8 Intervention Types and Therapy Goals

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> Instead of merely putting the body in order technically, part by part, through the art of healing, the physician turns to the patient as a rational being. Rather than treating him as an object, he enters into communication with him.
>
> Karl Jaspers (1913/1965: 666)

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Abstract: In an initial interim assessment, it can be stated that physician-patient relationships as a whole and, moreover, the physician's key professional competencies (§ 6) are challenged in many ways in view of societal change and the altered mortality spectrum (§ 5). In all these cases of chronic illness with and without comorbidity/multimorbidity as well as with and without pathological organ disease, a number of *instrumental, psychosocial* and *communicative* functions of work with the patient come into play, which will be summarized and further differentiated here and in the following chapters. Thus, first of all, the theoretical and evaluative foundations are to be worked out, which can then be used for the didactics (§ 13-16) and practice (§ 18-23) of medical conversation.

In this chapter (§ 8), the instrumental and communicative *patterns of action* that are constitutive for the interaction between doctor and patient are to be elaborated. In the sense of functional conversation analysis, as outlined above (§ 2), the *purposes of action* are to be reconstructed, which both interaction partners follow under the institutional conditions of action, possibly with different relevance settings (§ 10, 17), so that conflicts of goals are to be expected, which are to be decided in cooperative negotiation processes. First (§ 8.1), the research desiderata on the general objectives of medical action are to be formulated, which are discussed in medical research as "clinical endpoints". Via the first formulation of (types of) endpoints, the problems of action coordination in *instrumental* action (examination, laboratory, etc.) and *communicative* action between physician and patient can then be presented in an ideal-typical process model (§ 8.2), in which the *decision paths* that both interaction partners have to follow are described as *communication paths* (§ 8.3). Finally, it will be shown by way of example (8.4) how the doctor and patient arrive at viable *formulations* of perspectives for action in the joint conversation work, which are essentially determined by the negotiation of various therapy goals (endpoints).

8.1   Goals in doctor-patient communication

Medical practice is a complex process in which *conflicts of objectives* can easily arise. A purely *rational choice of means and ends* is problematic precisely because it must be coordinated with a partner whose complaints, concerns, and preferences must first be explored through dia-

logue in the medical history (§ 9) before he or she can be sufficiently informed to participate in the decision-making process (§ 10).

8.1.1   Research desiderata

Street points out at the beginning of his article that the state of research on the relationship between physician-patient communication and health outcomes is still very modest. In his article, he offers the following critical assessment:

Box 8.1   Critical research summary
Although researchers have long investigated relationships between clinician-patient communication and health outcomes, much of the research has produced null, inconsistent, or contradictory findings.

Street (2013: 286)

This critical summary in 2013 may be both a consolation and an incentive for further research, which, while not necessarily breaking new ground (§ 2, 40), has obviously not yet found the royal road in this field of investigation.

First problems arise with the terminology. Like all action, medical action has to be considered under a *teleological* aspect, because the actors pursue certain purposes of action, as in other everyday and institutional action situations (Ehlich, Rehbein 1977, Fisher 1984, Have ten 1991/2013, Koerfer 1994/2013, Scarvaglieri 2013, Ehlich 2020, 2022, Scarvaglieri et al. (eds.) 2022). Physicians and patients act for the general purpose of *healing* or even merely *improving* the ill partner, and all other purposes of action are subordinate to this main purpose.

Accordingly, in medical conversation research (§ 2.2), too, the connection between *communication* and *health outcomes* is repeatedly asked for – as above by Street (2013) – because of which doctor and patient finally enter into a helping relationship first of all by *talking,* before other, *instrumental* actions such as physical examination or even surgical interventions can come into play at all.

Parallel to this traditional term (*health outcome*), the expression of the "*endpoint*" has meanwhile become established, which doctor and patient try to reach together. We want to adopt these terms, which are common in medicine, here in order to maintain the reference to medical

conversation research (§ 2), without abandoning the traditional terminology of sociological or linguistic conversation research (*goals, purposes, tasks, functions,* etc.).[1]

Regardless of the terminology, however, it is still disputed which (types of) *endpoint(s)* should be distinguished and how these are effective among each other and in the communication between physician and patient. Without claiming to be exhaustive or systematic, a series of questions on the interrelationship of *communication* and *endpoints* will be formulated here in loose succession:

- What are "medically relevant" endpoints"?
- To what extent do "medically relevant" endpoints coincide with "patient-relevant" endpoints?
- To what extent can a hierarchy (of primary, secondary, etc.) endpoints be determined?
- To what extent can more or less (in)indirect endpoints be traced back to physician-patient communication?
- How valid is the distinction between "hard" and "soft" endpoints?
- What are the "hard" endpoints (*blood sugar levels, lifespan,* etc.)?
- What are the "soft" endpoints (*understanding, emotional well-being,* etc.)?
- To what extent does the distinction between "hard" and "soft" endpoints coincide with the distinction between "objective" and "subjective" endpoints?
- What should/can (for whom/for what) be considered a "surrogate" (*blood sugar values* for *survival time* of a *diabetic,* etc.)?
- What are specific psychotherapy endpoints (*anxiety reduction, stress reduction,* etc.)?
- How do different (types of primary and secondary, "hard" to "soft") endpoint(s) interact?

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[1]   For terminological clarification: We adopt the term "*endpoint*" because it has become established in both German and English-speaking countries (e.g. Schmacke 2006, Mühlhauser, Meyer 2006, Sawicki 2006, Sachverständigenrat 2009, Haes, Bensing 2009). Otherwise, there is nothing to stop us from continuing to talk about *treatment goals, purposes, functions, tasks,* or *results* (*outcomes)* (e.g., Woopen 2001, Bollschweiler 2001, Hulsman 2009, Street et al. 2009, Street 2013, Laidsaar-Powell et al. 2014, Haskard-Zolnierek et al. 2021, Albus et al. 2022, Stivers, Tate 2023, Lelorain et al. 2023, Zhou et al. 2023, Bruch et al. 2024). We prefer different terms depending on their function in context, but we will stick predominantly to "endpoint" for the sake of common usage.

- How are the connections between communication and different (types of) endpoints made and verified in practice and research?

Some of these questions will be (re)addressed here immediately, others later or in further chapters of the handbook. The relationship between communication and "hard" (*objective*) and "soft" (*subjective*) endpoints has been explored in numerous theoretical and empirical studies, despite Street's (2013) critical review cited above, some of which we return to under the aspect of *evaluation* (§ 40-43). Here, we will first explore the differences between *primary* and *secondary* endpoints as well as between *short-* and *long-term* endpoints, in order to finally distinguish between more or less *direct* or *indirect* therapeutic pathways.

8.1.2 Hierarchy of endpoints

The communication between doctor and patient is about different types of endpoints, which the doctor seeks to achieve together with his patient more or less in the short to long term and which, if possible, are "in the service of the health" of the patient, whereby already the concept of health (§ 5.3) can be perspectivized differently, for example from the perspective of *human medicine* (von Uexküll, Wesiack 1991, 2011) or *psychocardiology* or *psychotherapy* (Herrmann-Lingen, Albus, Titscher G (eds.) 2022, Scarvaglieri 2013, Scarvaglieri, Graf, Spranz-Fogasy (eds.) 2022).

What is then sensible and expedient in each case in the "service of the health" of the patient is not always easy to determine, especially since "health" or even "cure" are here initially only generic terms and placeholders for all possible endpoints, which can be "relative" endpoints depending on the (chronic) disease. As is well known, a "diabetes" patient cannot be "cured," but he or she can be more or less "adjusted" to his or her disease, both medically in the narrower sense and in the sense of promoting his or her understanding and processing of the disease with the overall goal of improving or merely maintaining his or her life expectancy and quality of life, which we will return to with empirical examples (§ 22.5-7).

As a rule, one will have to distinguish between *primary, secondary, tertiary,* etc. endpoints, depending on the clinical picture and treatment options. For example, in a multicenter study on psychosomatic inter-

vention in somatoform disorders (PISO study) (Ronel et al. 2007, Lahmann et al. 2007), the patients' *quality of life* is pursued as the primary treatment goal, to which other endpoints up to the "biomedical" level are subordinated, which will be illustrated here only with an exemplary description of the study (Box 8.2):

Box 8.2	Primary and secondary endpoints
The primary endpoint is the improvement in quality of life after one year as measured by the SF-36 (...) Secondary endpoints will be changes in heart rate variability during a stress test, health care utilization, and various test psychological scales. In a continuing research project, functional magnetic resonance imaging (fMRI) will also be used to measure changes in neuronal activity in prefrontal and limbic areas in patients from certain study centers, allowing conclusions to be drawn about the functionality of central regulatory systems (...).	

Lahmann et al. 2007: 134

This study example is merely intended to illustrate what has already been made clear: Regardless of whether *instrumental* action (examination, surgery) or *communicative* action (anamnesis, informative discussion), medical activities always move within a *hierarchy* of different *functions*. This applies not only to the hierarchy of psychosocial endpoints (such as "quality of life") and biomedical endpoints (such as "heart rate variability"), but also to the interaction-logical prerequisite-consequence relationship, according to which certain primary endpoints (e.g., *relief*, *improvement*, *recovery*) can only be achieved if the patient is first *willing* and *motivated* to change his or her behavior (exercise, diet).

