7 Dialogical Communication and Medicine

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> Both physician and patient 'teach' one another in dialogue.
>
> Pellegrino, Thomasma 1981: 65

Abstract: After introductory remarks on didactics (§ 7.1), selected communication models and theories of communication will be presented, which have also become significant for the empirical analysis of doctor-patient communication (§ 7.2-7.4). In addition to various criteria (interdisciplinarity, relevance, practicability, etc.), the selection is determined above all by how the various (*semiotic*, (*language-*)*philosophical*, *linguis-*

tic, *conversation-analytical*, *communication-psychological,* etc.) models and approaches can contribute to the analysis of commonalities and differences between *everyday and medical-therapeutic* communication, which is also to be understood essentially as *dialogue-based* communication in the institutional framework of action. Thus, communication between doctor and patient should also be essentially *understanding-orientated*, so that *strategic* action that relies on *coercion* in a strictly paternalistic model, for example, or on *manipulation* in an extreme service model, is largely frowned upon.

In spite of all institutional restrictions, a "dialogue principle" must also be brought to bear in the medical consultation and ward round, according to which doctor and patient can meet as unequal but equally entitled dialogue partners in a "real" conversation. Following the relevant *philosophy of dialogue* (7.5.1), a brief historical overview will trace the development in which the pendulum initially swung from purely *doctor-centered* to purely *patient-centered medicine,* before these extremes could be mediated in a *relationship-* and *dialogue-centered* medicine (§ 7.5.2). Accordingly, traditional concepts and analyses of the *asymmetry* of the relationship and communication between doctor and patient are to be subjected to critical reflection before a plea is made for a *dialogical symmetry*, which is to be justified within the framework of an *ethics of discourse* (§ 7.5.3).

Finally, the consequences for the evaluation and didactics of doctor-patient communication are shown by means of a *dialogue cube* (§ 7.5.4), in which the dialogical sub-principles (of *cooperation*, *rationality*, *transparency*, *relevance, function, structure*) are summarised, which are to accompany us with thematic emphases through the handbook as a whole. Finally (§ 7.5.5), the bridging function of dialogue for the mediation between the patient's *life world* and *medicine* is to be put into perspective, in which the *basic trust* in the doctor-patient relationship plays an essential role.

Since this handbook is also an *interdisciplinary* project, with authors contributing from very different (*medical*, *psychological*, *sociological, linguistic*, etc.) traditions, some remarks should be made at the end (§ 7.6) about *terminology*, which should be kept as "reader-friendly" as possible overall, even if the individual disciplines occasionally make it (unnecessarily) difficult for each other.

7.1 Preliminary remarks on didactics

In the following presentation of selected communication models and theories of communication, we have endeavoured, from a didactic point of view, to provide a generally understandable presentation that can also be used for teaching purposes in "non-subject-specific" learning contexts for which the thematic study of language and communication is less central.[1] Those who find this introduction to topics and problem areas of communication research too "abbreviated" due to the necessary didactic reductions are immediately referred to the further reading at the end (§ 7.7) or the original sources of the "classics".

For a better understanding of the following chapters and conversation analyses on doctor-patient communication, a series of selected *terms*, *categories* and *concepts* will be introduced here, for which some "classics" of language and communication research will be "discussed" in detail, if possible "in their own words". In doing so, some basic *technical* terms and categories will be introduced and explained here, which will be applied in the course of further argumentation and empirical analysis on doctor-patient communication, if possible in colloquial "translations", on which we will conclude (7.6) with some remarks on the terminology in this handbook.

The compilation of the following selected models and theories of communication under a uniform "label" (such as *communication psychology*, *speech act theory, linguistic pragmatics, conversation analysis (CA), discourse analysis (DA), conversation analysis* or (simply) *conversation analysis* etc.) is not without problems. Their relationship and interdependency is not always clear, even if it is sometimes explicitly claimed. Likewise, a strict demarcation of different communication models and theories often remains as contentious or at least difficult as their reception history varies.

For example, Karl Bühler's long misunderstood *Organon model* (§ 7.2.2) has meanwhile experienced a broad, *interdisciplinary* resonance in quite different research currents, such as for semiotics ("theory of

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1 In addition to the selection and design according to criteria of interdisciplinarity, relevance as well as practicability for teaching purposes, learning objective requirements should be taken into account here, such as those formulated in the National Catalogue of Learning Objectives in Medicine (NKLM 2021), which explicitly include knowledge of the "classics" (such as Bühler, Uexküll, Watzlawick, Schulz von Thun, etc.) in the curriculum.

signs") in general, but also specifically for "communication psychology" approaches (§ 7.4.2) and especially for "linguistic-pragmatic" research directions (§ 7.3.2.). Overall, the following is intended to provide a brief overview of specific problems in communication research for teaching purposes in medical, but also social science subjects, with a varying depth of presentation for selected models and theories of communication as well as their methods of analysis.[2] These introductions will certainly meet with different basic knowledge and specific levels of knowledge during reading, which is why an attempt has been made here to provide a presentation that is as free of prerequisites as possible, which will hopefully nevertheless be able to "appeal" to beginners and advanced users alike.

7.2 Semiotic models of communication

Because of its direct relevance to medicine, the *function* and *situation circle model* is presented here first, as it was designed by the biologist Jacob von Uexküll and further developed and concretised by the two physicians Thure von Uexküll and Wolfgang Wesiack in numerous works. Following on from this, Karl Bühler's *Organon model* will be presented here as a *semiotic* model, because it has become known beyond the boundaries of individual disciplines (such as *psychology*, *linguistics*) in an extensive history of reception, which can be summarised under a general term of *semiotics* ("theory of signs").

7.2.1 Functional and situation circle model

In the preceding remarks on the *biopsychosocial* model, attention had already been drawn to the *scientific-historical* and *epistemological* foundations of this model (§ 4). In the development and justification of their comprehensive "Theory of Human Medicine" (1991), Thure von Uexküll and Wolfgang Wesiack, as well as in their basic article in the "Uexküll

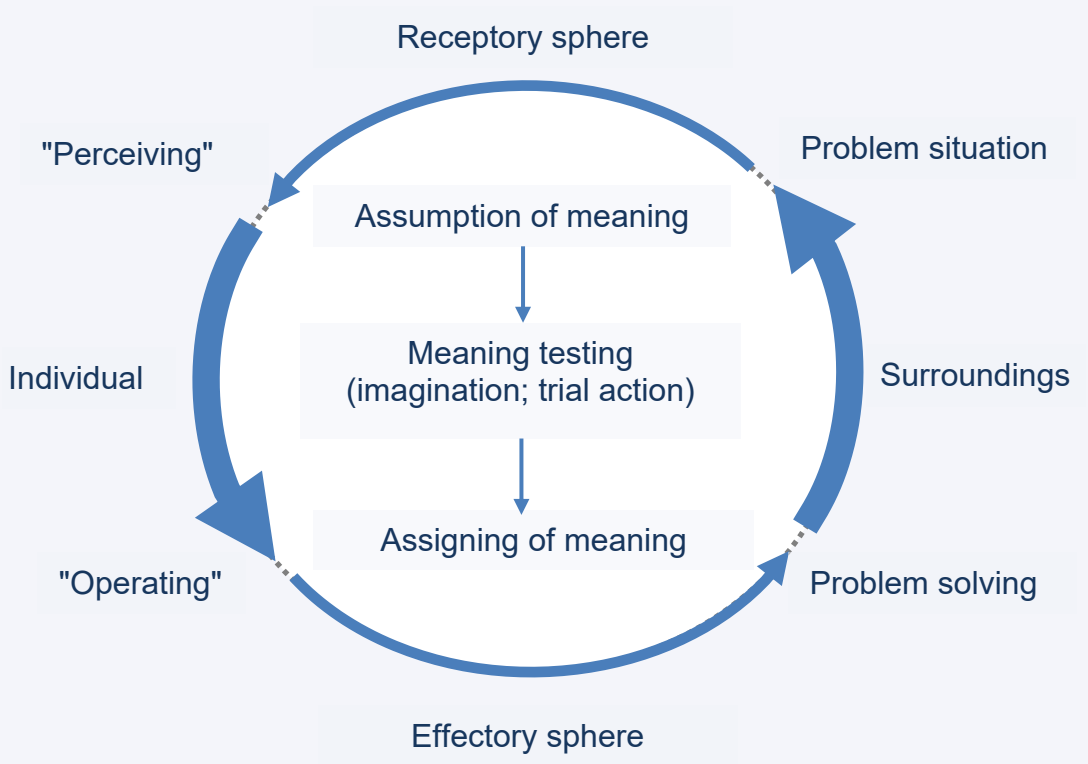
2 On the one hand, the selection and depth of presentation was (as always) dependent on our own insights and interests; on the other hand, we were also guided by the history of reception, according to which the relevance of certain approaches is also reflected in curricular influence (e.g. in adult education).

Handbook" on "Psychosomatic Medicine" (2011), already refer to strongly *interdisciplinary* traditions, which, as early as George Engel (§ 1), seek to lift the epistemologically narrow framework of a purely *biomedically* oriented research and medical care.

In particular, Thure von Uexküll has expanded the model of the *functional circle,* as developed by his father, the biologist Jakob von Uexküll on animal behaviour, from the specific perspective of *semiotics* ("theory of signs") in more than 30 years to a model of the *situation circle* (Fig.7.1) (Uexküll 1981, Uexküll, Wesiack 1991, 1997, 2011). This semiotic foundation and expansion of the *functional circle model,* originally developed from a biological perspective, primarily concerns the *trial-and-error* behaviour characteristic of human problem-solving behaviour, as it comes into play in particular before and during *linguistic* action.

Testing is constitutive for human existence, and it is no coincidence that it is at the center of the situation circle (Fig. 7.1). Already in childhood we acquire the necessary competences, which are continuously developed until they are finally increased to everyday practical or scientific hypothesis formation. In the trial-and-error interaction with the environment, however, *mismatches* can arise at an early stage, which, according to Uexküll and Wesiack, lead to *maladjustment*, which can eventually manifest itself in illnesses. We cannot trace in detail the *sociological*, (developmental) *psychological*, *system-theoretical* and above all *semiotic* perspectives and applications of the situation circle model described by Uexküll and Wesiack in this context here, but only refer back to the remarks on *biopsychosocial* medicine and the *body-soul problem* (§ 4).

Under both aspects, the *example of application* to the situation circle model in the GP consultation, interpreted in detail by v. Uexküll and Wesiack (1991, 2011), had also been discussed, in which the task of the doctor as interpreter is basically to recognise and solve the *problem situation* "consisting of signs (that) the patient brings along" (2011: 38). In this case with an obese patient, discussed in detail (§ 4.3), several rounds of conversation were about *meaning testing, meaning making* and finally meaning *utilisation of the patient's story* dramatically told by the patient.



The situation circle differs from the functional circle in that the imagination is an obligatory intermediary, in which programs for assigning of meaning ("perceiving") and meaning utilization ("effecting") are at first be tested as assumption of meaning and testing of meaning, before the ego releases them for the motor activity. In this process, the situation (which corresponds to the characteristic or problem situation in the functional circle) is quasi-experimentally pre-structured in the imagination: This means that assigning meaning is initially given as a hypothetical assumption of meaning, whose consequences can be probed in the imagination by means of "testing acts".

Fig. 7.1: Situation circle (on v. Uexküll, Wesiack 2011: 32)
(cf. in: Adler et al. (Eds.) (English edition) (1997)
(Psychosomatic Medicine): 31f; and v. Uexküll, Wesiack 1991: 274)

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This extended as a *medical history* from the difficult childhood to the failed marriage to current losses and separation fears, which, in view of the son's impending departure, triggered the current nocturnal attacks of respiratory distress with further medically significant *accompanying signs. The* development of the current complaints and symptoms had been explained by Uexküll and Wesiack (1991, 2011) in *upward* and *downward movements* in the biopsychosocial model, the sign meanings of which the doctor and patient first had to ascertain laboriously and conversationally.

This reconstruction of sign-like meanings is not possible with traditional anamnesis and conversation. As the example discussed in detail above (§ 4.3) made clear: Whoever as a doctor wants to follow a *biopsychosocial* medicine must increasingly engage with *biotic*, *psychological* and *social* themes, and whoever as a doctor wants to engage with these themes must choose a different way of conducting the conversation than is usual according to Balint (1964/1988: 171, 186) in the traditional, *biomedical* taking of anamnesis. Precisely because life stories and medical histories in their individual meanings for patients cannot be adequately *asked*, but only *told,* doctors must be prepared to change their traditional way of conducting a conversation from an *interrogative* anamnesis, which according to Balint (1964/88: 382) consists of an "almost completely formed sequence of questions", to a more *narrative* anamnesis (§ 9), in which patients have their say by telling their stories.

As already described above and to be elaborated on in the further course of the handbook: the biopsychosocial model is not only to be shown as a model of *knowledge* and *treatment,* but also as a model of *communication, in* which a changed conduct of conversation follows a changed model of medical care. To this end, we will repeatedly return to the *situation circle model*, for example when, with Uexküll and Wesiack (1991: 291ff), it is to be described how doctor and patient exchange "scenic information" right at the *beginning of the* consultation (§ 9.2), which they mutually gain in both verbal and non-verbal communication (§ 12, 18) and know how to use for further processes of *testing of meaning.*

7.2.2 Organon model and I-here-now-origo

The importance of the *psychologist* Karl Bühler, who can still be considered a universal scholar of the natural sciences and the humanities, not least because of his studies in *medicine* and *philosophy* (both with doctorates), was initially misjudged for a long time. Thus, not only from the perspective of *semiotics* ("theory of signs"), Sebeok still finds it "deplorable at the beginning of the 1980s that a large part of the researchers in this field, whether they toil in American or European institutes, are only to a very small extent aware of standing on Bühler's broad shoulders" (Sebeok 1981: 223). It was not until the 1960s that Bühler was widely received, for example by the phonetician and communication scientist Gerold Ungeheuer (cf. e.g. Schmitz 1990), and this reception continues to this day.

Initial example of "dialogue screws without end“

In his *Theory of Language* (1934/1982), Bühler presents his now widely received *organon model*, which he previously developed in several sketches. He starts with a simple example ("it is raining"), the scope of which can unfold for speaker and listener in "dialogue form" to a "screw without end" (Box 7.1).

Box 7.1	Example of a "screw without end" in "dialogue form

Two people in a room - one looks at a pattering sound, looks at the window and says: it*'s raining* - the other also looks there at the window, either directly from hearing the word or from looking at the speaker. That happens, and the circle is closed in the most beautiful way. If you like, you can even let the events in the closed circle go on like a screw without end. If the thing or event is rich enough for ever new stimuli, which are taken up alternately by one or the other partner, if the incident appeals to both of them extensively (as one is wont to say pithily), then they will indulge for a time in observing and talking about the thing or the affair in dialogue form.

Bühler 1934/1982: 25f. (emphasis in the original)

It is easy to fantasise beyond Bühler how such "dialogical screws without end" can develop, which take their harmless beginning from the simple example ("It is raining") (B 7.1), from which then (as constructed here) "one word can yield the other", to which we will return with further (and then empirical) examples from doctor-patient communication.

E 7.1		"It's raining" - with a "dialogue screw without end"
01	A	It is raining.
02	B	Yes.
03	A	There's quite a bit coming down. The garden chairs get all wet.
04	B	Do you want me to bring in the lawn chairs?
05	A	You can do that.
06	B	You do it!
07	A	All right, I'll get them in.
08	B	Take the umbrella with you. Otherwise you'll get all wet.
09	A	Where is the umbrella?
10	B	Why are you asking me that?
11	A	You had it last!
12	B	Look for it yourself!
13	A	You'll have misplaced it again.
14	B	Always me.
15	A	[Quoting Schiller ironically:] Holy order, blessed daughter of heaven.
16	B	[aggressive] You're one to talk, you know-it-all! Take a look around your room! It looks like Sodom and Gomorrah!

Even at first glance it becomes clear that it is about "more" than the mere reference to an "outer" world in which it rains and garden chairs get wet, but that the dialogue partners have and pursue *attitudes* (wishes, preferences, intentions, etc.) in their "inner" world, which they also try to influence reciprocally, so that actions occur which may also result in changes in the "outer" world (e.g. when the garden chairs are brought into the dry). Before we go into more detail later on such "dialogue screws" as dialogical sequences in doctor-patient communication as well, which, with reference to *speech act theory* (§ 7.3.1), also deal with the question of "indirectly" realised "speech acts", we will first continue to follow Bühler's explanations following his simple dialogue example ("It's raining") (Box 7.1).

Organon model

After an excursus in the history of science, in which he discusses, among other things, the distinction between "signs" and "signs of action" by the biologist Jakob von Uexküll (§. 7.1), Bühler then systematically develops, via preparatory sketches, the final illustration of the *organon model,* which he explicitly justifies following Plato: "I think it was a good touch on Plato's part when he states in the Cratylus that language is an *organum* for one to communicate something to another about things" (1934/82: 24). At the center of the organon model is the *sign* (=Z; S), whose position and relations will be described here in excerpts in Bühler's own words (in Fig. 7.2).

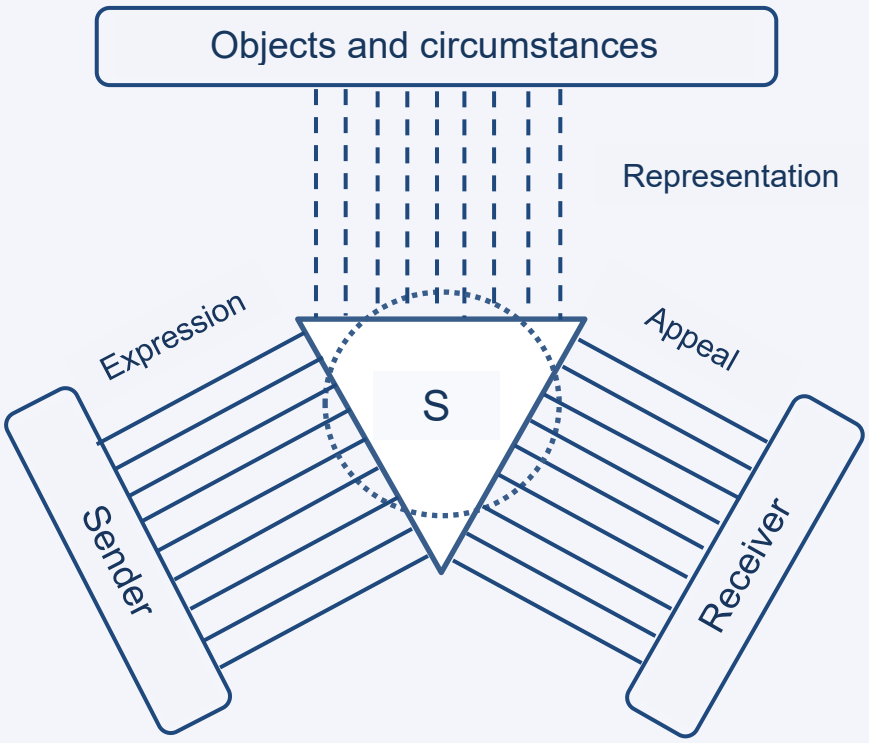
Originally still based on a different terminology (German: *Kundgabe*, *Auslösung*, *Darstellung*), Bühler's terminological reorientation is certainly guided by considerations of science and everyday practice that were current at the time, when, for example, he follows the tendencies "in the circle of linguistic theorists" when choosing "expression" or, in the case of "appeal", takes into account associations with "sex appeal".

Box 7.2 Terminology: *expression*, *appeal*, *representation*

Today I prefer the terms: *expression*, *appeal* and *representation,* because in the circle of language theorists 'expression' is gaining more and more the precise meaning demanded here and because the Latin word 'appellare' (English: appeal, German roughly: ansprechen) is apt for the second; as everyone knows today, there is a sex appeal, next to which the *speech appeal* seems to me to be an equally tangible fact.

Bühler 1934/1982: 28f. (emphasis in the original)

It is certainly a special merit of Bühler's to have brought the *expressive* and *appealing function* of language and speech into the focus of attention in addition to the traditional *representational function.* Although Bühler does not want to fundamentally deny the commonly assumed *dominance* of the representational function, he would like to relativise it in the sense that the other two basic functions can also come to the fore, individually or together.



The circle in the middle symbolises the concrete sound phenomenon. Three variable moments in it are called upon to elevate it three times differently to the rank of a sign. The sides of the triangle symbolise these three moments (...) The groups of lines symbolise the semantic functions of the (complex) speech sign. It is a *symbol* by virtue of its association with objects and circumstances, a *symptom* (sign, indicium) by virtue of its dependence on the sender, whose inwardness it expresses, and a *signal by virtue* of its appeal to the listener, whose external or internal behaviour it controls like other traffic signs.

Fig. 7.2: Organon model (on Bühler 1934/82: 28)

As examples, Bühler cites the dominant *appeal function of command language*, but also the "balance" of appeal and expression in "terms of endearment and swear words", whereby here, as in music, it is precisely the "tone" that is important. In the above "dialogue screw" (B 7.1), we can also fantasise the ironic to aggressive tone of the "exchange part-

ners". As we will see, such *paralinguistic* ("speech-accompanying") phenomena are also or especially significant in doctor-patient conversations, which will be a special topic under the aspect of *non-verbal* communication (§ 12, 18).

In the systematic justification of his Organon model, Bühler on the whole already makes use of a modern, at least still common description of the "speech situation", in which "sender" and "receiver" encounter each other as "subjects" and "addressees" of a "speech action", in relation to which they can finally take up "their own positions" (Box 7.3) as "exchange partners".

Box 7.3 The "Structure of the Speech Situation"

(...) the other is true, that in the structure of the speech situation both the sender as perpetrator of the act of speaking, the sender as *subject of the speech act*, as well as the receiver as addressed, the receiver as *addressee* of the speech act have their own positions. They are not simply a part of what is communicated, but they are partners in exchange, and that is why it is ultimately possible that the medial product of the sound has its own sign relation to the one and to the other.

Bühler 1934/1982: 31 (emphasis in the original)

These determinations of the constitutive features in the "construction of the speech situation" can already be considered essential preliminary work for a modern model of communication, which at the same time focuses on the *intersubjectivity* and *individuality* of the speech-acting exchange partners, who in communicative action reciprocally negotiate what of all possible communication functions should be of interest and relevance to them in a given speech situation.

I-Here-Now-Origo

With the development and justification of the triadic organon model, Bühler at the same time perspectives a structured task and topic for further (linguistic) scientific research, which he sums up as follows:

Box 7.4	Research tasks and topics

The decisive scientific verification of our constitutional formula, the Organon model of language, is achieved when it turns out that each of the three relations, each of the three functions of meaning of the signs of language opens up and thematises its own field of linguistic phenomena and facts.

Bühler 1934/1982: 32

Bühler has thus identified a research programme to which he already seeks to contribute in the same work. Already in the following chapter (1934/82: 79ff), Bühler outlines a specific theoretical and research concept, which became known above all through what he called the "Origo des Zeigfeldes", to which the "Grundzeigwörter" (basic deictic words) *here*, *now* and *I* belong in their "function as linguistic place marker, time marker, individual marker". This concept of the *I-here-now-origo* has been used in many ways and has led, for example, in linguistic pragmatics to numerous general and single-language studies of the *deixis* of person, space and time in texts and conversations (e.g. Ehlich 1979, Levinson 1983/2000). These *deictic* phenomena and expressions (Gr. *deiknymi*) play a specific role in doctor-patient communication in the "here and now" of a consultation:

- ***Taking anamnesis*** (§ 9), when patients as first-person *narrators* in the current narrative situation *here* and *now* tell a personal counterpart ("you") their medical history from "there and then".
- ***Detailed exploration*** (§ 22), when it comes to the *temporal* and *local* dimensions of complaints or specifically to pain localisations (§ 33), for example, in the case of pain that starts from a certain region of the body ("here") and can then move in another direction ("there")
- ***Clarification*** (§ 10, 26, 27, 39) if, in addition to oral information, doctors also refer to certain "places" in imaging procedures with "here" and "there" or accordingly use graphics or spontaneous drawings to illustrate where there is something to show with "here" and "there", etc.

Before we cite empirical cases in *these* (later) chapters, to which reference will only be made *here*, we should first appeal to our everyday experience that *deictic* phenomena can easily lead to misunderstandings when, for example, hosts verbally and with a pointing gesture offer the guest the seat *here* because *someone* (else) is already supposed to be sitting *there* (and afterwards, despite the pointing gesture, one is no wiser about where exactly one should sit). What often seems to be easily solvable in everyday life can become a *problem of understanding* with fatal consequences in the consultation, if it is not counteracted in a modified sense by Bühler by means of a "dialogical screw with a good ending" with a *safeguarding of understanding* (§ 27, 19).

Overall, Bühler's scientific work, which cannot be reduced to his well-known triadic *organon model* and the *I-here-now-origo*, has had a delayed but then all the stronger interdisciplinary influence. Relevant to *linguistics* and *psychology* anyway, Bühler has inspired *semiotics* ("study of signs") (e.g. Sebeok 1981, Nöth 2000) as well as exerted influence on *philosophy*, such as on Karl Popper, who studied psychology with him (with a doctorate). Thus, Bühler's distinctions between the three language functions also had an influence on Popper's development of his *three-world theory* (Popper 1972/94, Popper, Eccles 1977/94), which has already been discussed in advance (§ 4) in the discussion of the *mind-body problem.*

In a *communication psychology* approach, Friedemann Schulz von Thun (1981) in particular finally expanded Bühler's Organon model into a *communication square* and *four ears model,* which will be presented separately later (§ 7.4) because of its widespread use.

7.3 Speech action and communication theories

The linguistics and action sciences concerned with speech actions and language (in the narrower sense) have received, if not their impetus, then an enormous boost at the latest with and since John Austin's publication of "How to do things with words" (1962), which initiated the so-called *pragmatic turn* after the so-called *linguistic* turn (e.g. Karl-Otto Apel 1990). The fact that the "discovery" that we perform actions through our speech was so long in coming is characterised from a philosophical perspective by Wolfgang Stegmüller (1975) as a "shameful scandal" (Box 7.5).

Box 7.5 A "shameful scandal“

Actually, it is a scandal. In fact, it is a shameful scandal for all those who have dealt with languages in any way in the last 2500 years that they did not make the discovery of J. L. *Austin* long before he did, the essence of which can be expressed in a brief sentence: *With the help of linguistic utterances we can perform the most diverse kinds of actions* (...) For Schopenhauer's claim that it is particularly difficult for us to elevate the everyday and the obvious to the level of a problem because, due to its self-evidence, it escapes our attention, there can hardly be a better confirmation than the phenomenon of speech acts.

Stegmüller (1975: 64f)

In the following, the developments associated with this radical turn will be outlined in such a way that their significance for the empirical analysis of doctor-patient communication also becomes clear. First, the *speech act theory* of John Austin himself will be presented and introduced to some *basic concepts* of speech action analysis, which are still relevant today in the further developments by John Searle as well as in *linguistic pragmatics* and *conversation analysis*. Because of their interdisciplinary impact, the *cooperation principle* and Paul Grice's conversational *maxims,* which he developed in his theory of *conversational implicature,* will then be discussed. At the end of this chapter, Jürgen Habermas' *theory of communicative action* will be introduced and its application perspective for discourse ethics also in medicine will be shown, which will be concretised again and again in the rest of the handbook under the aspect of *evaluating* doctor-patient conversations.

7.3.1 Language philosophy and speech act theory

With his *theory of speech acts* ("How to do things with words"), John Austin (1962/72) certainly initiated a *paradigm shift* (Kuhn 1973), which has had an impact up to the present. Of course, as with (almost) all paradigm shifts, there are precursors and harbingers of development, for which one could name Karl Bühler (§ 7.1.2) or Ludwig Wittgenstein in the case of speech action theory. But Austin brought an emerging development to the conceptual and theoretical point for which

he himself (in all modesty) saw the starting point of a "philosophical revolution" (Box 7.6).

Box 7.6	The "philosophical revolution“

Philosophers have now long enough assumed that the business of "statements" is solely to "describe" a state of affairs or "assert a fact", either accurately or inaccurately (...).) [It] has now been shown in detail, or at least made very plausible, that many traditional philosophical difficulties have arisen from a mistake: statements which are *either* meaningless (for interesting non-grammatical reasons) *or* which are supposed to represent something quite different from statements or ascertainments have simply been taken to be statements of fact (...) and we can deplore however much the confusion into which the content and method of philosophy have once fallen: we cannot doubt that a philosophical revolution is now dawning with it.

