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The problem of the ‚second opinion‘: distrust in oncological therapy planning talks

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1. Distrust and the ‚second opinion‘

The interactional negotiation of trust and distrust is something that can often be observed within doctor-patient-communication. Patients typically fear that the diagnosis might not be correct or that the proposed therapy might not be the best possible for them, while doctors can doubt the frankness and sincerity of their patients (for example, concerning the description of their symptoms, their potentially health-risky actions such as drug abuse or their compliance regarding suggested therapeutic measures). The aim of this analysis is to focus on an interactional aspect which is important for both doctors and patients: The negotiation of trust and distrust regarding the proposed therapy in cancer pre-treatment discussions. For the patients, this negotiation is important because they wish the best possible treatment for themselves and therefore have to insure that the proposed therapy is indeed the best one and that there are no better alternative options. For the doctors, reducing distrust and building trust is important, because trust in the proposed therapy leads to patients' compliance, i.e. their active co-operation with the therapeutic measures, which may be decisive for the success or failure of the treatment.

On the basis of a corpus of oncological therapy planning talks a qualitative empirical analysis of the interactional processes of dealing with distrust in the context of the sensitive question of getting a ‚second opinion‘ concerning the proposed therapy will be presented. The question of the ‚second opinion‘ is a sensitive one because it can be interpreted as signaling a patient's distrust in the competence of the doctor, thus leading to a face-threat. That the possibility of a face-threat is something patients are acutely aware of can be seen in the fact that they often introduce the topic of the ‚second opinion‘ with metacommunicative, exculpating and modalizing utterances such as “nicht, dass ich jetzt da misstrauen würde oder so, aber... / not that I would distrust there now, or like, but”. In order to answer the question how distrust is negotiated interactionally, the paper proceeds as follows: First, the research project will be presented in whose context the data were raised. Then, a short overview of typical problems within doctor-patient-communication in general and of the negotiation of trust and distrust in particular will be given. Next, strategies will be discussed with which – on the one hand – patients introduce the topic of the ‚second opinion‘ within a therapy planning talk and with which the doctors react to this topic. Finally, the doctors' ‚pre-emptive‘ strategies with which they try to remove patients' distrust and build up trust in their diagnosis and proposed therapy will be analyzed.

2. The data

The data were raised in the context of the project “From pathology to patient: optimizing the transfer of knowledge and the securing of understanding in oncology in order to improve patient security” funded by the *Deutsche Krebshilfe* (*German Cancer Aid*; project number 111172). The project is led by myself in cooperation with Prof. Dr. med. Thomas Rüdiger (pathological institute) and Prof. Dr. med. Martin Bentz (medical clinic III), who both work at the *Städtische Klinikum Karlsruhe*.

The project intends to address two problems recurrent in clinical communication: First, there often occur problems concerning the interpretation of the pathological report by the doctors who are involved in planning the therapy. One aim, therefore, is to ask how these pathological reports can be improved to rule out possible misunderstandings. This aspect tackles inner-clinical written communication between the pathological and medical departments.

The second aspect concerns doctor-patient communication: Often, patients show trouble understanding the diagnosis, the proposed therapy and the consequences the therapy will have for their lives. This has to do with a wide range of communicative and cognitive problems, ranging from technical terminology used by the doctors to layman concepts of cancer and cancer treatments by the patients.

This article draws on the second research question, i.e. it will focus on therapy planning talks between doctors and patients, not on the inner-clinical written communication via medical reports. The aim in analyzing therapy planning talks is to find out – with the help of conversation analytic methods – at which places within these talks problems regularly occur, of what types these problems are and how they can best be solved. One recurrent source of problems concerns the topic of the ‘second opinion’. This topic is very important in those therapy planning talks because the patients at that point get told a definitive diagnosis based on their previous medical examinations and the pathological report for the first time. This means that both diagnosis and therapy planning occur within the same talk, and whenever patients suffer from a highly malign form of cancer, treatment will furthermore start only shortly after the therapy planning talk. Cancer therapy is never easy, and thus patients are faced with the sudden and potentially overwhelming fact that they have to agree to a potentially dangerous or at least very unpleasant treatment: This could range from operations to chemotherapy or radiotherapy (or, often, combinations thereof). Considering these prospects, it is natural that patients feel the need to make sure that the proposed therapy is the best possible and generally recommended one for them. Furthermore, some patients who are

thus inclined also want to know about alternatives outside conventional medicine, for example anthroposophical therapies. As the therapy planning talks are the place where the options for the treatment of the diagnosed type of cancer are discussed with the patient for the first time, they are the natural place for doctors and patients to talk about getting a ‘second opinion’.

The data were raised between October, 2014, to April, 2015. A total of 56 therapy planning talks of a length between ten to forty minutes (on average twenty minutes) were recorded at four different wards of the *Städtische Klinikum Karlsruhe*: Six recordings were made at the *Medizinische Klinik I* (internal medicine, nephrology, rheumatology and pneumology), thirteen recordings came from the *Medizinische Klinik III* (hematology, oncology, infectiology and palliative medicine), one recording from the Clinic for general and visceral surgery and the majority, twenty-six recordings, from the gynecological clinic.