These motivational ("soft") endpoints may be missed, for example, due to a lack of medical *competence* or a lack of *cooperation on the part of the patient,* or they may be achieved, which can be facilitated precisely by observing evidence-based *guidelines* (§ 5), which draw attention not least to possible refusals to cooperate on the part of the patient (forms of resistance). However, the *situational* application of guidelines remains the responsibility of the individual physician, who should be able to use his or her psychosocial and communication skills *creatively* (§ 5, 10, 17). This includes both perceptual and action competencies, with which the physician has to adjust to the patient in an ad hoc way in the current conversation, which we will still elaborate on empirical cases under the aspect of the *fit* of verbal and nonverbal interventions (§

17-23). During interaction with patients, decisions with uncertain outcomes often have to be made because the chain of consequences of actions in terms of *intended* endpoints cannot always be adequately anticipated.

This already concerns the *anticipation* of patient reactions to simple verbal interventions (as above: "There is nothing wrong with you!", § 5.2.3), which the patient with a *somatoform* disorder may experience as an *insult,* to which he may react with defensiveness and withdrawal or even with a change of doctor. In these cases, the intended *short-term endpoint* ("informative clarification") is formally achieved, but because of the lack of *empathic* access to the patient, *more far-reaching* endpoints are missed.

They cannot even be "tackled" if the patient withdraws from treatment (for whatever reason), which brings us to further types of endpoints of medical action that concern the communicative design of the doctor-patient relationship itself. For example, before the "hard" biomedical target values (*HbA1c*) can be set for a "diabetes" patient, his or her *insight into the disease* or *motivation* must be encouraged (§ 21, 22, 29), without which all further-reaching therapy plans would remain unrealistic.

In order to find a reciprocal hearing for certain topics here at all, a special *relationship of trust* is again required between the two interaction partners, which can rather be understood as a "soft" end point. This, in turn, can be reached *immediately* in the conversation with the doctor, but can also be lost again in the meantime in the further course of treatment, so that it must be stabilized in the *long term,* etc. This brings us to a further distinction of types of endpoints, which follows more of a *temporal* order, in which, however, interaction-logical prerequisite-consequence relationships must be taken into account.

8.1.3   Short-, medium- and long-term endpoints

While the differentiation of *primary* and *secondary* endpoints rather follows a relevance order, as it can be justified especially in the research context (see above), endpoints can also be differentiated according to a rather *temporal* order. Their *normal form* suggests a certain *order of* (types of) endpoints, which, however, can also change in a complex set of conditions.

In a long tradition, research mostly distinguishes between *short-*, *medium-*, and *long-term* outcomes or endpoints (Pendleton 1983, Beck et al. 2002, Haes, Bensing 2009, Street et al. 2009, Christianson et al. 2012, Street 2013, Labrie, Schulz 2014, Hauser et al. 2015, Herrmann-Lingen et al. 2022). In this context, a specific classification is often implicitly or explicitly made, according to which certain "soft" endpoints" are (must be) achieved in the short term, which are then (can be) followed by other endpoints, as suggested for example by Beck et al. (2002: 27), who arrive at the following classification:

- Short term: patient recall, satisfaction, intention to comply, trust
- Intermediate: compliance
- Long term: symptom resolution, health status, quality of life, mortality

As we will see in detail, the situation in practice is often *more complex:* For example, "trust" and "satisfaction" may develop in the short term during the first consultation, but then both "fall by the wayside" in the meantime, or even turn into mistrust and dissatisfaction in the medium term if intended successes fail to materialize, only to stabilize again in the long term, and so on. The stabilization of patient satisfaction, for example, may occur after a partial biomedical success (e.g., pain relief after medication) and be caused by it, etc., so that the prerequisite-consequence relationships can also be reversed, just as a patient's initial skepticism can be transformed into lasting conviction by a good therapeutic success.

Similarly, adherence (to medications, for example), like the disease/health behavior itself (exercise, diet, etc.), may appear stable in the short term, but be subject to fluctuations in the medium term, because initial motivation wanes, which must then be renewed to achieve long-term success, and so on. Correspondingly, there should then also be downstream fluctuations in the "hard" endpoints (*biologic markers*), which would have to be taken into account as a precondition-consequence relationship in an interaction-logical overall model of the doctor-patient relationship that takes into account the complex actions of the two actors in a larger *time course* (§ 8.2). In doing so, provisions must be made for errors, misunderstandings, conflicts, and corrections in the *negotiation* of therapy plans and goals. Whenever possible, phases of *trial action* should be allowed, provided that this is feasible given the clinical situation.

Although an operation cannot be reversed, a drug can be dosed differently, discontinued or replaced by another drug because of excessive side effects, and so on. (§ 26). Such possibilities are mostly opened with the doctor's question "How did you manage?", with which the success of a specific therapeutic measure of the type of instrumental action is communicatively checked, which is to be elaborated on empirical examples (§ 8.4, 22, 26).

8.1.4   Direct and indirect therapy paths

As was made clear in the foregoing, the endpoints to be negotiated between physician and patient can rarely be realized directly; instead, the two interaction partners often have to follow branching paths and detours that are goal-directed in specific, more or less *indirect* ways. In an interim review, we first follow a schematic representation here (Fig. 8.1), which we will use for further orientation across chapters, following Street et al. (2009), Street (2013), and Laidsaar-Powell et al. (2014).

The initial thesis of Street et al. (2009) is that communication between physician and patient can also lead to a *health outcome in a* direct way, but that it usually requires *indirect, mediatized* ways. For example, while talking to the physician may lead to *reassurance* or even *anxiety reduction* in the patient directly ("talk itself can be therapeutic"), or increase his or her *hope* or *well-being.* For long-term goals, however, intermediate goals must be achieved, such as the patient's *understanding of the disease* or his or her *willingness* to participate in the treatment measure.
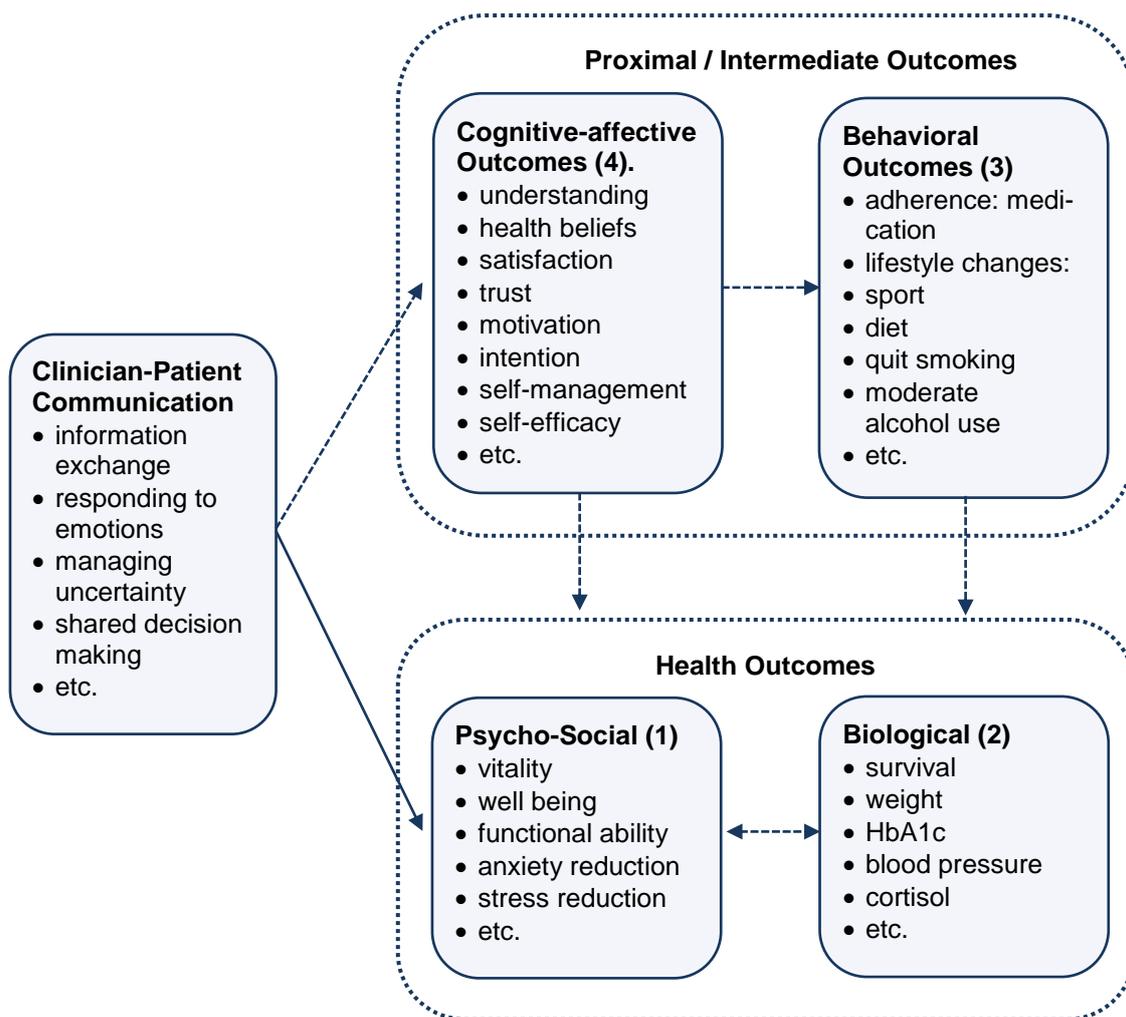
Figure 8.1: Direct (solid) and indirect (dashed) pathways between physician-patient communication and health outcomes (adapted from Street et al. 2009, Street 2013, Laidsaar-Powell et al. 2014; Koerfer, Albus (eds.) 2018).

Here, we adopt the distinction between *direct* and *indirect* pathways, but differentiate the indirect pathways into *cognitive-affective* endpoints and *behavioral* endpoints, and the *health outcome* into *biomedical* endpoints and *psychosocial* endpoints of medical action, without wanting to abolish their unity in the sense of a *biopsychosocial* medicine (§ 4).

Such a typology follows the "interaction logic" of medical action, according to which, for example, improvements in *biomedical* values (*HbA1c)* are not an "end in themselves", but serve higher *biopsychosocial* health goals (1st order) as intermediate goals (2nd order), which include, for example, the *vitality* and *well-being of* the patient (§ 5.3). The biopsychosocial health goals as a whole, in turn, are often not directly

achievable but require *behavioral changes* (3rd order), which in turn are based on *cognitive-affective* processes of *insight, motivation,* and *trust* (4th order). As a rule, these must be at the beginning of a chain of effects in the communication between physician and patient in order to establish a sustainable relationship on the basis of which long-term therapy goals can be negotiated and agreed in the first place.

The interaction-logical concatenation of actions and endpoints (of different order) raises a number of problems in the theory and practice of medical action, which will be explored here in several steps before we exemplify them in empirical cases (§ 8.4).

8.1.5   Methodological and practical problems

In theoretical and empirical studies on the relationship between communication and outcome, both "soft" (*cognitive-affective*) endpoints (such as *understanding, satisfaction, trust, self-efficacy*) and "hard" (mostly *biomedical*) endpoints are considered, sometimes in combination of both types of endpoints (e.g. Beck et al. 2002, Trummer et al. 2006, Haywood et al. 2006, Lee, Lin 2010, Hojat et al. 2011, Lelorain et al. 2012, Laidsaar-Powell et al. 2014, Albus et al. 2022, Zhou et al. 2023, Stivers, Tate 2023, Bruch et al. 2024). Depending on the (type of) endpoint, specific methods of elicitation are used, the results of which need to be specified in practice in terms of dialogic decision making (§ 10), which should take individual preferences into account.

The "soft" *endpoints* are mostly determined by patient ratings or questionnaires, which can also be used to check the (subjective) health status. Depending on the question, the "hard" endpoints refer, for example, to the length of stay in hospital (in days) (Trummer et al. 2006) or to certain *biomedical* values (HbA1c) as an "objective outcome variable" (Lee, Lin 2010, cf. Harvey 2014). Such empirical studies examine in detail what is differentiated or also critically reflected in diverse theoretical concepts.

For example, the "hard" (*objective*) endpoint of life span / survival time, which is particularly frequently claimed in research and practice because it is easily quantifiable, is certainly a "nonplus ultra" of assessment, but the remaining (*subjective*) "quality of life" can certainly be "offset" against the "quantity of life" (Konerding, Schell 2001, Gus-

tavson, Sandman 2015). Ultimately, we are concerned with "patient-relevant" outcomes (Sawicki 2006, Fischer 2006). As we will see in an example (§ 8.4), individual preferences of patients have to be taken into account here, who set up individual cost-benefit calculations that may also deviate from a "normal form" of expectations. Although the physician may orient himself to such a "normal form", which may be "methodologically" secured by quantitatively oriented studies (see above), what this individual patient prefers for himself as "patient-relevant" endpoints in his current "consultation hour" often cannot simply be retrieved by standard questions, but must be explored "conversationally".

Furthermore, in practice, the problem must be taken into account that the individual preferences and attitudes of patients can also change (in the course of life/illness), so that it is precisely not possible to assume the *one* valid formation of opinion, which could be assumed to be complete. Rather, the change in attitude in a dialogical decision-making process (*shared decision making*) (§ 10) must be systematically anticipated and planned for as a possible problem, as will be illustrated by the practical cases.

One specific problem is certainly the evaluation of so-called *surrogates* (e.g., *cholesterol levels* for risk of heart attack or life span), which can certainly be viewed critically in research (Mühlhauser, Meyer 2006, Sawicki 2006). In practice, it is often difficult for patients to understand the plausibility of these values because, for example, the "sugar values", "fat values" or "liver values" characterized by the physician as "excessive" or even as "bad" or "threatening" do not initially appear to affect the general health of the person concerned (*vitality, well-being*). In this case, a special, sustained "*information* and *education*" effort is required on the part of the physician in order to "convince" the patient of the health risk (*health belief),* if necessary, and to be able to sufficiently "motivate" the patient of the need to take medication regularly (*adherence*) or to change his problematic health attitude (*health belief)* and his associated (*behavioral*) risky *lifestyle* (lack of exercise, nicotine, alcohol abuse).

This *motivational work* on the part of the physician is aimed at the *long-term* "end points", and not only at achieving a stable improvement in *biomedical* (liver, fat, sugar) *values,* but also, and above all, at maintaining the patient's overall health (*vitality)* or at least counteracting a deterioration in an incipient disease (*diabetes*). In communicating with

the patient, there are often no *direct paths* to the goal, but rather many *indirect* paths and detours must be sought and used, which may have to be followed in communicative *multiple loops* (§ 8.2.3), before the intended endpoints are finally realized in the sense of a *consented therapy goal.*

Here, in practice, the problem of *cognitive-affective* "hurdles" must be taken into account, which can stand in the way of a *change* in the patient's *behavior.* General practitioners in particular know from their experience of caring for patients over many years (§ 24) how often they have to convince, motivate and control "doubting", "denying" or "relapsing" patients again and again, as well as continuously modify therapy plans and adapt them to the patient's willingness and ability, in order to achieve a *change in behavior* via *cognitive-affective* intermediate goals on the way to long-term stable *biopsychosocial* endpoints.

On this more or less "indirect" path to long-term endpoints of their actions, the two interaction partners pass through a series of *developmental phases* in common *interaction stories*, which will be described below in an *ideal-typical process model of* medical action in several steps and finally (§ 8.4) concretized in empirical examples.

8.2   Ideal-typical process model of medical action

The *general* endpoint of medical action, which can also be regarded as the *primary* endpoint, is to be defined here as the *relief* of the patient from the *burden of disease,* as stated previously (§ 5) with reference to the German Council of Experts ("Sachverständigenrat", 2009). The patient's relief moves more or less *relative* to the severity of the overall *burden of disease* (chronification, multimorbidity, inauspicious prognosis) along a continuum between death and perfect health, or less dramatically and more differentiated: between aggravation and improvement of physical or psychological well-being.

Relative relief often has to take place in *complex*, *hierarchically* organized processes of *understanding* and *comprehension* (§ 10, 22), which are characterized by both *simultaneity* and *non-simultaneity of* endpoints with multi-layered precondition-consequence relationships. This means a great challenge for both actors to solve upcoming coordination problems.

8.2.1   Complex action coordination

In the coordination of action sequences, not only *linear* but also *circular action patterns* have to be taken into account under *temporal* and *inter-action-logical* aspects, both for the action itself and for the (more or less) intended action consequences (*end points),* in which the actors in the interaction must jointly cope with a complex set of conditions. In this set of conditions, a number of (*instrumental, communicative, cognitive, affective, parative, motivational, behavioral,* etc.) aspects of action must be distinguished (Koerfer 1994/2013), which come into play in the interaction between doctor and patient in a variety of ways:

Information is exchanged (*communicatively*) by means of question-answer patterns, for example, and therapy plans and measures require both (*instrumentally*) the physical examination or current laboratory findings and (*communicatively*) the patient's explanation and consent. The patient's (*affective, motivational*) attitudes (*satisfaction, confidence*) and possibilities and readiness (*parative)* are in turn prerequisites for further action, which he must also be capable of (*cognitively).* This is not self-evident, for example, with older patients, as we have already indicated (§ 5) with demographic change and the changed spectrum of morbidity, which poses special challenges for communication with older patients (§ 37). For example, the overall success of therapy depends (*paratively*) on the patient's willingness and ability to cooperate and subsequently (*behaviorally*) on the patient's adherence to *therapy*, who must take the medication or adhere to the diet or exercise regularly.

This patient behavior must be *monitored* regularly, and depending on new findings (e.g., laboratory values), the therapy or dosage may have to be continued or modified, or other accompanying therapeutic measures (*supportive intervention*s) may have to be added, for example, because the patient (*emotionally*) threatens to despair or even decompensate. In an ideal-typical process model (Fig. 8.2), the specific processes of action and their respective endpoints, which play an essential role in medical action, will be presented and explained.

8.2.2   Conversation types, action patterns and action goals

In this ideal-typical process model of medical action, the elementary process stages are first considered as placeholders for specific types of

conversation, action patterns and action goals, which are to be presented in more detail below in the theory, didactics and practice of doctor-patient communication. Then it is a matter in detail of specific *action patterns* such as the *question-answer pattern* or *narrative patterns*, as they are characteristic for the biographical-narrative anamnesis conversation (Köhle, Koerfer 2017) (§ 9, § 19). There, it will then be necessary to justify why a *narrative interview pattern* is more suitable than an *interrogative* interview pattern for "addressing" the patient's *affects in the first place* and thus for making certain *patient-relevant* endpoints the topic of discussion in the first place. Likewise, information and decision patterns will have to be differentiated according to the extent to which active patient participation (SDM) (§10) is more likely to be promoted or prevented, so that certain "soft" endpoints (such as *patient satisfaction, increase in resources*) are more likely to be achieved or missed.

The basis for these empirical conversation analyses is the ideal-typical representation of the process model of physician action (Fig. 8.2), which captures the phase-specific process stages that do not necessarily have to coincide with individual physician-patient contacts, but can exceed them. In the ideal-typical representation, it is rather a matter of the complex interplay between communicative and instrumental action in a long-term *history of interaction between* doctor and patient, in which they pass through certain developmental stages, which in turn must be balanced communicatively in order to be able to initiate the next action steps in each case, and so on.

In this common interaction history specific *types of conversations* (column B, types 1-5) (Fig. 8.2) are realized in a typical sequence, which have been trained in a long tradition of the medical profession and serve as a structural template for the development and control of types of endpoints in a continuous communication process: The endpoints developed jointly between physician and patient in (repeated) *anamnesis conversations* (position 1), *educational conversations* (P2), *decision-making conversations* (P3) can be reviewed and modified by both actors in (repeated) *control conversations* (P4), if necessary, until they finally balance "their" joint therapeutic successes in a *catamnesis conversation* (P5). The structure and function of these *types of conversations* will be worked out in detail in the theory (§ 10, 17, 40) as well as in the didactics and empirics of medical conversation (§ 18-23).[2]

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[2] Because of their special features, the *ward round conversation* (§ 24), the *GP conversation* (§ 25) and the *prescription talk* (§ 26) are each examined in separate chapters.

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	A	B	C	D
1	Instrumental Action	Communicative Action	Endpoints A+P	Endpoints P
2		Anamnesis Conversation ①	Shared knowledge: History	Patient satisfaction
3	Examination Body/Lab	◇	Shared plan: Procedure	Safety, trust
4		Patient education Conversation ②	Shared knowledge: Diagnosis	Disease-insight
5		Decision-Conversation (SDM) ③	Jointly agreed therapy plan	Therapy motivation
6	Medication, surgery, physiotherapy	◇	Joint implementation	Individual responsibility
7	1st follow-up examination	◇	Shared expectations	Therapy adherence
8		Follow-up conversation ④	Therapy/ Modification	Resources Recovery
9	2nd follow-up examination	Catamnesis-Conversation ⑤	Shared benefits	"Healing" "Well-being"
10			Symmetry, autonomy, gratification Helping Alliance	

Fig. 8.2: Ideal-typical model of medical practice

The process model, which is intended to guide our *manual* on interviewing and our empirical *interview analyses,* can be further modified or differentiated if necessary. It's ideal-typical representation (Fig. 8.2), with which a "normal course" of (types of) doctor-patient interactions is assumed here, will be explained in several steps:

In a flow chart, we have first roughly distinguished between rather *obligatory* paths (*solid* arrows) and *optional* paths (*dashed* arrows), each leading to more or less *expectable* endpoints, which may also vary case-specifically from the perspective of the agents. For example, where "cure" is not possible, less ambitious endpoints (*increase in resources, improvement of symptoms*) (D8) must be expected, which are to be understood as *relative* relief from the overall personal burden of a patient's disease, as stated above (§ 5.4) with reference to the German Council of Experts ("Sachverständigenrat", 2009).

Thus, often in the case of "incurable" diseases, the preservation of the patient's remaining resources and his or her quality of life is the *primary* endpoint, as will become clear immediately from an example from an oncology practice (§ 8.4) (cf. also § 22, 38), in which a *conflict of goals* between *prolongation of life* and *quality of life* is involved.

Furthermore, a distinction was made between *instrumental* action (column A) and *communicative* action (column B) and, depending on the type of participation of the actors, between two types of endpoints, namely the *cooperative* and the *individual* type. In the *cooperative* type (column C), both partners are directly involved in achieving the endpoints, for which they are jointly responsible. This includes, for example, the shared knowledge of the patient's medical history (column C, line 2) or the jointly agreed therapy plan (C5), to which both partners attach shared expectations (C7), etc.

In the *individual* type (column D), the patient is primarily alone concerned and responsible, although in the doctor-patient relationship in particular little goes without the intervention of the other (§ 10). But in the end it is the patient who first (*cognitive-affective*) via a series of *indirect*, mediating intermediate goals (D2-4) develops the *motivation (*D5) which finally keeps him as an individual person (sic) in individual *responsibility* (D6) to "therapy adherence" (D7) by taking the medication or keeping to the diet or exercising regularly etc. (*behavioral*), which he probably would not have done without the "insistent" explanation (B4) of his physician.

In practice, this often requires specific persuasion work in the sense of a tailored *motivational interview* (Beni 2013, Harvey 2014, Martin

2014), in which, for example, the patient's *health beliefs* are to be made the subject of discussion and his reservations and resistance to behavioral change are to be dealt with. This tailored conversation work, to which we will return under the aspect of the *fit* of verbal interventions (§ 17-23), may require repetitions, restarts, deepenings, illustrations, retrospectives and outlooks, summaries, etc., which altogether refer to *non-linear* communication processes. These become necessary whenever, at a certain stage of the development of the history of interaction between doctor and patient, the intended endpoints do not occur in the intended sequence, i.e., the expected therapy adherence fails to materialize because the preceding cognitive-affective endpoints were obviously missed or were not communicated in a sufficiently stable manner.

As is yet to be worked out in detail in empirical conversation analyses, *repetitive*, *circular* and *cumulative* patterns of action are to be expected (as in everyday life) in the institutional interaction between doctor and patient as well as *linear ones,* which is due to the *complexity* of the functions that both actors have to master in communicative fine-tuning.

8.2.3   Repetitive, circular and cumulative action patterns

If in the ideal-typical representation (Fig. 8.2) a normal course is assumed, according to which the patient's *satisfaction* (D2) should already be established in the first medical history interview and his *insight into the disease* (D4) with a corresponding change in his *health beliefs* in the first educational interview, then in the empirical individual case precisely this ideal-typical process structure must be checked.

For further *repetitive*, *circular* or *cumulative* relations between actions and endpoints we have chosen a non-specific form of representation (dotted lines without arrow direction), which will be concretized in case of analytical need. Thus, the physician will mostly compare the results of a current examination with previous results in a retrospective manner and will usually also communicate the differences and their meaning etc. to his patient in more or less detailed *explanatory talks* ("Your values have improved pleasingly"), to which we will likewise return with examples (§ 22).

If necessary, the physician may also have to switch between the *types of conversation* several times, i.e., during the *decision conversation* he may have to go back to the *patient education conversation* or to the

anamnesis conversation because he is still missing important information about the medical history, etc., which is why the physician may invite the patient again to a *patient narrative* (Koerfer et al. 2010, Köhle, Koerfer 2017, Palla et al. 2024) (§ 9, § 19). Thus, an ongoing *deliberative* pattern of action in *shared decision making* (B/C5) may be briefly replaced by a *narrative* pattern of action to complete the history taking in order to stabilize the elementary shared *endpoint* ("shared knowledge") (C2) between physician and patient, etc. Furthermore, once achieved, endpoints can also be gambled away again, if, for example, the initially achieved patient satisfaction later turns into dissatisfaction due to a paternalistic decision-making pattern that ignores patient preferences, etc., so that a new start may become necessary at this endpoint.

Thus, the normal form of the sequence of types of endpoints of *different order,* as we have differentiated it before (§ 8.1.4), can be subject to a change as a whole. If, for example, after a long history of interaction between doctor and patient, the expected successes in the *health outcome* fail to materialize, the patient's adherence to therapy must first be brought into the focus of attention at the behavioral level, and then, if necessary (*cognitive-affective*), the lack of insight into the disease and motivation must be "put to the test" again, and so on.

In empirical practice, therefore, we must expect a variety of deviations from the ideal-typical process model, which must ultimately be captured with *gradual* and *dynamic* descriptions, according to which certain end points (such as *satisfaction, trust,* but also *relief, improvement*) can often occur "more or less" or "after initial delays" finally "gradually" or "spontaneously" and "immediately". In this context, *spontaneity* and *immediacy are* not to be understood as individual random developments, which they can also be in individual cases, but are to be reconstructed as the result of a common history of interaction.

Especially in empirical conversation analyses, it can be made clear how a *change* can be brought about in the physician's actions through verbal "key interventions" by the physician (§ 17-23), which can be perceived as a "new quality of conversation and relationship" both from the internal perspective of the participants themselves and from the external perspective of observers, which can also be used methodologically for *evaluative* studies (e.g., via expert and *lay* ratings) (§ 40-43). In addition to such special, "extraordinary" *moments of conversation,* which are described in psychotherapeutic conversation research (§ 2.2) under a variety of names (e.g. "innovative moments", "now moments") (§ 17), however, "as a rule" one must assume "less dramatic" developments,

which may be based on persistent patterns of repetition and re-admission, with which the physician can finally "reap his fruits" at the end of a *longer-term* history of interaction, even against initial "resistance" on the part of the patient.

In the daily work of the general practitioner or specialist, it is not uncommon to encounter forms of "resistance" on the part of patients to the explanatory work of the physician, which are similar to those in psychotherapy and which must therefore be countered by redundant conversation work ("repeating", "working through"). This will be discussed separately in the light of the fact that, for example, the general practitioner often has to provide "minor psychotherapy" as part of basic psychosomatic care (§ 15, 25), in which the physician's educational work can only gradually and in small steps achieve (partial) success against the recurring resistance (*denial*) to a (*behavioral)* change in a risky lifestyle (nicotine / alcohol abuse, lack of exercise, etc.) (§ 22, 29).

Likewise, the development of a "helping alliance" (Luborsky 1988) or "therapeutic alliance" (Street et al. 2009) (cf. Flückiger et al. 2018, Guxholli et al. 2021, Flückiger 2022, Albus 2022, Buchholz 2022, Iovoli et al. 2024, Saxler et al. 2024) will usually not take place immediately, but in a *cumulative* process, in which, since the greeting at the first establishment of the relationship, it is also (gradually) about *increases* in satisfaction, trust, improvement, etc., which can also occur immediately (for example, through "spontaneous healing"), but usually must be developed successively. Possibly, in the meantime, there are also regressive forms of movement, after which one must, as it were, "start all over again", because the expected success of the therapy (*improvement* of the symptoms) (D8) fails to materialize and the already achieved trust (D3) of the patient in his physician is possibly impaired or even shaken, etc.

Concerning the individual *decision paths*, we have only considered exemplary but typical *decision nodes* (diamonds) as placeholders at central development points (column B, lines 3, 6, 7), where joint decisions are made conversationally by the physician and patient in different directions, which at the end of the conversation are supposed to be "decided matters" between both conversation partners.

Their "contents" are then "discussed" again, for example after completion of the treatment measure (e.g. surgery) or after a certain period of behavior ("diet", "taking medication") as agreed, sometimes with dates and conditions ("fasting blood sugar") in subsequent *control conversations.* In the process, the physician and patient can again enter into an *educational* and *decision-making discussion* (§ 10), in which they may

make new decisions, for example because the medication must be changed due to the "unacceptable" side effects or the dosage must be changed (§ 26), which in turn can lead to new (control) conversations with further decisions, and so on.

Overall, the complexity of the representation, which can be reduced or extended depending on the (specialist) specific context, should be able to take account of the complexity of medical action, which requires coordination with the patient, especially as a communicative action. The patient, for his part, should be able to "have his say" in the formulation of endpoints "for good reasons," as we will see in empirical examples (§ 8.4, 10). After all, it is essentially about "his" individual endpoints (satisfaction, increase in resources, improvement). However, the satisfaction of the patient could of course also be a satisfying endpoint ("job satisfaction") of the physician, who would get the *gratification* (C/D10) for the creative application of his professional competences in a correspondingly reciprocal way, which we (not only according to Siegrist 1996) all need so much in our profession.

Likewise, it will have to be justified with von Uexküll (1993) (§ 10) that the *autonomy* of one partner as a particularly "noble" (*primary*) endpoint must not be at the expense of the other partner (win/lose), but *symmetry* must be largely maintained in the balance, so that we are again dealing with common endpoints.

Only the overall balance (C/D10) will show to what extent the multitude of instrumental and communicative art-patient contacts has led to a "Helping Alliance" (Luborsky 1988) or "Therapeutic Alliance" (Street et al. 2009 (cf. Flückiger et al. 2018, Albus et al. 2018, Guxholli et al. 2021, Albus 2022, Buchholz 2022, Flückiger 2022, Wampold, Flückiger 2023, Iovoli et al. 2024, Saxler et al. 2024), which must last beyond the first "consultation hours" also in the *long run* between physician and patient, so that in the sense of Balint (1964/1988: 186, 335ff) the "mutual investment society" (§ 25) can also prove itself to the good end to the advantage of both partners.

8.3   Decision paths as communication paths

The problem of how to achieve the "major" *endpoints* of medical action, expressed in *everyday language* in the wish for a "long life in good health", often presents itself as an "agony of choice" as to which could

be the "appropriate", more or less "direct" or "indirect paths" to the goal for this individual patient (§ 8.1.4). With exceptions such as emergency medicine, where the physician may have to decide and act alone without input from the "unresponsive" patient, decisions should in principle be communicatively mediated. In this sense, decision paths are always communication paths.

In this context, the communicative participation of the patient can superficially lead to paradoxes, because coordination can both create and reduce problems (§ 10). On the one hand, the agony of choice may seem simple because it reduces problems if the patient should have clear and immutable preferences, but on the other hand, it may be complicated if the patient's preferences conflict with the physician's preferences or even evidence-based guidelines (§ 5), to which we will return under the aspect of participatory decision making (SDM) (§ 10). In the following, we will describe the navigation problem that physicians face when they seek to use standard pathways in their orientation to guidelines (§ 5.4) whose feasibility (*viability*) for individual patients requires an individual *fit* – a problem that is briefly outlined here and will be an ongoing topic in the handbook (esp. § 17-23).

8.3.1 Navigation problems

In order to illustrate the difficult *navigational task* of the physician, the *travel metaphor* that has been handed down in medicine and psychotherapy since Freud will be specified here: It is well known that in earlier times all roads were said to lead to Rome. Today we know better: Many roads lead to Rome, but not all. Some lead to Antarctica or to the desert, where no one wanted to go. Once the "wrong ways" have been sorted out, many roads to Rome remain open, but they do not prove to be equally good for all patients.

With many patients you can get to Rome in a hurry by plane or race down the major highways, but not with those who suffer from a fear of flying or feel confined in tunnels because of their claustrophobia or fear the dark, etc. With some patients, it is necessary to walk through deep valleys and over high mountains and climb arduous passes. With some patients it takes so much help to carry the loads that one seems reminded of Hannibal's journey across the Alps with elephants, etc.

Carrying this great burden of patients not infrequently becomes a burden on the physicians themselves, as evidenced by physician train-

ing through Balint group work (§ 15), which is also about the appropriate demarcation and relief of the physician (keyword: psycho-hygiene) in order to preserve psychosocial competencies for the benefit of patients.

Irrespective of the question of how to deal with the additional burden on physicians, the *metaphor of the path* can be further concretized for the conduct of medical conversations and practice: In order to reach the "big" end points, many smaller "paths", possibly also "side paths" or even "sneak paths" and "detours" with specific end points each have to be taken with the patients. On these endpoints, *instrumental* and *communicative* actions can and must often intersect in many ways (Fig. 8.2: Decision nodes B3, B6, B7). At these *intersections,* decisions in different directions are again possible, which may turn out to be equally suitable. However, what is "suitable" for this individual patient often cannot be estimated in advance. The physician may have already "routinely" and successfully followed one or the other "beaten path" with many other patients, but not yet with this patient, of whom he does not know how difficult the path will be for him or whether it will even lead to the desired goal.

Thus, physician and patient often find themselves at *crossroads* where there are equally valid alternatives that both seem viable, even in the sense of *evidence-based guidelines* of medicine (§ 5, 10). The problem becomes clear when, for example, a physician is confronted with the decision-making situation of having to decide between *conservative* and *surgical* forms of treatment together with a seriously (e.g., oncologically) ill patient. Both paths could be "lege artis" in the sense that the forms of treatment are equivalent from the "medical point of view", which is to be further elaborated under the aspect of *balance* ("equipoise") in decision-making (§ 10).

8.3.2   Dialogical problem solving

In these cases ("equivalent" options), the patient's preference should ultimately be "decisive", although this must first be "discussed" in detail with the patient, because the patient's preference neither falls from the sky (*a priori)* nor can it simply be asked and answered with a *yes/no* answer. Even if the patient should later be "wiser" on the basis of his experience, for example after an operation (*a posteriori*), and perhaps regret the decision, the only basis of experience valid for him beforehand was the conversation with the physician. The physician's respon-

sible task was to "anticipate what was necessary" in order to allow the patient's decision to "mature" until a "sustainable" decision could be "spoken of" in a meaningful way.

Regardless of what other (Internet) media are "consulted", the mediating *dialogue* (§ 18) between doctor and patient remains the first and last source of a rational decision. We will see from empirical examples what helping function the physician has in making decisions in both simple and complicated cases. It is often the physician's *midwifery function* (Koerfer et al. 2007, 2010, Deppermann 2009, Köhle, Koerfer 2017, Koerfer, Albus 2018), with which the patient is brought to a self-exploration in the first place, in which he or she develops "own" and, above all, "lasting" *cognitions* and *preferences,* which can result in *patient-relevant* endpoints, which the patient, however, would not be able to *formulate* without the assistance of the physician, which is still to be illustrated by examples (§ 8.4, 9, 19-21).

Depending on the type and severity of the disease burden, *instrumental* action (physical examination, X-ray, surgery, physiotherapy, etc.) or *communicative* action by the physician may predominate (taking the patient's medical history, communicating the diagnosis, decision-making, etc.). In any case, however, instrumental action should be "framed" and "controlled" by communicative action in the sense that every operation, medication, etc. is "discussed" with the patient as comprehensively as possible beforehand and afterwards, in order to be able to determine and control the end points of their action. In these "discussions", despite all (institutional, etc.) restrictions as we have described them in advance (§ 5.1), physicians have communicative leeway which they can put "at the service" of their patients, for whom they certainly often personally make great efforts to achieve the "big" endpoints (*long life in good health*) for their patients.

In empirical conversation analyses, we will try to trace the more or less *(in)direct* paths to the stated or merely assumed and nonetheless *action-guiding* major therapeutic goals. Even if not always explicitly (in the sense of a medical jargon, cf. § 27), it can be observed often enough how the common goals of action in the "consultation hour" are "brought up" in an "everyday language" way, so that it can be proved in many ways how doctor and patient mutually assure themselves what they intend to do for which purpose or should better refrain from doing.

We will follow up these common *formulations* of their final actions and omissions again and again and in the following with selected examples in order to further concretize empirically the connection between

communication and endpoints of medical action discussed theoretically above.

8.4   Formulating perspectives for action

For mutual understanding, the participants in the conversation themselves make use of *formulations* in their interaction with which they indicate to each other what they (will not) do (can, want, etc.) because they (do not) like this or that, expect, hope, fear, consider good or bad, find useful or useless or (un)important, etc. (Tab. 8.1). The range of formulations extends not only to individuals' actions, intentions, preferences, etc., but also to their social roles and interaction roles in conversations in which they formulate who they (don't) are or (don't) want to be, etc. By way of introduction, the methodological significance of formulations for conversation analysis will be briefly highlighted, and then a typology will be presented to provide orientation for subsequent empirical conversation analyses.

8.4.1   Procedures of mutual understanding

Following the *formulations* of acting subjects is a method of conversation analysis (§ 2) to reconstruct the meaning and purpose of their actions from the participant's perspective (Garfinkel, Sacks 1970/76, Heritage, Watson 1979, 1980, Koerfer 1994/2013, Gülich et al. 2010, Scarvaglieri 2013). Without going into the discussion on terms, conceptions, and empirical analyses of *formulations* at this point,[3] only the early basic idea of Garfinkel and Sacks (1970/76) (Box 8.3) will be cited and exemplified here:

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[3]   We first use a broad notion of *formulation* here and later return to a narrower notion (as psychotherapeutic intervention, for instance, in the sense of *reformulation*); cf. in advance for differentiated use of terms Streeck 1989, 1990, Antaki 2008, Gülich et al. 2010, Scarvaglieri 2013.

Box 8.3	Participant formulations
We refer to the procedures used by conversation participants when they say at length what they are doing as *formulations*.	

<div align="right">Garfinkel, Sacks 1976: 147 (italics there).</div>

The spectrum of (*types of*) formulations is already described by Garfinkel and Sacks as very rich when they explain that we as participants in a conversation not only say with many words what we *do,* but also "what we are talking about, or who is talking, or who we are, or where we are" (147). Furthermore, they introduce abstract categories such as *topic, time, place, acting person* (1970/76: 152ff.). Such categories serve as elementary orientation not only for the participants in the conversation themselves, but also for their natural (participating) and non-natural (external) (scientific) observers, because they are part of our everyday knowledge, which cannot be circumvented in principle even in research, despite all critical reflection.[4]

What is a necessary process of understanding from the *internal perspective* of the actors in order to establish a "shared conversational reality" (in the sense of Uexküll/Wesiack 2011), serves us from the *external perspective* of external observers as a method of reconstructing subjective structures of meaning. Thus, what is generally considered a method of conversation analysis, as practiced throughout this handbook, will be applied here in advance specifically to the *formulation of objectives* by participants.

Also for such endpoints, as we have analytically distinguished and systematically discussed in advance (§ 8.1-8.3), manifold exemplars can be found in the analysis of conversations, according to which patients *formulate,* for instance, their satisfaction or dissatisfaction, their confidence or doubts, their preferences or aversions, their hopes or fears, etc., which extend to possible therapeutic paths and goals. In doing so, physicians and patients specifically follow general types of formulations as they serve in everyday as well as institutional contexts of individuals'

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[4] As pointed out elsewhere (e.g., Koerfer 1994/2013), we cannot get rid of the common sense conceptual framework we are trying to analyze ourselves, just as we remain attached to the everyday language we are studying.

understanding of their attitudes and participation roles in joint interaction.

8.4.2　Typology of formulations

Without claiming to be exhaustive, a *typology of formulations* can be obtained as a first approximation (Tab. 8.1), which should take into account the possible combinations of (types of) subjects and their actions, intentions, preferences, etc. in space (*here*, *there*) and time (*present, past, future*) by way of example. The empirical content of a typology of formulations, for instance for institutional communication, will be exemplified in the following by practical cases from doctor-patient communication.

In addition to a qualitative approach, which will be pursued here initially, *quantitative* follow-up studies are certainly possible, for example, under the question of which of the two acting subjects (physician and patient) realizes which types of formulation and how often, which can be used for evaluation purposes (§ 40-43). To this end, the following selected aspects should be mentioned in advance:

- Who uses how often formulations in which *ego* makes his own expectations (fears, hopes, etc.), preferences, intentions, etc. the subject?
- Who uses, and how often, phrases in which *ego* makes *alter*'s expectations (fears, hopes, etc.) or preferences an issue?
- Who uses, how often, formulations in which concrete collectives ("we", "you") or impersonal subjects/instances ("one") have intentions, preferences, or follow norms, etc.?
- How often do formulations of actions, intentions, preferences (respectively) refer to the past, present or future?
- How often are phrases used (by whom) that link the past, present, and future?
- Who uses phrases to downgrade or upgrade relevance and how often, etc.

Subjects	Participant formulations		Aspects
	positive	(negative)	
Ego	Who I am/want to be (or not)		Person/Role
	Where I am (not)/want to be (not)		Situation
	What I want (don't want) to talk about		Topic
	What I will (will not) do		Action (future)
	What I have done (haven't done)		Action (past)
	What I can (cannot) do		Competence
	What I want (do not want) to do		Preference
	What I find important (unimportant)		Relevance
	What I find good (do not find good)		Evaluation
	What I know (do not know)		Knowledge
	What I expect (do not expect)		Exspektation
	What I believe (do not believe)		Believe
	What I (do not) want		Wish
	What I (should not) do		Norm
	Why I do (do not do) something		Reason
	What I intend (do not intend)		Intention (future)
	What I intended (did not intend)		Intention (past)
	What I effected (did not effect)		Effect
	etc.		etc.
Alter	What others are (don't be)		Person/Role
	Where others are (are not)		Situation
	What others did (did not do)		Action
	etc.		etc.
Collective	What we/they (do not) do		Action
	etc.		etc.

Tab. 8.1: Types of formulations (mod. on Koerfer 1994/2013: 154)

Here, for example, conclusions can be drawn from frequencies in the use of *types of formulations* (with expectations, hopes, etc.) about the extent of *transparency* of conversations (or the validity of *taboo topics*). Conclusions about greater *transparency* would be suggested above all if the physician were also to increasingly formulate his own expectations (hopes, but also fears) with regard to therapy options, which he should see himself obliged to do anyway in the sense of patient education (§ 10).

Likewise, in the case of time variability, the psychodynamic "depth" of a biographical narrative anamnesis can be inferred, in which past, present, and future can be repeatedly linked in a way that promotes knowledge (§ 9). For example, a patient who has been suffering from stomach complaints for years, at the end of a long narrative about his missed career opportunities in the past, finally formulates his *preferences* and *intentions with* regard to the future, which he hopes to shape quite differently than his previous course of life suggests.

E 8.1	"I would prefer to stop (...) but will I still be able to do it then?"

01	D	yes, so you also always feel like you're selling yourself short, no?
02	P	I would prefer to stop and maybe start studying again, just as a hobby, somehow.
03	D	hm .
04	P	that might be an idea of me.
05	D	hm .
06	P	but will I still be able to do it then? ... I am (...)

Already in the doctor's formulation, the entire preceding narrative is empathically expressed as a generalized permanent conflict ("always") ("feeling ... selling yourself short"), which the patient obviously takes as a stimulation to "think about his future". For this future, he formulates his *preferences* ("I would prefer") and *intentions* ("to start studying"), but not without at the same time questioning his *ability to* shape the future ("but will I still be able to do it then?"). In these formulations of the patient, the entire *ambivalence conflict* is expressed, which was already inherent in the previously told life and medical history, to which we will return with a detailed analysis of the conversation (§ 19.8).

In the handbook, we will repeatedly address the *formulations of* the participants in the conversation, initially with examples from selected conversations in which "end points" are "put to the test", as it were, by the participants. We focus here on selected formulations from conversa-

tions that will be analyzed in more detail later in the larger context under further aspects (clarification, decision-making, negotiation, responsibility, etc.).

8.4.3 Quality of life versus quantity of life

The first example from an oncological practice deals with the formulation of endpoints which, via *intermediate goals* of instrumental actions, concern the *conflict of goals* between prolongation of life and quality of life which, despite previous agreements with the patient, is again put up for disposition by the physician. The formulations extend to the past, present and future of communicative actions (e.g. "decision", "agreements") and instrumental actions (e.g. "chemotherapy"), which are again made an issue by the physician in the current conversation ("here and now").

E 8.2		"for me it's okay when it ends"	Comment
01	D	which is now a bit different as .	Start of justification
02	P	I do not want chemotherapy.	Formulation (neg. intention)
03	D	the pain increases . so I-	Justification continuation
04	P	that is clear to me .	Strong affirmation
05	D	I remember our agreement . I still just wanted to simply . address it again, whether that somehow for you now got another weighting again .	Physician formulations: Résumé and perspectivation
06	P	[no . no .	Pre-Start
07	D	[so that-	
08	P	for me it's okay when it ends, but I don't want to be full with chemotherapy . just to live maybe a few weeks longer . no . so that's no option for me .	Patient formulations: positive and negative options and intentions.
09	D	good . we had talked about it .	Restrospective
10	P	yes .	Affirmation
11	D	and I think that's also completely okay . and I also want to support you quite explicitly in that, yes . that's, I think, the appropriate decision . and that's also where our agreement remains . yes .	Physician formulations: Assessments, intentions (support), consensus.

In view of the current development of the disease (03D: "increase in pain"), the physician initiates a sequence of *control* talks with a topic initiative, as previously described in the process model (§ 8.2). In an interim balance sheet, *retrospective* and *prospective* formulations are made of what both interaction partners have discussed, decided and carried out or refrained from doing in the past and what is now being put up for *discussion* again from the physician's perspective in a process of *deliberation* (§ 10).

This process of deliberation is initiated and continued here with the expressions typical for this purpose of conversation (05D: "to address"), and finally evaluated (11D: "completely okay") and at the same time concluded by consensus (11D: "appropriate decision"). Although the *consensus* is seemingly conclusively formulated by the physician here (11D: "and that's also where our agreement remains"), there is nevertheless a "post-history" with a short narrative by the patient, to which we will return separately (§ 22.6).

The fact that the preceding conversation sequence is continued thematically at all testifies to the scope of patient conflicts experienced subjectively in this way, in which a decision obviously has to be made between *quality of life* and *quantity of life*, in whatever units the remaining time (weeks, months, years) is estimated. The preference formulated by the patient in this context (10P: "I don't want to be full with chemotherapy just to live maybe a few weeks longer, no") is obviously not without ambivalence.

This knowledge of the ambivalence of patients in difficult decision-making at the *end of life* (§ 38) justifies medical interventions such as those in this conversation, with which opportunities for dialogue to clarify the "final" or even only current patient will are preserved for as long as possible. Since the validity of patient preferences can always be subject to *change* in the course of illness and life, everything must be "put to the test" again and again in *dialogue,* as long as the state of affairs permits this in the sense of *evidence-based* and *preference-based* medicine (§ 5, 10). In each case, appropriate invitations to talk must be formulated, as the physician obviously succeeded in doing with this patient.

8.4.4   Improvement of the individual quality of life

Whereas in the previous example the patient *formulated* her *dispreference* towards the possible chemotherapy, which prompted both interlocutors to *reformulate*, *elaborate* and *conclude* their shared positions once again, the patient opens the following conversation with a *concern formulation* in which he clearly and unmistakably "gets to the point" of his preference at the beginning, like a customer, immediately after the doctor's greeting and introductory question (omitted here).

E 8.3		"desired change to pump"	Comment
01	D	what brings you to us? .	Opening
02	P	Diabetes type 1 .	Request (Start)
03	D	yes .	Listening signal
04	P	Basal-bolus .	Concern (cont.)
05	D	hm .	Listening signal
06	P	desired change to pump .	Request (end)
07	D	yes that means uh . there are difficulties in the basal-bolus concept with you? .	Exploration
08	P	let's put it this way . I want a simplification, more variability .	Expansion of the request
09	D	yes .	Listening signal

Here, the patient chooses a *request formulation* that resembles a telegram style (or more modern: SMS style), which seemed like a "business order" in a Balint training group of physicians. Here, we first skip the transformation process that the physician experienced with the clinical picture (*diabetes*) initiates in order to achieve a change from the *service-leadership* to the *collaborative model of* decision-making (§ 10 and 22), and move to the end of the conversation, which is characterized in the decision-making process by a series of *formulations* concerning both the individual *quality of life* (E7.4) and the *patient and physician roles* (E.7.5).

In the middle of the conversation, the analysis of which can be found in § 22, the focus was initially on the individual medical and life history of the young diabetic, who was increasingly unable to cope with the "disadvantages" of the "bloody injection" (pen) in his professional and private life. In the further course of the conversation, the *advantages* and *disadvantages* of the alternative therapy methods ("injection" ver-

sus "pump") and the associated therapy goals are formulated, leading to the following *consensus formulation* between physician and patient at the end of the conversation, which is abbreviated here and reproduced and analyzed in more detail later (§ 22).

E 8.4	"I can't relax like that, you don't have to torture yourself"	Comment
01 D	(...) whether I will make you the therapeutic offer (...)	Formulation: Doctor options
02 P	(...) more flexible (...) dirty fingers (...) the job of a photographer is not always as clean as one imagines (...) inhibitions to unpack the pen (...) blood (...) dirty fingers (...) I can't relax like that . you don't have to torture yourself . after all .	Everyday language formulation: Lifeworld (occupation) and psychological experience: "struggling".
03 D	yes, that's right, I think that's a very important aspect that you're addressing (...) how is your quality of life (...)	Formulation: Relevance + translation: "Quality of life"

First, the patient's insistently formulated distress at the previous therapy procedure ("injections") is noted ("uncleanliness," "inhibitions," "not being able to relax"), which leads to his equally insistently formulated appeal to the physician: "you don't have to torture yourself, after all." This strong appeal is also understood and answered by the doctor, who follows it up with an equally strong affirmation ("yes, that's right"), before he then makes a specific, repeatedly marked *relevance upgrade* (§ 17.4, 19.4) of the topic: "I think that's a very (sic) important aspect". This relevance upgrade is again reinforced with the personal acknowledgement of the patient's topic initiative ("... aspect you address"), to which the physician thus responds here with a personal address ("you").

The doctor stays on this line of a personally addressed recognition of the patient's participation role also in the subsequent (terminological) *translation,* with which he brings the patient's appeal formulated in everyday language ("you don't have to torture yourself") in turn to the concept with a personal address ("*your* quality"): "how is your quality of life". What makes the difference here becomes clear in the case of a hypothetically assumed *impersonal* turn of phrase (e.g., "one"), where, after all, a personal subject could also be erased altogether (e.g., "it's a

question of quality of life"). The personal address here further corresponds to the *individualization* of the topic addressed, in that the physician seeks to bring the patient's "personal life experience" to bear in the decision-making process at the end of the conversation.

E 8.5		"you become the specialist for yourself" - "doctors are the advisors, companions"	Comment
01	D	so that is again your very personal life experience (...) the self-observation, the self-experience in the area . what happens when you do something .	Formulation: Self-observation role of the patient
02	P	yes . is clear .	Strong affirmation
03	D	you become the specialist for yourself .	Formulation: Patient role
04	P	yes, yes sure .	Strong affirmation
05	D	doctors are the advisors . companions for a while .	Formulation: Physician role

This sequence, to which we will return later (§ 22.5), contains a number of highly complex formulations in a small space. Entirely in the spirit of *patient-centered* and *individualized* medicine (§ 4-6), the patient's *personal experience* ("your very personal life experience") is first brought into play here as the ultimate basis for decision-making, and then the different *participation roles* of patient and physician are formulated entirely in the spirit of *participatory* decision-making (§ 10): The patient will (have to) find himself in his role as "specialist for himself" and the physician will (only) be able to take on the role of "advisor" and "companion". This medical formulation, whose complete, (co-)meant meanings we have paraphrased here (with additions in brackets), represents a quasi abridged version of the action program of *participatory* decision-making, which we will elaborate theoretically (§ 10) and also in detail (§ 22.5) on this example of a conversation.

8.4.5   The directly helping conversation

Whereas the previous examples of conversations dealt with *medium-* to *long-term* endpoints that can only be reached after a longer period of time has elapsed since the conversation, the following example formulates endpoints that are reached *immediately* and *directly* in or after the conversation, as differentiated in the previous section (§ 8.1). That ther-

apeutic endpoints of this type ("talk itself can be therapeutic") (Street et al. 2013) are often also achieved directly in conversations is taught by the conversation experience of clinicians, who can perceive a reduction in anxiety, for example, in the body language of their patients (§ 12, 31). That such conversational effects are also *formulated* directly by patients in this way is observed rather more rarely - perhaps because the self-evident is often not discussed as a matter of course. For example, it is not self-evident that a patient who visits the doctor because of long-standing stomach complaints will, right at the beginning of the second consultation, take stock of the therapeutic success of the first consultation in the following way:

E 8.6		"I think: did that actually help after all?"	Comment
01	D	yes	Listening signal
02	P	and that also changes with me constantly . now in the stomach area . it has become a little better, I was already wondering . the next day, after our conversation I think: 'did that actually help after all?' . I have almost felt nothing in my stomach anymore (...)	Formulations: Surprise: improvement of the complaints Cognition: "did that ... help ...?"

At the beginning of the second consultation, the patient expresses his own astonishment ("I was already wondering") about his own perception of his complaints ("it has become a little better"), and then, as he did the next day ("after our conversation"), he asks the doctor in a kind of "thinking aloud" the indirect question about the effect of "our conversation", because with "that" he clearly refers to the conversation ("did that actually help after all?"). He answers the question posed in this way himself, as it were, by increasing the degree of improvement compared to the previous formulation ("I have almost felt nothing in my stomach anymore"). It remains to be seen with what overall intention the patient chooses exactly these formulations, but the authenticity of the statements of improvement cannot be doubted at first. His experience of a "helpful conversation" apparently conforms to further experiences of conversation, from which he draws personal consequences for his own attitude to conversation (10P: "be open") at the end of the second consultation, which he formulates as follows:

E 8.7		"otherwise you can't help me at all"	Comment
01	D	now we are already more into the conversation, huh? . is also a bit of habituation . yes .	Formulation: Positive interview outcome
02	P	yes, I also have to do it myself. uh, because I'm not used to that either .	Self-appeal habituation
03	D	hm .	
04	P	and I have to trust a stranger, so to speak .	Foreignness and trust
05	D	yes, that's absolutely right .	Strong affirmation
06	P	[...]	
07	D	[...]	
08	P	yeah, eh I never thought as an adult that I needed help . mentally, right? .	Formulation: Need for help
09	D	yes, yes, and that's why it's clear that it's not so easy for you to talk to me now .	Formulation: Difficulty to speak (openly)
10	P	yes, but I also planned to do that because I thought to myself, I must be open to you, otherwise you can't help me at all .	Formulation: Intention: Being open + Purpose: Help
11	D	that's how it is, yes, that's how it is .	Strong affirmation

At the beginning and end, the patient, who has obviously already experienced an improvement in his complaints, subjects the conversation to his own evaluation by asking himself the question about the helping conversation (E 8.6, 02P: "did that actually help at all?"), which he himself answers positively ("I have almost felt nothing in my stomach anymore"). This evaluation is connected with the insight into the necessity of his own active participation role in the conversation, whose effectiveness he also recognizes as dependent on his own trust (E 8.7, 04P: "I have to trust") and his own openness towards the doctor (E 8.7, 10P: "I must be open, otherwise you can't help me at all"). As differentiated above (§ 8.1-2), both "hard" endpoints (*improvement of complaints*) and "soft" endpoints (*trust, openness)* were achieved *directly,* because they were achieved *conversationally.*

The fact that such a *successful conversation* can already be achieved in the second consultation is certainly reserved for the rarer "great moments" of medical action (§ 17). However the intervening physician's own share of the co-construction is to be assessed, the patient's-

initiated self-knowledge can be regarded as a good prerequisite for further *help to self-help.* Under the aspect of *empathy in cooperative narration,* we will return to the development of this conversation in an overall analysis (§ 20.9).

Realizing the ideal claim of a *directly helping conversation* certainly remains a primary objective of medical action, as it is conveyed, for example, by the further training of physicians in psychosomatic primary care (§ 15). As our conversation analyses will make clear, in the practice of medical action there are often cutbacks to be made from the *ideal* conversation management, which should be practiced with a realistic expectation: The medical dialogue does not have to be "perfect", but only "good enough" to achieve the *medium* and *long-term* therapeutic goals in addition to the *direct* therapeutic successes. In order to secure long-term therapeutic goals in the long term, it is often necessary to have "staying power" so that the complex *interplay* of *communicative* and *instrumental* action in the medical consultation described above can succeed.

8.5   Further information

In the preceding chapter, the relationship between patterns of action and therapeutic goals was presented in an ideal-typical process model of medical action, which was finally already illustrated by empirical examples from practice, which will be analyzed in more detail in the practice-based manual chapters (18-23) in particular.

For further literature on short- to long-term therapy *goals* (*endpoints*), *indirect* and *direct* therapy pathways and *outcomes* over a longer period of time, reference is made to: Pendleton (1983), Stewart (1984), Beck et al. (2002), Haes, Bensing (2009), Street et al. (2009), Hojat et al. 2011, Christianson et al. (2012), Street (2013), Kelley et al. 2014, Labrie, Schulz (2014), Laidsaar-Powell et al. (2014), Harvey 2014, Hauser et al. (2015), Haskard-Zolnierek et al. (2021), Sharkiya (2023), Stivers, Tate (2023), Lelorain et al. (2023), Bruch et al. (2024).

As specific literature on *formulations* as comprehension procedures, beyond the "classics" such as Garfinkel, Sacks 1970/76, Heritage, Watson (1979), (1980), the partly highly empirical works of Streeck (1989, 1990), Antaki (2008), Gülich et al. (2010), Deppermann (2011), Scarvaglieri (2013), Tiitinen, Ruusuvuori (2014), Landmark et al. 2016, Buch-

holz, Kächele (2013), (2016), (2017), Scarvaglieri (2020), Scarvaglieri, Graf, Spranz-Fogasy (eds.) (2022) should be mentioned.

For the concept of *relevance negotiation* also of therapy goals, special reference should be made to the following chapters on "Dialogical Decision-Making" (§ 10) and on "Negotiating Procedures" (§ 22). The specific goal of *adherence* (when taking medication) is particularly considered in chapter 26 ("Prescription Talk"). Using empirical examples, the *typology* of *verbal interventions* is further differentiated in the chapters on the *Cologne Manual of Medical Communication* (C-MMC) (Part IV of the handbook), particularly in the chapters on *listening to concerns* (§ 19), *empathic communication* (§ 20) and on *detailed exploration* (§ 21). In anticipation of this typology, the *Cologne Manual* is presented at the end of this chapter.

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

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Citation note

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Cologne Manual & Evaluation of Medical Communication
see next page

Armin Koerfer, Pauline Albus, Christian Albus

Cologne Manual & Evaluation of Medical Communication	C-M+EMC
OSCE Checklist for Medical Interviewing	[1]1998
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No.	Course	Interviewer	Date	Patient (SP)	Rater	Sum:
						☐☐ 50

1 Building a relationship ☐ 4

1 Framing
- Enable confidentiality
- Avoid disturbances

2 Greeting ⓪❶
- Make eye contact
- Verbal greetings, shaking hands
- Address by name

3 Introducing yourself ⓪❶
- Introduce yourself by name
- Communicate function ("ward doctor")

4 Situating ⓪❶
- Speak sitting down (chair to bed)
- Ensure convenience
- Coordinate proximity/distance

5 Orientation ⓪❶
- Structure conversation
- Goals, time frame

4 Exploring details ☐☐ 12

1 Inquire about complaint dimensions ⓪❶❷❸❹
- Localisation and radiation
- Quality, intensity (scale 0-10)
- Dysfunction/disability
- Accompanying symptoms
- Time (beginning, course, duration)
- Condition "In what situation ...?"

2 Exploring subjective ideas ⓪❶❷❸❹
- Concepts "What do you imagine?"
- Explanations "Do you see causes?"

3 Complete anamnesis ⓪❶❷❸❹
- Systems ("From head to toe")
- General health, sleep, etc.
- Previous illness, pre-treatment
- Family risk factors
- Family, friends, job, finances, etc.
- Addressing gaps (sensitive issues)

2 Listening to concerns ☐☐ 10

1 Start the conversation openly ⓪❶
- Offer "What can I do for you?"
- Occasion "What brings you to me?"

2 Encouraging storytelling - feedback ⓪❶❷❸❹
- Listener signals hm, yes, nod, etc.
- Avoid interruptions
- Allow pauses, free choice of topics

3 Active listening - verbal support ⓪❶❷❸❹
- Encourage speaking up
- Repeating statements verbatim
- Paraphrase statements
- Openly ask further: "How did that come about?"

4 Ensure understanding ⓪❶
- Ask "Do I understand correctly ...?"
- Summarise

5 Negotiating procedures ☐☐ 12

1 Plan an evidence-based approach
- What is secured?
- Do diagnostics have consequences?

2 Clarify expectations ⓪❶❷❸❹
- Ideas, wishes, hopes
"What did you have in mind?"
- Control beliefs
"What could you change yourself?"

3 Explaining previous findings ⓪❶❷❸❹
- Communicate diagnosis
- Communicate problems ⓪❶❷❸❹

4 Examination or therapy plan
- Explore decision model (SDM)
- Discuss proposals and risks
- Consider reactions
- Strive for consensus

3 Eliciting emotions ☐ 8

1 Pay attention to emotions
- Verbal (e.g. metaphors)
- Non-verbal (e.g. gestures, facial expressions, gaze behaviour, etc.)

2 Empathise with patient's situation

3 Respond empathically ⓪❶❷❸❹
- Offer appropriate help and comfort
- Acknowledge burdens, coping

4 Promote emotional openness ⓪❶❷❸❹
- Addressing "I perceive that ...?"
- Naming "You are sad then?"
- Clarify "What do you feel then?"
- Interpret "Your fear may come from..."

6 Drawing conclusions ☐ 4

1 Summarise the conversation ⓪❶
- Reason for consultation, complaints,
- Diagnosis, therapy agreement

2 Offer clarification of outstanding issues ⓪❶
- Information "Do you still have questions?"
- Satisfaction "Can you handle it? "

3 Arrange follow-up appointments ⓪❶
- Examination appointments
- Set a meeting date

4 Say goodbye to the patient ⓪❶

5 Complete documentation
- Coding & conversation impressions
- Topics for follow-up talks

⓪❶ [⓪ = not met; ❶ = met] ⓪❶❷❸❹ [⓪ = not met ...❹ = fully met]

Fig. 8.3: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)