Austin 1962/72: 23-25

Austin illustrates his "revolutionary" view right in the first of his twelve lectures with a series of utterance examples where anyone would say "that I am doing something specific with these utterances (only under appropriate circumstances, of course)" (27). Such specific circumstances must be present, for example, in the case of *betting*, *baptism*, or *marriage*: "When I say 'yes' before the registrar or at the altar, I am not reporting that I am entering into marriage; I am entering into it" (ibid.). For such utterances, Austin would first like to use the term "performative": "The name, of course, comes from 'to perform': one "performs" actions. It is meant to imply that someone who makes such an utterance is performing an action" (27f). Austin then develops his "speech act theory" on further examples also under other "circumstances" which must "fit" the respective utterances. A specific method of investigation comes into play here, namely to conclude from the possible "failures" of communication (i.e. from *misfortunes* such as *abuses*, *misappointments*, *misexecutions*, etc.) that it is rule-like.

7.3.1.1 Subject and categories of speech act analysis

In this context, it is less a question of the well-formedness of sentences, as has traditionally interested linguistic research on grammar, but ra-

ther of the expansion of the subject area, which later gradually extended to the study of the *context* in which action is taken under certain conditions and for certain purposes. Initially, however, the speech act as the *basic unit* of linguistic communication was the focus of consideration, as formulated following Austin by John Searle (1969/1971) (Box 7.7).

Box 7.7	The speech act as the "basic unit of communication

The reason for concentrating on the study of speech acts is simply that linguistic acts belong to every linguistic communication. The basic unit of linguistic communication is not, as has been generally assumed, the symbol, the word or the sentence (...), but the production or bringing forth of the symbol or word or sentence in the performance of the speech act. (...) Speech acts (...) are the basic or smallest units of linguistic communication.

Searle 1969/1971: 30

This "concentration on the study of speech acts" then laid the foundation for entire research programmes. These deal, for example, with the (systematic) spectrum of *performative* ("speech act-designating") verbs (*assert*, *promise, command*, etc.), a possible *classification* of speech acts, their *direct* or *indirect* forms of realisation, as well as the "appropriate circumstances" of speech acts, up to and including the social *contexts* that can be extended by specific actions in specific *institutions.* Before we go into some aspects in more detail, let us roughly mark two research directions. In the alternation of the various epistemological interests in the analysis of speech acts, the following two questions, for example, have become significant, as they were already formulated with a different focus in the two essay titles of the *philosopher of language* John Searle (1965/72) and the *linguist* Dieter Wunderlich (1979) at a distance of more than a decade.

1. What is a speech act? (Searle 1965/72)
2. What kind of speech action is that? (Wunderlich 1979)

Without wanting to assign these two questions one-sidedly to a strict dichotomy of *theoretical* and *empirical* research, this nevertheless marks different directions of research and sets focal points (Koerfer 1994/2013). The first line of inquiry is primarily concerned with the

structure and function of speech acts or speech acts in general, the second with the identification of speech acts (of a certain kind) in a certain context. Both research directions will be briefly outlined here and their relevance for the study of doctor-patient communication will be put into perspective under special aspects.

Austin already distinguished essential aspects of (every) speech act in the first research direction (Box 7.8). Although the terminology (Latin *loqui* 'to speak') may seem strange,[3] it will be adopted here for the time being, because the distinctions thus designated by Austin have become established in the further discussion and have remained current to this day.

Box 7.8 Locutionary, illocutionary and perlocutionary act

First of all, we have described a series of things that one does with an utterance and that together constitute a *locutionary* act. It amounts, roughly speaking, to uttering a certain proposition and thereby saying something definite about something definite; and that is to say, roughly, that the utterance has "meaning" in the traditional sense. Secondly, we have said, we also perform *illocutionary acts,* such as informing, commanding, warning, committing ourselves, etc., i.e. we do utterances that play a certain (conventional) role. Thirdly, we can also perform *perlocutionary acts*; we bring them about by saying something. Examples are convincing, persuading, dissuading, also for example surprising or misleading.

Austin (1962/72: 123)

The three types of acts are not performed in isolation, but can be understood as partial acts or *aspects* in the performance of the speech act as a whole. While the *locutionary* act itself is generally indisputable, the boundaries between the *illocutionary* act and the *perlocutionary* act cannot always be drawn sharply. The distinction has been exemplified by so-called clear cases, but with which the possible or even relevant areas of investigation can at best be illustrated (Koerfer 1994/2013). Thus there are many clear cases, most of which can be distinguished - as already exemplified by Austin - by linguistic tests: Thus I can *explicitly* say (somewhat awkwardly, but acceptably), "I hereby *assert*, *com-*

3 Correspondingly: illocution (lat. *il-* 'in', *loqui* 'to speak', i.e. 'action that is performed in speaking') - perlocution (lat. *per-* 'through', i.e. 'action that is effected by speaking') (Bußmann 1983).

mand, *promise* that ..." etc. In contrast, we would reject the following cases as unacceptable: "I hereby *convince*, *frighten*, *unsettle, offend* you" etc. Obviously, it is a matter for the listener whether he is *convinced*, *frightened* or *offended* (and whether he might *react* accordingly) or not.

Certainly, I can do everything to *convince*, *unsettle* or *frighten* someone, etc., but these are then *attempts* that can remain unsuccessful. Conversely, I can also *frighten* or *unsettle* or *offend* someone, although this need not have been my intention at all. Thus we will discuss with the cardiologist Bernard Lown cases from his many years of practice in which the medical "power of the word" can have extremely "negative" effects (§ 17.1), although this may not necessarily have been the intention of the doctor. Here first are three examples from Lown (2002: 53), to be supplemented later with further examples:

- They live on borrowed time.
- Her next heartbeat could be her last.
- You are going downhill fast.

Whether intentional or not, the *effects* possibly achieved with these examples (uncertainty, alarm, fright, etc.) often depend on the doctor's choice of (perhaps ill-considered) words as well as on the sensitivity of the patient, whose evaluations may turn out differently (from what the doctor thought). If "full intention" cannot necessarily be assumed in such cases, a certain *negligence in* the use of words could be recognised or an *attitude* could be attributed that could be colloquially labelled as "cheaply accepted". It is therefore often not a matter of the dichotomous question (yes/no) of whether *intentionality* is present, but of possible (also gradual) attributions of *responsibility* for calculable consequences of action, even or especially in the case of doctors' verbal actions.

The problem with the distinction between *illocutions* and *perlocutions* remains the clarification of what role the conventions in general and the intentions, volitions and evaluations of the participants in particular (should) play. This controversy over the justification of the distinction between *illocutions* and *perlocutions* has led to extensive, wide-ranging discussions from Austin (1962/72) to Searle (1969/71) and Strawson (1971/74) to Habermas (1981, 1988) and Apel (1990), to which reference can only be made here (Savigny 1974, Koerfer 1994/2013). In Habermas, the distinction between *illocutions,* which can be expressed *openly,* and *perlocutions,* which must remain *concealed,* ultimately played a prominent role: it is a centrepiece of his "theory of communica-

tive action", to which we will still return with specific aspects on the *conflict* between *lifeworld* and *medicine* (§ 10.2) as well as *communicative* and *strategic* action (§ 7.3.4).

7.3.1.2 Speech act classification

Another initially more theoretically motivated topic and problem area was various concepts for the *classification* of speech acts, which could apply, for example, universally, i.e. independently of language and culture. There have been many approaches and variants on the classification of speech acts, from Austin himself via Searle to Habermas and Wunderlich. Here we follow a taxonomy by Searle (1979/82) as an example, which we summarise in a table (Tab 7.1). The Latin designations are chosen in speech act theory to avoid confusion between *directives* and individual speech acts of this type (such as *requests*).

	Types	Exemplary speech acts
1	Assertive	Making statements, assertions, descriptions, prognoses, diagnoses, hypotheses, etc.
2	Directive	Requests, pleas, orders, instructions, suggestions, recommendations, advice, etc.
3	Commissive	Promises (with listener's preference), threats (dispreference of H), bets, offers, etc.
4	Expressive	Apologies, thanks, congratulations, condolences, regrets, etc.
5	Declarative	Appointments, resignations, (war) declarations, excommunications, etc.

Table 7.1: Taxonomy of speech acts (on Searle 1979/82)

Among many other problems, such as those concerning the discriminatory power of the classification, one specific problem also consists in taking into account the special *institutional* binding of speech acts (Koerfer 1994/2013). Here, the aspect of institutionality is at odds with the other speech act classes, at least in the sense that certain types/examples from these classes experience a certain *institutional character:* While we can all make *assertions*, issue *requests* or make *promises* in our everyday lives, not all of us can issue *orders*, give *instructions,* perform *baptisms,* pronounce *judicial sentences* or make

medical *diagnoses* in certain contexts. Making certain pronouncements only makes sense if we have the necessary *competence in the sense of authorization* (to do so) (Koerfer 1994/2013). Mere *competence* in the sense of *ability* is not enough. A public prosecutor also had the ability to *instruct* the witness, but its execution is reserved only for the judge. Similarly, an accurate diagnosis could also be made on the part of nursing staff, but only doctors are competent to do so, etc.

7.3.1.3 Institutional communication

The *institutional* binding of (types of) speech acts to certain institutions has certainly been seen by speech act theorists such as Searle, who mentions the *state*, the *legal system* or the *church.* In this case, certain speech acts cannot be performed by "some random speaker" vis-à-vis "some random listener", but rather certain "extra-linguistic institutions" 1979/82: 6 (Box 7.9) are necessary for their performance, which seem to be dispensable for other types of speech acts.

Box 7.9	Institutional binding of speech acts
Many illocutionary acts can only be accomplished by virtue of an extra-linguistic institution - and generally by virtue of a special position that speaker and hearer occupy in this institution. A blessing, an excommunication, a baptism (...) do not come about merely because some runaway speaker says to some runaway hearer "I bless you", "I excommunicate you" and so on. A position within an extra-linguistic institution is necessary. Austin sometimes expresses himself as if he thought all illocutionary acts were of this blow, but that is flatly not true. To make a statement that it is raining, or to promise to come by your house, I need only follow the rules of language. No extra-linguistic devices are necessary.	

Searle 1979/1982: 24

However, the borderline between (types of) speech acts where *extra-linguistic institutions* are necessary and those where they are not has not yet been drawn.[4] Likewise, it has not yet been decided to what ex-

4 Thus, Searle also admits certain "overlaps" and creates a special class labelled "assertive declaration" to account for "factual assertions" by judges

tent Searle's criticism of Austin is "flatly" exaggerated. In any case, both cite sufficient examples of speech acts in which a certain *social relationship* between speaker and listener must be presupposed, which is determined not least by their *position* in *institutions.*

For example, Austin states: "(...) an instruction is only in place where the subject of the verb is 'a commander'" (1962/72: 47). Austin cites such examples from the point of view of analysing failures of communication, where speech acts can "go wrong" for a variety of reasons: "We have the most diverse special terms for diverse cases: 'incompetence', 'not doing its job', 'unfit object', 'the wrong person', 'unjustified' and so on" (52). Searle, too, occasionally cites cases in which speaker and hearer must be in a special *asymmetrical relationship,* such as in *ordering* and *commanding,* where a certain "authority relation" must be presupposed so that the speaker, "by virtue of his dominion", can make the hearer perform the corresponding action (1969/71: 101). Under such presuppositions, it is then not surprising, according to Searle (1982: 22), that the "common soldier" could not simply turn around the *order* to tidy up the parlour: "If the common soldier tells the general that the parlour must be tidied up, this is probably rather a suggestion, a proposal or a request, but not an order or a command" (1982: 22). Whether, in view of the power relations in the barracks, the alternative chances for these weak forms of a directive (suggestion, proposal, request) considered by Searle exist at all for the soldier here should, however, be rather doubted.

The debate about speech act classification and the nature and extent of the institutional binding of speech acts cannot be continued here. As Searle's criticism of Austin shows (Box 7.9 above), the pioneer of speech act theory has occasionally been reproached for having oriented his analyses one-sidedly to the *model of institutional communication*, not only by Searle but also, for example, by Habermas (1976: 247, 1981, vol.1: 395ff.). As has been further explained elsewhere (Koerfer 1994/2013), general speech act typologies that are created with speech act semantics or universal pragmatics in mind are themselves subject to the danger of substituting one "one-sidedness" for the other. Insofar as institutionally bound speech acts are systematically considered at all, they are often segregated as bulky material in a residual category, so that the entire typology can contribute little to an empirical analysis

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in court or referees on the playground, for example, when they find "Out" or "Guilty".

of institutional as well as non-institutional communication. In fairness, however, it should be added that such a contribution to an empirical speech action analysis, such as that of Habermas (1981: Vol.1: 437. 440ff), is also claimed only very cautiously. In the empirical further development of a *linguistic pragmatics* and *conversation analysis,* topics and questions have then also emerged and been dealt with, with which the narrow linguistic-philosophical view of the analysis of (types of) speech acts has been considerably expanded in favour of an empirical analysis of real conversations in real contexts.

7.3.2 Linguistic pragmatics and conversation analysis

The limits of speech act theory were soon recognised within its own questions. Thus, for example, Searle, from the perspective of the philosophy of language, has definitely seen the reduction of speech act theory to isolated speech acts without context. In an extremely (self-)critical and ironic assessment (Box 7.10), he puts into perspective the abolition of the previous reduction, in which speaker (S) and listener (H) - contrary to all everyday experience - only meet for the production and reception of a singular *acoustic* blast and then go their separate ways.

Box 7.10	Reductions and extensions of the speech act theory

Traditionally speech act theory has a very restricted subject matter. The speech act scenario is enacted by its two great heroes, "S" and "H"; and it works as follows: S goes up to H and cuts loose with an acoustic blast; if all goes well, if all the appropriate conditions are satisfied, if S's noise is infused with intentionality, and if all kinds of rules come into play, then the speech act is successful and nondefective. After that, there is silence; nothing else happens. The speech act is concluded and S and H go their separate ways. Traditionally, speech act theory is thus largely confined to single speech acts. But, as we all know, in real life speech acts are often not like that at all. In real life, speech characteristically consists of longer sequences of speech acts, either on the part of one speaker, in a continuous discourse; or it consists, more interestingly, of sequences of exchange speech acts in a conversation, where alternately S becomes H; and H, S.

Searle 1992: 7

The extension of the subject area to longer, dialogical sequences in real conversations of "real life" also has the consequence, according to Searle, that the analysis of language and action must refer to the *background knowledge* of the speakers and listeners, who in their dialogical exchange must refer to a common knowledge of *language, action* and the *world.* This knowledge cannot be assumed to be known in advance, nor can it simply be gained through questioning, but must be reconstructed through more or less participatory observation of interactions in context.

In order to reconstruct this action-guiding knowledge of the actors, it is not enough to examine singular speech acts (in constructed contexts), but *comparative* action analyses are required in changing social action situations, in which the actors make manifest in recurring *dialogue screws* (in Bühler's sense) (Box 7.1), also for external observers, what is relevant for their actions, for what reasons or motives, and for what purposes of action. In this context, it is part of the methodology of an empirical analysis of language and action to first follow the same *formulations* of the participants from the observer's perspective as the participants themselves, before general patterns of communication can be concluded from observations in individual case analyses via comparative investigations, the validity of which is in turn to be verified in comparative action analyses.[5]

At the latest with the empirical expansion of the subject area to real fields of action, the change from the first question posed above by Searle ("What is a speech act?") to the second question posed by Wunderlich ("What kind of speech action is that?") has been completed, according to which linguistic action must be examined in its embedding in concrete everyday and institutional action situations. This question has been pursued particularly within the framework of *linguistic pragmatics*, which has also been understood and specialised as *institutional pragmatics* (Wunderlich 1976), insofar as it concerns investigations in specific *institutions* such as *court (e.*g. Hoffmann 1983) or *school* (e.g.

5 The methodology of an empirical action analysis cannot be further elaborated here (cf. Koerfer 1994/2013). In order to prevent misunderstandings, it should be noted that an empirical analysis of action naturally does not begin without theory, because it is rarely necessary to start from a "tabula rasa", but can usually refer back to traditional research knowledge, which is to be taken into account in the circular research process described and, if necessary, modified or corrected.

Ehlich, Rehbein 1986) or even *consultation hours* and *rounds, for* which a current overview of research has already been given (§ 2).

7.3.2.1 Analysis aspects and main topics

This empirical turn in language and action analysis as a whole was accelerated in detail with the development of various disciplines with different traditions and objectives, which under different names (*linguistic pragmatics*, *discourse analysis*, *conversation analysis*, etc.) have set different focal points of empirical communication research.[6] Without claiming to be exhaustive, we would like to mention the following aspects of analysis and main topics, some of which have been worked on together in these disciplines, which we will summarise here under the term *conversation analysis:*

- ***Speaker change organisation*** (with two or more interlocutors: without/with moderator, overlaps, interruptions, etc.)
- ***Procedures to ensure comprehension*** (through various forms of active listening, listener signals, queries, translations of technical terms, repetitions, etc.)
- ***Sequential organisation*** of conversation within and between speeches (assertion-justification, question-answer, reproach-justification, etc.).
- **Direct and indirect forms** of realisation of speech acts (e.g. *question* as *request*: "Can you bring a stool sample to the next appointment?").
- ***Complex conversation units*** (*narrative*, *report*, *lecture*, etc.), which in turn can be embedded in specific *types of conversation* (small talk, seminar, hearing, office hour)
- Specific ***institutional patterns*** *of action* (such as the *examination of witnesses* in court, the *teacher's lecture to the* class, the *taking of a medical history* or *explanation* or *prescription* in the doctor's consultation and ward round, etc.).

6 We cannot pursue the controversies about differences and similarities between individual disciplines (*Pragmatics*, *Conversation Analysis* (CA), *Discourse Analysis* (DA) etc.) here, but only refer interested parties to specific literature and handbooks at the end of this chapter. It should be noted that many authors of this handbook are committed to several of these research directions.

- Institutional ***technical communication*** (law, administration, political parties, university, medicine)
- ***Topic organisation*** (curricular teaching topics, biopsychosocial anamnesis topics, manifest versus latent topics, "sensitive" topics (alcohol, sex, abuse, violence, etc.) or taboo topics, etc.).

These questions and aspects of investigation were already taken into account in the presentation of the state of *interdisciplinary* conversation research (§ 2) and will be deepened in the further course of the handbook in the empirical analyses of doctor-patient communication, partly throughout and partly with specific emphases, such as in the analyses of *action patterns* and *therapy goals (*§ 8), *patient narratives (*§ 9, 19) or *specialised* medical *communication,* which concerns the problem of *securing understanding* between doctor and patient (§ 19, 27). *Indirect* forms of communication also play a role here, which have experienced a special institutional manifestation in doctor-patient communication. Therefore, this aspect of the institutional binding of medical action should be emphasised first, which again touches on the problem of speech act classification described above.

7.3.2.2 Institutional binding of medical action

The *institutional* binding of medical action applies to the clinical sphere of action as a whole. Here, too, no "runaway" speaker (in Searle's sense above (§ 7.1.5)) could perform certain actions that are reserved only for doctors. This already applies to diagnosis, for which Searle himself gives a medical example from the class of *assertives* ("I diagnose his case as appendicitis" 1979/82: 44). The essential difference is already expressed in the comparison with the "rest" of the nursing staff. Although nursing staff might also be able to make a diagnosis or prognosis or even "determine" the death of a patient, only the doctor is *entitled* to do so. This also applies (from the class of the *directive*) to the *medical order or prescription (*§ 26), which is not called that for nothing. And last but not least, the prescription must have been issued by the doctor and finally signed before it becomes valid, and so on. Similarly, the patient's consent prior to an operation only becomes valid if it is documented with a signature after the patient has been informed (Bührig, Meyer 2007), i.e. at the end of a joint and documented history of interaction.

In addition, there are further differences in certain exemplars/types of action that also fell undifferentiated into the class of *directive,* even if the institutional binding is obvious. For example, the doctor's *recommendation* in the medical consultation has a different quality of action than the well-intentioned *advice* of a neighbour, which is also often given when it is not asked for at all, etc. In contrast, competent medical advice is not only expected, but also more or less directly requested by patients, as this becomes clear in the following example (B 7.2) (shortened here with relatively large omissions "(...) (...)").

E 7.2		P02: "what are your tips for this?" – P30: "more or less advice"
01	D	(...) these complaints have been around for a while (...) .
02	P	so, all in all, I have to say, it hasn't gotten worse (...) (...) (...) sometimes it takes hours for it to get better. umm what are your experiences or what are your tips for this? .
03	D	yes . we have to look first , these . the pain is just still there . and you are thinking .
04	P	not always .
05	D	not always, that means, there are differences? .
06	P	huge . yesss .
07	D	huge differences . um . we have to look at how ... when ... how does that come about? . what are .
08	P	so for example (...) (...) (...) . [longer description]
	D	(...)
	P	(...)
29	D	well . Mr. [X] we have to see . um . the . what did you expect from me . that we .
30	P	hm . so more or less eh advice . or whether I should try something eh with some medicine . Medicine something uh try ... (...) (...) (...)
31	D	so I would definitely suggest . that you take a medication to support . that the pain is somewhat alleviated . yes . and that physiotherapy also continues, yes (...)

This example, in which other treatments are also considered and the doctor advises against cortisone treatment, for example, and similar examples will be discussed in detail under the aspect of *dialogical negotiation* (§ 22). This is first of all about the institutional binding of the doctor's actions, which is why the doctor is also responsible for his *suggestions*, *recommendations,* etc., - whether requested or not - in a different

way than our neighbour, who cannot be held responsible for the further consequences of his actions, but in the worst case risks our neighbourly relationship. This is where our relationship with the doctor differs, however, with whom we are also allowed to build up a different trust, which is due to his professionalism: everything the doctor says and does, he does with *institutionalised authority, i.e.* with a *competence* in the sense of ability *and* responsibility.

This is true even if his communicative competence fails, i.e. not only in instrumental action such as surgery, but in communicative action such as education, where the *information* preceding the surgery may have been incomplete, erroneous, etc. (§ 10, 17, 22, 27, 39). However, there is also a failure if the doctor lacks *empathic* competence (§ 3.2), as we have seen above with the examples of Bernard Lown and will explain with further examples (§ 17.2). Again, unlike the neighbour in action (from the "class" of the "expressive"), the doctor must develop and apply a special *empathic* competence not so much because of interpersonal relations, due to which even a neighbour can *pity* us, but rather for reasons of his *profession,* in order to be able to help the patient "appropriately".

To *empathically* recognise the suffering and burdens of patients as well as their coping capacities is not a mere everyday competence, but a professional competence in medical practice (§ 3.2, 20). The fact that it is often missed in practice will still be encountered in many examples, some of which are to be reported drastically from the experiential practice of Bernard Lown (2002), when the institutional-authoritarian "power of the doctor's word" (§ 17.1) is made an issue. As a rule, communication between doctor and patient is less drastic and dramatic, sometimes very discreet and subtle, because - for whatever reason - very *indirect* forms of communication are preferred, which will be elaborated below.

7.3.2.3 Direct and indirect communication in the consultation

Institutional communication shapes the understanding of speech action of all participants (e.g. doctor and patient) in a specific way, from different active or passive participation perspectives. What also applies elsewhere in everyday life is reshaped, modified or specialised in institutional action without fundamentally suspending basic categories of our understanding of communication. This also applies to the ways in

which *direct* and *indirect* or *implicit* forms of realisation of speech acts are used, on which there is also a large spectrum of studies, from which only a few works will be referred to here as examples (Searle 1979/82, Wunderlich 1976, Levinson 1983/2000).

The relevance of this distinction is already expressed in the fact that in conversational practice we can more or less rely on the so-called *indirect* or *implicit* forms without this having to lead to communication problems to a greater extent. If necessary, we then use a so-called *explicit performative formula*, which we usually place in front of the so-called *propositional content* (in the subordinate clause), as in the following example under (1). As a rule, however, we are *more economical* and, depending on the context, will enter into shorter and nevertheless similarly binding commitments for our future behaviour, such as with (2). Depending on the context, a simple "yes" will also suffice, for example in (3) if this would answer a question previously asked by the doctor ("Can you bring a stool sample tomorrow?"), which can already be understood as a weak (conditional) request (see below).

1. I *promise* you (hereby) that I will attend the next screening appointment in good time.
2. I'll be there in time next time.
3. Yes.

As already becomes clear in example (3), the *meaning* and *purpose* of an utterance can also result from the dialogue position during the conversation, depending on whether it is an *initiative* or a *responsive turn of* speech. Often there is also a greater *sequential* organisation in the conversation, so that the communicative *function* of speech contributions (A: question – B: query to A – A: answer to B – B: answer to A) also results from the dialogue position (as, for example, with assertion-objection or reproach-justification) etc. [7]

The role of the dialogue position of utterances for their function is one thing, their institutional binding another, whereby a typical interplay often occurs. Because of the special institutional binding of speech

7 As has already become clear in the foregoing, we refrain as far as possible from using technical terms previously introduced for the understanding of the classics and use colloquial terms here last when certain differentiations are not necessary; cf. the remarks on terminology at the end of this chapter. Cf. also illocutionary *wit* (point) or *role* (force) or *purpose* in Searle 1979/82 or *sense* and *function* in Wunderlich 1976.

acts, in the appropriate context of a consultation there are also no misunderstandings of the familiar medical utterances such as (1)-(7):

1. You need to undress.
2. Can you undress first?
3. Undress (please)!
4. (Please), free your upper body (arm, etc.).
5. I have to take a look at it now.
6. Can I have a look at that?
7. We have to take a closer look at that now.

The fact that these utterances (1)-(7) - with all other similar variants - are equally understood *primarily* as *requests* (in Searle's sense of "directives") (Tab. 7.1) and not merely as questions, which (2) and (6) also are secondarily, is not surprising in the context of a (orthopaedic, dermatological, etc.) consultation. Here, as elsewhere in life, the doctor predominantly chooses "moderate" forms (of one type) of *request*, which we also prefer in everyday life, for example, when we address our neighbour at the table with a question of this type instead of an *imperative* ("Pass me the salt!"): "Can you pass me the salt?" This classic example of a question is also used by Searle (1979/82: 57ff) in his analysis of *direct* and *indirect* speech acts in order to distinguish the following *indirect* subtypes (*secondary* illocutionary act) in the class of the "directive", which we have selected from lists by Searle and Wunderlich (in Tab. 7.2):[8]

8 Searle (1979/82: 53ff) distinguishes between the *primary* and *secondary* illocutionary (*literal*) act. We cannot pursue the long controversy surrounding this distinction here (e.g. Levinson 1983/2000 and Hartung 2002) and refer to the further references to textbooks given at the end of this chapter. Roughly speaking, a counter-position is that the relevant function of utterances in their position is also always heard or understood in this way by contexts, without having to assume secondary functions. Nevertheless, the differences in the formulations of speech acts are of course still of considerable relevance, as we will see from examples.

	Types	Exemplary formulations
1	Ability of the listener to do h	"Can you ...", "Could you ...", "You could ...", "Are you able to ..." etc.
2	Speaker's wishes/preferences that H h does	"I would like you to ...", "I would like you to ...", "I would be very grateful if you would ...", "I wish you would", etc.
3	Willingness of the listener to do h	"Would you be willing to ...", "Would it suit you to ...", "Would you mind ..." etc.
4	Obligations of the listener to do h	"It would be better if you ...", "You should actually ...", "Why don't you try ..."

Table 7.2: Indirect directives (on Searle 1979/82: 57ff, Wunderlich 1976: 308ff)

Which occasions, reasons or motives lead us to choose or *should* choose or even *must* choose which variants in which social situations, etc., has hardly been satisfactorily clarified so far and would require above all the investigation of certain social, not least institutional fields of action. Intuitively, it is already plausible that we speak differently "privately" than in the "public" sphere, where even the form of address (*Du* versus *Sie* [German formal versus informal “you”]) makes a first significant difference. An aspect that is certainly often applicable is highlighted by Searle himself when he brings a "leitmotif" of action down to a certain denominator ("politeness") as a social rule.

Box 7.11 Politeness as a leitmotif for indirectness

In the landscape of indirect illocutionary acts, the field of directives yields the most for investigation, because the utterance of flat imperatives ("Leave the room"), or explicit performatives ("I order you to leave the room") is usually considered uncouth behaviour in the politeness required in ordinary conversation, and we therefore look for indirect means for our illocutionary purposes (such as "I hope you don't mind going out for a moment"). In directives, politeness is the leitmotif for indirectness.

Searle (1979/82: 56f)

As long as the social phenomenon of politeness itself has not been clarified in terms of its origin and function, this "leitmotif" for indirectness can only be assumed to be provisional, whose validity and effectiveness must be examined as a function of further social features of situations of action. A question, no matter how politely formulated ("Would you

please be so kind to undress?") will not be purposeful in everyday life, but it will be in the institutional setting of a consultation, although even there an excessively polite variant (8) would tend to be counterproductive. Statements in which the speaker's *wishes* or *preferences* are formulated in this context and with this content, such as (9), would certainly be inappropriate or even unacceptable in this context, which is why (8) and (9) are marked accordingly (with: *).