All of the talks share the same basic setting: The patients are informed about the diagnosis and the planned therapeutic measures for the first time. The talks are conducted by a senior physician. Other participants in the talks besides the senior physician and the patient can be relatives or partners of the patient, ward physicians, student apprentices and students of medicine. In almost all instances the talks were held directly after the attending physician received the pathological report and was finally able, on the basis of that report, to plan the therapy. Both type and grade of the cancer as well as the proposed therapy are now told the patients. All talks were recorded with small audio recorders by the senior physicians themselves and without the attendance of the project employees in order to avoid interferences with the natural setting of the talks. The recordings were anonymized and transcribed according to the standards of the *Conversation Analytic Transcription System GAT 2* (Couper-Kuhlen/Barth-Weingarten 2011; see appendix for an overview of the most important transcription conventions).

3. Methodological Approach

The theoretical and methodological basis relied on in this study is ethnomethodological conversation analysis. Conversation analysis has been developed by Sacks, Schegloff and Jefferson (e.g. 1973; 1974; 1977). Especially for the analysis of highly complex institutional communication conversation analysis has turned out to be a fruitful approach. This has even led to the emergence of a branch of applied conversation analysis which focuses on medical communication (e.g. Becker-Mrotzek/Meier 2002; Brünner/Fiehler/Kindt 2002; Drew/Heritage 1993; Gülich 2007; Gülich/Lindemann 2010; Gülich/Lindemann/Schöndienst 2010; Jakobs 2008; Jakobs et al. 2011; ten Have 2007).

The aim of all conversation analytic studies is to capture human interaction on the basis of a strictly empirical analysis. By recording and transcribing authentic, i.e. naturally occurring, interactions it is possible to draw intersubjectively valid conclusions regarding the structure of conversations. One of the central tenets is the assumption that meaning is something that is created interactionally: “A dialogue is a joint construction [...]. This collective construction is made possible by the reciprocally and mutually coordinated actions and interactions by different actors. No part is entirely one single individual’s product or experience.” (Linell 1998: 86) What this means is that a central resource, which allows us to reconstruct what is happening in an interaction, are the *reactions* of the partners-in-talk to each others’ utterances. With the help of the so-called ‘next turn proof procedure’, i.e. the analysis of the reactions of partners-in-talk to an utterance, reliable results can be obtained, for example, about whether some formulation is interpreted as positive or negative (see Hutchby/Wooffitt 2008) by the interactants. More specifically and within the context of the aim of this paper, this means that the question of the association of the topic of the ‘second opinion’ with the feeling of trust or distrust in doctor-patient-communication needs to be answered by reconstructing step-by-step how and by whom the topic of the ‘second opinion’ is initialized, how the partners-in-talk react to it and how it is evaluated sequentially.

The analysis of medical communication is a big and important field of study, which means that up to now there have been carried out many conversation analytic studies on which to build up. In the following chapter, based on these analyses, the typical structures and problems of doctor-patient-communication will be presented, with a special focus on the negotiation of trust and distrust in institutional communication in general.

4. Communicative problems in doctor-patient-communication

There is a wide body of research in medical communication. One type of communicative setting that has received most attention were anamnesis talks, because they are viewed as the “prototype of all medical discourse patterns” (Lalouschek 2005: 92; my translation). Other than anamnesis talks, there has also been some research in medical rounds as well as pre-operation discussions (Köhle/Raspe 1982; Meyer 2000; Rosumek 1990). The result of these analyses is that a recurrent problem within doctor-patient-interactions has to do with the special structure of question-answer-sequences. Because of an inherent asymmetry – both as representatives of the institution *clinic* as well as because of their professional knowledge and experience doctors are ascribed power and dominance by the patients – doctor-patient-interactions often proceed in a dysfunctional way. Asymmetric question-answer-patterns as

well as a highly routinized (on the side of the doctors) serial structure of, for example, anamnesis talks lead to the omission of for the therapy planning potentially relevant aspects, because patients do not dare to take the floor and take the time they need to describe their symptoms fully. One demand based on such analyses is, consequently, to involve patients more strongly as equal partners-in-talk and to break up the rigid sequential structure of doctors' questions and patients' answers (Ehlich et al. 1990; Lalouschek 2002a; Nowak/Spranz-Fogasy 2008; Quasthoff 1990; Quasthoff-Hartmann 1982; Redder/Wiese 1994; Rehbein 1993; Spranz-Fogasy 1987, 2007). Another well-known problem area besides that of the 'working off' of rigid routines by doctors concerns aspects of the management of understanding: How do doctors explain patients their disease, possible cures, the use of medication etc. and by which strategies do they check whether the patients have understood these aspects? Checking patients' understanding can be central to the success of a treatment because understanding (or lack thereof) influences the patients' compliance with the proposed medication and other therapeutic measures. If patients either do simply not understand what the doctor means or if they do not realize how relevant or urgent some action is that is required from them, this can lead, for example, to a wrong or sporadic intake of prescribed medicine (or even to a breaking off of the therapy). