tell-Ask" scheme of conversational guidance, which has since been widely used (e.g. Barrier et al. 2003, Back et al. 2005, 2008, Kemp et al. 2008, Goodlin et al. 2008, Schell, Arnold 2012, Hausteiner-Wiehle, Henningsen 2015, NKLM 2.0 2021). In contrast to *positive* anchor examples (*best practice*) of *dialogue-based* information, however, the *negative* case of *monologue-based* information should first be used to show how doctors can dispense with their legal obligation to

provide information in "lecture form" without allowing themselves to be "drawn into a conversation".

22.3.1 Avoid educational monologues

The fact that *dialogue-based* information, which is initially oriented towards the level of knowledge and knowledge needs of individual patients, is not a matter of course, can be illustrated by an empirical example from an older study by Mann (1984). Although the individual measures or operations may be "outdated" from a purely medical-surgical point of view, Mann's study has the merit of having contrasted different cases of *dialogical* and *monological* education in an empirical collection of material for practice purposes, also in teaching, at an early stage of empirical research on doctor-patient communication. For illustration purposes, we only reproduce the abbreviated beginning of a 7.5-minute preoperative informative conversation (E 22.9), in which a patient is to be informed about an upcoming knee joint operation. The informative talk is conducted in the presence of a second doctor, who occasionally (18 A2) intervenes in a supportive manner beyond his function as a "witness" to the informative talk.

E 22.9		"something taken out, at the calcaneus, so that's a bursa"
01	D1	Mr. X., the following, we have taken something out of the lower part of the calcaneus, that is a bursa. And then you probably have the beginning of a PCP, i.e. a rheumatic disease, which very often also begins to spread in the joint mucous membranes, and therefore one must assume that these changes belong to this clinical picture in the knee joints as well as in the fingers. And now it makes sense to remove the joint mucosa of the affected joints, because antibodies or ... particles that maintain the disease are formed there. And for this reason it was recommended to perform a synovectomy on your knee joint, i.e. to remove the synovial membrane... In rare cases there are complications, which I have written down here, one is the wound healing disorder, nerve disorder, there is a nerve that supplies the front of the tibia. This can become numb after the operation, and if it is cut, depending on how atypical it is, when the skin is cut [...] but it is done subtotally, not as far as you can get it. And then as a further complication, movement restrictions that can lead to stiffen-

		ing of the knee joint. These are more legally addressed complications, but they can certainly occur.
02	P	Is an operation absolutely necessary?
03	D1	One should, yes, and for the reason: [...]
		[...]
		[...]
12	P	Yes, with the operation, I would like to think about it again.
13	D1	Hmm, uh, hmm, how long do you think you'll want to reconsider?
14	P	One or two days.
15	D1	Hmm. We'll just have to make sure that we get you off the surgery schedule again, won't we?
16	P	yes.
17	D1	And the chance of getting you back on it is always incredibly bad [...].
18	D2	Yes, now it must be made clear that it is a prophylactic intervention to prevent later damage [...] This is similar to underbody protection in a car, not, it's not a good example, but it doesn't have to be. /Hm/, not, but there is a point to it [...].

The dialogue *asymmetry* of the conversation or the doctor's *dominance* is manifested solely in the ratio of the interlocutors' contributions. The first speech of the informing doctor, which has already been abbreviated here and is supported by a second doctor [=D2], is followed by further long speeches which are only "interrupted" by shorter questions or answers from the patient. Although in a clarification phase, the word can in the meantime essentially fall to the doctor (§ 17.3), he should by no means use this *speaking privilege* to "lecture", which a layperson cannot follow anyway, especially if they are characterised by specific technical terms (in the further course of the conversation e.g.: *chronic polyarthritis*, *progressive, antibodies* etc.). Although translations/paraphrases ("that means ...") are offered in a few cases, their understanding is neither implicitly indicated by listening signals from the patient nor explicitly secured by queries from the doctor.

As is already clear at the end of the first medical contribution, the doctor is functionally essentially concerned with a legally relevant duty to inform, in which possible complications must at least be mentioned ("These are more legally addressed complications, but can certainly occur"). In this context, *risk communication* (e.g. about probabilities) is not

further deepened, as is actually part of the standard of information for medical measures (§ 3, 10, 26). Beyond the formal-dialogical and content-related-functional dominance of the doctor, the decision-making pressure that the doctor interactively exerts on the patient is already perceptible in the excerpt reproduced here, not least through the references to the surgery schedule (15A1), from which the patient is in danger of falling out.

All in all, according to Mann (1984), the doctor's effort to "convince the patient of the necessity of the operation or of the negative consequences of withdrawing from the operation with all possible arguments, not without applying pressure" (1984: 127) also becomes clear in the course of the conversation. Other cases in his collection of material from empirical conversations, to which we can only refer here as positive examples of dialogical and comprehensible explanation, show that in principle it can also be done differently. Empirical conversation analyses on specific problems of ensuring understanding in *preoperative anaesthesiological* informed consent conversations can be found in Klüber (2015), whose topics range from the opening of the conversation to the structure and function of the informed consent procedure to the patient's written consent. The specific problem of written consent ("signature") is also explored by Bührig, Meyer (2007). Further mostly "problematic" examples of patient education are given in the case of ward round communication (§ 24). In the following, however, the lack of information is to be shown by means of "positive" examples from the practice of general practice consultations, in which general practitioners often have to "vicariously" compensate for the "omissions" of their colleagues from the clinic and specialist practice. In doing so, the omissions as knowledge deficits of the patients must often first be explored by asking questions before they can then be remedied by appropriate information.

22.3.2 Dialogical education: Ask-Tell-Ask

The asymmetry of knowledge between laypersons and experts cannot be eliminated in principle, but the necessary exchange of information between the interlocutors can be mediated in dialogical forms for the benefit of both (§ 10). The education of patients can hardly succeed in a *monological one-way communication,* in which they are confronted with a quasi-scientific lecture ("ex cathedra") that satisfies a merely "objec-

tive" standard of a "complete" conveyance of information, which may correspond to a legal duty to inform (§ 39), but quickly exceeds the patients' ability to receive information.

Insofar as patients can be "dizzied" by a flood of information, there is a danger of "*confused consent*" (§ 10.7). In order to avoid a pseudo-consensus, the doctor must engage in conversation with the *individual reality of* his patients, i.e. choose the form of dialogue in which *sharing* leads to "sharing with each other" (Uexküll 1987). Before a *shared decision making* can finally take place, the information between the two dialogue partners (*shared information)* must be exchanged in such a way that above all the patient's individual level of knowledge and need for knowledge can be taken into account. [2]

The essential aspects of a dialogical process of understanding and comprehension have been described with the *Ask-Tell-Ask scheme* of interviewing, which has since found wide application (e.g. Barrier et al. 2003, Back et al. 2005, 2008, Kemp et al. 2008, Goodlin et al. 2008, Schell, Arnold 2012, Hausteiner-Wiehle, Henningsen 2015, NKLM 2.0 2021). For further orientation, we reproduce here in excerpts the overview presentation by Back et al. (2005) (Box 22.3), which at the same time contains a series of concrete doctor's questions, the answers to which can in turn guide further patient-oriented information provision.

Box 22.3 Ask - Tell - Ask

Ask the patient to describe his/her current understanding of the issue. This will help you craft your message to take into account the patient's level of knowledge, emotional state, and degree of education. Some sample questions to open your conversation include:

- What brings you here today?
- What is the most important issue for us to talk about today?
- To make sure we are on the same page, can you tell me what your understanding of your disease is?
- What have your other doctors been telling you about your illness since the last time we spoke?

2 The fact that the need for knowledge is not constant, but can increase continuously with a good structured and motivating conversation, was explained earlier (§ 10) in the justification of dialogue-based information and decision-making. Even in patient-oriented education, the legally relevant duties of disclosure (§ 10, 39) must be fulfilled when conveying the necessary information.

Tell the patient in straightforward language what you need to communicate - the bad news, treatment options, or other information. Stop short of giving a long lecture or huge amounts of detail. Information should be provided in short, digestible chunks. A useful rule of thumb is not to give more than three pieces of information at a time. Avoid medical jargon.

Ask the patient if he/she understood what you just said. This gives you the opportunity to check his/her understanding. Did he/she get the facts straight? Is his/her understanding appropriate? Did he/she hear what was said? Consider asking the patient to restate what was said in his/her own words. This will give him a chance to ask questions, which will tell you where to go next - what details to elaborate, what implications to discuss, what things to repeat. For example, you could say, "Who are you going to tell about this visit when you get home?" or "To make sure I did a good job of explaining this to you, can you tell me what you are going to say?"

Back et al. 2005: 166

Some of the question types, especially from the first round of questions, should of course already have been asked and answered in the anamnesis interview (§ 9, 19-21), such as the question about the patient's *subjective understanding of the illness* (§ 21.5). Likewise, questions to ensure understanding between doctor and patient are a permanent task (§ 9.2, 19.5), which, however, plays a special role in the clarification phases of conversations, because patients are usually unfamiliar with the topics negotiated there. Here, in the second round of questions, specific questions about understanding through repetition "in the patient's own words" can be a useful procedure for securing understanding in general. The fact that medical information itself has to be conveyed in small and "digestible" portions (*digestible chunks*) and the use of "medical jargon" has to be avoided or explained in a way that is understandable in everyday language (§ 10, 26, 27) may mean that additional communicative *effort* has to be made at first,

As soon as doctors are prepared to follow the information needs and reception abilities of their patients, they have to regularly check their understanding in the ongoing conversation by asking questions and gradually adjust their further information accordingly, i.e. depending on the recognisable (in)understanding of their patients, they have to correct, modify, complete etc. the level of knowledge currently achieved. In this way, a distinctly *repetitive* structure (Ask-Tell-Ask-Tell-Ask etc.) can

develop, which, as with all dialogue-based communication processes, may initially appear to be more time-consuming, at least in direct comparison to monologue education (§ 22.3.1), in which the information is conveyed *en bloc* - with whatever short- and long-term reception effects.

However, the additional effort in dialogue-based information can be "amortised" in time if patients achieve "*informed consent",* which proves to be sustainable in the long term, for example in their subsequent *adherence*. In contrast, "poorly" informed patients are proven candidates for *non-adherence*, with all the negative consequences for their individual health and the societal follow-up costs (§ 10, 26). However, the deficits in information are not only reflected in objectifiable follow-up costs, but in the consultations themselves, where both partners can suffer equally from their *dissatisfaction*. On the part of the patients, dissatisfaction not infrequently leads to a break-off and change of relationship ("*doctor hopping"*), which in turn can be associated with further follow-up costs (solely due to multiple treatments).

For research purposes on inadequate information, however, it is precisely those consultations that prove to be excellent "study objects" in which patients complain about the inadequate information behaviour of pre-treatment doctors towards their current treating doctor in the current consultation. The complaints are often triggered by the questions asked by the current doctor according to the *Ask-Tell-Ask* scheme, such as the relevant question type from the first round of questions: "What have your other doctors been telling you about your illness since the last time we spoke? (Box 22.3). If a particular prescription has already been initiated or even an operation has been scheduled by the previous or co-therapist, questions of this type are asked in a variation of the basic type: "What have you understood about why and how you should take the medication?" or in the case of an operation: "Do you know what is to be done to you (for what reasons)?". If patients are unable to communicate their understanding "in their own words" (Box 22.3), the doctor currently treating them automatically comes under a duty to provide appropriate information. GPs are often particularly challenged here, as they have to "compensate" for the *inadequate* information provided by the *hospital's* or *specialist's* previous or co-treating physician.

Their compensation then consists in the initiation or continuation of the *Ask-Tell-Ask scheme,* whose patient-appropriate application was more or less "missed" "elsewhere". Without lapsing into colleague "bashing", a "natural" design can be methodically used here for research purposes, in which the deficits in medical education that have arisen else-

where are studied, as it were, "in the mirror of the current consultation". The empirical conversation analyses from various GP consultations, in which the problematic understanding of insufficiently informed patients is revealed, will also contribute to this in the following.

In this context, the first step is not only to explore and convey *knowledge* (§ 22.3.3), but the second step is also to build *trust* in the doctor (§ 22.3.4), which the doctor must build up beyond the "mere" conveyance of information in order to give the patient sufficient *certainty of knowledge*.

22.3.3 Exploring and communicating knowledge

Anyone who wants to impart knowledge must know the level of knowledge of his or her interlocutor in order to be able to build on it. In medical consultations, patients often bring in their "previous knowledge" in terminological forms that they adopt, as it were, quoting from their previous treatments, without having the corresponding understanding. This often results in a mixture of everyday and professional language, which can lead to pseudo-professional categorisations (Löning 1994, Brünner, Gülich 2002). Morgan and Engel already warned against a pseudo-understanding and use of professional terms, especially if this is connected with an uncritical adoption of the diagnosis mentioned by the patient: "For perhaps the patient has misunderstood something or the diagnosis may be incomplete or wrong due to new findings" (1977: 52). Simply to counter such risks of misunderstandings and pseudo-understandings, the verbalised knowledge of patients should be put on a "test bench" from which both interlocutors can benefit if the results of the test lead to more clarity. The relevance of testing knowledge before imparting knowledge is to be exemplified in the following conversation examples.

Cardiological findings: "How did you understand that?"

In the following example, the doctor tests the patient's prior knowledge by repeatedly asking and questioning the patient's understanding according to the *Ask-Tell-Ask scheme.* In the initial consultation with the GP, the patient tells a long patient history with many stations and treatments/surgeries in clinics and specialist practices (among others

with a "cardiologist"), which included - as she herself says - her "cardiac arrhythmias". She brought "findings" from the "cardiologist" with her to the GP visit, which the GP could hardly or did not want to receive during the consultation (E 22.10: 05D: "I'll have to look at that again in detail"). Instead, in a variant of the question types from the *Ask-Tell-Ask* scheme (Box 22.3), the doctor asks the patient about her subjective understanding, at the same time offering himself as a listener (07D: "and how did you understand that, if you had to explain it to me?") and later (E 22.10) still alternatively bringing the husband into play as a potential addressee of her explanation.

E 22.10		"And how did you understand that, if you had to explain it (...)?"
01	D	[you have- .
02	P	[now I don't know, the EC/Long-term ECG result, I can't figure it out either ... (3) ...
03	D	of the seventh of March? .
04	P	hm .
05	D	ah so, that's the same, yes ..... (6) ..... then maybe I have to look at it again ah yes ... (3) ... I have to look at it again uh . I have to look at it again in detail . did doctor X explain it to you uh .? .
06	P	yes .
07	D	and how did you understand that, if you had to explain it to me now? .
08	P	he said it wasn't dangerous, and ... after a year I should come back, but now he sent me this long-term ECG, and I don't know, I couldn't figure it out, something else has come up.
09	D	hm .
10	P	or not? I wanted to have this explained anyway.

The patient first of all takes the initiative to express her need for clarification (02: "I can't figure it out either"). After she answers the doctor's question (05) in the affirmative as to whether "Doctor X explained it to her" (06), the current doctor asks her first question about her understanding, initially offering himself on the level of a professional listener (07: "If you had to explain it to me now"). Thus asked for her understanding, the patient, after quoting a general assessment by the cardiologist (08: "he said it's not dangerous"), again expresses her specific *lack of knowledge* ("I couldn't figure it out") with regard to an unclear additional piece of information from the subsequently sent report,

which obviously makes her feel irritated to worried ("but [...] something else has come up"). Although the patient again expresses the need for clarification (10P: "I wanted to have that explained anyway"), the doctor makes another attempt (E 22.11) to inquire about the patient's prior knowledge and understanding.

E 22.11		"you didn't understand it in a way (...)" - "no!"
11	D	yes . so let's say . you didn't understand it in a way that you could explain it to me or your husband..
12	P	hm .
13	D	you didn't .
14	P	no! .
15	D	you see . I don't want to examine you .
16	P	hm .
17	D	but I want to understand what your idea of the findings is .

Again, in a modification of the question types from the *Ask-Tell-Ask scheme* (Box 22.3), the doctor builds an *everyday language* bridge to the patient's *everyday understanding* with this further conversational step (11D): By going back even further behind his own level of a *professional* listener and imagining her husband as the exemplary addressee of the explanation, the patient could now explain her understanding "in her own words" at the level of a *layperson* for a *layperson* (her husband). But despite the "low hurdles", the question about the possibility of an explanation by the patient is also answered tersely in the negative ("no!"). Thus a summary is drawn for the time being, to which the doctor then subsequently explains the meaning and purpose of his questions about the patient's understanding with a *meta-comment,* in order to apparently prevent a possible misunderstanding with an appeal (15D: "You see ..."): he does not want to "examine", but rather "understand what your idea of the findings is". With this *meta-comment,* the doctor formulates a general *maxim of conversation* in the middle of the ongoing conversation, which should have a special validity in medical conversation, namely to *understand* the patient's *understanding*.

Reciprocally, patients should experience that their doctors follow this conversational maxim because they have an interest in the subjective understanding of their patients for professional reasons - which was exemplarily expressed in the current case. As is the case every-

where in action, those acting are at the same time learning subjects, so that in the long term, reciprocal insight can also be gained into the conversational benefit that is possible through a disclosure of the subjective understanding of patients in the consultation.

Following the doctor's lengthy excursion to explore the patient's subjective understanding, the detailed anamnesis is continued, in which the complaints and the patient's further medical and life history are discussed in detail. At the end of the conversation, the doctor renews his promise of further *clarification of* the *findings* (05D: "I have to take a look at it in detail"), before he then starts the physical examination of the patient in the same consultation room.

Operation: "Do you understand what is being done?"

While in the previous case the lack of information could only be determined, but not yet directly compensated for in the current conversation, the doctor succeeds in a "substitute" explanation in the following conversation, which can obviously contribute to the patient's satisfaction, because it can also contribute to reassurance. Before this, however, the knowledge with which the patient comes to the GP's consultation must be checked and secured. Right at the beginning of the conversation, the patient's deficient level of knowledge becomes clear, with which she had obviously been "released" from the consultations of the pre-treatment doctors. The patient's insecurity is already evident in her handling of the documents ("forms") (E 22.12), which she sends to her family doctor immediately after the opening of the conversation.

E 22.12		"yes, the skin cancer"
01	D	Mrs X, please, take a seat.
02	P	er... I'll come to (name of place or clinic) on Monday, right .
03	D	what is being done? .
04	P	[points to nose] .
05	D	with the nose? .
06	P	yes, the skin cancer, no... and now I've got a form here ... I don't know if it's to fill out, or what it is ...
07	D	yes ... they just gave it to you there? .
08	P	yes .

Without any specific signs of a fear of contact with a "taboo word" being recognisable here at first glance, the basic topic of the consultation ("skin cancer") is brought to the fore right at the beginning. However, it is "unmistakable" that the patient, both by her vague announcement ("I'll come to ... on Monday") and by her pointing gesture to the nose, is in a way "guessing" the doctor (05D: "With the nose?") before she introduces the corresponding everyday language name of the disease. It is also "unmistakable" that the first "concern" is not possible worries about this current illness and its treatment, but the organisational problems associated with the treatment, which may also already be perceived by the doctor as "advanced" problems.

In the passages of the conversation omitted here, it is then essentially first about further *organisational problems*, namely journeys between the different practitioners (dermatologist, clinic) as well as questions of responsibility for referrals or admissions, before the topic comes back to the "documents", which the doctor flips through in the meantime, and the disease ("skin cancer"). In his subsequent questions (E 22.3) about *subjective understanding,* the doctor in this example also varies the basic types of the *Ask-Tell-Ask* scheme (Box 22.3) in forms that are easy to understand in everyday life: "have you understood what is being done and why it is being done . when they say 'skin cancer', what does that mean to you now?" (D07). Although easy to understand, this initial question is at the same time complex because it asks both the "what" and the "why", combined with the question about the subjective understanding of what it "means" for the patient when the [doctors] "say: skin cancer". Perhaps the patient, for all her comprehensibility in detail, is overwhelmed by the complex multiple question; in any case, she initially shifts the focus of her deficient understanding to her ignorance of the technical terms used by the doctors.

E 22.13		"have you understood what is being done and ..."
01	D	from me now? .
02	P	yes . there's all kinds of stuff in here . uh ...
03	D	you can't handle it...
04	P	no .
05	D	what it is, which is also a lot of papers and forms ... Jesses! [Jesus] and now you don't know what to do with them?
06	P	no! . and I can't see it either (...) then I'll get new glasses . now I can't see it either .

07	D	have you understood what is being done and why it is being done? when they say 'skin cancer', what does that mean for you?
08	P	yes, I ... I can't remember the foreign word, that was a foreign word ... now I don't know.

In view of the richness and complexity of the entire conversation, we can only focus on a few aspects here. For the *categories* from the conversation manual used below, we refer back to comparable anchor examples for active listening (§ 19) and *empathic* communication (§ 20). First of all, the doctor reacts with an appropriate *acknowledgement* of the patient's burdens due to the upcoming organisational problems. On the one hand, this acknowledgement acknowledges and expresses her feeling of insecurity (03D: "you can't handle it"). On the other hand, he authentically reveals his own emotions in an *empathic* response with an everyday language "exclamation" (05D: "Jesses!"). When the patient apparently begins to talk more about further (abbreviated here) organisational problems related to the adjustment of her glasses after eye surgery, the doctor initiates a change of topic in the direction of the basic topic introduced at the beginning ("skin cancer").

With its central questions about the patient's subjective understanding, which refer both to the understanding of the disease itself (07D: "skin cancer") and to the upcoming operation (07, 09), the conversation could already take a turn that gradually leads from the existing feeling of insecurity in dealing with the documents to the patient's *primary emotions,* as they will still come up later in the conversation. However, the patient only accepts the doctor's invitation to talk about the topic to a limited extent when she initially only expresses her ignorance of the "foreign word" ("I can't remember the foreign word (...) I don't know it"). In order to move from this *conceptual* kind of *not knowing* to the patient's *subjective understanding*, the doctor renews his specific question in the following conversation sequence (E 22.14) with a narrower thematic focus on her *idea of* "what is being taken away". But here too, the patient first expresses her *ignorance*, both non-verbally by shrugging her shoulders and verbally: "I don't know". She then thematically shifts to the part of her knowledge that she probably still remembers well, namely the dermatologist's *warning,* which she quotes dramatically ("dermatologist said ...") in order to then reveal her "terrible fear" after another *empathetic* response from the doctor (03).

E 22.14		"how do you imagine what will be taken away?"
01	D	hm . how do you imagine what will be taken away? .
02	P	[shoulder shrug] I know ... I don't know ... that's ... the skin ... the GP ... ah ... the dermatologist said that if I didn't have it done, I wouldn't have a nose in 5 years ... and that was a bit...
03	D	well . that sounds bad, doesn't it .
04	P	and it's always red and then the ... the nodules appear ... but I have to have something done... but I'm terribly afraid.
05	D	you are afraid, yes ....
06	P	[nods] ...
07	D	what do you think might happen? .
08	P	yes, that first of all it comes back ... could be... and... and also of the operation itself ...
09	D	of the operation, yes .

In this sequence of the conversation, the turn to a new quality of conversation finally takes place, in which the patient's *primary emotions are expressed.* The doctor forces this development through multiple upgrades of relevance by giving *empathetic* feedback to the dramatic descriptions of the negative consequences of possible non-treatment ("that sounds bad") and reacting to the disclosure of the "terrible fear" with the simple means of repetition ("You are afraid, yes") in the sense of *active listening* (§ 19, 20). After the patient merely nods in agreement, the doctor intervenes into the pause with his question about her ideas about "what could happen". Thus stimulated to further self-exploration, the patient reveals her fear of both a recurrence ("that it could come back first") and her fear of the operation itself, which is part of the general fear of patients before and in hospital (§ 24.1). With this disclosure of her double fear, the topics are predetermined that will be taken up and worked on again by both interlocutors in the further course of the conversation. Since the patient herself has already formulated the necessary understanding of the treatment ("04P: "I have to have something done"), the doctor's further explanation is initially directed towards the fear of a recurrence, which he tries to dispel in several steps, the tendency of which to reduce her "terrible fear" is already clear in the following sequence of conversations (E 22.15).

E 22.15		"so that you don't have to be afraid that (...)
01	D	yes. that is, it would only be on the spot, so to speak, and when it is removed, it is then also good . it only has to be cut out completely, yes . so that you don't have to be afraid that it becomes a stray cancer, so to speak, that continues to grow in the whole body, yes . uh . what is otherwise always the danger with such cancers ....
02	P	yes, there are also, as one hears, so many different .
03	D	yes .
04	P	types of skin cancer .
05	D	yes . and what have you understood now, what type do you have? .
06	P	I'm afraid I can't tell you ... I don't know...

The doctor first presents to the patient what he considers to be a "good" prognosis, which can probably be justified on the basis of the patient's medical history and an examination of the "files", to which he also makes direct reference later after casually reviewing the documents brought by the patient. In the *Ask-Tell-Ask scheme* of the dialogue-based explanation, the doctor's informative contributions now also become longer, with which he also tries to alleviate the patient's fear (01D: "so you don't have to be afraid"). However, the patient's remaining scepticism is unmistakable.

The doctor responds to her "objections" directly, first by listening signals ("yes") and then by asking her again for her understanding (05D: "what did you understand now, what type do you have?"), whereupon the patient again expresses her non-knowledge, several times and marked with a specific expression of regret ("I'm afraid I can't tell you ... I don't know..."). Obviously, the interlocutors have reached a critical point of development in the clarification conversation here, where not only the exchange of information can simply be continued *ad infinitum,* but the emotions involved must be taken into account.

In this conversation, too, the patient's skepticism and fear can obviously not be overcome by merely increasing the amount of information. Rather, through the doctor's initiative, the relationship of trust itself is put to the test, beyond knowledge, in order to achieve sufficient certainty in the patient's knowledge to enable her to look forward with some

confidence to the scheduled operation, which both conversation partners had already considered necessary.

22.3.4 Securing knowledge and trust

Trust is often a particular challenge in the dialogue-based educational conversation when doctors try to convince their patients of the usefulness of a medical measure. In the process, possible doubts on the part of the patients must also be dispelled, which can also affect the relationship aspect of medical truthfulness. Especially when it comes to the "existential" issues in the consultation, patients' skepticism about the matter can easily turn into skepticism about the doctor as a person. Such a change can take place behind the backs of those acting without being immediately noticed by them.

In the present case, the doctor's perception leads to a double strategy: he links his further "educational work" with the "question of trust". In the continuation of the previous conversation, he initiates a *meta-communication* in which he deals offensively with the problem of trust (E 22.16) by asking the patient directly about her "belief" in the matter and at the same time about her "feeling" towards him.

E 22.16		"do you get the feeling that I'm just trying to comfort you?"
01	D	which eh, so I assume that you have such a form of cancer, yes . which only needs to be operated on, yes . and where the cancer is then also removed, yes . so something that can be cured very well today, yes . so that you have very good prospects . is that understandable to you? .
02	P	yes .
03	D	yes? . can you believe that, or do you have the feeling that I only want to comfort you? .
04	P	oh no, I don't think so ... comforting... I mean, otherwise you'd say so too.
05	D	yes, I would tell you that too, yes, but it looks like you have a form of cancer that is very well curable, yes (...)

If one takes only the "wording" of the first conversation sequence (01-02), the doctor could have justifiably continued "at first glance" in his explanation according to the extended *Ask-Tell-Ask-Tell scheme*: After a

long chain of information and questions, he explicitly concludes his relatively short, well-dosed educational contribution with a question about her understanding, which the patient again explicitly affirms ("yes"). Apparently, however, the doctor interprets this kind of affirmation as too "weak" to simply continue. When interpreting *singular* utterances in context, it is always also a matter of the entire prehistory of the interaction, which enters into the perception of individual phenomena. The patient's *fear* and *skepticism* had become abundantly clear in advance, so that an "aftereffect" can be assumed here in the current conversational situation. In addition, the doctor can also be guided by his "scenic understanding" (§ 9.2), which also includes the perception of *non-verbal* phenomena (§ 12). Finally, the specific knowledge of the profession always flows into the interpretation of certain developments in the conversation, which includes not only clinical knowledge (in the narrow sense), but also communicative experience in conducting conversations in "difficult" conversation situations.

As an experienced general practicioner, he knows about the persistent fears of patients, which can concern not only the meaning and purpose of medical interventions, but also the relationship with the doctor himself. That is why the doctor's overall interpretation of this sequence of conversations, for which the patient's sparing affirmation ("yes") probably proved too "meagre", puts precisely this relationship to the test when he asks her about her *beliefs* and *feelings* (03D: "can you believe that, or do you have the feeling that I only want to comfort you?"). Here precisely the difference to pseudo-actions of consolation is marked, which would not be justified on factual grounds.

The doctor tries to dispel precisely this possible reservation on the part of the patient by tackling the subject head-on. In doing so, he can "weigh in the balance" for his own credibility the previous joint experience between the two of them, according to which the patient can obviously trust the open word of her doctor (04P: "otherwise you'd say so too"). This is, of course, a "proof of trust", which in this form can probably only be both "retrieved" and "provided" in a long-term history of interaction and relationship.

This advantage of a long-term doctor-patient relationship, which had already been repeatedly characterised by Balint (1964/88) as a "mutual investment society", does not, however, relieve the patient of the necessary obligation to provide information and build trust in less long-term care. Here, the lack of information and supportive preparation can lead to consequential burdens for all involved, even in the short term, if the

cancellation of planned operations is threatened (§ 22.3), for example because the doubts of poorly informed and motivated patients should finally "gain the upper hand".

The example of the "skin cancer" patient from the GP's practice makes it clear how *doubt* can develop into *despair*, which the GP had to deal with in a caring clarification in which he finally puts his own relationship to the test. After his excursus of a *metacommunication* on *belief* in the matter and *feeling* in the relationship, the further dialogue-based clarification work continues successively step by step, in that the transfer of knowledge is secured by constant questions of assurance for the patient's understanding. The further topics of information range from cosmetic problems and healing to fears about the operation and anesthesia to the patient's own previous illnesses, which can only be reproduced here in excerpts as examples (E 22.17).

E 22.17		"but what worries you is the operation and anesthesia".
01	D	(...) taken away, yes, in e, uh, that may not look good cosmetically at the beginning, but - that can heal very nicely over time . yes ... but what worries you even more is the operation and the anesthesia, yes.
02	P	[nods]
03	D	in, and that are also the forms here, yes...that inform you about the [risk, what happens there . yes .
04	P	[ahso (=I see).
05	D	that is, they gave you a piece of paper with the risk about the operation and what will be done, yes.
06	P	aaahja (=I see) .
07	D	now you moan .
08	P	one with the other . first the heart, then the eyes [=op] . now this . no so .
09	D	yes . a lot comes together .
10	P	yes .
11	D	have the feeling . you can't make it any more? .
12	P	exactly .
13	D	hm . yes .

After the renewed *empathic recognition* of the burdens, the doctor enquires about possible help from relatives and continues to try to probe and reduce the problems in dealing with the burdensome "documents",

which he briefly goes through again, and to encourage the patient to close the gaps together with the attending doctors in the hospital, who would question and examine her again thoroughly before the operation anyway, etc.

In the further course of the conversation with the GP, it becomes clear that the patient is able to overcome, if not completely, her "terrible fear" of the operation itself as well as of a recurrence, but at least to alleviate it and to look forward to the operation with a certain confidence, whereby the insight into its necessity was once again strengthened.

In an explanatory consultation, which lasts about 8 minutes at its core, the general practitioner, in a repetitive passage through the dialogic *Ask-Tell-Ask scheme,* took on a *pre- and caring explanatory role* of the specialist colleagues, by whom the patient had apparently been insufficiently informed and prepared before the operation. This deficiency manifested itself "in the mirror of the current consultation", in which the patient was able to adequately "bring up" her doubts and despair. In her distress, the patient had to turn to her GP for help, who had to "*compensate*" for the inadequate information and preparation for the operation.

22.4 Planning diagnostic and therapeutic procedures

In all possible variants of the relationship design, three basic models had been distinguished in advance in decision-making: *Paternalism, Service* and *Cooperation* (SDM) (§ 10.4). While patients with a paternalistic relationship preference want to hold back their own expectations and leave the decision for further action to their doctor (§ 22.2), other patients come to the consultation with a fixed request, in which they seek out the doctor as a service provider for certain diagnostic or therapeutic procedures. If the doctor does not want to accept the paternalistic or service-providing roles without further ado, he or she must first establish a transformation to the cooperation model through conversation.

But here, too, mixed forms will occur in conversation practice (§ 10.4), in which both conversation partners make compromises in the matter as well as in the design of the relationship, which may have to be negotiated in a lengthy manner as long as the pressure to make a decision still permits this factually. In the following, the mixed forms or

transformations between the relationship models will be exemplified first in shorter conversation sequences (E 22.4) and then in longer conversation processes (E 22.5-6).

22.4.1 Transformations to the cooperation model

Patients can bring their concerns to the consultation in different forms, in which they hand in their personal "*ticket of entry*" (§ 19.4). This "ticket of entry" may consist of dramatic complaints of severe discomfort such as unbearable "pain" or "nausea", but also "restlessness" or "anxiety". The corresponding descriptions of complaints are considered traditional reasons for consultation.

For example, in a case documented and analysed in detail (§ 19.7), the patient opened the conversation with her complaint about "such dizziness that I can hardly walk". Further exploration of the complaints led the doctor and patient to a biopsychosocial anamnesis in which the current stresses of the patient, whose daughter suffers from a recently "broken out" "MS" disease, became clear, which led to a considerable break in the patient's previous life narrative and self-image. In this conversation, the patient's descriptions of her complaints could be directly transferred into a biographical narrative anamnesis.

In contrast, in the case also documented and analysed in detail (§ 19.8), the patient opened the conversation with the request for a specific examination ("outpatient endoscopy") (E 22.18), for which the doctor had been specifically recommended by a colleague.

E 22.18		"an outpatient endoscopy"
01	D	yes, Mr B . what's up? .
02	P	yes, I . came here because my colleague . [name] . said that you have . uh . uh . such special examination methods . among other things you do an outpatient endoscopy and uh . determine that . what's the name . bacteria and .
03	D	hm .
04	P	stuff like that .
05	D	hm .
06	P	are in the stomach .
07	D	hm . hm ...

In this case, the *ticket* to the consultation is initially a biomedical examination request to the doctor as service provider. In the further course of the consultation, the doctor asks about the patient's complaints and his 30-year treatment history, which, from the patient's point of view, has not been satisfactory, despite short phases of improvement. Therefore he comes back to the examination, for which he had stayed "on an empty stomach" in order to fulfil the "formal" conditions for a "gastroscopy". Afterwards, the doctor accommodates the patient ("yes, okay, yes, we can do it"), but announces the continuation of the conversation with further questions.

E 22.19		"I just have a few more questions..."
01	D	hm .
02	P	that's why I haven't eaten (...) drunk anything (...) so I'm (...) ready .
03	D	yes . okay . yes . we can do it . but I still have a few questions .
04	P	yes .
05	D	It's been going on for a few years now and then, right? .

These "few questions", which the doctor then asks one by one, and their corresponding answers then lead to a completely different quality of content and cooperation in the conversation, in the development of which the dramatic life narrative is told by the patient, after which he had to change his professional perspective because of an examination failure, from which he suffers to this day.

As was worked out in detail above (§ 19.8, 21.6), the subsequent cooperation between doctor and patient extended to the emergence and development of the life narrative, the joint processing of which in the further course of the conversation as well as in a follow-up session led to a new life orientation for the patient. This development of the conversation is essentially due to the intervention services of the doctor, without whose constructive participation in the patient's story, the anamnesis would have remained at the level of a reconstruction of the "treatment career" of a "stomach" patient.

In the following example (E 22.20), a patient also initially opens the conversation with a "biomedical" ticket according to the service model by wanting the doctor to do a "total check", based on a recommendation from a friend who is also being treated by this doctor.

E 22.20		"I actually wanted to do a total check with you"
01	D	yes, Mr F . what's up? .
02	P	I actually wanted to do a total check with you.
03	D	hm .
04	P	so complete . a friend of mine is also with you .
05	D	hm .
06	P	Mr K .
07	D	yes .
08	P	and he recommended to me that this is done well here and so on. I also wanted to do it in this form, with a stress ECG and a lung X-ray and so on .

In this example, too, the patient presents a certain biomedically oriented request ("total check, so complete") in a way according to which the doctor-patient relationship could be reduced to a mere service if the doctor were to comply with the patient's request without further ado.[3] However, here too the doctor's first intervention makes it clear that he is not prepared to be reduced to the mere role of a service provider without taking an appropriate medical history. Even with his simple *why-question* (E 22.21: 09: "why do you want this?") the doctor elicits from the patient a whole bundle of *motives* for visiting the doctor, ranging from the still superficial "prevention" to the subjective experience of complaints and illness and ("stress", "substance reduced", "heartache").

E 22.21		"and why do you want that?"
09	D	yes . hm . and why do you want that? .
10	P	open [exhales] ... I am 38 now and would like to prevent a bit.
11	D	hm .
12	P	And lately I've had the feeling, due to a bit of stress and then also sometimes, that my substance is being degraded a bit.
13	D	yes .

3 In teaching and training we use the didactic method of conversation simulation described above (§ 13.5), in which the group members make their own suggestions for an intervention ("it's your turn") at such a directionally relevant point in the conversation. Their suggestions can then be critically compared with the subsequent real continuation of the conversation by the real doctor in order to find out the optimal intervention ("best practice").

14	P	that I sometimes have heartaches . at least that's how I feel .
15	D	hm .

Here, the *subjective* reasons for the consultation behind the biomedical admission ticket ("total check") already come to light in the confined space of the conversation, which can only "break through" through the doctor's "why" question. In the further course of the conversation, the specific complaints and the stressful situations (at work, in the family, etc.) are deepened as topics of a biopsychosocial anamnesis, in which the patient shows himself increasingly open and cooperative. The topic of the stressful job also brings up the subjective participation perspective, which is characterised by a "certain ambition" in the patient, as expressed by the doctor after the patient's description of his "professional career" and explicitly confirmed by the patient ("a certain ambition is there, no question about it"). At the end of the conversation, the patient agrees to a part of the physical examinations, which have already begun in an adjoining room.

In the preceding conversations, the initial service-oriented relationship offer of the patients is gradually transformed by their doctors into a cooperation model in the course of the conversation, in which at the same time narrative self-explorations are promoted, which makes the biomedical treatment request more understandable for both conversation partners. The professional handling of "treatment-related" tickets should not "devalue" them, but "enhance" them in the sense of a biopsychosocial anamnesis, at the end of which the desired treatment procedure can ultimately prove to be useful, if it is evidence-based.

Under this condition, it may also be helpful if doctors signal their possible *consent* to the requested treatment procedure at an early stage, if they can justify it, as in the preceding example (E 22.19) or in examples cited elsewhere (§ 20.7, 25). In these cases, the "pressure" can be taken out of the conversation, which can be conducted in a much more "relaxed" manner if the patients no longer have to "fight" "unnecessarily" for the granting of their request in the further course of the conversation.

22.4.2 Diagnostic planning in initial interviews

Normally, however, the interlocutors should be "patient" in making decisions for or against certain treatment options until a certain point in time when the conversation has sufficiently "matured". In the decision-making process, one can roughly distinguish between two typical conversation processes: whether the decision is reached rather quickly, in that one partner can easily follow the initiative of the other, or whether a longer negotiation process is necessary, because there are real alternatives between treatment options, in which the patient's preferences play an important role.

Irrespective of particularly complex cases, in which it also makes sense to seek a "second opinion", cases in which an approximate *equivalence* ("equipoise") of treatment options can be assumed are already a problem (§ 10.3). In the case of simple decisions, preferences and evidence coincide; in the case of more complex decisions, doctor and patient must first enter into a more or less protracted process of negotiation in which a *balance* between preferences and evidence has yet to be found. We can only illustrate the broad spectrum of more or less *cooperative* decision-making (§ 10.4-7) here with a few shorter example sequences, before longer negotiation processes are to be shown using exemplary conversation processes. We begin with the relatively simple cases in which consensus is reached "succinctly".

First of all, we would like to refer back to the previous example of a consultation (E 22.2), in which the doctor asked about the patient's *expectations* and both conversation partners were able to quickly agree on the continuation of the therapy that had been started (pain medication, physiotherapy). If, in a consecutive consultation, a likewise shorter anamnesis survey should not reveal any significant changes, the extension of a therapy can be decided accordingly and quickly, provided that this is in accordance with the patient's preferences and expectations.

The following examples deal with *initial interviews in* which diagnostic and therapeutic steps still have to be explored and initiated, as well as with *follow-up interviews* in which continuations and modifications of initiated therapies are agreed upon. For initial conversations, we initially assume a diagnostic focus, although the ratios can also be reversed or mixed: Depending on the stage of development, therapy decisions can of course already be made in initial interviews and diagnostic decisions can be made again in follow-up interviews. Especially if the hoped-for

therapeutic successes fail to materialise, further diagnostic steps often have to be initiated, which lead to the testing of further therapies, and so on. In all cases, this raises the question of the *extent of participation of* patients and their *participation roles in* decision-making for further diagnostics and therapy, which of course also depends on different "factual" conditions under which the *right* of patients *to have a say* is more or less challenged.

As has already become clear in previous cases (§ 22.2), the medical competence in initial conversations is usually given a special credit of trust by the patients because the suggestions for diagnostics or therapy must first prove themselves in further treatment practice, in which the patients can then later have a qualified "say" based on their own experience. In the following initial consultation (E 22.22), after a thorough anamnesis, the doctor makes a large number of suggestions for further diagnostic procedures, which receive unreserved approval from the patient, without him having to question the sense and purpose of the individual measures further. Probably completely trusting in the doctor's competence, the patient can give his "sparing" approvals in the form of mere listener feedback (*yes, hm*), which he only supplements with brief information in two sequences after doctor's information questions (03, 15).

E 22.22		"we still have to clarify the somatic side, of course"
01	D	yes, and of course we still have to clarify the somatic side . I would also suggest that . because we hardly have any findings at all now . no .
02	P	[nods] .
03	D	so . how was it with the lung function . had that already been done .
04	P	this was done by Doctor G .
05	D	yes . but I would also like to do that again .
06	P	hm .
07	D	and then I would do an exercise ECG .
08	P	yes .
09	D	that we just quantify the/your per/physical performance, yes .
10	P	yes .
11	D	and if we see that you then pedal 200 watts or 300 [laughs] . or so . then it's more of an objective perception .
12	P	yes .
13	D	than a subjective one . and that already says something . and .

		then I would do another extensive lab .
14	P	hm .
15	D	so with signs of inflammation . all the stuff . did doctor G x-ray the lungs too? .
16	P	No . he only did this function test in a cabin like this.
17	D	yes .
18	P	yes .
19	D	I would do it again .
20	P	yes .

The examination steps suggested by the doctor are listed in a series of individual examinations whose meaning and purpose are either not explained at all or quite vaguely ("all the stuff") or only in keywords ("performance", "objective" vs. "subjective", "signs of inflammation", etc.). In this example, the patient's "cooperation" in decision-making is limited to mere signals of agreement and two shorter answers to the doctor's information questions. Of these answers, at best the information (04) about the pre-treatment can be understood as a possible "objection", after which a repetition of the examination in question could seem obsolete. However, this possible reading is not even realised by the doctor, so that the patient's *minimal cooperation* in this example is finally exhausted in the affirmation (*yes, hm*) of the doctor's examination suggestions.

The following example is also a first interview, but the two interview partners have to deal with the "possible risks and side effects" of medication prescribed by a previous doctor. Due to a change of location, the patient now has to look for a new GP, to whom he complains about skin changes right at the beginning of the conversation and then expresses the suspicion that these could have occurred as a side effect of medication. The doctor looks at the skin changes in between, also takes a look at the medication the patient has brought with him and first spontaneously judges the quantity ("You have a lot of blood pressure and heart medication") before he then takes up the patient's suspicion about possible side effects (E 22.23) and specifies them.

E 22.23	"... do a blood test on you for clarification".

01	D	I think your/your idea is very good, yes . that is a medication side effect, yes .
02	P	yes? .

03	D	and that is due to several things, one is due to [drug name 1], very likely, yes . but the other is also . You see this stripe, these skin changes, yes . that is possibly due to this [drug name 2], yes? . but I would also like to do a blood test on you to clarify this .
04	P	yes, we could do that .
05	D	yes . that we check it out . (...)

In the omission, alternative explanations are already examined at the same time, but these can be discarded during further detailed exploration based on the information given by the patient. After this interim assessment, in which the consensus in the decision-making process is already apparent, the doctor also expands the anamnesis to include other complaints of the patient ("my problems with my back") and his family and professional situation, before returning to the patient's current reason for consultation at the end of the conversation (E 22.24).

E 22.24		" then we'll do the following"
01	D	then we'll do the following, we'll just have a short talk today ... please continue to take the medication, I'll check it next week in the blood test .
02	P	all right .
03	D	yes, and then you please make an appointment for 20 minutes or so .
04	P	yes, it's no problem .
05	D	that we get to know each other a little better .
06	P	no problem doctor .
07	D	agree? .
08	P	agree .
09	D	fine, I'll make you the appointment in front .
10	P	we will do that .

Precisely because the need for further clarification of the possible side effects of medication is obvious, both conversation partners are able to reach a consensus relatively "briefly and succinctly" in this conversation, which also concerns the further intake of medication, which is to be continued subject to the results of the examination (02P: "all right"). At the same time, the consensus extends to the next appointment, for which the doctor agrees on a longer conversation time with his new pa-

tient, "so that we can get to know each other a bit better", which is then alternately agreed on several times.

In the preceding conversations, the focus was mainly on diagnostic planning where decisions were more or less made by the doctor "single-handedly" qua professional competence, because the specific diagnostic procedures themselves (laboratory, ECG, etc.) do not initially represent risky "interventions" in the patient's life. In other cases, where considerable risks would have to be expected or potentially serious findings would affect the patient's knowledge and life in a momentous way, the patient's consensus would be just as explicitly required for diagnostic procedures as for a more or less risky therapeutic procedure, which, as in the last example, must already meet a *transparency standard* (§ 10.5) of communication for the *prescription of medication* alone (§ 26). From the point of view of transparency of medical action, there are no differences in principle, at best gradual differences between diagnosis and therapy.[4] The more significant their "effects" and "side effects" are for individual patients, the more medical action is dependent on their active cooperation.

22.4.3 Decision-making in follow-up meetings

The active cooperation of patients usually comes about of its own accord when they have made their own experiences with the treatment and with the practitioner. Especially when therapy is not successful, the critical potential of so-called "dissatisfied" patients grows. Whereas in *initial consultations,* the doctor's diagnosis and therapy suggestions are often still accepted without reservations, trusting in the professional competence, in ongoing treatments, the patients already have concrete experiential knowledge, on the basis of which they can already "have a better say" in the decision-making process - be it still *questioning* or already *critical.*[5] In the following examples, the patients try to use their

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4 The principle symmetry of diagnosis and therapy is "negatively" reflected in the patient's right not to know and not to be treated, which to ignore would be tantamount to neo-paternalism (§ 10.6-7). Thus, a patient's "active" cooperation may be limited to this very claim to the rights of non-knowledge and non-treatment.

5 Of course, patients with a chronic disease (§ 29) can have this experiential knowledge at their disposal in both initial and follow-up consultations, in which they can often identify themselves as "experts" on their own disease,

experiential competence in decision-making for further treatment with varying degrees of success.

In the first example (E 22.25) of a follow-up conversation, after a concrete suggestion for a further diagnostic procedure, the doctor first gives his patient a greater *say* by explicitly asking her for further or other "wishes".

E 22.25		"Referral to radiologist"
01	D	yes, yes . pay attention! . I'll give you a referral now [clears throat] . I'll give you a referral to the radiologist . six months have passed since May . changes may have occurred . and then I would send you, with/ . if you wish . with these documents I would send you to [clinic name] . yes? .
02	P	hm .
03	D	or do you have any other wishes? . or do you want to go somewhere else? .

The patient is first confronted with a double question that is not easy to answer. The first question addresses possible further wishes ("do you have any *other* wishes?"), while the second question probably asks about alternatives to the previously mentioned clinic ("or do you want to go somewhere else?"). Although the patient answers directly afterwards (E 22.26: 04P) with a firm negative ("no!"), the reference to one or both questions remains unclear. Nevertheless, her continuation of speech makes it clear that the patient has another "wish" concerning the treatment of her unbearable pain ("I can't stand it anymore"). In this way, the patient takes over the decision-making initiative at an advanced stage of the conversation, which, from the doctor's point of view, seemed to have already ended with the suggestions of a referral to a radiologist and further treatment in a certain clinic. With a *but*-introduction, she formulates an *objection* in her follow-up speech (04), according to which the conversation can by no means already be ended before her "pain" is adequately taken into account.

especially if they have already gained many years of experience in relevant support/peer groups. Depending on the way in which this patient experience is used, the work of the consultation can be "facilitated", but also "made more difficult" if these patients notoriously appear to be "know-it-alls".

E 22.26		"but (...) what am I going to do about the pain?"
04	P	no! . now . but how/what do I do now with the pain? . I can't stand it anymore .
05	D	today? .
06	P	[Nods] .
07	D	I know that last week, or a fortnight ago, after two or three infusions, you were initially better off.
08	P	yes . and I got an injection rather last week . I think on Monday morning or something . I had a day or two of rest . I thought, great, it's going to work . and then I was here on Wednesday . it also got better over a few hours ... and on Friday nothing, no reaction at all, not at all .
09	D	so . please take off your coat .

By taking the initiative and expanding the decision topic ("pain"), the doctor is put under pressure, which he initially meets with a specific question about the current treatment concern ("today?"), which the patient, for her part, only needs to confirm by nodding her head. Thus, beyond the communicative pressure, the doctor comes under medical treatment pressure, which he tries to satisfy with a treatment procedure that seems to have already proven itself several times in the recent past (07D: "I know that you (...) were better off after two or three infusions"). Although the patient exercises her right to have a say not only in the topic initiative ("pain"), but also in the criticism of the ineffectiveness of the last treatment measure thus experienced by her (08P: "no reaction at all"), this measure is initiated by the doctor without further comment (09D: "so, please take off your coat"). This "instruction", which already in the introduction ("so") comes across as a conclusion, proves to be not only factually but also linguistically inappropriate in relation to the reservations just formulated by the patient.

From the point of view of *cooperation* in decision-making, there are overall discrepancies in this conversation example between the patient's *right to have a say,* which was initially granted, and then curtailed again. While on the first decision topic ("referral to the radiologist" etc.) the consensus could be found "succinctly", on the second decision topic of the current pain treatment ("today") the treatment measure already initiated by the doctor is not only not consented to by the patient, but the dissent remains more or less manifest.

The decision to continue the "infusion" is made by the doctor "briefly", but not "painlessly", because it is obviously made "over the patient's head". The doctor thus falls back into a *paternalistic* model in which he increases his medical autonomy towards self-sufficiency, while the patient's corresponding loss of autonomy increases her dependence on the doctor (§ 10.4). By completely ignoring the patient's reservations about the treatment ("infusion") with his direct "instruction" (to take off the coat), the doctor reduces his previously underprepared *cooperative* relational offer, which was still based on free choice, to mere obedience. Thus, the *right to have a say,* which was initially explicitly granted by the doctor ("wishes") and then claimed by the patient on her own initiative, in this example gets "stuck halfway" because the *communicative* action and *instrumental* action ("infusion") (§ 7, 8) are ultimately not *congruent*.

In contrast, the congruence between communicative and instrumental action is much greater in the following example (E 22.27). In the joint interaction history of this case, many diagnostic and therapeutic steps have already been taken, which the doctor sums up at the beginning of the conversation before the patient complains of a persistent cough.

E 22.27		"now we have x-rayed and everything is sorted out . yes ."
01	D	now we have X-rayed and everything is sorted out. yes.
02	P	yes, that's right, but the cough hasn't gone away yet and it's still a bit mucousy.
03	D	what does it look like? .
04	P	oh . what does it look like? uh ... the cough? .
05	D	yes .
06	P	if I spit this out? .... pff ... a bit greenish...
07	D	greenish, yes . (...)

Although at first "everything seems to be sorted out", the patient insistently introduces the *persistent* complaints as a significant topic with a *but*-introduction to her contribution (02P: "yes, that's right, but the cough hasn't gone away yet ..."). In this way, the topic is upgraded in relevance, to which the doctor must react; in any case, he is prompted to ask about the "quality" of the cough, which the patient answers only after a query on her part ("greenish"). Since we had already dealt with this sequence in advance under the aspect of *detailed exploration* of the

quality of complaints/symptoms (§ 21.4) and had focussed on the following sequence, omitted here, under the aspect of *empathic feedback* (§ 20.6), we can go directly to the decision-making phase here after introducing the central complaint topic, which concerns the (further) treatment of the persistent cough. After the doctor has "listened in", there is initially an ambiguity in the doctor's announcement (E 22.28) (03D: "we'll do the checks again (...)"), which the patient immediately tries to resolve on *her own initiative* by asking a corresponding question of understanding ("what kind of checks?").

E 22.28		"what kind of checks?"
01	D	then I'll listen to your lungs again .
02	P	yes good . [Off-camera conversation while the doctor listens to the patient's lungs, before they both take their seats again] .
03	D	we'll be doing checks again next week .
04	P	uh . what kind of checks? .
05	D	that I listen to your lungs again .
06	P	yes . and can you write down anything else for me, or do I have to get everything myself? .
07	D	(no) .
08	P	for the cough .
09	D	I'll write it down for you, yes . something expectorant .
10	P	Yes, something to loosen up the mucus would be good, it's still very mucousy and still hurts a bit, but there's no comparison to how it was, so ... but no more antibiotics, right? .
11	D	is not necessary.

After explaining that the controls refer to listening to the lungs, the patient initiates another request, namely a prescription "for a cough", which is combined with an *indirect* complaint in the alternative case of a refusal ("or do I have to get everything myself?"). Although the doctor immediately gives his consent to the prescription "requested" in this way, afterwards the patient again intensifies her complaints to justify her request, and then, despite a relative improvement (10P: "but it's no comparison"), brings the subject of antibiotic treatment into play by asking a question of reassurance ("but no more antibiotics, right?"). After the doctor clearly denies this treatment option (11D: "is not neces-

sary"), the conversation seems to have reached a conclusion that now only needs to be completed.

Accordingly, the doctor gives a summary of the further procedure (E 22.29), whereby, however, he makes a further topic offer by asking the patient the traditional closing question about possibly still open *questions* (05D: "Would you like to ask me anything else?"). This topic invitation is proactively perceived by the patient by asking about the continuation of a previously practised treatment measure ("radiation"), which had not yet been addressed in today's consultation.

E 22.29		"anything else you would like to ask me"
01	D	then we only do the mucolytic.
02	P	yes .
03	D	and next time I'll listen to your lungs.
04	P	yes . i'll come in again .
05	D	anything else you want to ask me? .
06	P	should I continue to take radiation ? .
07	D	we'll keep going through this.

Since the doctor confirms without reservation this question of reassurance from the patient about the continuation of radiotherapy, which he himself perhaps no longer "had in mind", a positive balance can be drawn overall from the patient's perspective. Through her active cooperation, which was encouraged by the doctor, the patient was able to exert a significant influence both on the development process of the decision-making as a whole and on the individual measures that were consented to in the dialogue by both conversation partners. From the doctor's point of view, stimulating the active cooperation of patients is always a challenge, as is also shown in the continuation of the conversation, which is not yet over, although the decision-making phase seems to be sufficiently saturated.

As will be discussed under the aspect of ending the conversation ("summing up") (§ 23), the question of *open questions* always carries the risk of a "never-ending story", including in this conversation, which we will therefore come back to (§ 23.4). It will have to be made clear that the suppression of patient concerns/issues as opposed to a dialogue-based conversation cannot be a successful alternative in the long run.

22.4.4 Consensus negotiations

The preceding examples were already rudimentarily characterised by negotiation processes, in which the patients, however, achieved different successes. While one patient's reservations about a certain treatment measure ("infusion") were ignored, the other patient was largely able to push through her requests for further treatment of her persistent cough. However, negotiation processes cannot be "measured" solely by the success of individual participants.

Rather, "good" arguments must always flow into a dialogue-based negotiation process, which must be weighed against each other by the interlocutors as *pros* and *cons* in a *scale* in order to advance *participatory decision-making* (PDM) in one direction or the other (§ 10.3). In this sense, the interlocutors should engage in a "real" conversation, which, according to Buber (1954/1986), should not be "pre-disposed" (§ 7.5). Although the scope for negotiation in medical decision-making is limited within the framework of *evidence-based* medicine (§ 10.3), conversations within this framework should initially be *open-ended.*

In the following, three conversations will be used as examples to reconstruct dialogue negotiation processes from different fields of practice (general practitioner, medical outpatient clinic, oncology), which deal with different main topics and objectives. While in the case of the medical polyclinic a patient with diabetes mellitus type 1 wants a change of therapy method ("injection" versus "pump") (§ 22.5), in the oncology consultation it is about improving the quality of life of a patient at the end of life, to which an optimal pain therapy should contribute (§ 22.6). We start with the example from the GP consultation, in which the recurring topic of the "old fear" of cancer soon comes up, which is still bothering the patient because of her pain despite an operation ("You no longer have an ovary, why still?"). The multi-layered development of the entire conversation can only be given here in broad strokes. The patient initially comes to the consultation with specific *tickets* (§ 19.4) ("nausea", "dizziness"), and these symptoms are initially placed in the context of her "menopausal symptoms" and "hormones". Although the doctor makes her the offer of a thorough examination (E 22.30), the patient downgrades the relevance by initiating a change of topic (02P), with which she "currently" moves the "only thing that gives me grief" into the focus of the conversation.

E 22.30		"it's the only thing that causes me worries at the moment"
01	D	What I would like to know is, do you have the feeling that we should investigate this thoroughly? .
02	P	[considers] I don't think so much . because I just think it's the only thing that's causing me worries at the moment . I'll be honest and say that for . about . 4 weeks, I'd say, I've had the same complaints as last year, which is why I was in the clinic. with my abdomen . and he also examined me . um . the doctor S and then diagnosed a high degree of inflammation, as he says, I was allowed to swallow antibiotics again, but it's not better . and above all, which is strange . if I stand for a longer time ... it's bad .
03	D	what is bad then? .
04	P	the pain .
05	D	listen, that is, you have now felt the pain again, yes, especially when standing . and then the old thing comes back again, yes ....
06	P	I think ... I think ... that I'm worried ... especially because a good friend of mine also has problems ... went to the doctor (...) ... they also did a CT, etc., found adhesions, operated, removed ... complaints still there . she went and told the doctor . and they said: that's it . it's not worth it . we'll do an MRI, and then they found out that she has something that could have two causes . and they're going to check that out now .

After the relevance of the new topic has been upgraded, its emotional content as the "only worry" is once again brought to the fore by an affirmation of her openness ("I'll be honest"), the patient gradually develops a specific concern, the formulation of which she begins to "launch" *indirectly* via the short story about her friend's medical history. The transition is made in cooperation with the doctor, who already empathically expresses the individual meaning of the patient's own medical history from her perspective of experience (05D: "then the old thing comes back"). The patient's repeated reaction ("I think . I think . that I'm worried") proves how much the two interlocutors are already in mental and emotional harmony with the memory of the "old thing".

This joint memory work can be done in the sense of the original meaning of *anamnesis* (§ 9.1) already qua keyword communication ("old thing"), because both interlocutors in the GP consultation can fall back on a long-standing history of interaction and knowledge and can easily retrieve the associated context of meaning. Once the "old thing" is established in the focus of the conversation, the patient can, as it were

according to the principle of *association* (§ 9.3), linguistically *associate* her own medical history with the current medical history of her friend (06P: "I'm worried, especially because a good friend ..."). A little later (E 22.31), the patient can further develop the already initiated "launching" of her concern by introducing her friend into the conversation as a "quoting authority" (02P), who indirectly lets her say what she probably does not yet dare to demand so directly herself.

E 22.31		"that gave you a shock at the time"
01	D	(...)
02	P	(...) only she said, and I'll soon believe it myself, she said, listen, she said . make sure you have an MRI done . because, she said, you still have the complaints .
03	D	in eh . that means, that was also one of your considerations, that we also do such an examination, an MRI? .
04	P	yes, because I just think, I'm not brain-crazy . and you know that I'm not someone who fakes being sick . I don't care, I don't want to . but ... it drives me crazy that I always have the complaints and think: for heaven's sake . you don't have an ovary on the right anymore, why still?' .
05	D	uh . and at that time, the/the whole hospital thing, yes? .
06	P	yes... you don't put that away. you don't put that away... I mean, the, the, the, the, uh, uh ... what the [name] said, the ... it is ... cancer . quotation marks open, quotation marks closed . is inside, especially when you still get the complaints again.
07	D	yes, that is, that gave you a shock at the time, that .
08	P	yes of course .
09	D	it could be cancer, and if you feel something now, down there, then .
10	P	she thinks there's something else .
11	D	There's something that's waking up again .
12	P	yes . of course . I just think (...)

Despite the patient's relativisations (02P: "I'll soon believe it myself"), the doctor understands what is "actually" meant and can formulate the patient's request on her behalf (03D: "... an MRI?"). This is immediately answered in the affirmative by the patient and, as it were, further justified with the previous painful medical history, to which both interlocutors again find a mental and emotional *harmony,* which is retrieved in terms of content with the corresponding thematic *key symbols* ("shock",

"cancer") and manifests itself formally-dialogically in a mutual *completion* of sentences (*joint sentence production),* in which the thoughts of the other are anticipated and formulated in advance.

In the course of the conversation, the doctor and the patient exchange a number of "good" arguments as to why the previous examinations might not have been sufficient and why they should be supplemented by an MRI, whereby the doctor even mentions the "best device" in the vicinity, etc., but at the same time expresses the suspicion that "the examination result will be useless". Without being able to go into the details of the further development of the conversation, in which the patient's recurring "old fear" of an "inconclusive" examination is also addressed, there is then a sequence of conversation (E 22.32) that sets the course, which has already been mentioned under the aspect of the patient's *expectations* (§ 22.2) and will be reproduced here in expanded form.

E 22.32		"how important is the investigation for you?"
01	D	yes... in eh... what should we do? what should I advise you?...
02	P	Doctor ... you are the doctor . you have studied ... good eh? ... [laughs]
03	D	how important is the examination for you?
04	P	I think just to reassure myself very much.
05	D	hm, that means that would be necessary, that would really give you some reassurance? ...
06	P	yes . because I . because I just think, just like with my foot (...)

Although the patient has now more or less made her concern with the specific examination preference known for long enough, she cannot accept the doctor's invitation to disclose her expectations. Instead, she tries to hold on to her relational preference with a traditional distribution of roles by referring - laughing coquettishly - with humour to the profession of the doctor qua training, who is once again challenged as the "official" decision-making authority. The doctor, for his part, plays the ball back again by asking the patient about the relevance of her desired examination ("how important is the examination for you?"). After the patient again cites her "reassurance" as a reason, which the doctor emphasises again by asking ("that would really give you some reassurance?"), the "official" decision is made (E 22.33), which the doctor can only support very cautiously, clearly recognisable to the patient.

E 22.33 "we can do the examination, I don't recommend it".

01	D	I would say the following: we can . we can do the examination, yes . I don't recommend it, yes . I even think that it is not really necessary . but it is important to me that you are reassured . above all, it is important to me that you have the feeling that you have really one hundred percent, yes .
02	P	been checked through, yes.
03	D	yes and . when we have the result, yes . and we have the point, then I would like to continue the conversation.
04	P	we can .
05	D	yes? .
06	P	yes sure .
07	D	that we'll see how it is then .... Yes, what do you think of that? .
08	P	yes okay, agreed, why not .
09	D	yes? should we stay like this? .
10	P	yes sure .
11	D	great . do you have anything else to . address? .
12	P	oh no, but the girl can take my blood pressure, then I don't need to bother you (...)

The conversation, which lasts about 10 minutes in total, revolves thematically essentially around the "fear of cancer", which is deeply rooted in the patient's medical history. Due to a long history of interaction, the interlocutors can easily fall back on this when they agree on a few *key thematic symbols* ("old thing", "shock", "old fear of cancer"). After a long process of negotiation, the doctor can finally agree to the examination procedure preferred by the patient ("MRI"), although he explicitly "cannot recommend" it - which seems to amount to a paradox. Even though the doctor's reservations are unmistakable in the now "official" decision for the patient, both interlocutors come to an amicable "solution" to the patient's problem, which consists above all in her "reassurance".

This reassurance is not only repeatedly emphasised by the patient herself as "important" after the doctor's enquiries, but is also mirrored by the doctor as an objective ("but it is important to me that you are reassured"). The high degree of agreement manifests itself again in the mutual adoption of another central key term ("checked through") before the basic consensus is then alternately "sealed" by a series of complementary confirmations and reconfirmations (04-11). This strongly ratified consensus extends not only to the now mutually accepted and in-

tended investigation, but also to its debriefing in a subsequent follow-up conversation ("then I'd like to continue the conversation (...) that we'll see how it is then"). It is to be hoped that this follow-up conversation will be similarly *open-ended* as the preceding decision-making conversation, which in the end will have found a consensus with which both conversation partners can apparently "get along" in their own way in the future.

22.5 Change of the therapy method

The relationship between doctor and patient is not fixed outside the consultation, but is shaped between the two partners through communication and, if necessary, changed in the course of the conversation. For research and teaching, it is precisely those conversations in which certain communication and relationship models are not realised homogeneously from beginning to end, in a "pure culture", so to speak, that prove to be interesting, but in which "breaks" and "mixtures" occur. Thus, there are relatively frequent conversations in which the relationship offers of the patients are not (completely) rejected by their doctors at first, but in a more or less pronounced negotiation phase, a transformation from the *paternalistic* model or *service model* to the *cooperation model* is carried out through corresponding communicative coordination.

The following conversation from a medical outpatient clinic initially represents a type of decision-making characterised by a communicative transformation process in which the patient moves with his doctor from an initial *service model* towards a *cooperation model.* With Balint (1964/88), it can be assumed that patients make a so-called *patient offer* to their doctor right at the beginning of the consultation. Such a patient offer is not limited to relevant thematic *presenting symptoms* (e.g. "pain", "nausea"), with which "tickets" to the consultation are bought (§ 19.4), but at the same time represents a relationship offer towards the doctor himself. The patient initiates a certain model of the doctor-patient relationship by bringing a certain concern to the doctor in a certain way in the conversation, with which the doctor is offered a certain role. For example, the doctor can be approached by the patient from the outset as a *helper* or *saviour* (paternalism model) or as a *service provider* (business model) (§ 10.4). The problem relevant for the further course of

the conversation is how the doctor deals with the patient's offer as an offer of a relationship, for which examples of a change in relationship have already been given (§ 19.8, 22.4.1). In the following conversation, the change from the *service model* to the *cooperation model* takes place, in which both conversation partners finally prepare a joint decision in the course of an initial conversation, which they then also make by mutual agreement in the follow-up conversation.

22.5.1 Service model: "Change to pump“

The interview takes place in a polyclinic outpatient clinic where a specific consultation is offered for patients suffering from *diabetes mellitus*. In this case, we are dealing with a patient who comes to the doctor with an "organised" disease in the sense of Balint (1964/88), for whom the diagnosis has already been made and therapy has been successfully initiated. The patient, who is about 25 years old, has known the diagnosis ("diabetes mellitus type 1") for a long time and is being treated with insulin. The patient now comes to the consultation with a specific request (E 22.34) (06P: "desired changeover to pump"), with which he "opens the door", so to speak. With this specific "entrance ticket", the doctor is obviously given the role of a service provider right at the beginning of the conversation, who is supposed to provide the "desired" service without further consultation.

E 22.34		"Desired change to pump"
01	D	Mr. Müller! . what brings you to us? .
02	P	Diabetes type 1 .
03	D	yes .
04	P	Bolus basis .
05	D	hm .
06	P	desired change to pump .

Already in the formulation of the request, the *business tone* is striking, with which the doctor's opening question is answered by the patient in an elliptically shortened "telegram style", in which the "desired" is directly expressed. In various training groups, this opening sequence was made the subject of reflections on possible continuations of the conversation. In a simulation situation, the group members mostly reacted

spontaneously in a very indignant, dismissive or even reprimanding way to this video sequence, which was supposed to encourage a proxy medical intervention ("It's your turn") (§ 13.5.2). The irritation was so great that no direct interventions were made, but rather evaluative statements were made in a critical meta-perspective on this video sequence. The tenor of these was that the doctor would be contacted by the patient in a mere service provider role (e.g. as a "salesperson") in a real conversation, which would not be acceptable without further ado. In an exemplary list, some doctor's reactions are compiled (Box 22.4), which can certainly be considered typical.

Box 22.4 Medical responses from training groups

1. The relationship is very distant
2. Like a text message
3. It's more like the military
4. As if one makes a report
5. Like in the spare parts warehouse
6. 'We're not in the shop here,' I'd tell him.
7. A pure service is required
8. I would tell him that we don't have any goods here.
9. He pushes me as a doctor into the role of a salesman
10. A pure business relationship
11. We refer here to sensitivities, not things
12. I would pull the plug

Even if the consequences are not always clearly recognisable ("pulling the plug"), the doctor's "displeasure" is "unmistakable" in all statements, if it is to be imagined that this patient would have to be confronted with this kind of concern in a separate conversation. The patient would have to reckon with strong "sanctions" with which he would have to be more or less "put in his place", which he has obviously exceeded in the doctor's overall judgement. If the medical intervention were to turn out according to one of the preceding statements (1)-(12), the patient would in turn have to react to the thematisation of the (in)appropriateness of his utterance, and so on. As is well known, such meta-communicative feedback loops can lead to considerable communication and relationship disturbances, which then have to be laboriously

overcome through time-consuming corrective work in the direction of a new understanding.

22.5.2 Change to the cooperation model: "Difficulties“

While in the case of the interventions suggested above from the training situation, risks of meta-communication on the *relationship level* are to be expected, the real doctor seeks an understanding on a *content level*. With his real intervention, the real doctor chooses a continuation of the conversation in which he does not even make the relationship problem in question a topic, but inquires about the patient's "difficulties" with the current treatment concept, i.e. about his *subjective experiential knowledge,* which the patient then reveals just as readily (E 22.35). With this *patient-oriented* offer of topics, a *transformation* from the *service model* to the *cooperation model* is already initiated here, in which the first *life-world* conditions and individual *preferences* of the patient are brought up.

In the process, the patient allows himself to be gradually "drawn into a conversation" by the doctor, in which the apparently "biotechnical" concern of a change of therapy ("injection" versus "pump") is gradually expanded in a "biopsychosocial" anamnesis into a complex history of motives that concerns the way of life as a "diabetic" in general. This development of the conversation in an approx. 30-minute polyclinic consultation can only be rudimentarily traced here in excerpts of the conversation, in which, as in the following transition, specific thematic switches are made.

E 22.35		"that means there are difficulties ..."
07	D	yes, that means . uh . there are difficulties in the basal bolus concept with you? .
08	P	let's put it this way ... I would like a simplification, more variability ...
09	D	yes .
10	P	and greater freedom ...
11	D	yes ...
12	P	because disappearing with the pen . and so . is also ... sometimes in my profession specifically not so favourable .
13	D	yes . yes .

14	P	so .
15	D	so, disappearing means that you have to go away from time to time because you have to inject the insulin.
16	P	right, for example .
17	D	yes .
18	P	and that is sometimes very bad . i am an industrial and advertising photographer ...
19	D	yes .
20	P	practically the customer is almost always there ...
21	D	yes, yes .
22	P	and so, so he probably notices that less [points to imaginary pump] or is rather not noticed as much as when you have to disappear and so . and then people don't understand that and then you have to lead big explanations or so .
23	D	yes, yes .
24	P	I think to myself . that could be a relief.
25	D	yes .

Instead of reacting to the way the patient's request is formulated in the introductory sequence, the doctor, who is very familiar with the clinical picture, draws the corresponding conclusions ("that means ..."), which are already suggested by the patient with his "desired change to pump". The doctor anticipates the patient's personal "difficulties" with his current treatment as a "diabetic" and with his interventions already elicits the first information relevant to the patient's life, with which the patient seeks to plausibilise his motivation for a change in the therapy procedure vis-à-vis the doctor.

For this purpose, the patient introduces *thematic key symbols* right at the beginning ("simplification", variability", "freedom"), whose personal meaning is first justified via the previous impairments in professional life (12P: "because disappearing with the pen ... is ... not so favourable in my job"). Again, the doctor draws a corresponding conclusion (15D: "so, disappearing means that ..."), with which he signals to the patient an "anticipatory understanding" of the conflict situation that arises when "disappearing with the pen" in the middle of the customer conversation. The doctor's interventions each have a high degree of *accuracy of fit* (§ 3.3, 17.2), as can be seen in the reactions of the patient, who obviously feels well understood by the doctor (16P: "right").[6] The longer in-

6 Equally appropriate was the doctor's "tacit" correction of "bolus basis" (04P) to "basal bolus" (07D), with which he (audibly unmarked) makes a

terventions and numerous, partly doubled listener feedbacks (*yes, yes*) of the doctor set up a relevance upgrading of the topics brought in by the patient, which leads to a continuous flow of conversation in which the patient adds the further central *key symbol* (24P: "relief"), with which, however, he still confines himself entirely to his professional life. In the further course of the conversation, it then becomes clear to what extent the patient sees his overall *quality of life* impaired by the current therapy procedure ("injections"). As a prerequisite for later decision-making, the biopsychosocial anamnesis must be expanded by several aspects beforehand.

22.5.3 Biopsychosocial anamnesis: "Mental story"

After the first relevance upgrades of the *lifeworldly* "voice" of the patient (§ 10.2), who initially articulated his "difficulties" with the basal bolus concept addressed by the doctor mainly as a photographer in his professional dealings with his clients, there is a mutual exchange of information between doctor and patient about the advantages and disadvantages of the two alternative treatment concepts ("injections" versus "pump") in further rounds of conversation, which can only be reproduced here in excerpts. These are the doctor's first explanatory steps, with which the open information is conveyed according to the dialogue-based *Ask-Tell-Ask scheme* (§ 22.3) and the respective "pros" and "cons" are provisionally weighed up before the doctor inquires again about the patient's motivation for changing the treatment concept.

E 22.36		"... to understand even more precisely what your motivation is ..."
01	D	yes .
02	P	and uh . ( ) listens to it all and so . [you simply have to (.....)
03	D	[yes yes yes, that's true . there are extraordinarily convinced pump carriers . especially when they realise that this enables them to manage their metabolic disorder better .
04	P	hm .
05	D	in principle there are two reasons ... [disturbance from outside:

terminological clarification without embarrassing the patient in a lecturing way.

		knocking on the door] yes please ( ) hello . I am still talking to the patient . it will take a while ... um . there are two main reasons for a pump from our point of view .
06	P	hm .
07	D	that either the metabolic adjustment to the basal bolus concept is not satisfactory.
08	P	hm .
09	D	that's the main reason . and the second reason . if the patient specifically wants a pump treatment [...] and uh there's always a lot going on in the market . so sometimes there are really good pumps . and sometimes there are not so good pumps .
10	P	hm .
11	D	therefore, I think it would be very, very important to first understand more precisely what your motivation is that you are dissatisfied with the basal bolus concept .

After the first, here abbreviated, explanatory steps, which finally end with the presentation of the objective situation on the "market", where pumps of different quality are to be expected ("sometimes very good, sometimes not so good pumps"), the doctor again makes the patient's "motivation" the topic, which is upgraded several times in relevance. With a causal link ("that's why") and special emphasis ("very, very important"), the doctor marks his medical interest in understanding ("to understand") the patient's motivation for changing the therapy method ("what your motivation is"), focusing here as a possible topic on the "dissatisfaction" with the previous basal bolus concept. Beyond these markings, the doctor exerts increased pressure on the patient for further self-exploration with an emphasised demand for more precision ("understand *more precisely*"), so that a mere repetition or paraphrase of the previously stated motivation would no longer be sufficient. The patient, who is thus put under "pressure", then also reveals further motives, to which he subsequently gives a relevance upgrade (E 22.37) by casually classifying them as first-ranking ("first").

E 22.37		"this is an inner, mental story"
12	P	well, first of all it's also . uh from a human point of view I'm not necessarily, like many others, so necessarily taken with the needle, no .
13	D	yes .
14	P	that's, that's an inner, mental story maybe, too, ne .
15	D	yes .
16	P	well, you get used to it after half a year, but I think that with a catheter that you can leave in the same place for a few days, under certain circumstances, I might get along better, without always having pain overcoming or something like that.
17	D	yes . is it the case with you that you/that you so . so . before you go to the prick . uh . already anticipate the pain mentally . and are afraid of getting pricked? .
18	P	more or less . yes . so I have developed a technique . where I manage to relax the body, yes ... so the muscles in the abdominal wall are not so tense, no . so the puncture is not so painful, no .

This reaction of the patient to reveal his "inner, mental story" (14P) is undoubtedly owed, from the aspect of *fit* (§ 3, 17), to the preceding doctor's intervention (11D), through which the patient was placed under a certain - however gentle - compulsion to continue for further self-exploration in the sense of *conditional relevance* (§ 9.4). The functional performance of the physician's intervention consists precisely in the fact that at this point in the conversation the physician offers the possibility of an expansion of the topic, which concerns both the scope and the weights in the patient's needs and motives. This invitation by the doctor to discuss a topic can now be accepted by the patient in a way that shows that the doctor has obviously met the patient's need for communication.

The fit of the intervention (E 22.36: 11D) is well indicated by the patient's subsequent reaction (12P): the psychodynamic fit of the intervention obviously consists in the fact that the doctor rightly anticipates that the already aforementioned occupational impairment as the patient's offer (E 22.35: 12P: "disappearing with the pen ... is not so favourable in my profession ...") is not the only and perhaps not even the dominant motive of the patient for the desired change to an apparently less invasive imagined treatment method. The time sequence of the

presentation apparently does not correspond to the ranking, which is often the case with patient offers.

With these self-explorations of the patient, who further discloses his motives for a change of therapy, the biopsychosocial anamnesis, which was previously limited to practicality in professional life, is expanded to include an "inner, mental story", which covers the patient's everyday life as a whole. In doing so, the topic of the "inner, spiritual history" experiences an immediate upgrade in relevance after it is initiated and barely concretised under the keyword "overcoming pain". The doctor promotes the patient's further emotional opening with a specifically *empathic* intervention (§ 20.6) by making explicit the emotion that the patient has only implicitly expressed (B.22.37: 17D: "... being afraid of getting pricked"). With this change of topic, a new quality of conversation is finally achieved, which is manifested in the development of the *thematic key symbols* alone, which will be compiled here in advance in a tabular overview (Tab. 22.1) for the entire conversation.

Thematic key symbols	
Opening of talks	Conversation development
biomedical	biopsychosocial
Diabetes Basal Bolus Pump Simplification	Greater freedom, relief, Human, Inner, Mental, Overcoming Pain, Anxiety, Shame, Fear, Inhibitions, Agonising

Tab. 22.1: Biopsychosocial theme development

While the opening of the conversation was still characterised by a *biomedical* vocabulary ("diabetes", "bolus basis", "pump"), a *psychosocial* vocabulary is gradually developed in the further course of the conversation, which was stimulated right at the beginning of the conversation with the doctor's question about the "difficulties" and with the further follow-up questions about "motivation" etc. ("freedom", "relief", "human", "mental", "fear"). Once such an open *biopsychosocial* topic development has been initiated and established, it is all the easier for both interlocutors to continue this development and to expand it to include further psychosocial aspects, as this becomes clear in the subsequent conversation connection (E 22.38).

E 22.38		"then of course it's not so great"
19	D	hm .
20	P	I don't know what causes it, but I don't know .... so injections on the thigh are a bit more difficult.
21	D	yes .
22	P	yes . so I do it like this . in the abdominal wall during the day .
23	D	yes .
24	P	and then the basal insulin in the evening.
25	D	yes .
26	P	in the thigh .
27	D	yes . yes .
28	P	So it's also the case that there are bruises or something. and then it's not so great when you want to go swimming, of course.
29	D	yes . yes
30	P	or swim .

For example, immediately following the description of how he overcame the pain of the puncture "technique" (18P), the patient can speak openly about an emotion that indirectly presents itself as *shame* in front of the public when he discusses the psychosocial consequences of his "bruises" in the public perception (28P: "and then of course it's not so great when you want to go swimming"). In addition to the aesthetic aspect, the patient alludes here to possible misunderstandings that lay people could be subject to due to their perception of the consequences of the puncture, so that negative personal attributions would have to be expected overall. Since "bathing" or "swimming" are only exemplary occasions for a feeling of shame, implicit conclusions can also be suggested or drawn by both interlocutors to comparable situations in which the bodily perception by other persons (e.g. in sexuality) plays a significant role.

Later in the conversation, another emotion of the patient is added, namely his "fear" of an infection, which could be triggered by "dirty fingers" in the "photographer's profession", which is "not always as clean" "as one imagines", so that he has "inhibitions" about "unwrapping the pen". It is precisely in this context that the patient then expresses his preference for a change of therapy once again through a general maxim: "You don't have to torture yourself", to which the doctor again responds with full agreement ("yes that's right").

In the course of the entire conversation, a whole series of *emotion-related motives* come up, with which the initial "desired change to pump" can be plausibilised in many ways. However, since such a change in therapy cannot simply be carried out "without problems", doctor and patient must enter into a *negotiation process* in which medical *evidence* and the patient's personal *preferences* must be sufficiently *reconciled.*

22.5.4 Consensus: "We can try this out"

In the course of the entire conversation, *participatory decision-making* (PDM) (§ 10) is cumulatively prepared again and again by partly meta-communicative key interventions, each with special functions of setting the course under specific topics. In the process, the doctor emphasises both the conversational quality of *rational communication,* which is about the exchange of *pros* and *cons* ("rational pros and cons"), and the active participatory role of the patient, who is once again encouraged to disclose his or her preferences for a change of therapy, especially since the previous form of therapy has led to an "optimal metabolic setting".

E 22.39		"rational pros and cons"
01	D	(...) I think before we really get into these purely rational pros and cons ... I would be interested to know ... what are the aspects ... that make it difficult for you ... the basal bolus concept, which obviously in your case leads to an optimal ...
02	P	hm .
03	D	metabolic control, to continue that.

This conversation sequence is about an interim balance with a weighing of goods, in which "objective" and "subjective" weights have to be weighed in a "scale" of decision-making (§ 10.3). The "optimal metabolic adjustment" mentioned by the doctor had already been the subject of conversation before, in which the patient had described with a certain pride the success of the therapy so far in a pre-post comparison of the "HbA_1 values", to which the doctor had already expressly expressed his *appreciation* to the patient with an *empathetic* feedback.

E 22.40		"Gosh . that's a very, very good value then".
01	D	(...) but that's how you get closer to it.
02	P	Yes, I have also done that so far. The last HbA value was , which is perhaps quite good.
03	D	yes .
04	P	because it was still quite high before . with Dr. Z and also with my GP . it looked like . that at some point I was at 12.1 or something .
05	D	hm .
06	P	I started in January ... and am now at 5.8 on April 26th ...
07	D	wow . gosh . that's a very, very good value then . when were you diagnosed .
08	P	uh . [reaches for pocket] October last year (...)

In view of this "objective" data on "metabolic adjustment", it would be "appropriate" from a "purely" biomedical point of view to stick to the treatment concept that has been successful so *far*, which would have to be weighed in a new decision-making process, the *counterweights* of which still had to be determined through conversation.

Therefore, in this conversation it became necessary again and again to include the "subjective" weightings of the patient, i.e. his *preferences* ("motives"), which are essentially determined by lifeworld experiences and attitudes, in the joint deliberations ("deliberation") (§ 10.4-6), in order to finally be able to arrive at a *participatory decision-making* (PDM) (§ 10.4). On the way there, a number of aspects significant to the patient's life had been addressed and openly discussed in their specific relevance for the patient in several rounds of talks between doctor and patient, which can be summarised in the following way:

1. The impairment and shame in professional life ("disappearing with the pen" in the middle of conversations with customers)
2. Overcoming pain or fear (of the "injection")
3. The shame of being in public ("bruises when bathing")
4. Fear of infection ("dirty fingers at work")

In view of the patient's dispreferences towards the previous therapy method ("injections"), the "desired switch to pump" seems plausible at first. However, the objective therapy success to date must be weighed in the balance as well as the "contra" arguments of the alternative therapy

option ("pump"), which must be taken into account in the "rational pros and cons" (E 22.39) in order to be able to conduct a "genuine" *risk communication* (§ 3, 10, 26). In several rounds of conversation, in which the doctor doses the necessary information in each case according to the *Ask-Tell-Ask scheme* (§ 22.3) to suit the patient, the two therapy methods are subjected to critical *evaluation* under a number of comparative aspects (treatment frequency, foreign body sensation, dosage, comfort, maintenance economy, hygiene, phobias, habituation tolerance, etc.). In the joint reflection process ("deliberation"), both the professional knowledge of the doctor and the life-world experiential knowledge of the patient are taken into account under these aspects.

Beyond problems of detail, such as "compatibility" in connection with the seat belt when driving a car, the doctor also expresses the "crux" of the upcoming self-experience through trial and error on behalf of the patient, who cannot yet know what experiences he will have in the case of a change of therapy (E 22.41). This uncertainty factor is also reflected reciprocally in the doctor's reflection, who is equally unable to "estimate" the patient's tolerance of the new therapy procedure "at the moment".

E 22.41		"I think it's about trying"
01	D	I think it's also about trying .
02	P	hm .
03	D	for example, at the moment I am not able to assess whether you can tolerate a catheter with a steel needle under the skin.
04	P	yes. I don't know that either.
05	D	this is a very important aspect .

While here, despite the difficult-to-calculate *risk*, a consensus in the direction of a *trial treatment* is already emerging, the joint objective should be *expressis verbis* about an individual improvement of the "quality of life" in the patient's "everyday situation", in which a "relief" is to be created. Towards the end of the conversation, both partners agree (E 22.42) to obtain and exchange further information for a follow-up session (e.g. pump types, statement and cost coverage of the insurance provider), in order to finally be able to initiate a trial phase with a pump treatment of the patient (01D: "we can try it out"). This agreement between the two conversation partners is initially reached in a perspective that remains *open-ended*, in which the doctor, entirely in the sense of

participatory decision-making, emphasises the *togetherness* in a conversation ("clarify with each other"), in which the patient has the opportunity to "really say what is on your mind". After the patient's agreement, who accepts the doctor's offer just as emphatically ("hm . that's right"), the doctor first moves on to complete the anamnesis, and then (E 22.43) characterises the distribution of roles between doctor and patient in more detail again.

E 22.42		"We can try this out"
01	D	yes . Mr Müller . we can try it out (...) first of all I want to tell you . I don't want to talk you out of the pump . I respect your wish . completely .
02	P	hm . hm .
03	D	completely . but I also think that it is important . that we clarify in conversation with each other . what your motivation is and that you have the opportunity . to really say . what is on your mind .
04	P	hm . that's right .
05	D	well . er. I have a few general questions to understand your situation . because I don't have any data to fall back on . how has your body weight developed recently? .

After completing the anamnesis, which extends to a series of *detailed explorations* (§ 21) (weight, bowel movements, urination, allergies, stress, etc.), the doctor returns once more to the consensus reached in the meantime in this consultation and again describes in a meta-communication the distribution of roles entirely in the sense of *Participatory or Shared Decision Making* (SDM). Accordingly, the patient is assigned the self-referential *expert role* ("you become the specialist for yourself"), while the doctor's own participatory role is explicitly described as the patient's "advisor" and "companion".

E 22.43		"You become the specialist for yourself" - "Doctors are advisors"
01	D	so that is again your very personal life experience (...) the self-observation, the self-experience in the area . what happens when you do something .
02	P	yes . right .
03	D	you become the specialist for yourself .

04	P	yes , yes of course .
05	D	doctors are the advisors . companions for a while .

As we know from the further catamnesis, the doctor continued to *advise* and *accompany* the patient for a while until finally a *mutually agreed decision* with a lasting result was reached between the two conversation partners. After several trial and adjustment phases, the patient was able to characterise himself as a "satisfied pump wearer" according to his own statement after more than a decade.

22.6 Quality of life at the end of life

Whereas in the previous conversation the change of therapy procedure was connected with a change of doctor, whom the patient had specially visited in a specialised polyclinic outpatient clinic, the following conversation is about a decision review, which mainly concerns a pain therapy in one and the same oncological practice with the same doctor. At the same time, however, a fundamental decision that had already been made by mutual agreement between the doctor and the patient in the context of palliative medicine is put up for discussion again at short notice. In this decision-making conversation it becomes clear that the interlocutors must always reassure themselves of the stability of their decisions, especially when the quality of life of patients at the end of life is affected.

22.6.1 Stocktaking: "This is not a good balance"

The approx. 65-year-old patient, who suffers from advanced ovarian carcinoma, comes regularly twice a week to the oncology practice, where she has developed a trusting, open relationship with her doctor. Chemotherapy was wisely discontinued, and the patient has opted for a "purely supportive" therapy, which is supposed to be about her "quality of life". Today, she visits the doctor because of her persistent "pain". Right at the beginning of the conversation, the doctor extends an open invitation to tell her about the "state of affairs". For a better understanding of the conversation, the two introductory sequences that were already

mentioned in the *detailed exploration* (§ 21) under the aspects of *intensity*, *quantity* and *quality of* complaints (§ 21.4.3) should be mentioned again here. The first verbal descriptions of the patient's complaints ("bad", "it was terrible") already lead the doctor to draw a negative balance, which he provisionally sums up in the form of an understatement (*litotes*) ("that's not a good balance"), before he then switches from the verbal descriptions of complaints (E 22.44) to the use of an *analogue scale* (E 22.45), which he holds up to the patient.

E 22.44		"it was terrible" - "that's not a good record"
01	D	so, Mrs. Schmid . now you have to tell us . what is the state of affairs? .
02	P	bad .
03	D	is not good, no . hm .
04	P	I was here on Monday.
05	D	right .
06	P	(...) at night (...) the drops had no effect at all.
07	D	you already woke up with pain already .
08	P	yes .
09	D	and had hoped for help directly.
10	P	yes . it was a bad night (...) it was terrible .
11	D	that is not a good record .

Despite this overall assessment by the doctor, the patient again extends her description of her complaints (E 22.45) by describing the consequences of the "greater pain" which affects her facial expressions (02P: "my face also tenses up like this"). Following this, the type switches from verbal descriptions of complaints to the use of a *visual analogue scale*, which he holds up to the patient with commentary. Previously (§ 21.4.3), attention had already been drawn to the fact that the doctor can not only assume knowledge of the scaling procedure, which he mentions again (03D: "You already know my scaling"), but that both interlocutors are already a "well-rehearsed team" in the use of the *analogue scale*; in any case, the patient already leans towards the table and points to the scale as soon as the doctor holds it out to her across the table. For both of them, the procedure seems to be routine and needs no further justification.

E 22.45		"You already know my scaling" - "that's not good"
01	D	hm .
02	P	I notice that my face also gets so tense . when you're in constant pain . it's better in the afternoon .
03	D	hm . you already know my scale . would you perhaps for the moment again . the current . [holds up scale over desk]
04	P	as it is at the moment . [bends over beforehand]
05	D	yes .
06	P	like this [shows] .
07	D	that‘s not good, yes . do you dare to try a completely different way again . because that is not what we both wanted, that there is a bit of reassurance for you . I think we are at the point that we should try that with the pain patch . both in terms of tolerance and strength . [...]

Again, the doctor reacts with an "understatement" (*litotes)* ("that is not good"), which can be regarded as the "normal form" not only of doctors but also of patients, if they do not (want to) aggravate (more or less consciously) and therefore tend to "exaggerate" (*hyperboles).* The sense and purpose of different uses of *understatements* and *exaggerations* in doctor-patient communication has already been critically discussed in detail (§ 21.3) using examples in which the evaluation vocabulary reveals a difference between the professional attitude perspective and the subjective experience perspective of patients.

Also in the present case, the direct comparison of the evaluation vocabulary from the opening phase already reveals certain differences in the choice of words between doctor and patient (Tab. 22.2), which is not arbitrarily interchangeable. For example, the doctor's anticipation or adoption of a "strong" choice of words (such as: "awful") will remain rather the exception, which should not necessarily be interpreted as a professional doubt about the authenticity of patients' descriptions of their complaints, whose "exaggerations" should be levelled out - which may well be a doctor's option for action in individual cases with "aggravating" patients.

Evaluation vocabulary	
Patient	Doctor
bad bad night, terrible constantly in greater pain like this [points to scale]	not good - no good record [you know my scaling] this is not good

Tab. 22.2: Evaluation vocabulary ("pain")

Similarly, a change from verbal description of complaints to the non-verbal form of using a *pain scale* is by no means intended to eliminate the subjective meanings in patients' descriptions of complaints. Of course, questions about the *intensity* of pain could be asked *ad infinitum*, but here too verbal communication can reach its limits. Insistent follow-up questions ("How bad?" - "How much worse than last week?") can also lead to communication crises in which the need for detail is eventually interpreted as "quibbling". Compared to possible endless loops of communication between doctor and patient, pain scales are an economical form of "data" collection, which cannot be a substitute, but a supplement to verbal communication.

In the previous example, the doctor uses both modes of communication, the results of which allow him to draw the conclusion for a new form of therapy. In any case, the patient's verbal presentations of complaints or her "indicated (comparative) values" are perceived by the doctor overall as so "serious" that he immediately afterwards makes a new therapy suggestion (07D: "to try a completely different path"). This conclusion had already been suggested by his *empathic* feedback, which went beyond the explicit evaluation vocabulary ("not good" etc.). Thus, the doctor had already addressed the patient's disappointed "hope" for "direct help" at the beginning, now adopting this disappointment in a joint perspective adoption ("we"): "because that's not what we both wanted, that there would be a bit of reassurance for you" (07D). Before the new therapy suggestion ("pain patch") is taken up again towards the end of the conversation, the doctor and patient explore some further aspects, which also include a re-examination of the basic decision made ("no chemotherapy").

22.6.2 Decision-making: "No chemotherapy"

The further course of the conversation is first to update the anamnesis. Specific complaints such as the patient's "dry mouth" and her "sleeping problems" and "bowel problems" are addressed before her "mobility" becomes a topic, for which the patient is dependent on the help of relatives and neighbours, but does not want to use taxis ("not necessary"). When a short pause creates a break, the doctor opens a new topic ad hoc, on which he once again puts the jointly made decision "not to do chemotherapy" up for discussion.

E 22.46		"I don't want chemotherapy"
01	D	I would like to know one more thing, Mrs. Schmid, because I thought that in these difficult two weeks this could perhaps be a reason for you to reconsider the decision not to have chemotherapy .
02	P	yes . no .
03	D	it's a bit different now .
04	P	I don't want chemotherapy .
05	D	where the complaints also increase . so I .
06	P	I realise that .
07	D	I think I remember our agreement, but I still just wanted to mention it again, whether it somehow has a different weighting.
08	P	no .
09	A	for you now .
10	P	no .

The short excerpt from the conversation refers to a shared history of interaction between doctor and patient that has already been developed and to which both interlocutors can now refer as shared knowledge in a *shared reality* (von Uexküll, Wesiack 1991, 2003, 2011) (§ 4.5). The doctor addresses the already *negotiated consensus* from the past (07D: "I remember our agreement") and at the same time puts it up for discussion again in the present of this consultation (07: "I still wanted to ... address whether ..."). In this way, the doctor initiates a new process of reflection, as is characteristic of the middle phase of "deliberation" in *participatory decision-making* (§ 10.4-6). The initiated interactive *review process* contains overall reciprocal reassurances as to the extent to

which the decision taken can still retain its *validity* given known treatment options, but under a current course of disease.

In other words, a *completed* decision-making process is *resumed* with an *open-ended* perspective in which the conversation partners have to perceive their respective participation roles again in their own way. In this *resumption process, ambivalences* also come to light in several rounds of talks, which both conversation partners have to deal with *reciprocally* in a process of dialogue and negotiation.

The doctor introduces the fact that the decision already made could possibly turn out to *need revision* in the *deliberation process* (01: "perhaps to reconsider ...") with the changes that have already occurred in the meantime or that are to be feared in the future (01: "difficult two weeks", 05: "where the complaints are also increasing"). The patient reacts relatively spontaneously with early interruptions, so that the doctor has difficulty continuing in his speech to introduce his *thoughts in one piece.* Although the patient seems to have already made her position sufficiently clear with a dialogue pre-start (02: "yes . no") and then with an explicit verbal statement (04: "I don't want chemotherapy"), the doctor insists on a possible correction of the decision with further objections (07: "different weighting"), which increasingly puts the patient under pressure to make a further statement.

22.6.3 Acceptance at the end of life: "Okay when it ends"

The doctor's previous contribution to the reopened *deliberation phase* of *participatory decision-making* had already been accompanied or "interrupted" by the patient with many interjections, ranging from brief feedback ("yes . no" - "no" - "no") to the assurance of understanding ("I realise that") to the primary objection ("I don't want chemotherapy"). When the doctor has now come to a relative conclusion of his contribution to the initiated "considerations" (D01), which he obviously nevertheless wants to continue (11D: "so that-), the patient finally begins to "cut him off" with a "rejoinder" (E 22.47: 12P), at the center of which is her clearly formulated and justified *objection to* "chemotherapy".

E 22.47		"for me it's okay when it ends"
11	D	so . that-
12	P	for me it's okay . when it ends . but I don't want to be full of chemotherapy . just to live a few weeks longer . no . so that's out of the question for me .
13	D	good . so we had talked about it .
14	P	yes .
15	D	I also think that's completely okay . and I also want to expressly support you in that, yes . I think that's the appropriate decision . and that's also where our agreement remains, yes .

After the doctor had put the decision already made up for disposition in an open *re-admission procedure*, the patient concludes the opened decision dialogue with a complex *statement* in which she again *explains* and *justifies* her *patient will* in a kind of oral "living will" ("I don't want ..., just to ..."). Finally, the *authenticity* of her *preferences* and *intentions* is once again decisively demonstrated in a *résumé* which, in its communicative *clarity,* apparently leaves no room for doubt (12P: "... that is out of the question for me"). This seems to be the final point in the decision-making process, where the doctor once again expresses the *acceptability* of the decision (13D: "good", 15D: "completely okay", "appropriate") and assures his further support (15D: "expressly support it"), before he once again affirms the *validity* of the joint agreement (15D: "and our agreement remains the same"). The decision dialogue, which was conducted in a *second edition,* as it were, for mutual *reassurance,* was apparently brought to a marked end.

22.6.4 Consensus check: "You're behind it, too"

However, the conclusion of the second edition of decision-making proves to be deceptive in the further course of the conversation. As is well known, a dialogue "screw without end" (Bühler 1934/1982: 25) can occur if the participants have and keep alive a further interest in the *things*, *events* or *affairs* in question (§ 7.1). In the present case, the patient prolongs the current topic of conversation by beginning to tell a short story directly after the medical conclusion (15D) (E 22.48), in which she contrasts her own story with that of her brother.

E 22.48		"my brother ... he wanted to live"
15	D	[see above] (...) and there our agreement also remains with .
16	P	I spoke to my nephew today.
17	D	hm .
18	P	he said: he also told his father: I would stop it . but my brother was offended . he wanted to live .
19	D	hm .
20	P	no, but it's a bit different for me . I know what chemotherapy is.
21	A	good . you have now tried this again for the last year and we must not forget that this was also very problematic for you .
22	P	yes .
23	D	that's how I remember it .
24	P	yes .
25	D	good ( ) .
26	P	the last two years or three already .

The patient's *new start* on a topic of decision-making, which seemed to be completed after several *saturations,* may be *contrary to expectations*, but is understandable after the course of the conversation so far. If the previously assumed *self-evident facts* are called into question, the consequences of further *uncertainty* can provide sufficient cause for further *conversation.* Once in doubt, the mainly argumentative reassurances of both interlocutors are apparently no longer sufficient, but new obligations to give reasons arise, which the patient seeks to fulfil in a *narrative* form with the prima facie evidence of a *personal narrative* (§ 9), in which she compares her brother's experiences and attitudes with her own (P 16ff.). Although it remains unclear to what extent the doctor also has knowledge of her brother's medical history, he is obviously well able to comprehend the *emotional* content of his patient's comparative short narrative, in which he once again expresses the appropriate *recognition* of her *burdens* (§ 20.5) in an *empathic* communication.

With a relatively "strong" evaluative choice of words ("very problematic"), the doctor can reactivate the shared knowledge of the patient's medical history with just a few words (21D: "we must not forget", 23D: " that's how I remember it"). The *precise* use of *words* may already be indicative of the relationship in the meantime when the patient corrects her doctor, who focuses on "the last year", accordingly regarding the duration of her medical history (26P: "the last two years or three already").

This "correction" is confirmed by the doctor ("hm . hm") before he sets a "communication stopper" (*truncator)* ("good") to then return to the current topic on an argumentative level (E 22.49), on which both interlocutors once again seek to *consensus* on their "final" decision.

E 22.49		"and that's where we'll stay . so . yes"
27	D	hm . hm . good . it was important to me . because I thought . if the situation changes . then it makes sense . just to ask again .
28	P	yes .
29	D	it could .
30	P	no .
31	D	come to a different decision .
32	P	no .
33	D	but then I think that's fine too . and that's where we'll stay . so . yes .

The impulse previously set by the doctor, which in retrospect, in his current words, he "just wanted to ask", has in the meantime become a "thought-provoking impulse" that has "made waves" in the *deliberation phase* of decision-making that can hardly be "smoothed out". Once again, the doctor recapitulates the meaning and purpose of his "question", the alternative answer to which he once again puts up for discussion as a *hypothesis* by formulating it in the subjunctive ("could"). Since this *option* is clearly denied by the patient already in the beginning of the doctor's formulation (30P: "no") and after the conclusion (32P: "no"), the doctor can now *ratify* the decision as a *joint* decision, which he does in two steps: (1) on the one hand, he explicitly acknowledges this decision with a personal subject expression ("I") ("but then I think that's okay"); (2) on the other hand, he emphasises the commonality ("we") of the perspective of action that follows from this decision ("and that's where we'll stay. so . yes"). At this point in the conversation, the decision node seems to be sufficiently resolved, so that here the doctor could expect ratification through minimal feedback from the patient (e.g. "yes", "good" etc.), but this fails to materialise in this simple form. Instead, the communication continues as follows:

E 22.50		"Yes, but I think you're behind it too"
34	P	yes, but I think you're behind it too .
35	D	yes . [nods several times]
36	P	yes .
37	D	yes .
38	P	I don't want to go through chemotherapy at any price ... and no ... it doesn't change the fact that it's coming to an end ... only .... but that also prolongs the suffering. [leans back] and I don't want that.
39	D	it can be like that . that's right . yes . and I think we'll just concentrate on trying it out right now .
40	P	yes .
41	D	my suggestion . my suggestion how we can check this again here in practice today . that we don't just give you the pain patch, but that you can now directly try out the remedy . which is also intended to have an immediate effect . you can also try it out directly here . (...) do you have so much time?
42	P	yes (...)

Instead of a mere affirmation, the patient follows her speech with a *yes-but formula*, with which complex *all-round functions* can be perceived in the dialogue link (Koerfer 1979). The function of "yes" often remains vague simply because of the unclear reference, while after the adversative *but-connection* a variety of contents can be addressed as (co-asserted) insinuations (*presuppositions),* which can become the subject of further questions, objections, rejections, etc., so that further topics of conversation open up in the sense of a "dialogue screw without end" (§ 7.1).

The doctor is asked again for his opinion, which the patient tries to assure herself of (34P: "yes but I think you're behind it too"). Although the doctor expresses his agreement verbally and non-verbally (35D, 37D), the patient again prolongs the topic under discussion by putting another argument at her disposal. The doctor leaves it at a vague and ambivalent answer (39D: "it can be like that ..."), before at this point at the same time making a pragmatic conclusion to the decision-making process by returning to his current therapy proposal ("pain patch"), to which both interlocutors then find a quick consensus with a concrete perspective for action.

22.7 Decision-making as a negotiation process

If, in the present case, the patient specifically states her belief regarding the doctor's attitude ("but I think you are behind it too"), doubt cannot be ruled out. This doubt often cannot be completely dispelled, even if the two conversation partners should take sufficient "time" to come to a joint decision. Rather, residual doubts may have to be endured as a "paradox" without this being blamed on either partner as a lack of willingness to reach an understanding.

22.7.1 Paradoxes and ambivalences

The doubts are basically justified in this type of decision because the joint decision and the physician's preference (in the sense of a "1st choice") do not have to be congruent in every respect. As explained under the concept of *participatory decision-making* (§ 10.3-4), *complete congruence* is not necessary, but it is sufficient if the physician can sufficiently support the decision, especially in the context of *evidence-based* medicine. If necessary, the two partners have to "live with the paradox" of having finally come to an agreement with a residual non-agreement, which has to be tolerated to a certain extent by both decision-makers.

Thus, a patient will have to cope with a rejected request for care if it is contrary to evidence-based medicine, and a doctor will not be able to reject what he or she considers to be a "second-best" solution as long as it is within this evidence-based framework. Especially in decisions involving *equal* alternatives (*equipoise*) (§10.3), patient preferences must ultimately be the deciding factor.

In the case of existential decisions, in which the relationship between *quantity of life* and *quality of life* must be balanced, the individual preferences for a personal lifestyle will be decisive, which ultimately cannot be decided by someone else. Although everything should be allowed to be discussed in a medical consultation that is desired by the patient, not everything can be "discussed to the last" in such a way that the patient's life-world orientations, i.e. also his social, cultural and religious attitudes, are put to the test. Temptations in this direction with

the aim of overcoming remaining discrepancies of this kind are subject to the risk of encroachment on both sides. [7]

Here there should also be no confusion between different concepts of competence (Koerfer 1994/2013). *Professional* competence, which consists of medical *information* and *counselling,* is one thing, competence in the sense of *responsibility* is another thing, which to exceed would be tantamount to a kind of "presumption of authority" in matters of *lifestyle.*[8]

22.7.2 The "gradual finalisation" of decisions

Apart from emergencies, decisions relevant to life should be made *carefully*, which, as we know, takes time ("good things take time"). The *slowness* of a decision-making process, in which the alternatives in question are chosen carefully, should not only be *constitutive* in difficult life situations, but also in medical consultations (§ 10.6-7) (Koerfer 2013, Koerfer et al. 2005, Koerfer, Albus 2015). The problems that arise there can often not be *solved ad hoc,* but must be constantly *reconsidered* conversationally. Analogous to Kleist's dictum "On the gradual production of thoughts in speaking" (1878/1966), thoughts must first be developed in conversation with the doctor, in which they must mature sufficiently to be able to endure.

Yesterday's "finished" thoughts can, however, turn out to be "unfinished" in today's consultation, especially if new experiences and insights have been added. The first decision may turn out to be a mistake due to new developments, which must be corrected in time. As a result, the preferences developed and decisions made may be subject to change, which in turn must be taken into account for a new edition of the decision-making process, as long as the medical state of affairs still permits this. Assessing this falls primarily within the professional competence of

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7 Because this discrepancy often cannot be overcome, patients repeatedly ask their doctors what they would decide if they themselves or their relatives were affected, in order to hear their "real" opinion. If a doctor is at all prepared to give personal information here, he would answer in this case, if necessary, that his mother would decide quite differently for certain (religious, etc.) reasons, because she would be interested in prolonging life "under all circumstances", etc.

8 It is, of course, part of a doctor's competence to point out the risks of an "unhealthy" lifestyle, as the preceding examples on *smoking cessation* (§ 22.2) make clear.

the doctor, who is obliged vis-à-vis the patient to take the initiative for new "considerations", i.e. to reopen the decision-making process in a new edition "open-ended".

It was precisely in this setting that the doctor in the preceding case had made the new topic offer and offered himself as a conversation partner to help with the patient's further self-exploration. In several rounds of talks, the patient's (dis)preferences had proved to be sufficiently stable so that the old "decisions" held after the decision-making process was resumed.

Although the readmission procedure had not led to any revision, an *irritation* has obviously set in with the patient, which she tries to overcome conversationally by *drawing* the doctor into the *conversation* several times, which leads to repeated affirmation of the decision that has been made. Although a sufficiently saturated decision point was reached, the patient now feels compelled to put her doctor's approval to the test again (24P: "yes, but I think you're behind it"), even though it was already abundantly clear (E 22.47: 15D: "completely okay"). Obviously, the patient feels that another, specific type of medical consent is indispensable in the further treatment perspective, which is then also marked several times by the doctor (35D ff). This medical "assurance" obviously serves to restore the patient's "security", who may have been "unsettled" by the doctor's initial exploratory initiative, because in the current course of the conversation something was again called into question by him, which had previously seemed certain in previous conversations.

It remains to be seen whether the doctor's agreement fully corresponds to the patient's expectations, but she does not insist further. Instead, she explains her position in a longer reply (38P), to which the doctor reacts vaguely to ambivalently (39D: "it can be like that, that's right, yes"), before finally changing the subject ("I think we'll concentrate on trying it out like that again"). This concludes the major excursion into decision-making, and both interlocutors return to the starting point of the conversation, where, in view of the current pain, a new pain therapy was to be tried out, for which the doctor renews the "suggestion" he made at the beginning.

22.7.3 Repetitive communication patterns

The *repetitive* course of *deliberation* is at the same time a sign that decision-making processes cannot usually be reduced to simple yes/no formulations in the *question-answer pattern* of understanding, but are to be designed as negotiation processes in which the "contentious" is not concealed, but undergoes a repeated upgrading of relevance (§ 17.4, 19.4). Even if the alternative therapy options could be formulated cognitively and interactively in a decision question that could be answered just as easily (*chemotherapy? - Yes/No*), further *communication patterns of understanding* are obviously needed to obtain the necessary certainties for both interlocutors.

In addition to *interrogative*, *informative* and *argumentative* communication patterns (§ 10), this also includes *narrative* communication patterns (§ 9), which, as in the present case, can fulfil the function of reassuring oneself of lost evidence by expressing the emotional experience in *medical histories.* For example, the patient had tried to make her own decision plausible by contrasting it with the medical history of her brother, who had decided and behaved differently from herself, whereby both options for action "come into play" as possible alternatives, which are basically presented as *worth telling* because they are *worth considering.*

The patient's *own medical history* could be recalled by both interlocutors in a few words (21D: "very problematic for you ... that's how I remember it") through a joint recollection of a long *history of suffering,* and "put into balance" again in the upcoming decision-making process, in which "subjective" and "objective" weights are to be *weighed* together (§ 10.3). Negotiation processes of this kind, which can be characterised by a high redundancy of reassurances on both sides, are a very first prerequisite for further joint action, as can be summed up in this example:

In a digression, the doctor had initiated a communication initiative, which initially seemed sensible to him due to the current course of the disease and treatment (E 22.45: 17D: "if the situation changes . then it makes sense . just to ask again"). This again involved clarifying the "big" endpoints of further action (§ 8.1), which were *formulated* by the patient right at the beginning (12P: "for me it's okay when it ends . but I don't want to be full with chemotherapy . just to/to maybe live a few weeks longer"). However, these already early formulated endpoints had to be

further *formulated* and *ratified* communicatively in order to secure again the previous understanding between doctor and patient, which seemed to be in question.

Only after this relative clarification of the "major", long-term *endpoints,* which ultimately concern the patient's *life expectancy* and at the same time her *quality of life,* can the interaction be continued on "subordinate" endpoints, namely on the modification of *pain therapy* for the purpose of short- or medium-term pain relief (39, 41D). The consultation can then be concluded with the consensual decision to also try out the proposed *pain therapy* in the short term ("do you have time?"), which was still initiated immediately after the consultation.

22.8 Further information and references

Those interested in a historical-systematic presentation and justification of a *dialogical* medicine as well as informed consent and decision-making, in which the various models of relationship and communication are differentiated, are referred to the relevant chapters (§ 3, 7, 10) in the theory section of the handbook. Further extensive literature references on general overviews and specific topics had also been given there. Of the literature on (*Teaching*) *Shared Decision Making* (SDM) cited there, only the following current references should be mentioned here: 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, Stivers, Tate 2023, Weber et al. 2023, Chmielowska et al. 2023, Lehane et al 2023, Zhou et al. 2023, Giorgi et al. 2024, Xiao et al. 2024.

Specific aspects of information and decision-making are dealt with in the chapters on *professional communication* (§ 27) and *prescription talk* (§ 26), which also deal with *risk communication* in medication. The possibilities of *patient education* through the use of *multimedia* are discussed separately (§ 39). The topics of communicating serious diagnoses and communicating with dying patients are dealt with in specific chapters of the handbook (§ 16, 38, 43).

Well suited for didactic purposes is the older work by Mann (1984), which contains an empirical collection of material of more or less successful educational conversations. Empirical examples that are also suitable for didactic purposes can be found in the works on preopera-

tive, *anaesthesiological* educational conversation (Klüber 2015) and on *written* consent (Bührig, Meyer 2007). Spranz-Fogasy (2014) examines the special type of conversation of the *pre-diagnostic* communication with many empirical examples. Rich examples and sample analyses, also under didactic aspects, are contained in the easily accessible online publications by Becker (2015), Peters (2015), Kliche (2015), Groß 2018 and Buck (2022).

For the specific *Ask-Tell-Ask scheme,* please refer to the literature cited above (§ 22.3), examples of which are Back et al. (2005), (2008), Hausteiner-Wiehle, Henningsen (2015) and the NKLM 2.0 (2021). The NURSE scheme, which is not only used in education and decision-making, but throughout doctor-patient conversations, has been discussed in detail under the topic of *empathic* communication (§ 20.4) in critical comparison with our *Cologne Manual of Medical Communication* (C-MMC) (Fig. 22.2) (see last page). For the importance and exploration of *subjective patient perceptions,* reference should be made back to the relevant subchapter on *Exploring Details* (§ 21.5).

References

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

Koerfer A, Reimer T, Albus C (2025): Negotiating Procedures. From Paternalism to Shared Decision Making. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung.

Cologne Manual & Evaluation of Medical Communication see next page.

Cologne Manual & Evaluation of Medical Communication						C-M+EMC
OSCE Checklist for Medical Interviewing						[1]1998
© Department of Psychosomatics and Psychotherapy at the University of Cologne						[6]2022
No.	Course	Interviewer	Date	Patient (SP)	Rater	Sum:
						☐☐ 50

1 Building a relationship	☐4	4 Exploring details	☐☐ 12
1 Framing • Enable confidentiality • Avoid disturbances		1 Inquire about complaint dimensions • Localisation and radiation • Quality, intensity *(scale 0-10)* • Dysfunction/disability • Accompanying symptoms • Time (beginning, course, duration) • Condition "In what situation ...?"	❶❷❸❹
2 Greeting • Make eye contact • Verbal greetings, shaking hands • Address by name	❶		
3 Introducing yourself • Introduce yourself by name • Communicate function ("ward doctor")	❶	2 Exploring subjective ideas • Concepts *"What do you imagine?"* • Explanations *"Do you see causes?"*	❶❷❸❹
4 Situating • Speak sitting down (chair to bed) • Ensure convenience • Coordinate proximity/distance	❶	3 Complete anamnesis • Systems ("From head to toe") • General health, sleep, etc. • Previous illness, pre-treatment • Family risk factors • Family, friends, job, finances, etc. • Addressing gaps (sensitive issues)	❶❷❸❹
5 Orientation • Structure conversation • Goals, time, frame	❶		
2 Listening to concerns	**☐10**	**5 Negotiating procedures**	**☐☐ 12**
1 Start the conversation openly • Offer "What can I do for you?" • Occasion *"What brings you to me?"*	❶	1 Plan an evidence-based approach • What is secured? • Do diagnostics have consequences?	
2 Encouraging storytelling - feedback • Listener signals *hm, yes,* nod, etc. • Avoid interruptions • Allow pauses, free choice of topics	❶❷❸❹	2 Clarify expectations • Ideas, wishes, hopes *"What did you have in mind?"* • Control beliefs *"What could you change yourself?"*	❶❷❸❹
3 Active listening - verbal support • Encourage speaking up • Repeating statements verbatim • Paraphrase statements • Openly ask further: *"How did that come about?"*	❶❷❸❹	3 Explaining previous findings • Communicate diagnosis • Communicate problems	❶❷❸❹
4 Ensure understanding • Ask "Do I understand correctly ...?" • Summarise	❶	4 Examination or therapy plan • Explore decision model (SDM) • Discuss proposals and risks • Consider reactions • Strive for consensus	❶❷❸❹
3 Eliciting emotions	**☐8**	**6 Drawing conclusions**	**☐☐ 4**
1 Pay attention to emotions • Verbal (e.g. metaphors) • Non-verbal (e.g. gestures, facial expressions, gaze behaviour, etc.)		1 Summarise the conversation • Reason for consultation, complaints, • Diagnosis, therapy agreement	❶
2 Empathise with patient's situation		2 Offer clarification of outstanding issues • Information *"Do you still have questions?"* • Satisfaction "Can you handle it? "	❶
3 Respond empathically • Offer appropriate help and comfort • Acknowledge burdens, coping	❶❷❸❹	3 Arrange follow-up appointments • Examination appointments • Set a meeting date	❶
4 Promote emotional openness • Addressing *"I perceive that ...?"* • Naming *"You are sad then?"* • Clarify *"What do you feel then?"* • Interpret *"Your fear may come from..."*	❶❷❸❹	4 Say goodbye to the patient	❶
		5 Complete documentation • Coding & conversation impressions • Topics for follow-up talks	

❶ [❶ = not met;❶ = met] ❶❷❸❹ [❶ = not met ...❹ = fully met]

Fig. 22.2: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)