8. *Would it perhaps suit you to undress?"
9. *I would like/want/have you to undress.

In the medical consultation, too, there are social rules for the *fit* of "directives" that doctors address to their patients when it is no longer just a matter of "taking time off", but of adhering to a diet or medication in each case in the sense of adherence ("therapy compliance") (§ 10, 26, 29).

Often it is also about *conditions*, *possibilities*, *necessities* or *urgencies* of actions, such as can be negotiated in the following (hypothetical) dialogue between doctor and patient:

D: *Can* you bring in another stool sample?
P: *Does* it *have to* be this week?
D: No, but you *should* come by next week. We still *have to* wait for the lab results.
P: Good, then I will do that right at the beginning of next week, I *promise.*

In empirical analyses of longer dialogues (with variant-rich embedded return questions and answers, etc.) we will differentiate such *negotiation processes in* detail, which are conspicuous solely by the accumulation of certain modal verbs (*can*, *may, should, must*) when it comes to clarifying *abilities*, *willingness*, *preferences, obligations,* etc., which is not always just a question of politeness. In regular *dialogue screwing* (in the sense of Bühler) (§ 7.2.2), "words are then weighed", for instance to probe, plausibilise or motivate certain actions or their omissions, etc. Thus patients will also have to find "suitable" formulations for their patient concerns, which should be beyond an *imperative* (of the type: "Give me a sick note!" or "Do a gastroscopy!") if they want to "win" the doctor over to their cause.

Here we will differentiate a whole spectrum of "direct" to "indirect" realisations of patient concerns in the practical part. If both partners often prefer *indirect* formulations, then they do so, but not just for the sake of mere politeness, but because we all - for other good reasons - often also want to or should or even have to grant the partner *social action spaces.*

In all these cases, however, it is astonishing that indirect or implicit forms of communication hardly pose any major communication problems between speaker and listener compared to direct variants. On the contrary, indirect forms of communication prove to be extremely effective and economical in suitable contexts. This will be further explained in the following with the theory of *conversational implicature*, which goes back to the philosopher Paul Grice. The *cooperation principle* formulated by Grice in this context and his *conversational maxims* have been referred to by Searle (1979/82) and many others after him (see below) who have researched the theory and practice of everyday and institutional communication.

7.3.3 Cooperation principle and conversation maxims

Although communicative processes are certainly prone to disruption and can lead to misunderstandings, it is astonishing how often they succeed and speakers and listeners routinely overcome the communicative hurdles in the triad of *saying*, *meaning* and *understanding in* effective cooperation, proceeding extraordinarily economically. This will be further elaborated in the following with the theory of *conversational implicature*, which Grice already outlined in his lectures in the 1960s and published in 1975. There, Grice systematically explored the basic problem of understanding, which has to do with ordinary differences between *what is said* and *what is meant,* but which hardly seem to affect *understanding*.

7.3.3.1 Rationality and cooperation

Grice directs interest to examples where it is clear that what a speaker "gave to understand, implied, meant, etc., is something different from what he said" (1975: 51). He illustrates such differences with examples such as the following dialogue, in which the validity of a specific *implicature* is expressed:

A: Smith doesn't seem to have a girlfriend these days.
B: He has been paying al lot of visits to New York lately.

Although B's replication may seem nonsensical at first glance because it does not seem to have any meaningful connection with A's utterance, A can nevertheless draw appropriate conclusions that make the utterances meaningful, namely: "B implicates that Smith has, or may have, a girlfriend in New York" (51). Regardless of whether this example allows for further/other speculation about *implicature*, Grice introduces the term *implicature* as a "term of art" for such examples,[9] in order to capture a kind of understanding based on obvious inferences that the hearer can or should legitimately draw.

Now, in order to be able to explain why communication processes that rely so heavily on *hints* can function at all as well as they generally do, Grice makes a strong assumption regarding the *rationality* that guides all of us in everyday conversational practice: "I would like to be able to think of standard type of conversational practice not merely as something that all or most do *in fact* follow but as something that is *reasonable* for us to follow, that we *should not* abandon" (1975: 252: 48). Under this assumption of rationality, Grice now formulates the principle that sustains us all as a general *cooperative principle* (CP) (Box 7.12), the validity of which is constitutive for all possible, subordinate conversational maxims (see below).

Box 7.12 The *cooperative principle* (CP)

Our talk exchanges do not normally consist of a succession of disconnected remarks, and would not be rational if they did. They are characteristically, to some degree at least, cooperative efforts (...) We might then formulate a rough general principle which participants will be expected (ceteris paribus) to observe, namely: Make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged. One might label this the *cooperative principle*.

Grice (1975: 45; cf. 1979: 248)

9 "I wish to introduce, as terms of art, the verb *implicate* and the related nouns *implicature* (cf. 'implying') and *implicatum* (cf. *what is implied*)" (1975: 43f).

Under this basic assumption of a universally valid principle of cooperation, Grice now differentiates a series of subordinate conversational maxims (Box 7.13), which he classifies according to Kant's table of categories under the categories of *quantity*, *quality*, *relation* and *manner/ modality*.

Box 7.13 Conversation maxims

Maxim of *quantity*

The category of quantity relates to the quantity of information to be provided, and under it fall the following maxims:

1. Make your contribution as informative as required (for the current purposes of the exchange).
2. Do not make your contribution more informative than is required.

Maxim of *quality*

Under the category of quality falls a supermaxim – 'Try to make your contribution one that is true' – and two more specific maxims:

1. Do not say what you believe to be false.
2. Do not say that for which you lack adequate evidence.

Maxime of the *relation*

Under the category of relation I place a single maxim, namely: 'Be relevant'.

Maxime of *modality*

Finally, under the category of manner (...) I include the supermaxim: "Be perspicuous" – and various maxims such as:

1. Avoid obscurity of expression.
2. Avoid ambiguity.
3. Be brief (avoid unnecessary prolixity).
4. Be orderly.

Grice 1975: 45f

For all these maxims, Grice now discusses individual groups of examples that help to prove the validity of the maxims in our everyday conversations, even or especially when they seem to be violated at first glance.

7.3.3.2 Conflicts of maxims

Thus, in the above example, the specific *implicature* ("B implicates that Smith has, or may have, a girlfriend in New York") could only be assumed because A could at the same time trust in a *rational* conversational behaviour of B when applying the general *cooperation principle* (CP), with which the validity of the maxim of *relation* ("Be relevant") can be assumed. Otherwise, a mere remark about Smith's frequent stay in New York would not make sense in this context. Only under the assumption that B cooperates in compliance with the "maxim of relevance" can B's replication be understood as a meaningful response to A. We proceed in a similar but different way with statements that at first glance violate a maxim of *quantity*, for example, because they do not seem to us to be sufficiently *informative*.

A: Where does C live?
B: Somewhere in the South of France.

According to Grice, the fact that B does not answer A more precisely here, although he knows that A might want to visit his friend C, must precisely not be seen as a violation of the maxim of quantity, but must be evaluated as a comprehensible attempt to avoid a *collision* with the maxim of quality ("truth maxim"), which leads to the corresponding implicature: "'Don't say what you lack adequate evidence for', so B implicates that he does not know in which city C lives" (1975: 51f). Such compromises in *conflicts of maxims* are a daily occurrence not only in everyday communication, but also between doctor and patient, when the latter "does not know better" despite the doctor's enquiries, and answers accordingly "vaguely", and therefore both partners have to "cope" with "ambiguities", for example, when taking anamnesis.

This specific problem of dealing with unclear, incomplete, contradictory, etc. patient knowledge is illustrated by empirical examples. This specific problem of dealing with unclear, incomplete, contradictory etc. *patient knowledge* will be illustrated by empirical examples. In particular, we will be concerned with the *relevance maxim* (§ 9, 17, 19), whose "compliance" causes difficulties for patients in a conversation with the doctor that is often "unfamiliar" to them, which they then also express in corresponding formulations (§ 19.4).

7.3.3.3 Criticism and application perspective

Grice's theory of conversational *implicature* as well as his associated *principle of cooperation* and the *conversational maxims* have had a broad resonance up to the present day, which is sometimes summed up euphorically: "Grice's maxims are a linguistic discovery of the century" (Ehrhardt, Heringer 2011: 72). One does not necessarily have to share this scholarly top rating of relevance, but the extensive history of the impact of Grice's maxims is beyond question. The *principle of cooperation* formulated by Grice and his *conversational maxims* were already referred to by Searle (1979/82) in his investigations of *indirect* speech acts (§ 7.3.2). Grice's theoretical approach and his conversational maxims have been criticised, applied or modified, shortened or extended in many ways, which can only be referred to here by way of example (Levinson 1983/2000, Koerfer 1994/2013, Keller 1995, Newen, Savigny 1996, Hartung 2002, Ehrhardt, Heringer 2011, Finkbeiner 2015). Criticism is directed in particular at the *assumption of rationality* in the cooperation principle and the *selectivity* and *completeness* of the conversational maxims in detail.

These aspects of criticism have already been anticipated and discussed by Grice himself, although perhaps not extensively enough. Grice refers to other types of maxims (*aesthetic*, *social*, *moral*), including the maxim "Be polite", "that are also normally observed by participants in talk exchanges, and these may also generate non-conventional implications" (1975: 47). The problem of *politeness* was already a topic when it came to the question of *indirect* forms of realisation of speech acts (§ 7.3.2). Furthermore, it is obvious that there are certain overlaps between the maxims of *quantity* and *relation,* for example, because "talkativeness" could violate one maxim ("Do (not) be (over)informative") as well as the other maxim ("Be relevant"). In addition, the problem of *redundancy* discussed by Grice himself arises here, whereby he is precisely concerned with plausibilising the meaningfulness of *tautologies* such as "women are women" or "war is war". The problem of so-called *redundancies* will also concern us with *patient narratives* (§ 9, 19), for example, which lose the initial appearance of "over-informativeness" on closer examination, because they follow a specific *narrative* logic of reason, which can certainly do justice to the meaning of a *biographical narrative* anamnesis, even from a medical perspective.

This also concerns the core of the *assumption of rationality*, which precisely should not be thought of in the idealistic sense of a mere *uto-*

pia, but must be examined as an assumption that is effective in everyday practice, the validity of which can be demanded by the participants themselves in everyday life as well as in the consultation hour, when its disregard seems all too obvious as senseless or even counterproductive. Here, following work on *institutional* and specifically *therapeutic* communication (Koerfer, Neumann 1982, Koerfer, Köhle 2007, Koerfer 1994/2013), we will repeatedly refer back to Grice's *cooperative principle* and *conversation maxims,* which need to be specified for the conversations between doctor and patient. In a historical review, it should be pointed out that Freud, in his writings on treatment (1912, 1913), had already established an anti-maxim catalogue long before Grice (§ 9.3), which is precisely intended to do justice to the specific meaning and purpose of therapeutic communication.

Finally, it should be noted that our own theoretical and didactic approach of formulating *conversational maxims* specifically for doctor-patient communication and also exploring maxim conflicts in conversational practice (§ 3, 17-23) is certainly one among many approaches inspired not least by Grice's general cooperative principle and conversational maxims.

7.3.4 Theory of strategic and communicative action

The "Theory of Communicative Action" (1981) of Jürgen Habermas has had an enormous interdisciplinary impact. The resonance can be explained not least by the fact that in this two-volume (main) work he seeks to integrate many theoretical approaches from various sociological, socio-psychological and language-philosophical disciplines. To justify his model of communicative understanding, Habermas refers to several "classics", with whom he deals partly affirmatively, partly critically (e.g. Max Weber, Talcott Parsons, Alfred Schütz, Karl Bühler, George Herbert Mead, John Austin, Paul Grice, John Searle). The basic ideas and concepts of some of these "classics" have already been presented and discussed in advance; we will refer to others (e.g. Alfred Schütz) when dealing with the conflicts between the *lifeworld* (of patients) and the professional world of *medicine* (of doctors) (§ 10.2), which, with reference to Habermas, can be presented as conflicts of principle between *lifeworld* and *system*.

Due to the interdisciplinary foundation of the *theory of communicative action,* the opinions from different academic traditions were correspondingly diverse. Exemplary for this discussion is the collected volume by Honneth and Joas (1986), in which Habermas (1986) himself responds to his critics in a "rebuttal". The methodological problems and possible applications of the *theory of communicative action* specifically for the analysis of *institutional* communication are discussed elsewhere (Koerfer 1994/2013). Reference will be made to literature on application specifically in the field of *medical* communication at the end of the following introduction, in which only selected aspects and basic concepts of the theory of *communicative action* can be considered.

7.3.4.1 Guiding idea of the ideal speech situation

The essential theoretical and methodological guiding ideas as well as basic concepts were already pre-formulated by Habermas in his *Preparatory Remarks on a Theory of Communicative Competence* (1971). There he develops his specific concept of an *ideal speech situation* within the framework of his universal pragmatic outline for a classification of speech acts, which ties in with speech act theory and linguistic pragmatics (Austin, Searle, Wunderlich etc.) (§ 7.3.1-2). This is characterised – however counterfactually – by a *symmetrical* distribution of opportunities of dialogue roles, which allows the free use of all possible speech acts (assertions, questions, proposals, objections, etc.) without the speakers having to reckon with social, institutional, etc. restrictions (sanctions) in advance. Restrictions (sanctions) would have to be reckoned with in advance. As Habermas sums up (Box 7.14), these ideal conditions are to be understood as structural features of a speech situation that come into play independently of personality traits of, say, "ideal" speakers.

Box 7.14 The ideal speaking situation

The counterfactual conditions of the ideal speech situation turn out to be the conditions of an ideal form of life. It now turns out that not only the model of pure communicative action, as shown, requires the possibility of discourse, but that, conversely, the conditions of discourse cannot be thought of independently of the conditions of pure communicative action (...) I have tried to characterise the ideal speech situation not by the personality traits of ideal speakers, but by structural features of a situation of possible speech, namely by the symmetrical distribution of chances to perceive dialogue roles and to perform speech acts.

Habermas 1971: 139

The "counterfactual conditions of the ideal speech situation" must be assumed to be effective in action practice even or especially when they should be ignored or even counteracted in extreme cases in real conversations. Such extreme types of conversations are conspicuous, simply because they generally cannot withstand even a spontaneous *test of acceptability,* because they obviously seem to violate elementary rules of understanding that we are more or less prepared to follow as commonly accepted standards.

Habermas has repeatedly emphasised that the "anticipation of the ideal speech situation" can be a "critical standard" (1971: 136) against which real communication must also be measured. Before examining the extent to which a critical standard for the evaluation of real doctor-patient conversations, which at first glance seem to be anything but *symmetrically* structured (§ 7.5.3), can be obtained by methodically anticipating the "ideal speech situation", some essential aspects and basic conceptual distinctions of Habermas should be considered, which should contribute to a further understanding of his theory of communicative action.

In doing so, he is essentially concerned with proving "that the communication-oriented use of language is the *original mode to* which indirect communication, giving to understand or letting understand, behaves parasitically" (1981: 388). This strongly *evaluative* basic conceptuality will be referred to in the following when *evaluating* doctor-patient communication.[10]

10 To justify his distinctions between *communicative* and *strategic* action, Habermas (1981, vol.1: 388ff) refers to the distinction between *illocutions* and

7.3.4.2 Instrumental, strategic and communicative action

With Habermas (1981), a distinction should be made here initially and subsequently also for the empirical conversation analyses between exactly three *types of action*, which he has compared in a tabular overview (Tab. 7.3).

Action situation	Action orientation	
	success-oriented	understanding-oriented
non-social	instrumental action	–
social	strategic action	communicative action

Tab. 7.3: Types of action (on Habermas 1981, vol.1: 384)

The distinction between *non-social*, *instrumental actions* on the one hand and *social* actions on the other proves to be relatively simple, even in the empirical analysis of concrete action situations. While instrumental action is undoubtedly success-oriented, in the case of social action the further distinction between *success-oriented* and *understanding-oriented* action proves to be much more difficult to handle, especially when it is to be applied to empirical conversation analysis (e.g. Koerfer 1994/2013). Here, too, there are more or less clear-cut cases, so that an unambiguous assignment can remain contentious if necessary. Before we pursue individual theoretical and practical problems of empirical conversation analysis further, the brief definitions of the types of action according to Habermas should be prefaced here in a further overview (Box 7.15).

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perlocutions, which has been traditionally established since Austin, and which we had previously introduced (7.3.1) .The problems and implications of this parallelisation of terms and their empirical application have been discussed in detail elsewhere (Koerfer 1994/2013).

Box 7.15 Definitions of the three types of action

- We call a success-oriented action *instrumental* if we consider it from the point of view of following technical rules of action and evaluate the degree of effectiveness of an intervention in a context of states and events.
- We call a success-oriented action *strategic* if we consider it under the aspect of following rules of rational choice and evaluate the degree of effectiveness of influencing the decisions of a rational opponent (...)
- On the other hand, I speak of *communicative* action when the plans of action of the actors involved are not coordinated through egocentric calculations of success, but through acts of understanding. In communicative action, the participants are not primarily oriented towards their own success; they pursue their individual goals under the condition that they can coordinate their plans of action on the basis of common definitions of the situation. In this respect, the negotiation of situation definitions is an essential component of the interpretive services required for communicative action.

Habermas 1981, vol.1: 385

Of course, according to Habermas, *instrumental* action can also be embedded in *social* action. As examples, one could cite the actions of architects and doctors, which can certainly be compared in some respects. For example, before an architect can dig the excavation pit in *instrumental* action (by surveying and digging), he must first have communicatively agreed with the client on a joint building project in which not only the statics but also the living culture and aesthetics of the building project play a role. In turn, the preferences of the client and the expertise of the architect may conflict, which may lead them to further communicative "disputes" up to a point where the common *situation definitions* ("Who does what with whom for what purpose?") have to be *renegotiated* communicatively.

Similarly, before a doctor reaches for the scalpel in *instrumental* action and thus proceeds to surgery, he must first have *convinced the* patient of the necessity of the procedure by means of information and argumentation, i.e. he must first have obtained unambiguous patient consent by means of rational information and detailed documentation (§ 10, 27, 39). Here, too, conflicts may have arisen in the communicative history between the preferences of the patient and the expertise of the doctor, who must limit the patient's wishes and expectations in the

sense of *evidence-based* medicine (§ 10, 22, 26). As we will see in more detail, even in *shared decision-making* (SDM) in the context of *patient-centered* medicine, controversies have to be discursively resolved, which may also entail a renegotiation of situation definitions. If necessary, the quality of the doctor-patient relationship itself must be put to the test (§ 8, 10), if, for example, the patient's trust in his doctor threatens to diminish.

In all cases, however, the actions of the participants in practice as well as in analysis must be critically questioned as to how a *consensus* (or even a dissent) came about at all, if it can be described as such at all. For example, *threats* and *intimidation*, but also *whispers*, *appeasement*, *trivialisation*, etc. can lead to a *pseudo-consensus* that would not stand up to a *rational* test of acceptability, either from the participant's perspective or even more so from the critical observer's perspective.

7.3.4.3 Overt and covert strategic action

Here another distinction comes into play which is used in general and also specifically by Habermas (1981 vol. 1: 388ff, 444ff) to further substantiate his *theory of communicative action*, namely on a further level (4th order) the distinction between *overtly strategic* and *covertly strategic* action (Fig. 7.3). Whereas in the first case a speaker openly makes a claim to power and exerts a certain coercion on his partner, for example by giving orders or issuing instructions or making threats, *covert strategic action* involves all possible forms of *manipulation* characterised by deliberate *deception* (Fig. 7.3). *Self-deception is* distinguished from this on the same level (5th order) (Box 7.16), which Habermas identifies as a specific type of action of *systematically distorted communication* compared to (conscious) *manipulation:*

Box 7.16	Systematically distorted communication

In contrast, the kind of unconscious conflict management that psychoanalysis explains with the help of defence strategies leads to communication disorders simultaneously on an intrapsychic and on an interpersonal level. In such cases, at least one of the participants deceives himself that he is acting in a success-oriented attitude and merely maintains the appearance of communicative action.

Habermas 1981, vol.1: 445f

While forms and functions of *systematically distorted* communication are to be expected in any case in psychoanalytic therapy, which, moreover, from a professional point of view is specifically raised to the subject and topic of the conversation, this is not necessarily self-evident for everyday medical care practice. Here, systematically distorted communication may have a latent effect without being recognised in medical practice and "answered" appropriately in the interaction with patients.

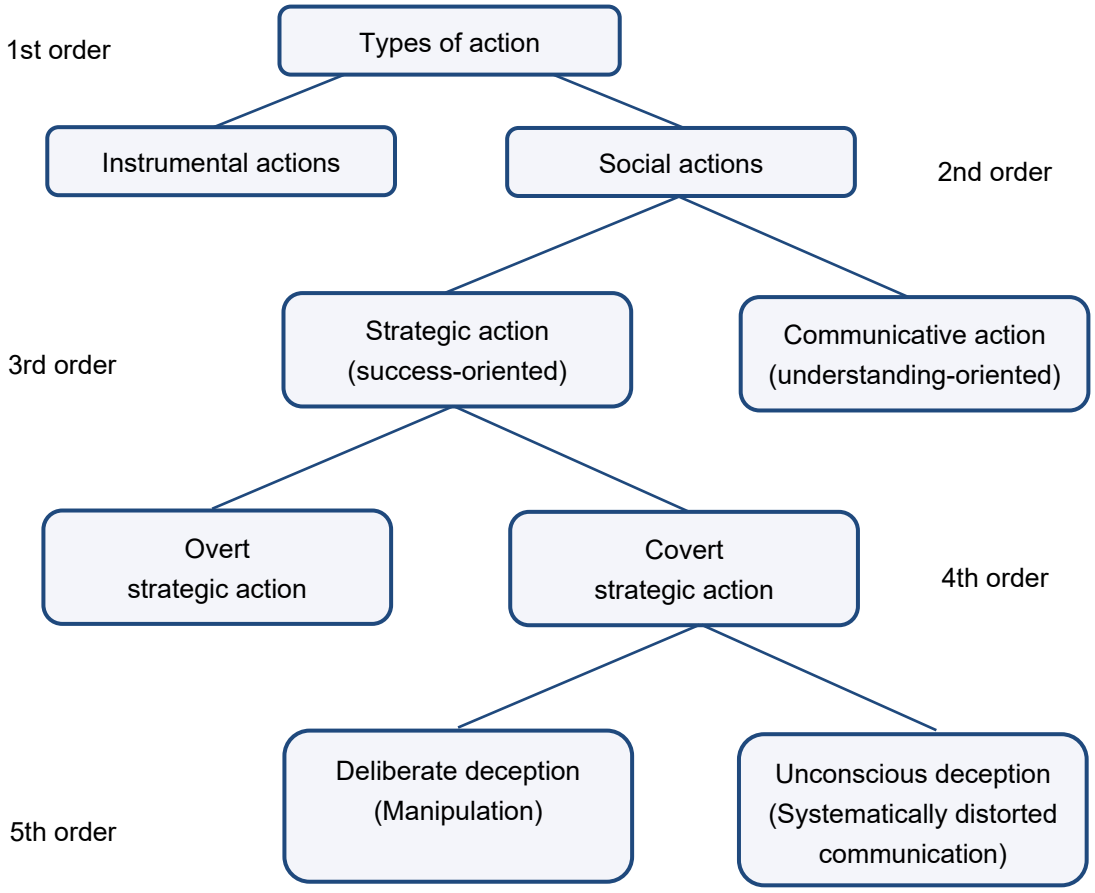

Fig. 7.3: Action typology (mod. and extended from Habermas 1981, vol.1: 446)

It is therefore no coincidence that basic psychosomatic care and interviewing have become the subject of continuing medical education (§ 15-16, 42-43). This is particularly about the promotion of general *relationship competences* and especially of *understanding* and *empathic* competences in dealing with *forms of defence,* for example, as this has already been described in advance (§ 3.3) and will be further elaborated in the

practical part (§ 17-23) using the *Cologne Manual of Medical Communication* (C-MMC) and empirical examples.

Such forms of *systematically distorted* communication, which may remain (completely) unconscious, are one thing, forms of more or less conscious *manipulation* are another.[11] It must be taken into account that the interlocutors in various everyday as well as institutional types of conversation are subject to manipulation without restriction, but can also counter them more or less well because they are more or less seen through.

Overall, *covert strategic* action in the sense of (conscious) *manipulation* (in the narrower sense) is not just a phenomenon of *advertising,* but an *everyday* phenomenon that is also an *institutional* everyday phenomenon. This does not exclude medical consultations and ward rounds, whose practice can be characterised by a mixture of different forms of *communicative* and *strategic* action, as will be discussed theoretically (§ 7.5, 10) and explained in the practical part with empirical examples.

7.3.4.4 Applied discourse ethics in medicine

For the development of an *applied discourse ethics* specifically in *medicine* (Kettner 1991, 1998, Kettner, Kraska 2009, Koerfer et al. 1994, 2005, 2008, Scambler (ed.) 2001, Koerfer, Albus 2015, Hoppen 2020, Walker, Lovat 2022), the critical standard can be obtained by analogy with a counterfactually assumed "ideal consultation hour", but deviations (disruptions and deviations) from the ideal understanding between doctor and patient in real conversation practice are to be assessed relative to the institutional framework conditions to which the actors are subject. As will be explained under the aspect of (a)*symmetry* between doctor and patient (§ 7.5.3), these framework conditions can be shaped differently by the actors, whereby there is an interaction of interaction and relationship design. At this point, we will only give a brief typological outline of what will be explained in detail and with examples later:

11 At this point, it can only be problematised, but not pursued further, to what extent a gradual differentiation would not also make sense for the empirical analysis on the last level (5th order), according to which manipulations can also be more or less (pre-)conscious, which perhaps also makes distinctions on further levels meaningful.

- ***Communicative action*** is more suited to a relationship model of ***cooperation*** and ***partnership***, in which the actors, from their respective professional or lifeworld perspectives, exchange their expertise or preferences regarding treatment options in a ***rational***, ***dialogue-based*** information and joint decision-making process with an open outcome. Here, above all, a principle of ***transparency*** comes into play, in which neither the doctor withholds information relevant to the patient, nor does the patient have to hide information because he would have to fear sanctions if, for example, he had to "admit" his problems with *adherence* (e.g. medication, diet, etc.) (§ 10, 26, 29), etc.
- An ***open-strategic action*** is rather given when a doctor makes his *orders* (medication, surgery) according to a ***paternalistic model*** (§ 10) without further discursive statements, which from his quite caring point of view can be in the best interest of the patient ("doctor knows best"), without the reasons having to be disclosed or even discussed together in *dialogue.*
- A ***covert strategic action*** would be present if a doctor, as a strategically acting agent of a ***service model*** (§ 10), were to be guided solely by his "egocentric success calculation" (see above) and were merely to *persuade* the patient to accept a commercially motivated offer (such as an individual paid health service) instead of *convincing* him in an explanatory communication. The worst case of successful (deliberate) ***manipulation*** would occur if the doctor were not even convinced of the medical measure himself and could only give pretextual reasons in a *pseudo-dialogue* when asked.

These types of medical action, briefly outlined here for the time being, will rarely occur in pure form in the practice of conversation. In the face of all possible mixed forms, which may be due to the special individual and institutional conditions of doctor-patient communication (§ 5, 7.5, 10), the "critical standard" of *communicative* action must be adhered to, which is to be recognised and acknowledged as the "original mode" of understanding, entirely in the sense of Habermas. Despite the possible practical limitations to which seriously ill, disabled, anxious or even desperate patients in particular may be subject on a very individual basis, the doctor and the patient should, as far as possible, meet as equally rational partners "at eye level", in which they conduct a conversation

that is as (result-)open as possible to the best of their knowledge and conscience (§7.5). Where social, cognitive or emotional limitations exist, they should be discussed as openly as possible with the patients themselves (or their relatives, if applicable).

A taboo in the sense of anticipatory "protection" would be just as much like incapacitation as a compulsion to communicate if the patient's willingness to communicate further has already ceased (§ 10). However, what the patient's declared will is in this case can only be determined in dialogue with the patient, i.e. in a longer process of negotiation in which it must be clarified by discussion whether the "first-best" decision, which may have come about in an individual snapshot, should also remain the "ultimately valid" one that will endure for a foreseeable period of time. As long as decisions can be kept open from a medical point of view, they should be reviewed with patients on an as-needed basis (§ 10, 22). What constitutes a "case of need" in each case can again only be determined in dialogue, in which the patient should have the "first" and "last" word.

7.4 Models of communication psychology

In the following, two models of relationships in the *psychology of communication* will be presented, which have found wide resonance in works on the theory and didactics of communication in many social areas of education and training. First, the model of human communication will be introduced, as it was developed and illustrated by Paul Watzlawick, Janet Beavin and Don Jackson (1967/ 2011) with the formulation of pragmatic axioms. Friedemann Schulz von Thun adopts their essential distinction between content and relationship aspects in his two-volume work on the *General* (1981/1992) and *Differential Psychology of Communication (*1989/1992) and combines it with Karl Bühler's *Organon Model,* which we presented at the beginning (§ 7.2.2).

7.4.1 Pragmatic axioms of communication

The communication model of Paul Watzlawick, Janet Beavin and Don Jackson (1967/2011) has experienced an extraordinary broad impact primarily because it suggested applications not only for psychothera-

peutic practice but also for the everyday practice of human communication, which not least often stimulated reflexive introspection of one's own relationship problems in everyday life. In contrast to the initial affirmative response, criticism was also increasingly voiced, for example in the title of the book, which confronted the "Watzlawick myth" as a "polemic" (Girgensohn-Marchand 1994). In the following, we will name a few selected aspects that may continue to "divide minds".

7.4.1.1 Communication concept and methodological problems

As justified in their remarks on the "conceptual foundations", Watzlawick, Beavin, Jackson (1967/2011) see themselves entirely in the tradition of *semiotics* ("theory of signs") (§ 7.2). With explicit reference to Charles Morris and Rudolf Carnap, they follow the traditional division into *syntax, semantics* and *pragmatics*. In doing so, they use a very broad concept of *communication* (Box 7.17), which corresponds to a broad concept of *pragmatics* as already claimed in the (English) title ("Pragmatics of Human Communication").

Box 7.17 All behaviour is communication

In this context, it should be pointed out from the outset that we use the two terms communication and behaviour here as practically synonymous. For the material of pragmatics is not only words, their configurations and their meanings - i.e. the data of syntactics and semantics - but also all non-verbal concomitants, including so-called body language. And finally, the role of the context, i.e. the "environment" of every communication, which co-determines the communicative processes, must be taken into consideration. In this pragmatic view, therefore, not only language but all behaviour is communication, and all communication - even the communicative aspects of each context - influences behaviour.

Watzlawick et al. 1967/2011: 25f.

This very broad concept of communication, which has been criticised many times (see below), already anticipates the first of the *pragmatic axioms* of communication, which are then gradually developed by the authors, illustrated with examples and finally summarised. Since these axioms form the core of their "Pragmatics of Human Communication",

they will be reproduced here in excerpts (Box 7.18) and then commented on very briefly.

Box 7.18 Pragmatic axioms of communication

1. *You cannot* not *communicate. (60)*
2. *Every communication has a content and relationship aspect, such that the latter determines the former and is therefore a metacommunication. (64)*
3. *The nature of a relationship is conditioned by the punctuation of the communication processes on the part of the partners. (69f.)*
4. *Human communication makes use of digital and analogue modalities (...). (78)*
5. *Interpersonal communication processes are either symmetrical or complementary, depending on whether the relationship between the partners is based on equality or difference. (81)*

Watzlawick et al. 1967/2011: 60-82 (there italic).

Criticism is mostly already directed at the very broad concept of communication, as already expressed in the conceptual foundation (Box 7.17) and then reduced to a short denominator in the first axiom. According to this, all behaviour is communication (see above), i.e. *action* as well as *non-action*, *words* and *silence* all have a "communicative character" (59). Watzlawick et al. illustrate their axiom of the *impossibility of not communicating* (58) with the example of the man in the waiting room who, for example, sitting with his eyes closed, "communicates" to the bystanders "that he does not want to speak or be spoken to, and usually his neighbours react correctly by leaving him alone" (ibid.). Such a broad concept of communication, under which even the man who has merely fallen asleep would consequently "communicate" something, is usually problematised as being too "vague" and therefore of little use for research, as the (linguistic) psychologist Hans Hörmann still formulates this relatively moderately in rhetorical question form:

> The danger, of course, lies in the vagueness of the concept of communication thus taken up: if all behaviour that takes place in the presence of another person is communicative - what scientific use can still be made of labelling behaviour as 'communicative'?
>
> Hörmann (1978: 316).

Likewise, the linguist Rudi Keller, while starting from a broad concept of signs, would like to maintain a narrower concept of communication. In his "Theory of Signs" (1995), he first describes the *sign-like nature* of our everyday life, which is almost "impregnated with signs". We only become aware of this "when the signs we surround ourselves with and use give rise to unexpected interpretations" (14f). Having a car or a bicycle is just as *symbolic* as not having one; wearing or not wearing a tie is just as *symbolic* as eating or not eating this or that, and so on. Insofar as there is "no escape from interpretability", according to Keller, one could be reminded of the "famous" sentence "You cannot not communicate" by Watzlawick et al. but Keller does not want to advocate this thesis:

> This thesis ["One cannot not communicate"] is based on the (...) inappropriate conclusion that everything that is interpretable must be communicated"
>
> Keller 1995: 15.

If we now apply this distinction between *interpretation* and *communication* to the above example by Watzlawick et al., we could - error included - continue to *interpret* that the man with the closed eyes in the waiting room "does not want to be disturbed", but also that he has merely fallen asleep and would even be grateful if we "disturbed" him and "woke him up" because the train has just pulled in, and so on. This would then be a possible act not only of politeness towards a stranger, but could also be an *obligation* within the framework of a higher-ranking *cooperation* (§ 7.3.3), if the man were known to us from common fateful days as a commuter and we had even woken each other up more than once. What the man with the closed eyes *wants* (as Watzlawick et al. imply above: "... communicates that he ... wants"), therefore, requires the *interpretation* of the situation, in which, in addition to a "physical" language of observation ("eyes closed"), quite other categories would have to be taken into account (*cognitions, volitions, intentions,* etc.), which Watzlawick et al., however, explicitly want to leave out of consideration.

As they already suggest in their *methodologically* oriented introductory chapter with an explicitly *systemic* theory and analysis perspective (see below) and repeatedly emphasise to clarify their methodological approach, "introspective" and "subjective" data "should be disregarded in a communication theory based on observable behaviour" (60). The price for the apparent abstinence from knowledge, attitudes and intentions of the participants themselves, which they often formulate themselves in their communication to secure understanding (§ 8.4) (Koerfer 2013), is

then speculation about all possible communication functions in arbitrarily open *communication situations*. Thus, even in the following example, in which the *content and relationship aspect* is to be explained, a whole spectrum of interpretations can remain possible, which can no longer be reduced.

7.4.1.2 Content and relationship aspect

The second axiom introduces the essential distinction between *content* and *relationship aspects,* which is illustrated by a "real-life" example (Box 7.19). This example also illustrates the difference between *verbal* and *non-verbal* communication, which is later described in the fourth axiom as the interaction of *digital* and *analogue* communication.

Box 7.19 "Are these real pearls?"

When Ms. A points to Ms. B's necklace and asks, "Are these real pearls?", the content of her question is a request for information about an object. At the same time, however, she is also defining - and cannot not do so - her relationship with Ms. B. The way she asks (the tone of her voice, facial expression, context, etc.) will express either benevolent friendliness, envy, admiration or some other attitude towards Ms. B. The question she asks is not a question. B, for her part, can now accept, reject or give some other definition of this relationship, but she cannot under any circumstances - not even by silence - fail to respond to A's communication.

Watzlawick et al. 1967/2011: 62

As long as the contextual information is not de facto reduced further, the utterance in question ("Are these real pearls?") may remain as *ambiguous* for an uninitiated observer as described by Watzlawick et al. As a rule, however, the participants know more about their preconditions for action and can use this *contextual knowledge*, which may include a long-shared *history of interaction* (§ 8, 20, 21), accordingly in *their* own *interpretations* in the overall situation. Under certain circumstances, it may still be primarily a matter of clarifying a "pure" question of information, through which a once established relationship between the two women does not have to be questioned at all or irritated or even changed. For example, Ms. A can also be an insurance agent who has been specially mandated by Ms. B to value all the valuables in the

house, etc. This does not have to pose any problems for the *interpretation* of the statement in question ("Are these real pearls?) as well as the possible reaction (answer) and finally for the further development of the relationship.

Irrespective of the interpretation of the example and the possible variants, which could only be reduced by further contextual information, practical problems arise primarily through the further theoretical determination of the *relationship* between the content aspect and the relationship aspect. In the formulation of the axiom, a certain *relationship of dominance* is assumed, in which the relational aspect "defines" or even "determines" the content aspect, but this is relativised again in the note (64f.). In an earlier version of the axiom, the content and relationship aspects were still placed in relation to each other in such a way that "in a given communication, one or the other can have the greater, relative weight" (Watzlawick, Beavin 1966/1990: 101). In the later version, the two functions are then contrasted (by analogy with computer language) in such a way that the *metacommunicative* function is emphasised in the relational aspect: "The content aspect conveys the 'data', the relational aspect indicates how these data are to be understood" (1967/2011: 63). In the medial mediation of the two aspects, Watzlawick et al. assume "that the content aspect is transmitted digitally, while the relationship aspect is predominantly analogue in nature" (74). At least implicitly, the distinction between *digital* (linguistic) communication and *analogue communication* coincides with the distinction between verbal and non-verbal communication.

However, linguistic communications are still possible "which lack a clear metacommunicative instruction for understanding" (64). This applies mostly to "written language" because it does not have the rich means of, for example, *emphasis* as in *oral* communication.[12] Independent of this specific problem of written communication, however, the lack or ambiguity of *comprehension instructions* is generally regarded by Watzlawick et al. as a source and expression of relational problems, which are made the starting point for their analysis of disruptions and paradoxes of communication in later chapters.

12 According to Girgensohn-Marchand (1994: 54), a strict interpretation of Watzlawick et al. would raise a fundamental problem of understanding in written communication: "Taken at its word, this would mean that we would not be able to understand a text, a letter, a poem".

7.4.1.3 Punctuations and disturbed communication

In order to be able to work out such disruptions, Watzlawick et al. extend their analysis to *circular* processes of communication, in which different *punctuations* of the communication processes can occur between the participants, through which the "nature of the relationship" is essentially "conditioned". In this context, the different punctuations can have serious consequences for the interpersonal relationship: "Discrepancies in the field of punctuation are the root of many relational conflicts" (67). The (stereotypical) example of a married couple's permanent quarrel that exhausts itself in a monotonous alternation of reproaches and defences ("I avoid you because you nag" and "I nag because you avoid me" etc.) has become well-known. Although according to Watzlawick et al. (1967/2011: 54) it is "meaningless" in feedback processes to look for a chronological "beginning" or even a "cause" because "a circle has neither beginning nor end", this cannot be generalised for circular communication processes. Girgensohn-Marchand (1994: 41) rightly points out a certain self-contradiction when Watzlawick et al. (Box 7.20) use the example of the *self-fulfilling prophecy:*

Box 7.20 The beginning of self-fulfilling prophecies

This leads us to the important concept of self-fulfilling prophecy, perhaps the most interesting phenomenon in the field of punctuation. These are forms of behaviour that trigger reactions in other people to which the behaviour in question would be an adequate response if it had not conditioned it itself. So we are dealing here with interactions whose beginning is not somewhere in the past of a long-lasting relationship, but which actually have a starting point insofar as here a person's interpersonal premise more or less imposes a certain behaviour on practically every partner. For example, someone who is convinced that no one respects him or her will display a distrustful, dismissive or aggressive behaviour to which his or her environment will most likely react with displeasure, thus "proving" his or her original assumption.

Watzlawick et al. 1967/2011: 111f

If in this special case of self-fulfilling prophecy a beginning of interaction is already conceded, this cannot generally be ruled out for the normal case of interaction between partners both in everyday conversations

and in doctor-patient communication. As we will see, there are, for example, conversational initiatives by one or the other interlocutor that can set a beginning for a new quality of conversation with new topics of conversation and new purposes of conversation (§ 3, 17). Otherwise it would not be possible, for example, to recognise key medical interventions that open up new possibilities in the conversation, for example overcoming previous taboos and thereby finally addressing "delicate" topics (§ 21), which can help to achieve a therapeutic breakthrough in a single consultation that has a long-term effect on the success of the therapy, etc.

7.4.1.4 Symmetry and complementarity

With this thematisation of communication between doctor and patient alone, we have arrived at the concepts of *symmetry* and *complementarity,* which are placed in relation to each other in the fifth axiom. In this context, *complementarity* is traditionally and precisely also determined by Watzlawick et al. as an essential characteristic of the relationship between doctor and patient as well: "Complementary relationships are based on social or cultural contexts (as, for example, in the case of mother and child, doctor and patient, teacher and pupil)" (80). As mother, teacher or doctor occupy *superior*, *primary* positions, so child, pupil and patient occupy the corresponding *inferior*, *secondary* positions. The interpersonal communication processes thus turn out to be overall *symmetrical* or *complementary*, "depending on whether the relationship between the partners is based on equality or difference" (81). Correspondingly, in the classroom as well as in the consultation hour, one must reckon with an unequal distribution of chances in interaction patterns, for example, in *questioning*, *answering*, *recommending*, *contradicting, ordering, evaluating,* etc., as well as in the *right to speak,* the granting of which would be linked to the superior position in each case.

Without denying the "evidence" of the *inequality* of partners in the respective institutions, however, it should be worked out that similar to the case of school, where "teaching as dialogue" (Wunderlich 1969) does not have to be a utopia, a "dialogue-centered" medicine is also possible and meaningful between doctor and patient, without having to come to a "pseudo-symmetry" (80) in the sense of Watzlawick et al.

With their approach to a *pragmatics of human communication,* Watzlawick et al. have certainly provided an impetus for a complex con-

sideration of the subject area of communication research that has lasted for over 50 years. With the claim to shift the focus from the "artificially isolated monad to the *relationship* between the individual elements of larger systems" (24), they have drawn broad attention to the function of verbal and non-verbal communication in interactive, circular processes between partners in contexts in which the histories of the emergence and development of "unequal" relationships are also to be studied. Despite the criticism of the formulation of individual axioms, which are explicitly "provisional formulations", one should take the claim the authors make with their axioms at their word: "However, we can contrast their theoretical weakness with their practical usefulness" (57). Instead of talking about pragmatic *axioms,* one should therefore perhaps rather talk about *aspects of* communication whose usefulness has to prove itself in the practice of analysis. Beyond the group of authors around Watzlawick (e.g. Watzlawick, Weakland (eds.) 1966/90), many approaches in this tradition have contributed to further applications in practice, among which Schulz von Thun (1981/1999 and 1989/1999) in particular is to be counted, whose approach will be presented below.

7.4.2 Communication Square and Four Ears Model

Schulz von Thun's approach, which claims to be a *General Psychology of Communication in* the subtitle of his book in Volume 1, is essentially based on the work of Bühler and Watzlawick, to whom he also explicitly refers in developing his model: "This model is inspired by Bühler (1934) and Watzlawick et al. (1969)" (Schulz von Thun 1981/1999: 30). Since we have described their communication models in detail in advance, we can limit ourselves here to the essential aspects of his integrative approach, which extends Bühler's *triadic* Organon model by Watzlawick's *relationship aspect to* a *four-sided* communication model (Fig. 7.4). This integrative model is labelled as a "psychological model of interpersonal communication" and is classified and evaluated with the following objective:

> I see the advantage of the model presented here in the fact that it allows a better classification of the variety of possible communication disorders and problems and opens the view for different training goals to improve communication skills.
>
> Schulz von Thun (1981/92: 30)

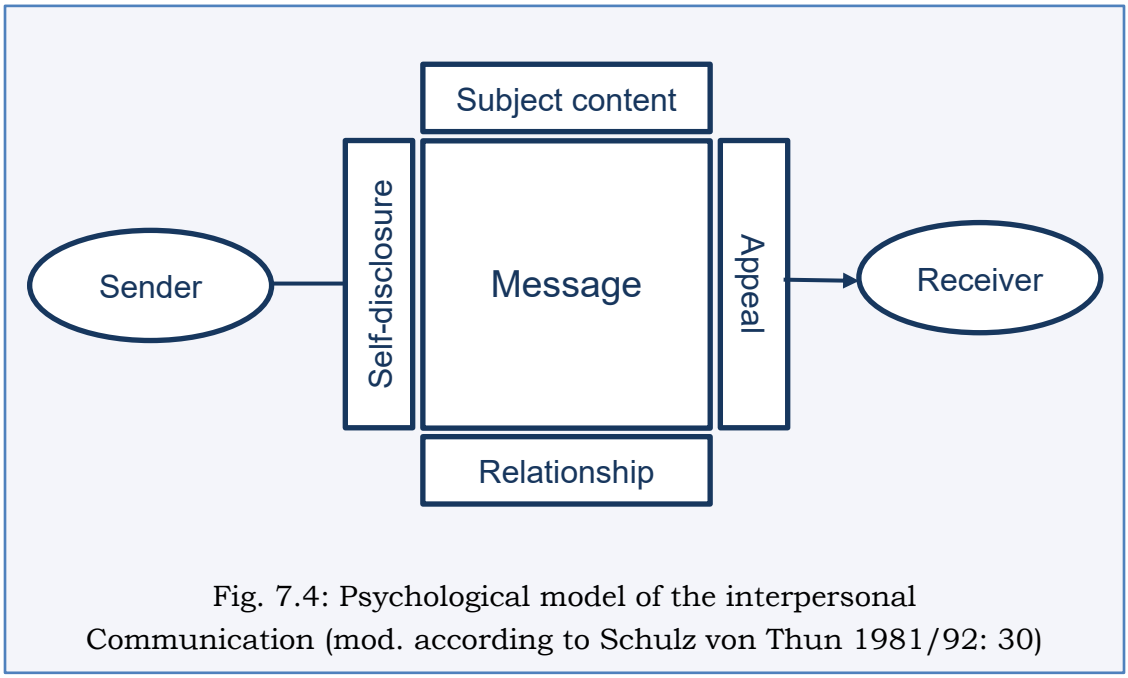

Fig. 7.4: Psychological model of the interpersonal Communication (mod. according to Schulz von Thun 1981/92: 30)

Before we go further into the structure and claim as well as the terminology of the model, a terminological clarification should be made in advance by the author himself. For the rest of the presentation, we should already take into account the *terminological* innovation that Schulz von Thun himself makes later in the second volume, in which he replaces the term "self-disclosure" previously used in the first volume with the term "self-revelation", which seems more "neutral" to him, with the following justification: "this is all too reminiscent of 'self-exposure' and unnecessarily frightening in the context of adult education" (1989/92: 19). Because this justification seems plausible from (the author's) obvious experience in adult education, the new term *self-disclosure,* which is also reminiscent of Bühler's original choice of term (*disclosure/Kundgabe)* (§ 7.1.2), will be adopted here from the outset and also already used in the *graphic* representation (Fig. 7.4).

7.4.2.1 The network of a message

In the subsequent *textual* rendering, we therefore also follow the formulations in Volume 2 (Box 7.21), in which the *four* sides are distinguished as *aspects of* the model ("square of the message") and briefly summarised.

Box 7.21 The "four sides" of the "square of the message

1. the *factual content,* which contains information about the things and processes in the world to be communicated;
2. The *self-disclosure* through which the "sender" communicates something about himself - about his personality and about his current state of mind (whether in conscious *self-presentation* or in more or less voluntary *self-opening* and *self-disclosure;*
3. The *relationship cue* by which the sender reveals how he stands to the receiver, what he thinks of him and who defines the relationship between himself and him;
4. the *appeal,* i.e. the attempt to influence in a certain direction, the request to think, feel or act in a certain way.

Schulz von Thun 1989/99 (vol. 2): 19f

The model of the four sides of a message is illustrated by way of introduction (1981/99: 25ff.) with a practical everyday example in which the passenger says to the driver: "You, there's a green light ahead". At the centre of the model is the *message*, from which the "messages it contains" are to be distinguished: "One and the same message contains many messages; whether he wants to or not - the sender always sends on all four sides simultaneously" (30). By putting the message "under the communication-psychological magnifying glass", the "network of messages becomes visible". We have dispensed here in the reproduction (Fig. 7.5) with the concrete image of a "magnifying glass", which in any case is not used other than merely metaphorically. No further explanation is given as to why the "sender" is now "sending" exactly these four and no other/further messages.

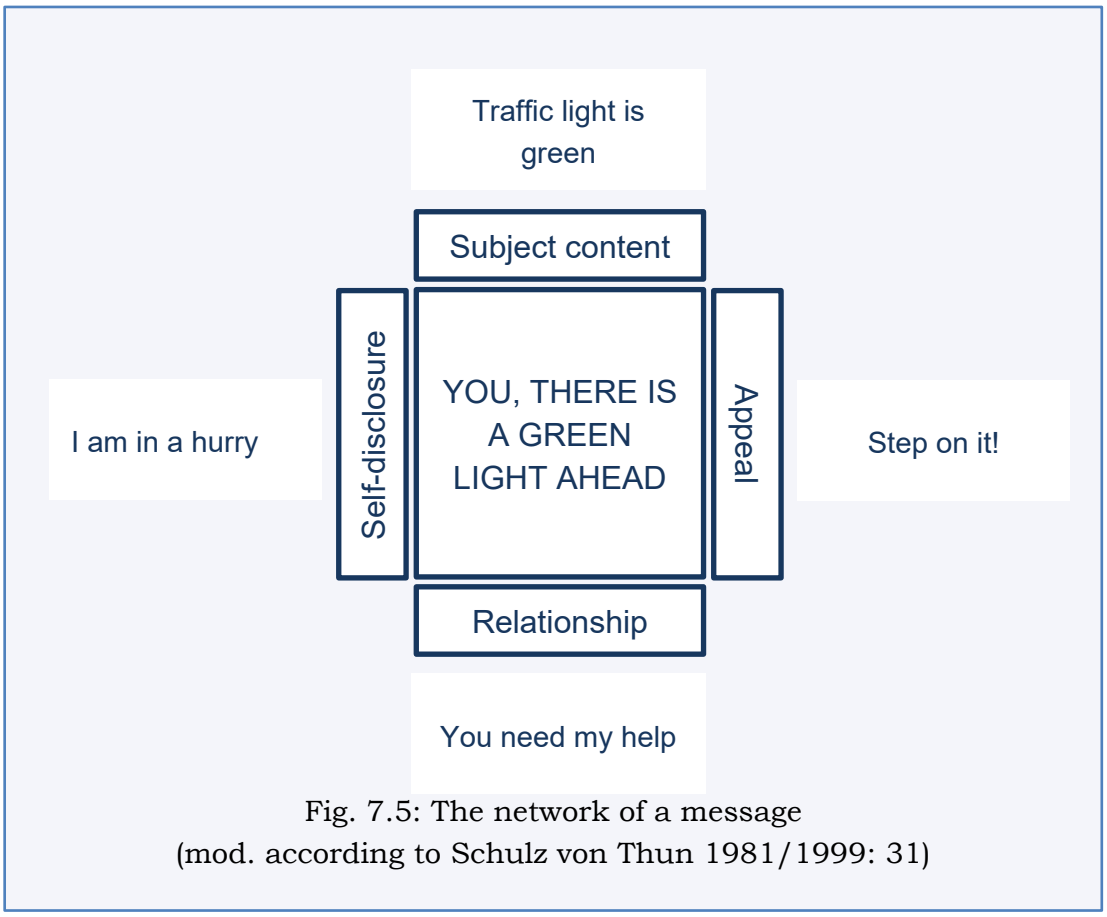

Fig. 7.5: The network of a message
(mod. according to Schulz von Thun 1981/1999: 31)

This would not only be an exemplary problem, but a problem of principle, in which the necessary to even possible number of (types of) "messages" would have to be differentiated. In doing so, a triad of *saying, meaning* and *understanding would have to be* taken into account, as it was differentiated in advance (§ 7.3) in the presentation of developments in the tradition of analytical philosophy of language and perspectivised with the specific distinction between *direct* and *indirect* speech acts.

In the given example, Schulz von Thun has the driver react as if to a "paternalism", to which he then has her respond with a "refusal" in a certain tone ("gruff"): "Are you driving or am I driving?" (28).While in this case one could probably assume a congruence of *meaning* and *understanding* (Hörmann 1978) between the two interlocutors in the car, this is not self-evident.

Thus, even according to Schulz von Thun's model, there can in principle be *discrepancies* between the messages *sent* and *received,* which is taken into account in the complementary extension of the "square of the message" on the side of the receiver, who should be able to receive with

four ears: "The receiver is biologically ill-equipped with his two ears: Basically, he needs four ears - one ear for each side" (44). In this context, messages can be received differently by the receiver with one or the other, more or less sensitively adjusted ear, which can also "hear grass grow" (58), which Schulz von Thun then further differentiates under the beautiful, ironically distancing chapter heading: "The incoming message: A 'work of art' of the receiver" (61).

7.4.2.2 Four Ears Model: The "Making" of the Receiver

In the process of *translating* signs, discrepancies can arise after *encoding* by the *sender* when *decoding* by the receiver, for example when "some messages are not received at all" or "when the receiver hears an 'accusation' on the relationship side that the sender did not want to raise" (61). Such "misunderstandings" are illustrated by Schulz von Thun with the example of the married couple sitting at lunch when the husband asks his wife the question, "What is the green in the sauce?" and the wife replies, "My God, if you don't like it, you can eat somewhere else". For the sake of simplicity and clarity, we present the comparison of the core statements of the original illustration (Table 7.4, which is again provided with the image of the "magnifying glass" (63), here in a contrasting table form.

		Sender (man)	Recipient (woman)
	Aspects	Sent message	Received message
1	Subject content	There is something green	There is something green
2	Self-disclosure	I do not know what it is	I do not like it
3	Relationship	You will know	You are a lousy cook
4	Appeal	Tell me what it is!	Next time, leave out the green!

Table 7.4: Comparison of the four sides of the sent and received message using the example according to Schulz von Thun 1981/92: 63

To understand the (possible) misunderstanding, one must of course start with Schulz von Thun's assumption that "the man wanted to ask a purely informational question (capers are unknown to him)" (62). If the woman had answered as if to a *question of information* ("These are ca-

pers"), her nevertheless possible *disgruntlement* might only have become apparent later, both to the man himself and to an outside observer. We cannot go into the discussion of the different variants of opportunities for the subsequent clarification of (concealed) misunderstandings discussed by Schulz von Thun as well as the systematic nature of "reception errors" here. We will return to specific problems of conveying information in art-patient communication separately (§ 10, 26, 27).

7.4.2.3 Criticism and application perspective

Just as von Uexküll (§ 7.2.1) cannot be reduced to the *situation circle model* or Bühler cannot be reduced to the *Organon model* (§ 7.2.2) or Watzlawick et al. to their *Pragmatic Axioms* (§ 7.4.1), Schulz von Thun should not be reduced to the *communication square* or *four-ear model* that has become so well known, although this has become a curricular *standard in* adult education, for example also in medical training (NKLM 2021). Its approach as a whole opens up and already contains many possibilities for connection to other traditions in theory and practice, such as *systemic* psychology or therapy, *transactional analysis* or *theme-centered interaction* (TCI). The observations and descriptions of *non-directive* conversation, *active* listening and *empathy* (§ 19, 20) are relevant for conducting conversations in therapy or in general in medical consultations. Likewise, the (eight) *communication styles* distinguished by Schulz von Thun could also be taken into account for doctor-patient communication, in which, for example, *helping, needy-dependent*, *aggressive-devaluing, determining-controlling*, *distancing* aspects of communication between the two interlocutors could be differentiated, which could contribute to a general typology of the two participants in helping professions in principle, but also in cases of conflict (for example with *authoritarian* doctors or *aggressive* patients) (§ 6, 34).

Of particular relevance here are also the remarks on the theory and didactics of *comprehensibility*, to which Schulz von Thun together with other Hamburg psychology colleagues (Langer, Schulz von Thun, Tausch 1990) contributed with their own concepts, research methods and tests, which are still current. However, we will come back to specific problems of *comprehensibility* in doctor-patient communication, which should of course also be characterised by *simplicity*, *brevity*, *conciseness,* etc., separately (§ 10, 21, 26, 27).

If the choice of *terminology* already "says" something about the theory itself, then some questions and comments arise about pairs of terms such as *message-statement*, *sender-receiver*, *encoding-decoding*, etc., about which Watzlawick et al. (1967/2011) had already reflected, in part critically, in their methodological introduction. As already mentioned above, the term *self-revelation,* which seemed too anxiety-ridden in adult education, was replaced in Schulz von Thun's second volume by the more neutral term *self-disclosure.* Schulz von Thun is similarly self-critical about the message tradition of certain terms, for example, in the second volume, where he uses the term *message* "in (questionable) reference to technical and cybernetic nomenclature" (1989/99: 19) without, however, explicitly distancing himself from it. Implicitly, however, the concept of message is replaced by the concept of utterance ("... message - or let us better say: *utterance"* (20)) - and this obviously in reference to language-theoretical or linguistic conceptual traditions as already considered above (§ 7.3). Schulz von Thun seems to follow this tradition later (2007: 19) when he considers the "more human" concept of *utterance* to be "more appropriate" than the "more technical" concept of *message.*

In his modelling and concrete communication analyses of many, rich (mostly remembered, constructed) examples, one can miss in Schulz von Thun's *Psychology of Communication* as a whole the reference and application of theories and categories from other "disciplines", which have found strong applications in empirical communication research and didactics in *speech action theory* or (empirically oriented) *conversation and discourse analysis* long before his book on "Talking Together" was written. Here, a reference to interdisciplinary communication research would certainly have been useful (§ 2, 7.3), the application of which could have contributed to the systematics of the manifold relational analyses of communication.

Nevertheless, the "General and Differential Psychology of Communication" has become a *classic* that is indispensable in adult education and has also found wide application in medical education and training (§ 15), which is reflected not least in the *National Competence-Based Learning Objectives Catalogue for Medicine (*NKLM 2021) (§ 44.1).

7.5 Dialogical medicine

As discussed above, the communicative exchange between doctor and patient during consultations and rounds is on the one hand shaped by institutional conditions that considerably limit their scope of action. On the other hand, a historical change has occurred that has to do with developments in society as a whole as well as within medicine (§ 3-5). Analogous to the "responsible" citizen, patient autonomy should be promoted through more participation, which, in the sense of greater participation and assumption of responsibility by patients in decision-making, can at the same time form favourable conditions for improved adherence ("treatment compliance") (§ 10). Characteristic of this development is, for example, the early book title by Paul Lüth (1974/86), which at this stage of development (not only in German-speaking countries) can still be considered a programmatic formulation:

"From silent to talking medicine" (Paul Lüth 1974/1986)

As was already made clear in the overview of international research (§ 2), a historical change has occurred since the 1970s at the latest, which places the conversation between doctor and patient at the center of their encounter. This change in focus was at the same time associated with a change in the traditional, paternalistic doctor-patient relationship: Here, the pendulum was initially to swing from an extremely doctor-centered to an extremely patient-centered medicine.

The following overview will critically illustrate that this dichotomous distinction, according to which either only the doctor or only the patient is in the center, by no means exhausts the potential for development. The aim is to demonstrate in a "dialogue-centered medicine" that both doctor and patient can "come into their own" conversationally, without having to deny the differences in their social roles and the *complementarity of* their relationship (quite in the above sense of Watzlawick et al. 1967/2011).

Rather, it is a matter of demonstrating that doctor and patient enter into a *cooperative partnership* for jointly negotiated purposes, which they ideally shape according to the same communicative principles of understanding, the validity of which for all of our communication has already been worked out in advance (with Grice, Habermas et al.) (§ 7.3). Their specific validity for doctor-patient communication will be further substantiated here within the framework of an applied discourse

ethics and will also be empirically elaborated in later chapters of this handbook.

7.5.1 Philosophy of dialogue and dialogical principle

When we use the term "conversation leadership" as a matter of course in medical conversation, this already seems to contain a *paradox,* because *conversation* and *leadership* seem incompatible.

7.5.1.1 Conversation and leadership

This paradox seems resolvable if we revise our traditional notions of conversation. Thus, Gadamer has emphasised as a possibility also between doctor and patient the "involvement" in a conversation (Box 7.22), as we know it "also otherwise in living together".

Box 7.22 "Getting into the conversation“

The word "conversation" already implies that one speaks to someone who answers one (...) All forms of the use of language are modifications of conversation or slight shifts of weight in the game of question and answer. There is the invitation to talk and the getting into the conversation, so that it almost seems as if the conversation is the active one, the perpetrator, which involves both sides (...).
So it is the conversation that can be helpful in the tense situation between patient and doctor. But this conversation is actually only successful when it is almost exactly like what we know in other ways of living together, namely that one gets into a conversation that no one actually has, but that leads us all. In the end, this also remains true for this kind of conversation between the doctor and the patient.

Gadamer 1993: 161f and 172

If, in this "involvement" in a conversation, the authorship can no longer be clearly attributed to one or the other partner, the question of the *art of conducting a medical conversation* arises in a way according to which the traditional role of conducting a conversation by the doctor is to be abolished or at least strongly modified. The initial withdrawal of the doctor's role in leading the conversation, as it has applied specifically to the psychotherapeutic conversation since Freud's writings on treatment techniques (1912/1913) (Thomä, Kächele 1989, Koerfer, Neumann

1982, Lang 2000, Kächele et al. 2006) (§ 9), can be generalised in a moderate form for the doctor-patient conversation in general, especially at the beginning of the conversation. Nevertheless, the differences in the roles of participation between doctor and patient remain even when the doctor largely withdraws in his traditional role of leading the conversation. In the concrete formulation of the art of conducting medical conversations (§ 17), the question of *(a)symmetry* in the conversation will again be at stake, which will be further differentiated here in advance.

At first glance, an *egalitarian/ symmetrical* participation of the conversation partners seems to be more difficult if one of them claims and exercises the role of *leading the conversation.* This would be more or less true for the medical communication leadership as it is traditionally perceived by the doctor's side. As is to be shown, the role of medical communication leadership, which is *attributed* in a recognised way, should be exercised in such a way that both partners can "come into their own". To "ensure" this right alone is essentially the responsibility of the doctor, who therefore has the main responsibility for the further course of the conversation.

7.5.1.2 The "real" conversation

The problem of (a)symmetry does not only apply to doctor-patient communication, but also to institutional and non-institutional communication in the same way, as long as we meet each other as "real" interlocutors and want to be taken seriously as such who are interested in a communicative understanding (e.g. on a problem to be solved together). No matter how different our (social, cognitive, cultural, etc.) preconditions for participating in a conversation may be, in a "real" conversation we should meet as equals among equals.

In order to overcome *asymmetries* (of whatever kind) (see below) in the long term, a "dialogical principle" should be applied, as is the case in certain traditions of the "philosophy of dialogue" (Martin Buber, Viktor von Weizsäcker, Gabriel Marcel, Emmanuel Levinas, Peter Kampits et al. or a *hermeneutic philosophy of conversation (*Hans-Georg Gadamer, Hermann Lang) or the *discourse ethics of the philosophy of communication* (Karl-Otto Apel, Jürgen Habermas, Matthias Kettner) (§ 7.3, 10). According to this, (certain types of "genuine") conversations are to be conducted as "unbiased" as possible and "open-ended" for as long as possible, as Martin Buber so pointedly described it in his own language (Box 7.23).

Box 7.23 "A real conversation cannot be predisposed".

But everyone must be determined not to withdraw if, according to the course of the conversation, it is up to him to say what he has to say. Of course, no one can know in advance what that will be: a real conversation cannot be predisposed. It has its basic order from the beginning, but nothing can be ordered (...) But this too is self-evident, that all participants, without exception, must be of such a nature that they are able and willing to meet the requirements of genuine conversation. Authenticity is already called into question if even a small part of those present are perceived by themselves and by the others as those to whom no active participation is intended.

Buber 1954/1986: 296

What is already generalised here for the multi-person conversation is, according to Buber, initially essential in the "*two-person" conversation*, as it is also conducted between doctor and patient. Not being able to "predispose" a "real" conversation between doctor and patient means that the "good" doctor may have prepared himself "well" for the conversation, in which he brings - as far as possible - his "good" knowledge of the file and his "good" professional competence in general with his nosological knowledge of the clinical picture as well as his structured professional experience of typical patient reactions (§ 3, 6).

But despite all professional competence in dealing with typical patient histories, the doctor just does not know the relevant biographical "data" and life attitudes of this individual patient with his very personal preferences (expectations, hopes, fears, preferences, etc.). Conversely, the patient's preferences are often not "clear and distinct" from the start, i.e. they cannot be "asked" at the beginning of the conversation, but are only specified in the conversation with the doctor or are only developed at all, because the situation can be "completely new" for the patient.

It is possible that the preferences initially expressed will be corrected, modified or completely revised, etc., in and through the conversation with the doctor, i.e. the doctor should ensure the sustainability of decisions for as long as possible (§ 10), which is still to be illustrated by examples (§ 22).

In any case, it should first be stated here that the doctor must by no means (for reasons of economy, for example) follow the "first best" pa-

tient's statements, even if they should already "fit into his own concept" qua doctor's preference. Particularly in the case of so-called serious diagnoses (§ 16, 38), for example in the case of life-threatening diseases, the treatment of which may entail certain risks (complications, death) or burdens (chemotherapy) with uncertain success, the doctor will not be able to anticipate the presumed will (wish, decision) of the patient in the individual case, but only to explore it *conversationally.* If both want to come to a decision that will last beyond the day and not be regretted tomorrow, they must enter into a negotiation process about the pros and cons with an initially open outcome, which can only be concluded as a process after a mutually experienced "saturation" of the decision-making process.

As in the anamnesis interview, in which the patient's narrative self-exploration is to be promoted (§ 9), the second part of the consultation, whose exploration has long been "neglected" (Elwyn et al. 1999), also calls for a helping participatory role of the doctor in midwifery function, which has less to do with "ordering" or "prescribing" and more with "negotiating" (§ 10). As is still to be explained under this aspect, it is not about the establishment of *compliance* "at any price", which can only ever be violated unilaterally by the "therapy-unfaithful" patient, but about *concordance* (German: "Eintracht", "Übereinstimmung") (§ 10), in which both partners bear the responsibility for the jointly made decision (Weiss, Britten 2003, Stevenson et al. 2004, Bissell et al. P 2004, Pollock 2005, Koerfer et al. 2008, Thornton et al. 2011, Winn et al. 2015, Koerfer, Albus 2015). If this decision does not prove successful, the doctor and patient must - if this is (still) possible - enter into a *dialogue*, i.e. also an *open-ended negotiation process,* in which the *question of power* (§ 7.5.3) does not arise at all or arises differently than in traditional relationship arrangements.

In the question of power, a clarification of the concept of *(a)symmetry* is necessary at the same time, which can be used quite differently (§ 7.5.3, 10.6). Here, within the framework of an applied discourse ethics, a *dialogical* symmetry is to be justified, with which the outlined dialogical principle is also asserted for doctor-patient communication, despite possible limitations. In more than 40 years of development, this has undergone several changes, which will be outlined here in advance in a brief historical overview, which at the same time concerns the change in the research of the (a)symmetry problem.

7.5.2 From doctor-centered to dialogue-centered medicine

The paradigm shift from a *biotechnical* to a *biopsychosocial* medicine, as it was founded in advance above all by George Engel (1977, 1988, 1997) and Thure von Uexküll and Wolfgang Wesiack (1991, 2011), requires at the same time a different way of shaping relationships and medical communication with the patient. As has been further explained elsewhere, the biospsychosocial model is not only a model of *scientific knowledge* and *treatment*, but also a model of *relationship* and *communication* (Koerfer et al. 1994, 2008, 2010). The focus of knowledge and treatment is no longer limited to specific *diseases*, but is directed towards the sick person himself, with all his subjective experience of illness (Levenstein et al. 1989, Barbour 1995/2013, Ishikawa et al. 2013). With this change of focus, the traditional medical interview proves to be ineffective in many respects.

The *biopsychosocial* spectrum of topics, which has expanded considerably compared to traditional *biomedicine*, can accordingly no longer be explored with the traditional, *interrogative* taking of medical history, but requires a different, more *narrative* approach to the patient: The patient's life story and history of suffering cannot merely be inquired about, but the patient must have his or her say as a narrator, actively and in the piece, to whom the doctor must listen actively accordingly (§ 9, 19) (Smith, Hoppe 1991, Koerfer et al. 2000, 2010, Epstein 2013). This also applies to the exploration of *subjective* patient attitudes (§ 10, 21) towards possible treatment options.

The patient's personal *life values* and *preferences* that are relevant in this context cannot simply be asked as a given in an interrogative interview style, but must often first be actively developed in dialogue with the doctor and, if necessary, reviewed and corrected conversationally depending on the course of the disease (§ 8, 10). This requires a specific way of conducting a medical interview in which conversation and guidance are not contradictory.

As will be elaborated (§ 9, 10, 22), a mere change of perspective from the traditional, purely *doctor-centered perspective to* a purely *patient-centered* perspective falls short, especially if this distinction is seen as a dichotomy. In a historical review, Beach (2013: 5) summarised four developmental stages of medicine in recent decades in a chronological representation as follows (Fig. 7.6), which will be supplemented here by two further stages (5-6) and commented with exemplary literature.

Phase	Stages in the development of medicine			Time	Exemplary literature (theories, models, didactics)
1	Doctor-centered Model	Bio-Medicine	Disease-centered		Traditional medicine (practised before and also after v. Weizsäcker 1940, 1946, Balint 1964, Engel 1977, 1981, 1988 and others).
		Autonomy D > P	Decision D → P		
2	Patient-centered Model	Bio-psycho-social			Balint 1964, Byrne, Long 1976, Engel 1977, 1981, 1988, White et al. 1988, Levenstein et al. 1989, von Uexküll, Wesiack 1991, 2011, Mead, Bower 2000, Grover et al. 2022, Zhou et al. 2023, Mezzich et al. (eds.) 2023
		Autonomy D ≥ P	Decision D ↔ P		
	Service Model	Autonomy P > D	Decision P → D		
3	Relationship-centered Model	Bio-psycho-social Medicine Disease & illness	Asymmetrical roles & equal autonomy (D ≥ P) Shared Decision Making (SDM) (D ↔ P)		Tresolini et al. 1994, Mead, Bower 2000, MC Beach et al. 2006, Rider, Keefer 2006, Suchman 2006, Kenny et al. 2010, Miller et al. 2010,
4	Interactionally Enacted Care Model				WA Beach, Dixon 2001, Robinson 2003, WA Beach, Mandelbaum 2005, WA Beach 2013
5	Partnership & Dialogue-based Model				Pellegrino, Thomasma 1981, Herzka 1990, Kampits 1996, Engel 1997, Anderson 1999, Roter 2000, Olesen 2004, Koerfer et al. 1994, 2008, 2008, Collins, Street 2009, Walseth, Schei 2011, Richard, Lussier 2007, 2014, Koerfer, Albus 2015, Chin-Yee 2019
6	Partnership & Narrative-based Model				Brody 1994, Greenhalgh, Hurwitz 1998/2005, Koerfer et al. 2000, 2005, 2010, Charon 2001, 2006, Mishler 2005, Goyal 2013, Köhle, Koerfer 2017, Milota et al. 2019, Weiss, Swede 2019, Galvagni 2022.

Fig. 7.6: Stages in the development of medicine
(added and modified on Beach 2013, cf. Mead, Bower 2000, Langenbach, Koerfer 2006, Koerfer, Albus 2015, 2018, Feldthusen et al 2022, Grover et al. 2022, Mezzich et al. (eds.) 2023, Kim et al. 2024

Such a chronological sequence of development and division into reform phases can of course only be regarded as an ideal-typical representation, which can only take into account the partly parallel, competing or even contradictory developments in the theory and practice of medical consultations to a limited extent. The simultaneity or even contradictory nature of development trends can already be seen from the temporal overlap of literature (e.g. early 1990s).

First of all, it must be taken into account that these are *prevailing* tendencies, which does not exclude the fact that there were *patient-centered* approaches in medicine even before Balint (1964), for example, which placed the subjectivity of the sick person at the center of medical theory and care (e.g. Viktor von Weizsäcker 1940, 1946). For specific developments and "classics" of *psychosomatic* medicine and psychotherapy, we refer to the brief overviews by Hoffmann, Hochapfel (1999) and Bertram (2013) as examples.

For the first change in tendency, initiated not only by Balint's seminal book ("The Doctor, His Patient and the Disease") (1964/1988), but above all with the empirical research into (recorded) doctor-patient communication (e.g. Byrne, Long 1976) (§ 2), it was initially quite understandable historically, that the pendulum had to swing from one extreme of *doctor-centered* medicine to the other extreme of *patient-centered* medicine at the beginning of the debate on the necessity of reforming (training in) medicine, in which above all the concerns, preferences and rights of patients were to be taken into account.

Here, the first phase of reform was essentially about strengthening *patient autonomy*, behind which the competence, authority and autonomy of the doctor should take a back seat as far as possible (Fig. 7.6). As we will see (in § 10), especially in medical decision-making, the pendulum can swing in an extreme direction in which the patient is exaggerated as "King Customer" and the doctor's role is reduced to purely *service functions* – a development that is by no means always to the patient's advantage.[13]

[13] These disadvantages of the service model can be serious if the treatment uncritically follows patient preferences, which can run counter to evidence-based medicine (§ 10, 22).

In order to overcome the mere dichotomy of *doctor-centered* versus *patient-centered* medicine, a "relationship-centered" approach then emerged (Tresolini et al. 1994, MC Beach et al. 2006, Kenny et al. 2010, Miller et al. 2010), which then developed further as an "interaction-centered" approach to care (in Beach's sense above). Compared to Beach (2013), however, the following modifications and supplements are appropriate in order to prevent possible misunderstandings here:

1. As already mentioned above, the *transitions* between the developmental stages of medicine are just as fluid as the conceptual self-labelling. The move away from purely "doctor-centered" medicine was primarily associated with criticism of the extreme development that the patient's gain in autonomy in a service model would come at the price of a loss of autonomy for the doctor (v. Uexküll 1993, Quill, Brody 1996, Sandman, Munthe 2009, Sandman et al. 2012). The criticism of purely *patient-centered* medicine is then directed above all against *libertarian* medical ethics, according to which "anything can be done" that is not explicitly "forbidden" in the sense of a "medicine of convenience" that is not evidence-based (§ 10).
2. Irrespective of this criticism, the general *umbrella term* "patient-centered" has remained current to this day (e.g. Grover 2022, Langewitz 2023). The terms *patient-centered* and *person-centered* are often used synonymously and a common abbreviation is used accordingly (*PCC*) (e.g. Grover 2022). On the basis of so-called "personalized medicine", Kriksciuniene and Sakalauskas (eds.) (2022) explicitly choose the term "person-centered medicine" in the title and justify this in the introductory chapter (2022: 6). Similarly, the title and all chapters in Mezzich et al. (eds.) (2023) uniformly use the term "person-centered medicine", not least with the aim of *overcoming* the traditional *patient role* ("'Patient' is just a role, while 'person' stimulates broadness and creativity in care") (2023: 7).
3. Insofar as the distinctions between "disease" and "illness" are seen as opposites, this dichotomy should be abolished in a *biopsychosocial* medicine (§ 4). The fact that "dialogue" is the "appropriate" form of communication for a *biopsychosocial* medicine was already justified in the introduction (§ 1) with George Engel for all phases of medical consultation, whose patterns of action and therapeutic goals are further differentiated (§ 8, 10, 22).

4. *Relationship-centered* and *interaction-centered* approaches should not necessarily exclude each other, but can complement each other. They should be seen as two sides of the same coin in that (types of) *relationships* are constituted by (types of) *interaction* and *vice versa*. Thus, *interrogative* conversation constitutes and stabilises a more *paternalistic* relationship, while *narrative* conversation corresponds more with a specific *partner relationship* (§ 8-10, 22).
5. Since, after all, the interaction between doctor and patient can initially only be realised essentially *by means of dialogue,* the interactive approach is to be identified here more specifically as "dialogue-centered medicine" (Box 7.24) (Kampits 1996, Anderson 1999, Engel 1997, Roter 2000, Olesen 2004, Koerfer et al. 2008, Walseth, Schei 2011, Richard, Lussier 2014). This developmental stage of medicine must be further elaborated both theoretically (Box 7. 24) (§ 7.5.3-3) and empirically, especially in the case of dialogue-based history-taking and decision-making (§ 9, 10, 19-22).
6. The particular development of *narrative medicine* (§ 9), which is not yet considered in the overview by Beach (2013), is to be defined as a specialisation of dialogue-centered medicine, in which the physician not only has to fulfil the role of an active listener, but also as a dialogical co-constructor of patient stories (§ 9, 19, 20, 24, 25).

For the further justification of a *dialogical medicine*, which allows both *narrative* history-taking (§ 9, 19) and *participatory* decision-making (SDM) (§ 10, 22), an interim conclusion should be drawn here, according to which the mere dichotomy of doctor-centered and patient-centered medicine should be overcome by a terminological and conceptual change of focus. As a representative example of many of the approaches mentioned, the programmatic remarks of Olesen (2004) (Box 7.24) on *dialogue-centered* medicine should be introduced here, which should be examined for their chances of realisation in the practice of dialogue between doctor and patient:

Box 7.24 Balanced, dialogue-centered medicine

In conclusion, the way forward lies in accepting that a good consultation is a meeting between two different experts: the patient and the doctor. These experts should realise that they each have a unique expertise, and from this position they should build common ground for their interaction. This demands that the doctor preserves his/her professional integrity and that the two parties respect each other's positions and are, indeed, willing to interact. The tool they should use in this process is dialogue, i.e. an exchange of thoughts and ideas and a discussion staged to come to agreement on a topic (...) The time may thus have come to stop focusing on the concept of patient-centred medicine and to go for developing a concept of balanced, dialogue-centred medicine.

Olesen 2004: 194

How this balance can be established in a *dialogue-centered* medicine, despite all the asymmetry between the apparently "unequal" partners, who are nevertheless equally "experts" (of different types) in their own way, will occupy us throughout the course of the handbook in both its theoretical and practical parts. To this end, various concepts of *(a)symmetry* and their empirical uses in the context of applied discourse ethics will be discussed first.

7.5.3 Dialogical symmetry and discourse ethics

The continuous application of the *dialogical principle,* as presented above (§ 7.5.1), will also be applied to the doctor-patient conversation, although the *asymmetry* between the (unequal) interlocutors, which is often emphasised in research, seems to contradict this. For example, ten Have (1991) begins his early study on asymmetry in doctor-patient communication with the following introduction (Box 7.25) on the state of research:

Box 7.25 Asymmetry as a "social fact" of roles ("leader" - "follower")

The idea that interaction between physicians and their patients is asymmetrical is widely shared among both participants and observers of medical encounters. It is assumed as a "social fact" that the roles of doctors and patients differ, and that this difference corresponds to that of leaders

> and followers. This "fact" has been explained in various ways by contributors to medical sociology, weather causally or functionally (...)
>
> ten Have 1991/2013: 149

Already in the case of ten Have, to whom we will therefore return again, a change of perspective in empirical communication research became apparent in the 1990s at the latest, in which the focus was directed towards the question of whether and how this apparent "social fact" of asymmetry in the institutional role relationship of the two actors is also "acted out" (*enacted*) "factually" in the *practice of conversation,* as is assumed with the traditional "leadership role" of the doctor and the "follower role" of the patient.

The change from *doctor-centered* to *patient-centered* medicine, which was postulated early on, gave rise to doubts as to whether the "reality" of conversational practice could be adequately captured with the traditional categories of description and analysis. The fact that the development did not stop with the mere change from an extremely *doctor-centered* to an extremely *patient-centered* medicine has already been outlined in a historical overview (§ 7.5.2), which at the same time revealed the necessity of a revision of research categories and methods in communication research, as this was already suggested in advance (§ 2, 3). Here it is first necessary to clarify the concept of (*a)symmetry, which* can be used quite differently.

7.5.3.1 Institutional asymmetry and role complementarity

The essential distinction, also in comparison to everyday communication (*conversation*), is often captured by the term *institutional asymmetry (*e.g. Roberts 2000/2013). According to this, the asymmetry between doctor and patient also corresponds to the asymmetry as asserted for a number of specific *institutional* types of conversation, which are characterised, among other things, by the fact that the interlocutors meet as *experts* and *laypersons* and thus already with an *asymmetry of knowledge* (Lakoff 1980, Mishler 1984, Herzka 1990, ten Have 1991/2013, Drew 1991/2012, Maynard 1991, Koerfer 1994/2013, Brock, Meer 2004, Koerfer et al. 2005, 2008, Peters 2008, Meer 2011, Pilnick, Dingwall 2011, Brünner 2005, Groß 2015, Peters 2015, Weiste et al. 2016, Ehlich 2020, 2022). Certainly, this (kind of) asymmetry

cannot and should not be denied, which already manifests itself in the fact that, for example, it is not the teacher's but the student's knowledge that is promoted and tested in class, or that in court the judge sentences the accused (and not vice versa).

Analogously, it is not a possible illness of the doctor that is at stake, but that of the patient, who has to actively assume his role as narrator, answer the doctor's questions about his condition, endure an examination by the doctor, etc. (and not vice versa). This (kind of) asymmetry, however, in no way prevents the application of the dialogical *principle* in the conversational practice of the two actors, which does not necessarily presuppose a *symmetry* (of all possible participation roles of the actors) that applies in every respect, but only requires a *dialogical* symmetry. This dialogical symmetry should apply in particular at "critical" development points in the conversation, in which it is especially important for the patient to form an "independent" opinion in medical decision-making.

7.5.3.2 Functional and dysfunctional asymmetry

The generally postulated *participation* of the patient cannot be measured by a *naïve* concept of symmetry that assumes a "halving of power" in the sense of a "half share" of both interlocutors in the conversation as a whole (50% share of speech) as well as in all (types of) utterances (listener feedback, speech acts, etc.). A mere "half share" in the conversation as well as in all (types of) statements, narratives and feedback, questions, answers, objections etc. would be tantamount to a *pseudo-symmetry* that would confuse communicative equality of opportunity with equalisation of the *dialogue roles* of the interlocutors.[14] As will be shown, it is rather a matter of symmetrical opportunities in the choice of communication topics and purposes and the means of communication necessary for this choice in the use of *words* and *speech acts* (questions, answers, objections, etc.), which all participants can basically

[14] Unless otherwise indicated, we use "dialogue role" here and in the following as a generic term for all possible communicative activities; however, cf. elsewhere the distinctions between *social roles* (such as teacher-student, doctor-patient), *action roles* or *interaction roles* (such as question-answer, reproach-justify) and *dialogue roles* in the *narrower* sense (speaker-listener), on this Koerfer 1979, Koerfer, Zeck 1983, Koerfer et al. 1994, 2005, Koerfer 2013.

freely dispose of according to their *relevance of topics*, for the *transparent* negotiation and clarification of which they seek the cooperation of the dialogue partner.[15]

In contrast to a *naïve* concept of symmetry, from the perspective of discourse ethics a *dysfunctional* asymmetry must be distinguished from a *functional* asymmetry between doctor and patient, which corresponds to the distinction between *strategic* and *communicative* action, as explained above (§ 7.3.4) (Habermas 1971, 1981, Westphale, Köhle 1982, Siegrist 1982, Koerfer, Neumann 1982, Koerfer, Zeck 1983, Koerfer 1994/2013). The fact that a patient narrates and the doctor listens more or less actively is a *functional* asymmetry, whereas the constant interruption of the doctor would be an example of *dysfunctional* asymmetry because the patient would be disproportionately restricted in his right to speak, similar to an "inquisition".[16]

Here, the *symmetry of speech* constitutive of *dialogical symmetry* would be violated not because of individual spontaneous interruptions, which can certainly be conducive to dialogue, but because of their frequency and regularity, with which a doctor systematically prevents the patient from continuing to speak. In this "authoritarian" type of "interruption", which is also frequently connected with a change of topic (§ 19, 24), doctors use the same (everyday) means of communication that are also used elsewhere when an interlocutor is to be "silenced" or "muzzled" in the sense of *strategic* action. This type of *strategic* action will be of interest to us in the justification and description of a *dialogical feedback model* (§ 17, 19, 20), which is used in a specific way in medical action.

Even in a medical consultation, both types of action are possible in principle, which were distinguished (above with Habermas) as *strategic* and *communicative* action and correspond with the distinction between functional and dysfunctional asymmetry: Whereas in the case of *dysfunctional* asymmetry one or more actors more or less openly place

15 In the institutional context of a medical consultation, it should not have to be specifically emphasised again the "asymmetry" that "normally" the doctors' illnesses, marital problems, holidays are not (or cannot) be made the subject of conversation, although some patients occasionally "manage" to do that too, as our material reveals.

16 Cf. Platt, Gordon (2004: 17). As we will see, an "inquisition" is by no means a special case, for example, in the police interrogation of a suspect, but can also be perceived in this way in a medical consultation, which will be shown in empirical examples (especially § 19).

themselves on the *power standpoint,* from which they shift entirely to *strategic* action (with deceiving, trivialising, persuading, intimidating, etc.), conversational asymmetry can be described as a "communicative action"), the interlocutors in a *functional* asymmetry are essentially guided by *communicative* action for the purpose of *understanding*, in which, for example, possible differences in knowledge (between teachers and pupils, politicians and citizens, doctors and patients) can be productively used for a transfer of knowledge in order to work on issues that are jointly recognised as problems and *negotiated transparently*.

Functional asymmetry then means that the interlocutors "conduct a conversation" in which they participate differently according to their *dialogue roles,* for example as *questioners* and *answerers*, *narrators* and *listeners.* If they perceive their dialogue roles *communicatively* and not *strategically*, the question of *dominance* or *control is* often idle.

7.5.3.3 Dominance and control

With principled assumptions about *(a)symmetry* in conversations based on dichotomous distinctions according to which the (distribution of) dominance and control to certain (types of) participants seems clear and indisputable, there is a danger of becoming entangled in *paradoxes* (Koerfer, Neumann 1982, Fehlenberg 1987, Koerfer et al. 1994, 2005, Koerfer, Albus 2015). In the further course of the handbook, further justification and empirical examples will be given, which will only be illustrated here with a few loosely formulated questions on the (distribution of) power in certain types of conversations as an example (Box 7.26) in order to show the research spectrum:

Box 7.26 Questions of power

- Is the speaker more powerful than the listener?
- Does the power lie with the one who (as a patient) tells a lot, or with the one who (in the sense of Freud 1913: 194) "lets tell" a lot?
- Is the questioner more powerful than the answerer or is it the other way round (depending on the situation)?
- Is the responder less powerful than the non-responder?
- Is the "frequent speaker" more powerful than the "silencer"?
- Who "owns" the "entered" silence, who "suffers" more from it, who can/must end it (for what reasons), and what does this say about the

question of power?
- How is power distributed when one partner initiates the issues (symptoms, complaints, concerns, etc.) and the other further explores, modifies, classifies, etc.?
- Who is more able to determine the topic, who the time and place, or who can change the partner at all, and how does that answer the question of power in each case, etc.?

The question of power often arises in many *institutional* as well as *non-institutional conversations in a* complex and specific way, in which both interlocutors are subject to social rules (laws, rituals, conventions) that they cannot simply evade, but must more or less submit to (Koerfer 1994/2013). This already applies to the relatively harmless case of a conversation (intended as *small talk*) over the garden fence with the neighbour, who uses the harmless question about the roses to instruct us about his rose cultivation, which we do not dare to evade for the sake of neighbourly care.

This also applies to dealing with "inquisitive" children, who can "embarrass" or even "drive their parents to despair" with their typical "why" *questions,* although in principle one seeks to encourage the inquisitive behaviour of one's children. Even if teachers in schools and universities basically appreciate the critical attitude of learners, they often fear for "their" curriculum, which could be endangered by all too "critical" enquiry and questioning as well as by a lack of participation or even a "refusal to teach", which may well be intended "strategically" as a "boycott of lessons".

The "question of power" is often more complex than it "appears" during consultations and rounds. This becomes clear in medical training courses (§ 15), for example, when doctors "complain" about so-called "difficult" patients (§ 34) who "make life difficult" for them by "closing off" or "refusing" to accept offers of medical conversation and treatment, or by "demanding" their own demands "vociferously" and "going to great lengths" in front of and in the treatment room, so that even the scheduling of appointments is in danger of getting "mixed up", etc.

Regardless of the "quality" of conversations, not even the "quantity" in conversation participation can be taken as a simple or clear "measure of power", as we will see in the *evaluation of* doctor-patient communication (§ 40-43). The fact that these are complex questions about power before, during and after the conversation is already clear from a special

case of therapeutic conversations (Koerfer, Neumann 1982), namely the psychoanalytic conversation, which according to Robin Lakoff (1980) (Box 7.27) is characterised by a specific *paradox*.

Box 7.27 Paradox of the psychotherapeutic conversation

(...) the analyst has the power to determine how the discourse shall proceed and exercises this power by allowing it to proceed at the patient's whim. Moreover, although the analysist thus controls the discourse, he does not directly control choice of topic. He governs the inception and termination of the discourse, but not the subject-matter. Thus we are dealing with a conversational situation replete with paradox.

Robin Lakoff 1980: 11

Although the psychoanalytic conversation is of course a special case of doctor-patient communication, this kind of paradox pointed out by Robin Lakoff will have to be considered when it comes to clarifying the participation of doctor and patient in the conversation, who may well have their respective domains of speech without jeopardising the *dialogic* principle and *dialogic* symmetry.

As will be shown, the relationships are more complex than that the power or control question could be answered in such a way that the speaker dominates the listener, the questioner dominates the answerer, although the latter (as patient) may have the relevant knowledge that the questioner lacks, such as the doctor at the beginning of taking the medical history, etc. This kind of non-knowledge leads to the further "paradoxical" perspective that doctor and patient meet in the (a)*symmetry* of *experts* (of different types).

7.5.3.4 Asymmetry of knowledge between types of experts

Whether, in view of the (a)symmetry(s) in the partnership of doctor and patient, the "production of a shared reality" (in the sense of von Uexküll, Wesiack 1991, 2011) (§ 4.4, 6.4) succeeds in individual cases depends on both partners, who must each cooperate as different (types of) *experts* in order to be successful: The patient has to participate in the cooperation as an expert of his disease and biographical knowledge, the doctor as an expert of the professional knowledge of his guild. The meeting of the two different types of experts in conversation has been

accurately described by Tuckett et al. (1985) as a "meeting between experts" who have to communicate their ideas to each other in order to be able to share them ("sharing ideas"). This is usually a lengthy process in which there must be multiple entanglements between the different types of knowledge of the two experts.

In recurring *dialogue threads* (in the above sense of Bühler) (§ 7.2), the information of one partner must necessarily build on that of the other in a way in which both partners use each other as experts: the doctor the patient as an expert in his history of suffering and the patient the doctor as an expert in his art of healing (cf. e.g. Tuckett et al. 1985, Smith, Hoppe 1991, Koerfer et al. 1994, 2010, Koerfer, Albus 2015). The patient is initially a "blank slate" for the doctor and only gradually does his knowledge of the patient fill in, to whom he can likewise successively impart his professional knowledge with reference to his individual illness. At first, there is a *symmetry of non-knowledge* on both sides of the scales, before they gradually fill up and a sufficiently shared knowledge has emerged for both interlocutors, which then needs to be deepened in order to throw new knowledge into the respective scales (Fig. 7.7) for the purpose of medical decision-making, etc.

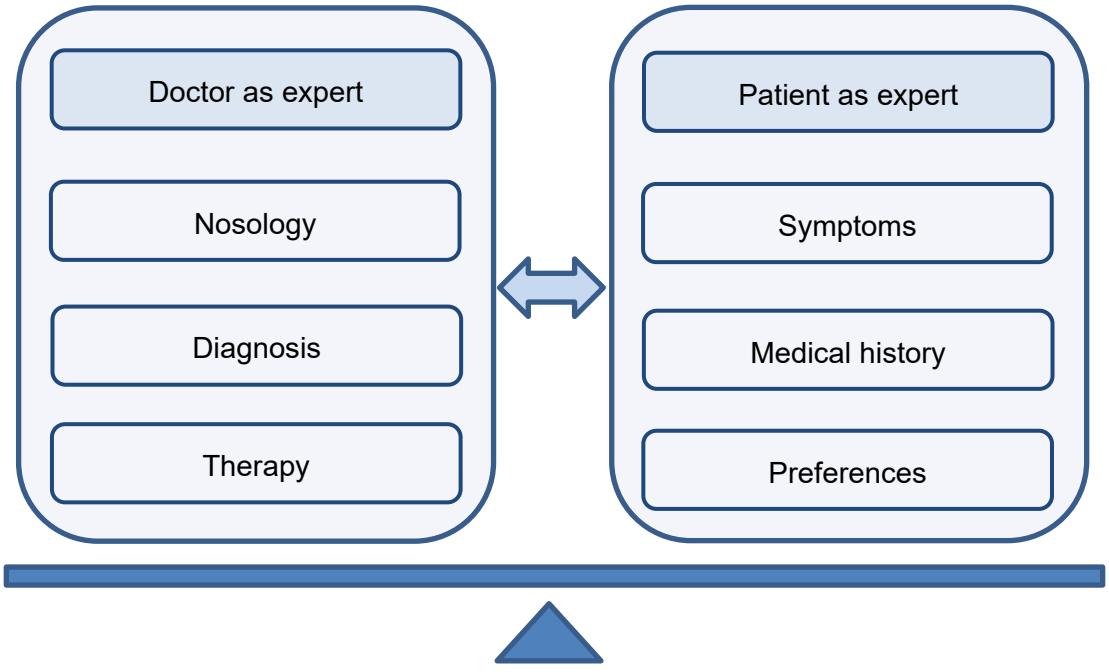

Fig. 7.7: On the scales: (A)Symmetry of (non-)knowledge

The specific expert roles refer to specific symmetry and asymmetry relationships, insofar as both interaction partners are equally *knowers* and

at the same time *non-knowers,* and this in turn in relation to different individual or professional bodies of knowledge, for which they must first make themselves mutually competent to a certain extent. The *transfer of knowledge* extends over various phases of conversation (§ 8), which begin with the narrative-biographical *collection of anamnesis* (§ 9) on symptoms and medical histories and progress through the *communication of diagnosis* and *clarification to decision-making* (§ 10), in which the evidence-based therapy options are to be compared with the patient's preferences in dialogue.

In this process, the specific communicative performances and counter-performances in the respective expert roles must be coordinated with each other in a joint negotiation process in which there is a relevance entanglement of, for example, questions and answers, narratives and listening, explanations and questions of return and understanding, suggestions and objections, etc. Here, a sufficient saturation of mutual understanding and agreement must be waited for, so that the two partners do not lose themselves in arbitrariness with first-best concordances that could lead to a *pseudo-consensus* that does not stand up to a rational, open-ended examination in a "real" conversation (in Buber's sense above) (Box 7.23). The application of the *dialogical principle* will be dealt with in detail in the context of an applied ethics of discourse, both theoretically (§ 10) and in the practice of conversation (§ 17-25). Here, we will merely draw an interim balance under the overall aspect that although the two experts meet as equal dialogue partners "at eye level", the medical experts qua professional *(meta-)competence (*§ 3.3, 6.4) must assume a disproportionately higher responsibility for the course of the conversation and its consequences as a whole.

7.5.3.5 Conversation and responsibility

In order to pre-structure the further discussion on the (a)symmetry of doctor-patient communication, the aspect that the doctor and the patient act with different responsibilities should first be emphasised, namely the one is essentially (co-)responsible for the other, the other in self-responsibility.[17] In order to overcome the mutual lack of knowledge

[17] The special case that a patient cannot directly assume responsibility due to the nature and severity of his or her illness and that he or she or others therefore delegate a mandate to the doctor cannot in principle invalidate what is to apply as a rule (§ 10). The dialogical principle does not become

described above, a conversational attitude is necessary according to which both interlocutors encounter each other as *teachers* and *learners,* as Pellegrino and Thomasma (1981) described early on (Box 7.28), not without emphasising who has to shoulder the greater responsibility in the conversation.

Box 7.28 Both physician and patient 'teach' one another in dialogue

The clinical interaction is the locus of mutual responsibility of a patient and physician. In the clinical interaction there must be an interpenetration of minds as well as physical contact, because, as Kant showed, the human mind deals with experience in concepts. Both physician and patient 'teach' one another in dialogue. However, in the clinical interaction there is an imbalance of scientific knowledge which places the heavier burden of responsibility on the physician.

Pellegrino, Thomasma 1981: 65

Despite all the reciprocity of responsibility, doctors bear a greater responsibility, which is based not least on their professional *knowledge,* which guides their *communicative* competences (§ 3.3). As will be explained (§ 10, 22), they cannot and must not follow arbitrary *patient preferences due to the* professional commitment of their actions, but must take these into account within the framework of *evidence-based* medicine, which can contradict the individual concerns, wishes and hopes of their interlocutors, which in turn must be justified and justified *transparently* and *rationally in* the conversation, possibly also against patient objections that initially seem irrational, etc. This also includes "false" subjective theories of illness, which can stand in the way of a successful therapy. If the patient's "errors" are to be "invalidated" in the long run, the doctor must do the corresponding *work of persuasion* and *motivation* (§ 10, 26, 29), with which he appeals to the patient's rationality, which can be assumed in principle.

invalid as a principle of understanding between doctor and patient even if a patient should "deceive" the doctor out of his distress (e.g. as an addicted patient), which was already discussed above with Habermas as a possibly *covert-strategic* action. The "good" doctor does not take such *strategic* actions personally, but recognises these actions as belonging to the clinical picture (anorexia, alcoholism) and knows how to adjust to them qua profession by helping the patient to have an open conversation again.

7.5.3.6 Symmetry of rationality

Apart from exceptions possibly due to illness, doctors should *normally* meet their patients as *equally rational* conversation partners, who may close their minds to the "better" arguments for a short time, but not in principle. This symmetry of rationality must in principle be assumed by and for patients even if *rational* competence may be temporarily limited, for example because it is overlaid by *affective factors.*

To deny the currently shocked or *desperate* or merely *insecure patient* a rational decision-making competence would be tantamount to *incapacitating* him, which could only be legitimised in extreme cases (§ 10), but not for the *standard case* of doctor-patient communication.[18] According to this, patients are not only to be *instructed* according to the paternalism model or only to be *persuaded* according to the service model. Rather, *convincing* them of good arguments according to a cooperation model is the very first duty in medical action, provided it continues to claim to be *communicative* rather than *strategic* action (§ 7.3.4). Thus, the "phenomenon of the peculiarly unconstrained compulsion of the better argument" (Habermas 1981, vol.1: 52f.) should also come into play in doctor-patient communication,[19] which must, however, be largely freed from "other" constraints.

However, it is well known that the *better* argument in each case can remain controversial even among interlocutors striving for consensus, in which doctor-patient communication is not fundamentally different from the rest of the "living world" outside and inside institutions. In this respect, dissent between doctor and patient should not be frowned upon in principle (§ 10), which can also result in a *rational* decision to sever the relationship.

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18 While agreeing with Ritschl's (2004) criticism of an *exaggerated* "idealism" or "dialogism", we also want to contradict an *exaggerated* criticism according to which the patient's competence in dialogue would at the same time deny him his competence in rationality and decision-making, which he can only "prove" in a "real" conversation with the doctor. Ritschl's justification of a story concept also for medicine is discussed separately in the biographical narrative anamnesis (§ 9), which also shows the patient to be a competent dialogue partner.

19 What is at stake here is dialogical insightfulness in the face of the better argument. The fact that patients can continue to behave "unreasonably" is another matter, where doctors themselves can behave just as unreasonably (as patients) "against their better judgement" as their patients, for example by maintaining their nicotine or alcohol abuse.

Before this happens, the *professional competence of* the *meta-physician,* whose reflexivity was described in advance by von Uexküll, Wesiack (1991 and 2011) (§ 4.4, 6.4) and will be further elaborated (§ 13), should be applied in such a way that patients can be "kept in conversation" for as long as possible - precisely because they are often particularly in need of help and protection.

This difference essentially marks the asymmetry in the relationship, in which the doctor's professional *meta-competence* reflects the shaping of the conversation as the shaping of the relationship and corrects it if necessary. Here, the *art* of leading a doctor's conversation (§ 17) often proves to be a "tightrope act" of promoting patient autonomy without jeopardising (the trust in) the relationship. Here, reference should again be made to specific forms of *tangential* communication (§ 3, 17, 32), which are suitable for "bringing up what is necessary and possible" between both partners in order to be able to use the chances of improvement at all.

Not to "gamble away" these chances is certainly the main responsibility of the doctor, which is manifested by the fact alone that "mistakes" in the way doctors conduct conversations can lead to greater "damage". As already illustrated by the examples of Lown (2002) and to be further proven by empirical cases of conversation, the "wrong" use of the "power of the word", for example, can ultimately have a "devastating" effect that amounts to *iatrogenic* harm to the patient in the sense of "mistreatment". The principle of medical ethics of preventing harm (*primum nil nocere*) also applies to the conduct of medical conversations.

For example, in the case of a patient who would not discuss her anorexia of her own accord, the doctor's failure to ask the patient about her eating habits or even to suggest her habits as normal with a "wrong" form of question ("Your appetite is normal?") would amount to a serious omission in the sense of a "malpractice" (§ 17, 21). Such "cardinal errors" of conversation can have devastating consequences for patients' health. To put it pathetically in a nutshell: The recurrent failure of the doctor to make the "eating" or "drinking" habits of patients with a relevant addictive disease the subject of conversation, in whom denial tendencies are to be expected, can have fatal consequences under certain circumstances, if the failure to recognise the need for treatment is due to the conversational omissions.

In this asymmetry of overall responsibility lies precisely the *differentia specifica* in the participation of the doctor and the patient in the conversation. They differ in the responsibility for conducting the conversa-

tion, where faulty or merely deficient conversation processes are not to be blamed on the patient, but on the doctor. It is up to the doctor to adjust to the patient's personal strengths and weaknesses. While patients are allowed to make "mistakes" or should at least be able to allow themselves to do so, the doctor must act "as error-free as possible". Although there are difficult patients (§ 34), patients must first be "treated" as they are.

Accordingly, patients are to be "taken" by the doctor in conversation as *individually as* they are individually different, i.e. also with their personal concerns, idiosyncrasies, forms of defence, (self-) denial tendencies (§ 3, 19, 34). The fact that a patient continues to behave "suboptimally" after an "optimal" anamnesis and clarification discussion "against better knowledge" and thus harms his or her health is a different matter, which must be subordinated to the principle of an individual communication.

7.5.3.7 (A)Symmetrical interaction and relationship models

The extent to which the institutional asymmetry, which ten Have (Box 7.25) initially presupposed as a "social fact", is "acted out" (*enacted*) by the interlocutors as an interactional asymmetry in the reality of conversation is ultimately an empirical question. In his empirical analyses of conversations, ten Have (Box 7.29) already comes to the conclusion, based on selected example sequences, that conversational practice moves more or less on a continuum between two poles, between which the participants themselves negotiate their position from conversation step to conversation step (turn-by-turn).

Box 7.29 "Zigzagging" between two poles

I have suggested (...) that "asymmetry", often conceived of as given and constant feature of medical interaction, should instead be seen as an interactional stream produced by doctors and patients (...) Consultations are sometimes almost like conversations. At other times they resemble interrogation. But mostly they are somewhere in between, zigzagging between the two poles in a way that is negotiated on a turn-by-turn basis by the participants themselves.

ten Have 1991/2013: 163

Despite all the *institutional* asymmetries and restrictions that define and narrow the scope of action for both partners, there remains sufficient individual room for manoeuvre for their conversation, which they can conduct in the sense of a "real" conversation if they both intend and accept it as such from their respective expert perspectives. Acceptance can also extend to the specific knowledge asymmetry, as long as the respective knowledge advantage is productively "invested" in the interaction and relationship between the two dialogue partners and their joint purposes of action. In this respect, doctor-patient communication does not differ in principle from other forms of dealing with knowledge asymmetries.

These knowledge asymmetries can be used in institutional as well as extra-institutional communication both to the advantage and to the disadvantage of one or more participants. In comparing everyday and institutional as well as specific doctor-patient conversations, Drew (1991/2012) comes to the conclusion, similar to ten Have (1991/2013), that knowledge asymmetries do not have to lead to interaction asymmetries per se, but can certainly lead to interlocutors seeking to use their knowledge advantage for strategic purposes in order to exercise corresponding interaction control. However, according to Drew (Box 7.30), what is the case in each case cannot be decided in advance, but ultimately remains a question of empirical investigation.

Box 7.30	Knowledge asymmetry and interaction control

(...) Interaction control is a property of sequence management and speech shaping that may occasionally be enabled by the advantage a speaker has by virtue of knowledge asymmetries between participants. But this advantage does not guarantee interaction control. Control is not synonymous with knowledge asymmetry; rather, the connections between the two should be the subject of empirical investigation.

Drew 1991/2012: 177

Using the example of an everyday telephone conversation, Drew interprets the conversational behaviour of a young woman who initially leaves the called young man, to whom she does not reveal her name, in the dark as to which of his "girl friends" is calling him. Because the called person obviously cannot recognise the identity of the caller from the features accessible to him (e.g. the voice), the caller can play strate-

gically with the ignorance of her interlocutor for a while, which Drew sums up as follows after a detailed analysis:

Box 7.31 Knowledge and interaction symmetry
This example illustrates that the unequal distribution of knowledge between participants in a conversation can be used by the 'knowing' side as a strategic means to do something with it interactively, for example to pull the other person's leg. In this way, the 'unequal access' turns into an asymmetry of interaction.

Drew 1991/2012: 163

As this simple example clearly shows, 'pulling the other conversation partner's leg' might be a 'relationship game' that both partners are still able to integrate positively, as is often the case with 'innuendos' (irony, etc.), whereby a symmetrical relationship in itself doesn't necessarily have to be endangered (in the spirit of: 'Humor is when you laugh anyway'). Such a relatively "harmless" case, in which the "damage" to the "victim" is recognisably limited, must be distinguished from serious cases in which an asymmetry of knowledge can develop into an asymmetry of interaction in such a way that the relationship between the interlocutors as a whole takes on an asymmetrical quality which can be to the considerable disadvantage of one or more partners.

Thus, as is well known, a knowledge advantage can be directed as "ruling knowledge" against the ignorant person, who in his "cluelessness" does not even recognise the problem of his dependence on the knowledge of the "ruler". Accordingly, some patients will remain "clueless" if they have been insufficiently informed by doctors who may "keep quiet" with their information for various reasons. According to this, different relationship models differ primarily according to compliance with the *principle of transparency* in dealing with information:

- Since, according to the *paternalism* model, the attending doctor knows what is best for the patient anyway ("doctor knows best"), the patient can be "spared" from "superfluous" information if he or she only willingly follows the doctor's *instructions* (*orders*, *prescriptions*).
- Since, according to the *business model,* the doctor only educates about what he has at his disposal anyway, he will (have to) be content with *persuasion* instead of *convincing* the patient of the

rightness of a medical measure "by virtue of the better argument", which should include the exchange of all relevant information and arguments (pros and cons) on competing treatment options.

- In contrast, in the *partnership* or *cooperation model,* knowledge asymmetries are used to the advantage of both partners, who mutually exchange their knowledge relevant to the treatment case from the respective expert perspective (see above) in such a way that the interaction does not end as in a zero-sum game for both interlocutors (win-lose), but a win-win situation is created.

Since these relationship models and their variants will be described and discussed in detail later (§ 10), the focus will remain here only on the application of the *transparency principle*, which will be placed in a specific context with further sub-principles that must be applied in the dialogical principle as a whole (§ 7.5.4). While the degree of *transparency* and that means the type and scope of information are essentially determined by the doctor in both the paternalism and the business model, in the partnership model doctor and patient enter into a dialogue-based, open-ended exchange process also about the extent to which information is necessary, useful or even only desirable.

In this process, the scope of application of the transparency principle can be extended or restricted by both partners in the interaction as needed. As we will see with examples, their relationship qua *dialogical symmetry* can also be "negotiated" conversationally in such a way that patients can quite consciously and rationally determine the extent of their participation themselves by determining the desired amount of information or giving the doctor a decision-making mandate ("You decide for me, doctor") to a certain extent. However, gradual limits as well as categorical differences must be taken into account here:

The patient's right to information must not be violated, nor must the doctor's duty to provide information (e.g. before an operation) to a standardised extent (§ 39). Likewise, a fundamental difference must be made between *strong* and *weak* paternalism, which can correspond to solicited or unsolicited paternalism on the part of the patient (Kampits 1996: 15ff). In the context of discourse ethics, patient preferences must also be taken into account in the choice of paternalistic and non-paternalistic relationship models, such as those suggested by the *shared decision making* (SDM) model (Legare et al. 2018, Thomas et al. 2020, Elwyn G 2021, Scalia et al. 2022, Galasiński et al. 2023, Zhou et al. 2023, Giorgi et al. 2024 (§ 10, 22). In principle, relationship models can be *offered,* but not *imposed.* Accordingly, Kettner concludes from the perspective of discourse ethics: "Non-paternalism strategically im-

plemented for the purpose of promoting autonomy is itself paternalistic" (1998: 34). If medical action is not to become entangled in paradoxes, the *principle of transparency* (see below) must be followed, according to which the meaning and purpose of (alternative) models of relationships and participation must be disclosed in dialogue with the patient and the choice itself must be made a topic of communication without prejudice to the outcome.

7.5.4 The Dialogue Cube of Conversation

Previously, an attempt was made to concretise the *dialogue principle* within the framework of an applied discourse ethics for doctor-patient communication as well. Despite all the asymmetries of their institutional roles, doctor and patient should and can enter into a "real" conversation at least at central points where, for example, a medically important decision is to be made and for which they are responsible, in which the dialogical principle is applied for a period of time, however limited (due to time constraints, etc.), in such a way that one can speak of a *dialogical symmetry.* This was not understood as a "factual" symmetry of participation, according to which it would be quantitatively "measurable" that there would be equal ("half") shares in the conversation in every respect, but rather an equality of opportunity for every participant to perceive the topics considered relevant to them with the forms of dialogical understanding they consider relevant. Other forms of communication, such as intimidation through open threats or persuasion through subtle manipulation, should be excluded or at least frowned upon.

7.5.4.1 The six sides of the dialogue cube

Irrespective of the fact that failures of all kinds can occur in the practice of dialogue, which may be caused not least by individual inadequacies of the individuals up to the point of self-deception, the counterfactual validity of the *dialogical principle* had been concretised by the interactive recognition of a number of *sub-principles*, among which the *principle of transparency* is to be counted above all. What must be effective overall in a dialogue worthy of the name is to be represented in a dialogue cube (Fig. 7.8), the sides of which correspond to the following dimensions:

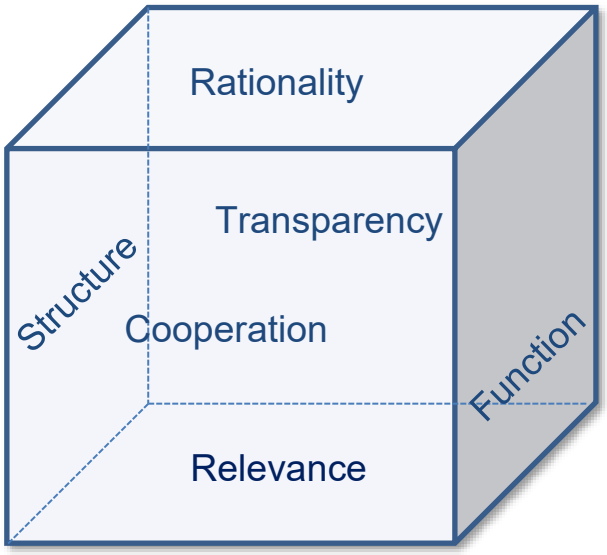

Fig. 7.8: Sub-principles as sides of the dialogue cube

The dialogue cube is to be specified here for doctor-patient communication, but it can also be transferred to teaching-learning conversations in schools or universities, as long as these are not understood as mere monological knowledge transfer ("teacher lecture"), but as dialogue in the *Socratic* sense. In this context, the specific *midwifery* handed down with Socrates should also interest us in the *art* of medical conversation (§ 9, 17-23). The concrete applications of the dialogue cube in medical conversation will first be outlined here in a rudimentary and thesis-like overview, before we elaborate on individual dialogue sub-principles (such as cooperation, transparency, relevance) both theoretically (§ 9, 10) and in the empirical practical part (§ 17-23).

7.5.5.2 Dialogical sub-principles

Here follows first the overview, which is intended to give a summary and at the same time contains references to later chapters of the handbook in which the dialogical sub-principles of the dialogue cube play a special role. The order in which the sub-principles are presented in no way implies a ranking of the sub-principles, which must be realised in interaction anyway in order for the dialogical *principle* as a whole to be fully effective:

1. Cooperation

This principle obliges both dialogue partners to cooperate in partnership for specific purposes, the relevance of which (see below) they negotiate together, review, correct, modify, etc. if necessary. They largely conduct a "genuine" conversation (in the sense of Martin Buber) (§ 7.5.1), which therefore cannot be "prearranged", but initially allows all possible developments to take place with an open mind. Precisely because the specific purposes of cooperation are still "unclear" or *must* remain "open" at the beginning of the conversation, patients often have and "show" their problems in applying the *principle of cooperation,* as was explained above with Paul Grice (§ 7.3.3) and will be illustrated with many examples (§ 9, 17-23). Insofar as it is still possible from a factual point of view, because, for example, medications can be changed (but operations can no longer be reversed), purposes of cooperation that have once been "ratified" can certainly also be revised. Decisions that have already been made can also be put up for discussion again (§ 10, 22, 26), for example if a medication has to be dosed differently or discontinued altogether because of too strong side effects, which can be the subject of dialogue between doctor and patient.

2. Rationality

Apart from exceptions, in which the patient's power of judgement may be limited due to illness (§ 10, 37, 38), both dialogue partners usually assume rationality from each other in the sense that they do not close their minds to the "casual compulsion of the better argument" (see above). In doing so, they throw their knowledge and their attitudes and experiences from the respective expert perspectives into the common balance (Fig. 7.6), in which *evidence-based* medicine is to be compared with the patient's *lifeworld* (§ 9, 10). Possible conflicts between the lifeworld and medicine are to be dealt with up to the point where a separation of the relationship makes sense, which can also be carried out for rational reasons, precisely because an understanding on the factual level seems hopeless.

3. Transparency

In doctor-patient communication, a *transparency principle* must be largely observed (§ 7.5.3) (§ 10.5). Here too, however, re-

strictions are reasonable and permissible, because all possible specific medical information could also overburden the patient, who must be protected from being overinformed (§ 10, 22, 27). However, a patient may assume that he or she will receive all information *relevant* to him or her. A distinction must be made between two forms of information: Patient questions must be answered appropriately in the sense of *responsive* transparency, but essential information must also be provided without being asked, i.e. in the sense of *proactive* (anticipatory) transparency. *Covert strategic* action in the above sense of Habermas (§ 7.3.4) should be frowned upon on the part of the doctor, but on the part of the patient it should be tolerated for the time being, if it is part of the clinical picture (in alcoholism, anorexia, etc.) as self-deception (denial, etc.), which the doctor would have to deal with professionally.

4. Relevance

It already became clear in the preceding sub-principles of dialogue that their application is also a question of relevance, which likewise must not be "pre-disposed", but must always be renegotiated between the dialogue partners, under certain circumstances from conversation step to conversation step (*turn-by-turn*). In their "subjective" patient offers, patients often "show" their uncertainty about the extent to which what they "offer" thematically is also of sufficient relevance ("I don't know now whether this is relevant, but I had Tbc as a child") (§ 19.4.1). Here it is above all part of the *art* of medical conversation (§ 9, 17) to counteract possible "self-censorship" on the part of patients and to encourage them through *relevance upgrading to* also address supposedly "unimportant" issues.

5. Function

Like all action, medical action is ultimately to be judged from a *teleological* point of view, even if initially no further purposes are to be pursued than the mere *understanding of* general purposes of action (of healing) (§ 8). When patients visit the consultation, this is usually already done with an unspoken understanding of "what it could or should be about". The general purpose of the consultation is that one partner seeks the *help* of the other. Below this main purpose, a number of sub-functions need to be perceived in the conversation, as they are handed down in the "classic" division of the conversation into *taking a medical histo-*

ry, *communicating a diagnosis* and *clarification,* and *decision-making,* and are usually "worked through" in this sequence (§ 8, 10, 17, 40). Insofar as traditional patterns of action and purposes are pursued here (§ 8), not everything can be freely chosen in doctor-patient communication either, but it should remain sufficiently open to be able to have a "genuine" conversation (§ 7.5.1) at the "relevant" switching points.

6. Structure

The sub-functions in the conversation (anamnesis, diagnosis, therapy) are usually realised in a logical-temporal precondition-consequence relationship, although this does not necessarily mean that a strict sequence of topics has to be "predisposed". As we will see from empirical examples, patients can sometimes "walk in the door" by immediately demanding a certain medical measure (examination, therapy) without first describing their complaints (§ 19- 22). In order to be able to uphold the *evidence-based* rules of medical art, a stronger structuring of the conversation is necessary in such cases, with which patients are also committed to the aspects of their patient-side expert role that concern their "duty to provide information" to the doctor. At the same time, the conduct of medical conversations always remains a balancing act between under- and over-structuring, as we will see in the application of our manual on the conduct of conversations in the practical part (esp. § 17-23) and in the evaluation (§ 40).

As has already been made clear, and is to be explained further with empirical examples, the effectiveness of the *dialogical principle* must be examined in the interplay of its *sub-principles.* In doing so, a contrast typological comparison can be made, which contrasts, for example, a strong, authoritarian paternalism with an extreme business model, in order to then also distinguish mixed forms between these two poles (§ 10). The model of "participatory *decision making*" (PDM) or "*shared decision making"* (SDM) is considered to be a possible middle position around which many variants can vary. Ideally, there is convergence among all possible aspects that can play a role between doctor and patient in shared decision making (*shared information, shared ideas, shared mind, etc.*). However, even according to this model, divergences can and may occur, which may relate to individual aspects on which compromises are possible.

Thus, the doctor can agree to a treatment option preferred by the patient, even if it should only be the "second best" solution from his medical expertise (e.g. *watchful waiting*) (§ 10). However, his consent can only be given on condition that the patient's preferences are within the framework of evidence-based medicine (§10). Maintaining the balance between preference-based and evidence-based medicine in a dialogue-based exchange can, however, also lead to failure, whereby the consensual severing of the relationship can remain an equally rational choice.

On the way to consensus or dissent, rational exchange should prevail, even if in individual cases the conversation should be "overlaid" or "thwarted" by the emotions of a (fearful, doubtful, suspicious) patient or the *persuasion attempts* (§ 21) of an (inattentive, impatient, stressed) doctor. However, as long as the demands of a "genuine" conversation (§ 7.5.1) are maintained in principle, certain forms of *strategic* action (trivialisations, appeasements, rebukes, threats, etc.) should remain frowned upon in the conduct of medical conversations (§ 7.3.4). For an empirical analysis and evaluation of conversations, it is important to go beyond singular phenomena and work out *tendencies* of *strategic* versus *communicative* action: For example, it is not the single or repeated spontaneous interruption of the doctor that silences the patient, but the cumulative effect of questions in the sense of an "interrogation" (§ 19.6) or the *monological* "instruction" (§ 10, 22, 26, 27), which can "nip in the bud" any "contradiction" by the patient.

7.5.5 Trust in dialogue

According to Habermas, one can rarely assume purely *communicative* action in practice, but rather mixed forms are likely, in which *strategic* use of language can also occur (§ 7.3.4). Under certain circumstances, this can hardly be avoided, especially under the *institutional* conditions of medical action, and must be tolerated within limits, as long as strategic action does not fundamentally obstruct a "genuine" conversation between doctor and patient where it is indispensable, such as in medical decision-making (§ 10), where questioning the patient's *rationality* and disregarding his or her *attitudes* (opinions, preferences, fears, hopes, etc.) motivated by the *world of life* would lead directly to his or her *incapacitation*.

7.5.5.1 The "dialogue" between lifeworld and medicine

Following Habermas, the conflict between the *lifeworld* of patients and *medicine* as a system has been modelled and empirically studied in many ways (e.g. Mishler 1984, Kettner 1991, Koerfer et al. 1994, Kettner 1998, Scambler 2001, Barry et al. 2001, Stevenson, Scambler 2005, Koerfer et al. 2005, 2008, Walseth, Schei 2011, Bezreh et al. 2012, Koerfer, Albus 2015, 2018) (§ 10, 22). In these studies, the model of *communicative* action as a way of overcoming the conflict of *lifeworld* and *medicine* provides a *normative* basis for the empirical analysis of the practice of medical conversation. All other actions, *covert* or *overt strategic,* can only increase the already smouldering permanent conflict between lifeworld and medicine, to which we will also return with reference to Habermas (§ 10.2).

The extent to which doctors enter into a "dialogue" with the patient's lifeworld in their medical conversation, i.e. ignore or integrate the patient's *individual* attitudes as well as *subjective* theories of illness, can only be clarified by empirical analyses, as can the question of whether their conversations as a whole are characterised more by an *understanding-oriented* use of language ("original mode") (§ 7.3.4) or *success-oriented* use of language. The fact that there will not be a strict dichotomy here in practice, but that *tendencies* are to be reconstructed, is also apparently expected by Habermas as a result of *empirical analyses* when he takes up the problem "of distinguishing and identifying understanding and success-oriented actions in natural situations" and refers to the necessity of sequence and phase analyses of conversations in which the identification of *strategic elements* is at stake:

Box 7.32 Strategic elements versus strategic actions

These *strategic elements within communication-oriented language use* can, however, be distinguished from *strategic actions* by the fact that the entire sequence of a section of speech is subject to presuppositions of communication-oriented language use on the part of all participants.

Habermas 1981, Vol. 1: 444 (emphasis in original)

Here, with the change in terminology, the research perspective has obviously also shifted from the analysis of *actions* to the analysis of *elements* of a *predominant language use* in a larger conversational context,

which, in Habermas' way of speaking, can be predominantly characterised by an "original mode" (§ 7.3.4) of understanding. However, since the case assumed by Habermas can also be thought of the other way round and elements of *understanding in* a *success-oriented* language use can be assumed, we are ultimately dealing with a gradual differentiation, which only justifies statements of dominance or tendency (Koerfer 1994/2013), as they are also made in empirical evaluation studies (§ 40-43).

As will be shown in empirical conversation analyses (§ 17-25), the way doctors conduct conversations is rarely extremely "good" or extremely "bad" overall. Although these negative as well as positive extreme cases can also be demonstrated, it is usually a mixture of conversation styles with which doctors move between purely communicative and strategic action, which dominate the conversation at times in one direction or the other.

The conflict between *lifeworld* and *medicine* can be intensified by *strategic* action or mitigated by *communicative* action (§ 9, 10). Thus, the patient's lifeworld can hardly be adequately opened up with a purely *interrogative* style of conversation, which can be increased to "inquisition" (§ 19), but with a *biographical-narrative* anamnesis, in which the patient, with his *narratives in* a lifeworld perspective, can "give voice in his own words" not only to his *subjective medical* history, but also to his *individual* attitudes (hopes, fears, preferences, etc.) with regard to his future life. Here the approach of a "narrative" medicine (Greenhalgh, Hurwitz 1998/2005, Charon 2001, 2013, Koerfer et al. 2000, 2010), which we will discuss in detail later (§ 9, 19), can take on a "bridging function" in the dialogue between *lifeworld* and *medicine*.

To prevent a possible misunderstanding: There is nothing to be said against so-called targeted *information questions* by doctors, as long as they are not asked in a *suggestive manner* (§ 21.2), for example to avoid objections from the patient and thereby supposedly gain time. Questions fulfil their purpose if they are well posed and appropriately placed. There is no violation of the *principle of transparency* if the doctor does not fully explain the medical *relevance* of each question. The fact that certain types of medical questions and topics *may* also remain more or less "unmediated" without this necessarily causing irritation or even mistrust among patients is related to their *basic trust* in the medical relationship, which is granted as a credit as long as this trust is not disappointed.

7.5.5.2 Basic trust in a dialogical medicine

In trust-building, all of our long-standing socialised knowledge is at work in the background as "*tacit knowledge*": Since the days of visiting the pediatrician as patients, we have all been socialised in such a way that we "know" in this (implicit) sense that doctors sometimes ask "strange" questions that seem to be "without sense or reason" according to our lifeworld perspective. For example, someone with back pain goes to the doctor and may wonder about questions about their sleeping, eating and drinking habits, or specifically about digestive problems or problems with urination, and so on. As patients, we generally tolerate such (symptom) (organ) (system) questions (§ 21, 22) and answer them *trusting* that the doctor would enlighten us further if they (should) become of "relevance" to us (depending on the answer).

Here, then, we trust in the *principle of transparency* under the condition that its validity becomes effective in connection with other dialogical sub-principles (of *cooperation*, *rationality*, *relevance*, etc.). This *basic trust* in the "good" doctor (§ 6) is based on the assumption of an *empathic assumption* of perspective, according to which the patient can "confidently" assume that the doctor usually does what is "good" for his patient not only in instrumental action (surgery, medication) but also conversationally.[20] As already explained above with the key competences of the "good" doctor (§ 6), *basic trust* in the doctor-patient relationship is an essential prerequisite for being able to make optimal use of the opportunities of a "real" conversation in a *dialogical* medicine. This will be the subject of the *empirical conversation analyses* of face to face interactions between doctor and patient in the practical parts of the handbook (IV-V).

A few preliminary remarks should be made on terminology, which can by no means be assumed to be uniform if an interdisciplinary approach to the study of D-P Communication is to be maintained.

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[20] For literature on the *good doctor*, see Chapter 6; on *trust in the doctor-patient relationship*, see Chapters 9, 10 and 22, and for examples, the following references: Charon 2001, Fugelli 2001, McKinstry et al. 2006, Hillen et al. 2011, Chawla, Arora 2013, Ozawa, Sripad 2013, Jiang et al. 2024.

7.6 Concluding remarks on terminology

Just as a "common language" can hardly be assumed at a certain stage of development of interdisciplinary communication research (§ 2), colleagues from different disciplines and traditions could not and should not be committed to a "common language" or uniform terminology in this handbook. In the absence of a standardised terminology in linguistics and communication studies, "colloquial" terms and paraphrases were mostly used or supplemented where this was possible and also made sense for didactic reasons.

If necessary, technical terms are explained in colloquial language. Thus, specific medical terms are also "translated" and replaced or supplemented by colloquial terms. Established terms such as adherence or *compliance*, which despite different meanings have mostly been translated as "adherence to therapy", are used according to context or citation. Similarly, established terms such as *shared decision making* (SDM) are retained or *Participative Decision Making* (PDM) is used.

From the perspective of communication studies, we will mostly be talking about communicative *actions* or *speech acts* and their *communicative functions* or *roles* in (specific) contexts, for example, when the "illocutionary" aspect of an utterance is to be highlighted (§ 7.3.1). Clear cases would be *assertions, requests, promises, suggestions, recommendations,* etc. If necessary, we speak of "propositional content", which can occur "visibly" as the *content* of assertions or questions (e.g. "I still have to ask you whether you are taking any more medication/ how your appetite is" etc.). The contents can also remain implicit, as in the case of simple answers ("no"), so that they have to be formulated explicitly if necessary with reference back (for example to a question).

Strategic action is particularly relevant when certain far-reaching (more or less negative) ("perlocutive") effects are (more or less obviously) pursued or achieved (§ 7.3.1). This includes intentional or accepted *offenses*, *injuries*, *intimidation*, etc. However, a distinction must be made between certain "uncertainties", which in medical-therapeutic communication serve their "healing" purpose, as long as the "disturbance" does not amount to "destruction" (§ 17.3.5). Similarly, in the case of *surprises,* one must differentiate according to whether they are found to be positive or negative from the speaker's and listener's perspective, just as we also judge in everyday life that someone could be "happy about the surprise" (or not).

Instrumental action should be referred to (§ 8) when it is a matter of medical action such as examinations, operations, but also medication, whereby the associated prescription talk (§ 26) would in turn be *communicative* action.

From *conversation analysis* (CA), traditional terms for the organisation of the *change of speaker* are occasionally adopted (*turn*, *turn-taking-system,* etc.). Sometimes, with reference to the literature, we speak of specific "fluent" continuations of speech when the primary speaker can continue with short "listener contributions" as if he had not been interrupted ("as if uninterrupted" according to Duncan 1974, Flader, Koerfer 1983) (§ 19, 17, 40). This type of continuation of speech is then occasionally abbreviated (as "AIU"). Otherwise, abbreviations are explained in the current text where possible or explained in relation to our *Cologne Manual of Medical Communication* (C-MMC) (see e.g. end of chapters 3 and 17).

7.7 Further information and references

We have tried to introduce various theories and models of dialogue-based communication that can be used for *dialogue-centered medicine*. A number of other aspects of dialogue-centered medicine are addressed in subsequent chapters of this handbook, such as specific theoretical chapters on *biographical narrative anamnesis* (§ 9) and on *dialogue-based information and decision-making* (§ 10), which are further elaborated with empirical examples in the practical part (§ 17-23).

Special problems of securing understanding and communication through dialogue are dealt with in specific areas of competence in medical practice, such as the *GP consultation* (§ 25), the clinical ward round (§ 24), the *prescription talk* (§ 26) as well as *professional communication* (§ 27) and *intercultural communication* (§ 28). In the other chapters of the practical part, too, specific *communication theo*ry, *communication psychology* and *discourse* or *conversation analysis* models and approaches are used for the empirical analysis, as presented above.

If you are looking for further specialist literature beyond our descriptions, we would like to refer you to the following (mostly recent) introductions, handbooks, compilations and overviews, each of which has been selected according to specific subject areas and topics: *Semiotics* (Nöth 2000), *Philosophy of Language* (Savigny 1974, Stegmüller 1975,

Newen, v. Savigny 1996), *Philosophy of Dialogue* and *Discourse Ethics* (Kettner 1991, 1998, Kettner, Kraska 2009, Koerfer et al. 1994, 2005, 2008, Scambler (ed.) 2001, Koerfer, Albus 2015, Chin-Yee et al. 2019. Hoppen 2020, Walker, Lovat 2022, Duvenhage 2024), *Conversation Analysis (and Psychotherapy)* (Deppermann 2008, Peräkylä et al. (eds.) 2008, Brinker, Sager 2010, Sidnell, Stivers (eds.) 2013, Buchholz, Kächele 2017, Barnes 2019, Birkner, Auer, Bauer, Kotthoff 2020, Scarvaglieri et al. (eds.) 2022), *Speech Act Theory* and *Linguistic Pragmatics* (Levinson 2000, Meibauer 1999, Ehrhardt, Heringer 2011, Finkbeiner 2015), *Discourse Analysis* (Gee, Handford (eds.) 2014). Recent literature on the *Philosophy of Dialogue* (Buber, Gadamer, etc.) is cited as an example: Chin-Yee et al. 2019, Hubert 2022.

Extensive literature on interdisciplinary conversation research has been listed in an overview with specific topics (§ 2), further literature on the concept of "communicative competence" has been given in the didactic conception of the *Learning Goal Communication Competence* (§ 3), for which supplementary literature references can be found in the chapter on *The Art of Medical Communication* (§ 17).

Problems of mediation between *lifeworld* and *medicine* as well as *risks of manipulation* are taken up again in the chapter 10 on *medical decision-making*. For the practice of dialogical doctor-patient communication, reference is made to relevant chapters on the *Cologne Manual of Medical Communication* (C-MMC) (§ 18-23) and on *Ward Round Communication* (§ 24) and *GP Communication* (§ 25).

References

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

Adler RH et al. (Eds.) (1997): Psychosomatic Medicine. München, Wien, Baltimore: Urban & Schwarzenberg, 11-42.

Andersen H (1997): Conversation, Language, and Possibilities. A Postmodern Approach to Therapy. New York. Basic Books.

Anderson H (1997/1999): Das therapeutische Gespräch. Der gleichberechtigte Dialog als Perspektive der Veränderung. Stuttgart: Klett-Cotta. (1997: Conversation, Language, and Possibilities. New York: Basic Books

Apel KO (1990): Ist Intentionalität fundamentaler als sprachliche Bedeutung? Transzendentalpragmatische Argumente gegen die Rückkehr zum semantischen Intentionalismus der Bewußtseinsphilosophie. In: Forum für Philosophie Bad Homburg (Hg.): Intentionalität und Verstehen. Frankfurt/M: Suhrkamp, 13-54.

Austin J (1972): Zur Theorie der Sprechakte. Stuttgart: Reclam (1962: How to Do Things with Words. Oxford: Oxford University Press.

Balint M (1964/1988): Der Arzt, sein Patient und die Krankheit. 7. Aufl. Stuttgart: Klett-Cotta (1964: The Doctor, his Patient and the Illness. London: Pitman Medical Publishing Co.).

Barbour A (1995/2013): The limitations of the medical model. In: In: Beach WA (ed.) (2013): Handbook of patient-provider interactions: Raising and responding to concerns about life, illness, and disease. New York: Hampton Press, 119-29.

Barnes RK (2019): Conversation analysis of communication in medical care: description and beyond. Research on Language and Social Interaction, 52(3), 300-315.

Barry CA, Stevenson FA, Britten N, Barber N, Bradley CP (2001): Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. Social Science and Medicine 53 (4), 487-505.

Beach MC, Inui T, Relationship-Centered Care Research Network (2006): Relationship-centered care. A constructive reframing. Journal of General Internal Medicine 21 (Suppl 1), S3-8.

Beach WA (ed.) (2013): Handbook of Patient-Provider Interactions: Raising and Responding to Concerns about Life, Illness, and Disease. New York: Hampton Press.

Beach WA, Dixson CN (2001/2013): Revealing moments: Formulating understandings of adverse experiences in a health appraisal interview. In: Beach WA (ed.) (2013): Handbook of Patient-Provider Interactions: Raising and Responding to Concerns about Life, Illness, and Disease. New York: Hampton Press, 433-51.

Beach WA, Mandelbaum J (2005/2013): "My Mom had a stroke": Understanding how patients raise and providers respond to psychosocial concerns. In: Beach WA (ed.) (2013): Handbook of Patient-Provider Interactions: Raising and Responding to Concerns about Life, Illness, and Disease. New York: Hampton Press, 405-20.

Bertram W (2013): Integrierte Medizin: Heilkunst für Körper mit Seelen – und Seelen mit Körpern. In: Hontschik B, Bertram W, Geigges W: Auf der Suche nach der verlorenen Kunst des Heilens. Stuttgart: Schattauer, 3-17.

Bezreh T, Laws MB, Taubin T, Rifkin DE, Wilson IB (2012): Challenges to physician-patient communication about medication use: a window into the skeptical patient's world. Patient Preferance and Adherence 6, 11-8.

Birkner K, Auer P, Bauer A, Kotthoff H (2020): Einführung in die Konversationsanalyse. Berlin, Boston: Walter de Gruyter.

Bissell P, May CR, Noyce PR (2004): From compliance to concordance: Barriers to accomplishing a re-framed model of health care interactions. Social Science & Medicine 58 (4), 851-62.

Brinker K, Sager SF (2010): Linguistische Gesprächsanalyse. 5. Aufl. Berlin: ESV.

Brock A, Meer D (2004): Macht-Hierarchie-Dominanz-A-/Symmetrie: Begriffliche Überlegungen zur kommunikativen Ungleichheit in institutionellen Gesprächen. Gesprächsforschung – Online-Zeitschrift zur verbalen Interaktion 5, 184-209.

Brody H (1994): „My story is broken; can you help me fix it?“ Medical ethics and the joint construction of narrative. Literature and Medicine 13 (1), 81-92.

Brünner G (2005): Arzt-Patient-Kommunikation als Experten-Laien-Kommunikation. In: Neises M, Ditz S, Spranz-Fogasy T (Hg.): Psychosomatische Gesprächsführung in der Frauenheilkunde. Stuttgart: Wissenschaftliche Verlagsgesellschaft, 90-109.

Buber M (1954/1986): Das dialogische Prinzip. Gütersloh: Gütersloher Verlagshaus (Orig. 1954). (1981: I and thou: The dialogic principle. New York, NY: Dutton).

Buchholz MB, Kächele H (2017): From turn-by-turn to larger chunks of talk: An exploratory study in psychotherapeutic micro-processes using conversation analysis. Research in Psychotherapy: Psychopathology, Process, and Outcome, 20(3), 161-178.

Bühler K (1934/1982): Sprachtheorie. Die Darstellungsfunktion der Sprache. Stuttgart: Fischer (UTB).

Bührig K, Meyer B (2007): Unterschriften und ihre diskursive Vorgeschichte: wie Patienten in die Durchführung medizinischer Methoden einwilligen. In: Redder A (Hg.): Diskurse und Texte. Tübingen: Stauffenburg, 641-50.

Bußmann (1983): Lexikon der Sprachwissenschaft. Stuttgart: Kröner.

Byrne PS, Long BE (1976): Doctors talking to patients: A study of the verbal behavior of general practitioners consulting in their surgeries. London: Her Majesty’s Stationary Office.

Charon R (2001): Narrative Medicine: A model for empathy, reflection, profession, and trust. Journal of the American Medical Association 286, 1897-902.

Charon R (2006): Narrative Medicine. Oxford: University Press.

Charon R (2013): Narrative medicine: Caring for the sick is a work of art. Journal of the American Academy of Physician Assistants 26 (12), 8.

Chawla N, Arora NK (2013): Why do some patients prefer to leave decisions up to the doctor: lack of self-efficacy or a matter of trust? Journal of Cancer Survivalship 7 (4), 592-601.

Chin-Yee B, Messinger A, Young LT (2019): Three visions of doctoring: a Gadamerian dialogue. Advances in Health Sciences Education, 24, 403-412.

Collins DL, Street RL Jr. (2009): A dialogic model of conversations about risk: coordinating perceptions and achieving quality decisions in cancer care. Social Science & Medicine 68 (8), 1506-12.

Deppermann A (2008): Gespräche analyiseren. Wiesbaden: Verlag für Sozialwissenschaften.

Drew P (2012): Wissensasymmetrien in (alltags) sprachlichen Interaktionen. Ayaß R, Meyer C (Hg.): Sozialität in Slow Motion. Theoretische und empirische Perspektiven. Wiesbaden: Springer VS, 151-80.

Duncan S Jr (1974): On the structure of speaker-auditor interaction during speaking turns. Language and Society 3 (2), 161-80.

Duvenhage PN (2024): Reflections on Habermas's discourse ethics. Verbum et Ecclesia, 45(1), 3009.

Eccles JC (1994): Wie das Gehirn sein Selbst steuert. München: Piper. (1994: How the Self controls Its Brain. Berlin: Sprnger.

Ehlich K (1979): Formen und Funktionen von HM - eine phonologisch-pragmatische Analyse. In: Weydt H (Hg.): Die Partikeln der deutschen Sprache. Berlin: de Gruyter, 503-17.

Ehlich K (2020): Linguistische Analyse und institutionelle Resilienz. In: Gruber H, Spitzmüller J, de Cilla R (Hg.): Institutionelle und organisationale Kommunikation: Theorie, Methodologie, Empirie und Kritik. Gedenkschrift für Florian Menz. Göttingen: Vandenhoeck & Ruprecht, 25-38.

Ehlich K (2022): Sprachliches Handeln und institutionelle Analysen–wieso eigentlich? In: Hohenstein C, Hornung A (Hg.): Sprache und Sprachen in Institutionen und mehrsprachigen Gesellschaften. Münster, New York: Waxmann, 21-40.

Ehlich K, Rehbein J (1986): Muster und Institution: Untersuchungen zur schulischen Kommunikation. Tübingen: Narr.

Ehrhardt C, Heringer HJ (2011): Pragmatik. Paderborn: Fink (UTB).

Elwyn G (2021): Shared decision making: What is the work? Patient Educ Couns 104: 1591–5.

Elwyn G, Edwards A, Kinnersley P (1999): Shared decision-making in primary care: The neglected second half of the consultation. British Journal of General Practice 49 (443), 477-82.

Engel GL (1977): The need for a new medical model: a challenge for biomedicine. Science, 196(4286), 129-136.

Engel GL (1981): The clinical application of the biopsychosocial model. In The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine, 6(2), 101-124. Oxford University Press.

Engel GL (1988): How much longer must medicine's science be bound by a seventeenth century world view?. In: White KL (1988): The task of medicine: dialogue at Wickenburg. Henry J. Kaiser Family Foundation, 113-136.

Engel GL (1997): From biomedical to biopsychosocial. Being Scientific in the Human Domain. Psychosomatics 38 (6), 521-8.

Epstein RM (2013): Whole mind and shared mind in clinical decision-making. Patient Education and Counseling 90 (2), 200-6.

Fehlenberg D (1987): Kommunikation zwischen Arzt und Patient. Bochum: Brockmeyer.

Feldthusen C, Forsgren E, Wallström S, Andersson V, Löfqvist N, Sawatzky R, et al. (2022): Centredness in health care: a systematic overview of reviews. Health Expectations, 25(3), 885-901.

Finkbeiner R (2015): Einführung in die Pragmatik. Darmstadt. Wissenschaftliche Buchgesellschaft.

Flader D, Koerfer A (1983): Die diskurslinguistische Erforschung von Therapiegesprächen. In: Osnabrücker Beiträge zur Sprachtheorie 24, 57-90.

Freud S (1912/1970): Ratschläge für den Arzt bei der psychoanalytischen Behandlung. In: Freud S (1970): Studienausgabe. Ergänzungsband. Frankfurt/M: Fischer, 169-80. [Recommendations to Physicians Practising Psycho-Analysis. The Standard Edition of the Complete Psychological Works of Sigmund Freud 12: 109-120]

Freud S (1913/1970): Zur Einleitung der Behandlung. Weitere Ratschläge zur Technik der Psychoanalyse. In: Freud S (1970): Studienausgabe. Ergänzungsband. Frankfurt/M: Fischer, 181-203. [On beginning the treatment. In J. Strachey (Ed.) (1966), The standard edition of the complete psychological works of Sigmund Freud. London: Hogarth Press.

Fugelli P (2001): James Mackenzie Lecture. Trust – in general practice. British Journal of General Practice 51 (468), 575-9.

Gadamer HG (1993): Über die Verborgenheit der Gesundheit. Aufsätze und Vorträge. Frankfurt/M: Suhrkamp.

Galasiński D, Ziółkowska J, Elwyn G (2023): Epistemic justice is the basis of shared decision making. Patient Education and Counseling, 111, 107681.

Galvagni L (2022): Clinical Narratives: Stories and Ethics in Healthcare. In Pegoraro R (Eds.): Introduction to Medical Humanities: Medicine and the Italian Artistic Heritage, 91-106, Cham: Springer International Publishing.

Gee JP, Handford M (eds.) (2014): The Routledge handbook of discourse analysis. New York: Routledge.

Giorgi F, Fanali A, Tramonti F (2024): A critical evaluation of choice negotiation for patient-centred medicine and psychotherapy. Journal of Evaluation in Clinical Practice.

Girgensohn-Marchand B (1994): Der Mythos Watzlawick und die Folgen. 2. Aufl. Weinheim: Deutscher Studien Verlag.

Goyal R (2013): Narration in Medicine. In: Hühn P, Meister JP, Pier J, Schmid W (eds.): The Living Handbook of Narratology. Hamburg: Hamburg University Press (abgerufen am 21.08.2015).

Greenhalgh T, Hurwitz B (Hg.) (1998/2005): Narrative-based Medicine – Sprechende Medizin. Bern, etc.: Huber (Orig. 1998).

Grice HP (1975): Logic and Conversation. In: Cole P, Morgan JL (eds.): Syntax and Semantics, Vol. 3. Speech Acts. New York: Academic Press, 41-58. (Logik und Konversation. In: Meggle G (Hg.) (1979): Handlung, Kommunikation, Bedeutung. Frankfurt/M: Suhrkamp, 243-265).

Groß A (2015): Asymmetrie und (Patienten-)Expertise in der HIV-Sprechstunde. In: Busch A, Spranz-Fogasy T (Hg.): Handbuch „Sprache und Medizin“. Berlin, etc.: de Gruyter, 282-99.

Grover S, Fitzpatrick A, Azim FT, Ariza-Vega P, Bellwood P, Burns J, et al. (2022): Defining and implementing patient-centered care: an umbrella review. Patient education and counseling, 105(7), 1679-1688.

Habermas J (1971): Vorbereitende Bemerkungen zu einer Theorie der kommunikativen Kompetenz. In: Habermas J, Luhmann N (1971): Theorie der Gesellschaft oder Sozialtechnologie. Frankfurt/M: Suhrkamp, 101-41.

Habermas J (1976): Was heißt Universalpragmatik? In: Apel K-O (Hg.) Sprachpragmatik und Philosophie. Frankfurt/M: Suhrkamp, 174-272.

Habermas J (1981): Theorie des kommunikativen Handelns. 2 Bde. Frankfurt/M: Suhrkamp.

Habermas J (1985): The theory of communicative action: Volume 1: Reason and the rationalization of society. Beacon press.

Habermas J (1985): The theory of communicative action: Volume 2: Lifeworld and system: A critique of functionalist reason. Beacon press.

Habermas J (1986) Entgegnung. In: Honneth A, Joas H (Hg.) (1986): Kommunikatives Handeln. Frankfurt/M: Suhrkamp, 327-405.

Habermas J (1988): Nachmetaphysisches Denken. Frankfurt/M: Suhrkamp.

Hartung M (2002): Ironie in der Alltagssprache. Eine gesprächsanalytische Untersuchung. Radolfzell: Verlag für Gesprächsforschung.

Have P ten (1991/2013): Talk and institution: A reconsideration of the asymmetry of doctor-patient interaction. In: Beach WA (ed.) (2013). Handbook of patient-provider interactions: Raising and responding to concerns about life, illness, and disease. New York: Hampton Press, 149-165.

Herzka HS (1990): The dialogics of a doctor-patient relationship. In: Raffler-Engel W v (ed.): Doctor-Patient Interaction. Philadelphia: Benjamins, 159-80.

Hillen MA, de Haes HC, Smets EM (2011): Cancer patients' trust in their physician – a review. Psychooncology 20 (3), 227-41.

Hoffmann L (1983): Kommunikation vor Gericht. Tübingen: Narr.

Hoffmann SO, Hochapfel G (1999): Neurosenlehre, Psychosomatische und Psychotherapeutische Medizin. 6. Aufl. Stuttgart: Schattauer.

Honneth A, Joas H (Hg.) (1986): Kommunikatives Handeln. Frankfurt/M: Suhrkamp.

Hoppen T (2020): Diskursethik fördert gute Behandlungs-und Ergebnisqualität. Pädiatrie, *32*, 26-30.

Hörmann, H (1978). Meinen und Verstehen. Grundzüge einer psychologischen Semantik. Frankfurt/M: Suhrkamp.

Hubert CC (2022): Dialogkultur: Dialog sein-Dialog führen-dialogische Beziehungen. Wiesbaden: Springer VS.

Ishikawa H, Hashimoto H, Kiuchi T (2013): The evolving concept of "patient-centeredness" in patient-physician communication research. Social Science & Medicine 96, 147-53.

Jiang S, Wu Z, Zhang X, Ji Y, Xu J, Liu P, ... Chen J (2024): How does patient-centered communication influence patient trust?: The roles of patient participation and patient preference. Patient Education and Counseling, 122, 108161.

Kächele H, Albani C, Buchheim A, Grünzig H-J, Hölzer M, Hohage R, Jimenez JP, Leuzinger-Bohleber M, Mergenthaler E, Neudert-Dreyer L, Pokorny D, Thomä H (2006): Psychoanalytische Einzelfallforschung: Ein deutscher Musterfall Amalie X. Psyche 60 (5), 387-425.

Kächele H, Albani C, Buchheim A, Hölzer M, Hohage R, Mergenthaler E, Jiménez JP, Leuzinger-Bohleber M, Neudert-Dreyer L, Pokorny D, Thomä H (2006): The German specimen case, Amalia X: empirical studies. International Journal of Psychoanalysis 87 (Pt 3): 809-26.

Kampits P (1996): Das dialogische Prinzip in der Arzt-Patienten-Beziehung. Passau: Wissenschaftsverlag Rothe.

Keller R (1995): Zeichentheorie. Stuttgart: Francke (UTB).

Kenny DA, Veldhuijzen W, Weijden Tv, Leblanc A, Lockyer J, Légaré F, Campbell C (2010): Interpersonal perception in the context of doctor-patient relationships: a dyadic analysis of doctor-patient communication. Social Science & Medicine 70 (5), 763-8.

Kettner M (1991): Diskursethik in der Medzin. Ärzteblatt Baden-Würtemberg 10, Sonderbeilage 41, 3.

Kettner M (1998): Beratung als Zwang. Die Beiträge im Kontext. In: Kettner M (Hg.): Beratung als Zwang. Frankfurt/M, etc.: Campus, 9-44.

Kettner M, Kraska M (2009): Kompensation von Arzt-Patient-Asymmetrien im Rahmen einer Theorie des kommunikativen Handelns. In: Vollmann J, Schildmann J (Hg.): Klinische Ethik. Frankfurt/M, etc.: Campus, 243-59.

Kim EJ, Koo YR, Nam IC (2024): Patients and Healthcare Providers' Perspectives on Patient Experience Factors and a Model of Patient-Centered Care Communication: A Systematic Review. In Healthcare (Vol. 12, No. 11, p. 1090). MDPI.

Koerfer A (1979): Zur konversationellen Funktion von ‚ja aber'. In: Weydt H (Hg.): Die Partikeln der deutschen Sprache. Berlin, etc.: De Gruyter, 14-29.

Koerfer A (1994/2013): Institutionelle Kommunikation. Zur Methodologie und Empirie der Handlungsanalyse. Opladen: Westdeutscher Verlag. Online 2013: Mannheim: Verlag für Gesprächsforschung.

Koerfer A, Albus C (2015): Der Entscheidungsdialog zwischen Arzt und Patient. In: Spranz-Fogasy T, Busch A (Hg.): Handbuch „Sprache und Medizin". Berlin, etc.: de Gruyter, 116-34.

Koerfer A, Albus C (Hg.) (2018): Kommunikative Kompetenz in der Medizin. Göttingen: Verlag für Gesprächsforschung.

Koerfer A, Albus C, Obliers R, Thomas W, Köhle K (2008): Kommunikationsmuster der medizinischen Entscheidungsfindung. In: Niemeier S, Diekmannshenke H (Hg.): Profession und Kommunikation. Bern: Lang, 121-56.

Koerfer A, Köhle K (2007): Kooperatives Erzählen. Zur Konstruktion von Patientengeschichten in der ärztlichen Sprechstunde. In: Redder A (Hg.): Diskurse und Texte. Tübingen: Stauffenburg, 629-39.

Koerfer A, Köhle K, Obliers R (1994): Zur Evaluation von Arzt-Patient-Kommunikation. Perspektiven einer angewandten Diskursethik in der Medizin. In: Redder A, Wiese I. (Hg.): Medizinische Kommunikation. Opladen: Westdeutscher Verlag, 53-94.

Koerfer A, Köhle K, Obliers R (2000): Narrative in der Arzt-Patient-Kommunikation. Psychotherapie und Sozialwissenschaft 2 (2), 87-116.

Koerfer A, Köhle K, Obliers R, Sonntag B, Thomas W, Albus C (2008): Training und Prüfung kommunikativer Kompetenz. Aus- und Fortbildungskonzepte zur ärztlichen Gesprächsführung. Gesprächsforschung - Online-Zeitschrift zur verbalen Interaktion 9, 34-78.

Koerfer A, Köhle K, Obliers R, Thomas W, Albus C (2010): Narrative Wissensgenerierung in einer biopsychosozialen Medizin. In: Dausendschön-Gay U, Domke C, Ohlhus S (Hg.): Wissen in (Inter-)Aktion. Berlin, etc.: de Gruyter, 91-131.

Koerfer A, Neumann C (1982): Alltagsdiskurs und psychoanalytischer Diskurs. Aspekte der Sozialisierung der Patienten in einen 'ungewöhnlichen' Diskurstyp. In: Flader D, Grodzicki WD, Schröter K (Hg.): Psychoanalyse als Gespräch. Interaktionsanalytische Untersuchungen über Therapie und Supervision. Frankfurt/M: Suhrkamp, 96-137.

Koerfer A, Neumann C (1982): Alltagsdiskurs und psychoanalytischer Diskurs. Aspekte der Sozialisierung der Patienten in einen 'ungewöhnlichen' Diskurstyp. In: Flader D, Grodzicki WD, Schröter K (Hg.): Psychoanalyse als Gespräch. Interaktionsanalytische Untersuchungen über Therapie und Supervision. Frankfurt/M: Suhrkamp, 96-137.

Koerfer A, Obliers R, Köhle K (2005): Das Visitengespräch. Chancen einer dialogischen Medizin. In: Neises M, Ditz S, Spranz-Fogasy T (Hg.): Psychosomatische Gesprächsführung in der Frauenheilkunde. Stuttgart: Wissenschaftliche Verlagsgesellschaft, 256-84.

Koerfer A, Obliers R, Köhle K (2005): Der Entscheidungsdialog zwischen Arzt und Patient. Modelle der Beziehungsgestaltung in der Medizin. In: Neises M, Ditz S, Spranz-Fogasy T (Hg.): Psychosomatische Gesprächsführung in der Frauenheilkunde. Stuttgart: Wissenschaftliche Verlagsgesellschaft, 137-57.

Koerfer A, Obliers R, Kretschmer B, Köhle K (2010): Vom Symptom zum Narrativ – Diskursanalyse der interaktiven Konstruktion einer Patientengeschichte. Balint-Journal 11 (4), 107-11.

Koerfer A, Zeck J (1983): Themen- und personenorientierte Interaktion in der Hochschule. In: Ehlich K, Rehbein J (Hg.): Kommunikation in Schule und Hochschule. Linguistische und ethnomethodologische Untersuchungen. Tübingen: Narr, 441-71.

Köhle K, Koerfer A (2017): Das Narrativ. In: Köhle K, Herzog W, Joraschky P, Kruse J, Langewitz W, Söllner W (Hg.): Uexküll: Psychosomatische Medizin. 8. Aufl. München, etc.: Elsevier, 325-40.

Kriksciuniene D, Sakalauskas V (eds) (2022): Intelligent Systems for Sustainable Person-Centered Healthcare (p. 250). Springer Nature.

Kuhn TS (1973): Die Struktur wissenschaftlicher Revolutionen. Frankfurt/M: Suhrkamp.

Lakoff RT (1980): Psychoanalytic discourse and ordinary conversation. Berkeley: Mimeo.

Lang H (2000): Das Gespräch als Therapie. Frankfurt/M: Suhrkamp.

Langenbach M, Koerfer A (2006): Körper, Leib und Leben: wissenschaftliche und praktische Traditionen im ärztlichen Blick auf den Patienten. Zeitschrift für qualitative Bildungs-, Beratungs-und Sozialforschung, 7 (2), 191-216.

Langer I, Schulz v Thun FS, Tausch R (1990/2000): Sich verständlich ausdrücken. München: Reinhard.

Langewitz, WA (2023): Patientenzentrierte Kommunikation. In: *Swiss Medical Forum* (Vol. 23, No. 6, pp. 888-892).

Legare F et al. (2018): Interventions for increasing the use of shared decision making by healthcare professionals. Cochrane Database of Systematic Reviews 7.

Levenstein JH, Brown JB, Weston WW, Stewart M, McCracken EC, McWhinney I (1989): Patient-centered clinical interviewing. In: Stewart ME, Roter DE (eds.): Communicating with medical patients. London: Sage Publications, 107-20.

Levinson SC (2000): Pragmatik. 3. Aufl. Tübingen: Niemeyer. (1983: Pragmatics. Cambridge: Cambridge University Press).

Lown B (2002): Die verlorene Kunst des Heilens. Anleitung zum Umdenken. Stuttgart, etc.: Schattauer.

Lüth P (1986): Von der stummen zur sprechenden Medizin. Frankfurt/M, New York: Campus.

Maynard DW (1991): Interaction and asymmetry in clinical discourse. American Journal of Sociology 97 (2), 448-95.

McKinstry B, Ashcroft RE, Car J, Freeman GK, Sheikh A (2006): Interventions for improving patients' trust in doctors and groups of doctors. Cochrane Database of Systematic Reviews 3, CD004134.

Mead N, Bower P (2000): Patient-centredness: a conceptual framework and review of the empirical literature. Social science & medicine, 51(7), 1087-1110.

Meer D (2011): Kommunikation im Alltag – Kommunikation in Institutionen: Überlegungen zur Ausdifferenzierung einer Opposition. Birkner K, Meer D (Hg.): Institutionalisierter Alltag: Mündlichkeit und Schriftlichkeit in

unterschiedlichen Praxisfeldern. Mannheim: Verlag für Gesprächsforschung, 28-50.

Meibauer J (1999): Pragmatik. Eine Einführung. Tübingen: Stauffenburg.

Mezzich JE, Appleyard WJ, Glare P, Snaedal J, Wilson CR (2023): Introduction to person centered medicine. In: Mezzich et al. (eds.): Person centered medicine (pp. 1-26). Cham: Springer International Publishing.

Mezzich et al. (eds.): Person centered medicine (pp. 1-26). Cham: Springer International Publishing.

Miller WL, Crabtree BF, Nutting PA, Stange KC, Jaén CR (2010): Primary care practice development: a relationship-centered approach. Annals of Family Medicine 8 (Suppl 1), S68-79; S92.

Milota MM, van Thiel GJ, van Delden JJ (2019): Narrative medicine as a medical education tool: a systematic review. Medical teacher, 41(7), 802-810.

Mishler EG (1984): The Discourse of Medicine. Dialectics of Medical Interviews. Norwood, New Jersey: Ablex.

Mishler EG (2005): Patient stories, narratives of resistance and the ethics of humane care: A la recherche du temps perdu. Health 9 (4), 431-51.

Newen A, Savigny E v (1996): Einführung in die analytische Philosophie. Stuttgart: UTB.

NKLM (2015/2021): Nationaler Kompetenzbasierter Lernzielkatalog Medizin.

NKLM 2.0 (2021): Nationaler Kompetenzbasierter Lernzielkatalog Medizin.

Nöth W (2000): Handbuch der Semiotik. 2. Aufl. Stuttgart: Verlag JB Metzler.

Olesen F (2004): Striking the balance: From patient-centred to dialogue-centred medicine. Scandinavian Journal of Primary Health Care 22 (4), 193-4.

Ozawa S, Sripad P (2013): How do you measure trust in the health system? A systematic review of the literature. Social Science & Medicine 91, 10-4.

Pellegrino ED, Thomasma DC (1981): A Philosophical Basis of Medical Practice. Oxford, etc.: Oxford University Press.

Peräkylä A, Antaki C, Vehviläinen S, Leudar I (eds.) (2008): Conversation analysis and psychotherapy. Cambridge: University Press.

Peters T (2008): Macht im Kommunikationsgefälle: Der Arzt und sein Patient. Berlin: Frank & Timme.

Peters T (2015): "Sie können sich quasi aussuchen, welches Sie nehmen": Die interaktionale Aushandlung der therapeutischen Entscheidungsfindung in der medizinischen Ausbildung. Empirische Kommunikationsforschung im Gesundheitswesen (EKiG) Band 2. Mannheim: Verlag für Gesprächsforschung.

Pilnick A, Dingwall R (2011): On the remarkable persistence of asymmetry in doctor/patient interaction: A critical review. Social Science & Medicine 72 (8), 1374-82.

Platt FW, Gordon GH (2004): Field guide to the difficult patient interview. Philadelphia: Lippincott Williams & Wilkins.

Pollock K (2005): Concordance in medical consultations. A critical review. Oxford: Radcliffe.

Popper K (1972): Wissenschaftslehre in entwicklungstheoretischer und in logischer Sicht. In: Popper K (1994): Alles Leben ist Problemlösen. München: Piper, 15-45.

Popper K (1994): Objektive Erkenntnis. Ein evolutionärer Entwurf. 2. Aufl. Hamburg: Hoffmann und Campe (1972: Objective Knowledge. Clarendon Press Oxford).

Popper K, Eccles JC (1989): Das Ich und sein Gehirn. München: Piper (1977: The Self and Its Brain. Berlin, London, New York: Springer).

Quill TE, Brody H (1996): Physician recommendations and patient autonomy: Finding a balance between physician and patient choice. Annual Internal Medicine 125 (9), 763-9.

Richard C, Lussier MT (2007): Measuring patient and physician participation in exchanges on medications: Dialogue ratio, preponderance of initiative, and dialogical roles. Patient Education and Counseling 65 (3), 329-41.

Richard C, Lussier MT (2014): The art of medical information exchange. In: Martin LR, DiMatteo MR (eds.): The Oxford Handbook of Health Communication, Behavior Change, and Treatment Adherence. Oxford: University Press, 54-83.

Rider EA, Keefer CH (2006): Communication skills competencies: definitions and a teaching toolbox. Medical Education 40 (7), 624-9.

Ritschl D (2004): Zur Theorie und Ethik der Medizin. Philosophische und theologische Anmerkungen. Neukirchen-Vlun: Neukirchener Verlag.

Roberts FD (2000): The Interactional construction of asymmetry: The medical agenda as a resource for delaying response to patient questions. In: The Sociological Quarterly 41 (1), 151-70. (Reprinted in: Beach WA (ed.) (2013): Handbook of Patient-Provider Interactions: Raising and Responding to Concerns about Life, Illness, and Disease. New York: Hampton Press, 185-99.

Robinson JD (2003/2013): An interactional structure of medical activities during acute visits and its implications for patients' participation. In: Beach WA (ed.) (2013): Handbook of Patient-Provider Interactions: Raising and Responding to Concerns about Life, Illness, and Disease. New York: Hampton Press, 453-72.

Roter DL (2000): The medical visit context of treatment decision-making and the therapeutic relationship. Health Expectations 3 (1), 17-25.

Sandman L, Granger BB, Ekman I, Munthe C (2012): Adherence, shared decision-making and patient autonomy. Medicine, Health Care, and Philosophy 15 (2), 115-27.

Sandman L, Munthe C (2009): Shared decision-making and patient autonomy. Theoretical Medicine and Bioethics 30 (4), 289-310.

Savigny E v (1974): Die Philosophie der normalen Sprache. Frankfurt/M: Suhrkamp.

Scalia P, Durand MA, Elwyn G (2022): Shared decision-making interventions: An overview and a meta-analysis of their impact on vaccine uptake. Journal of internal medicine, 291(4), 408-425.

Scambler G (ed.) (2001): Habermas, Critical Theory and Health. London, etc.: Routledge.

Scarvaglieri C Graf EM, Spranz-Fogasy T (eds.) (2022): Relationships in Organized Helping: Analyzing interaction in psychotherapy, medical encounters, coaching and in social media, 331, John Benjamins Publishing Company.

Schmitz HW (Hg.) (1990): Gerold Ungeheuer. Kommunikationstheoretische Schriften II: Symbolische Erkenntnis und Kommunikation: Aachen: Alano/Rader.

Schulz von Thun F (1981): Miteinander reden. Bd. 1: Störungen und Klärungen. Allgemeine Psychologie der Kommunikation. Reinbek bei Hamburg: Rowohlt.

Schulz von Thun F (1989): Miteinander reden. Bd. 2: Stile, Werte und Persönlichkeitsentwicklung. Differentielle Psychologie der Kommunikation. Reinbek bei Hamburg: Rowohlt.

Schulz von Thun F (1999): Miteinander reden. Band 1+2. Reinbek bei Hamburg: Rowohlt.

Schulz von Thun F (2007): Miteinander reden: Fragen und Antworten. (4. Auflage 2012). Reinbek bei Hamburg: Rowohlt.

Searle J (1965/1972): Was ist ein Sprechakt? In: Holzer H, Steinbacher K (Hg.) (1972): Sprache und Gesellschaft. Hamburg: Hoffmann und Campe, 153-73. (Orig. 1965)

Searle J (1969/1971): Sprechakte. Ein sprachphilosophischer Essay. Frankfurt/M: Suhrkamp (1969: Speech Acts. Cambridge University Press).

Searle JR (1979/1982): Ausdruck und Bedeutung. Untersuchungen zur Sprechakttheorie. Frankfurt/M: Suhrkamp (1979: Expression and Meaning. Studies in the Theory of Speech Acts. Cambridge University Press).

Searle J (1992): Conversation. In: Searle J, Parret H, Verschueren J: (On) Searle on Conversation. Amsterdam, etc.: Benjamins, 7-29.

Sebeok TA (1981): Karl Bühler. In: Krampen M, Oehler K, Posner R Uexküll T v (Hg.): Die Welt als Zeichen: Klassiker der modernen Semiotik. Berlin: Severin und Siedler, 205-32.

Sidnell J, Stivers T (eds.) (2013): The Handbook of Conversation Analysis. Malden: John Wiley & Sons.

Siegrist J (1982): Asymmetrische Kommunikation bei der klinischen Visite. In: Köhle K, Raspe HH (Hg.): Das Gespräch während der ärztlichen Visite. München, etc.: Urban & Schwarzenberg, 16-22.

Smith RC, Hoppe RB (1991): The patient's story: Integrating the patient- and physician-centered approaches to interviewing. Annals of Internal Medicine 115, 470-7.

Stegmüller W (1975): Hauptströmungen der Gegenwartsphilosophie. Eine kritische Einführung. Band II. Stuttgart: Alfred Kröner.

Stevenson FA, Cox K, Britten N, Dundar Y (2004): A systematic review of the research on communication between patients and health care professionals about medicines: The consequences for concordance. Health Expectations 7 (3), 235-45.

Strawson PF (1971/74): Logik und Linguistik. München: List.

Suchman AL (2006): A New Theoretical Foundation for Relationship-centered Care. Journal of General Internal Medicine 21 (S1), S40-4.

Thomä H, Kächele H (1989): Lehrbuch der psychoanalytischen Therapie. Bd. 1: Grundlagen. Berlin: Springer.

Thomä H, Kächele H (1989): Lehrbuch der psychoanalytischen Therapie. Bd. 2: Praxis. Berlin: Springer.

Thomas A, Kuper A, Chin-Yee B, Park M (2020): What is “shared” in shared decision-making? Philosophical perspectives, epistemic justice, and implications for health professions education. Journal of Evaluation in Clinical Practice, 26(2), 409-418.

Thornton RL, Powe NR, Roter D, Cooper LA (2011): Patient-physician social concordance, medical visit communication and patients' perceptions of health care quality. Patient Education and Counseling 85 (3), e201-8.

Tresolini CP, Pew-Fetzer Task Force (1994): Health professions education and relationship-centered Care. San Francisco, CA: Pew Health Professions Commission.

Tuckett D, Boulton M, Olson C, Williams A (1985): Meetings between experts. An approach to sharing ideas in medical consultations. London, New York: Tavistock.

Uexküll T v (1981): Die Zeichenlehre Jakob von Uexkülls. In: Krampen M, Oehler K, Posner R Uexküll T v (Hg.): Die Welt als Zeichen. Klassiker der modernen Semiotik. Berlin: Severin und Siedler, 233-79.

Uexküll T v (1993): Rückmeldung als Modell interpersonaler Beziehungen: Psychosomatische Medizin als Beziehungsmedizin. Fundamenta Psychiatrica 7, 58-63.

Uexküll T v, Wesiack W (1991): Theorie der Humanmedizin. 2. Aufl. München: Urban & Schwarzenberg.

Uexküll T v, Wesiack W (1997): Scientific Theory: A Bio-Psycho-Social Model. In: Adler RH et al. (Eds.) (1997): Psychosomatic Medicine. München, Wien, Baltimore: Urban & Schwarzenberg, 11-42.

Uexküll T v, Wesiack W (2011): Von der Zeichentheorie zur Grundlage einer modernen Semiotik. In: Adler RA, Herzog W, Joraschky P, Köhle K, Langewitz W, Söllner W (Hg.): Uexküll: Psychosomatische Medizin. 7. Aufl. München, etc.: Urban & Fischer, 10-4.

Walker P, Lovat T (2022): The moral authority of consensus. In The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine (Vol. 47, No. 3, pp. 443-456). US: Oxford University Press.

Walseth LT, Schei E (2011): Effecting change through dialogue: Habermas' theory of communicative action as a tool in medical lifestyle interventions. Medicine, Health Care, and Philosophy 14 (1), 81-90.

Watzlawick P, Beavin JH (1966/1990): Einige formale Aspekte der Kommunikation. In: Watzlawick P, Weakland JH (Hg.): Interaktion. München: Piper, 95-110. (1966: The Interactional View. New York: Norton).

Watzlawick P, Beavin JH, Jackson DD (1967/2011): Menschliche Kommunikation. Formen, Störungen, Paradoxien. 12. Aufl. Bern: Huber (1967: Pragmatics of Human Communication. New York: Norton).

Watzlawick P, Weakland JH (Hg.) (1966/1990): Interaktion. München: Piper (1966: The Interactional View. New York: Norton).

Weiss M, Britten N (2003): What is Concordance? The Pharmaceutical Journal 271, 493.

Weiss T, Swede MJ (2019): Transforming preprofessional health education through relationship-centered care and narrative medicine. Teaching and Learning in Medicine, 31(2), 222-233.

Weiste E, Voutilainen L, Peräkylä A (2016): Epistemic asymmetries in psychotherapy interaction: therapists' practices for displaying access to clients' inner experiences. Sociology of Health & Illness 38 (4), 645-61.

Weizsäcker V v (1940/1973): Der Gestaltkreis. Theorie der Einheit von Wahrnehmen und Bewegen. Frankfurt/M: Suhrkamp.

Weizsäcker V v (1946): Körpergeschehen und Neurose. Stuttgart

Westphale C, Köhle K (1982): Gesprächssituation und Informationsaustausch während der Visite auf einer internistisch-psychosomatischen Krankenstation. In: Köhle K, Raspe H-H (Hg.): Das Gespräch während der ärztlichen Visite. Empirische Untersuchungen. München, etc.: Urban & Schwarzenberg, 102-39.

White KL et al. (1988): The task of medicine: dialogue at Wickenburg. In: The task of medicine: dialogue at Wickenburg. Henry J. Kaiser Family Foundation.

Winn K, Ozanne E, Sepucha K (2015): Measuring patient-centered care: An updated systematic review of how studies define and report concordance between patients' preferences and medical treatments. Patient Education and Counseling 98 (7), 811-21.

Wunderlich D (1969): Unterrichten als Dialog. Sprache im technischen Zeitalter 32, 263-87.

Wunderlich D (1976): Studien zur Sprechakthorie. Frankfurt/M: Suhrkamp.

Wunderlich D (1979): Was ist das für ein Sprechakt? In: Grewendorf G (Hg.): Sprechakttheorie und Semantik. Frankfurt/M: Suhrkamp, 275-324.

Zhou Y, Acevedo Callejas ML, Li Y, MacGeorge EL (2023): What does patient-centered communication look like?: Linguistic markers of provider compassionate care and shared decision-making and their impacts on patient outcomes. Health Communication, 38(5), 1003-1013.

Citation note

Koerfer A, Koerfer K (2025): Dialogical Communication and Medicine. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung.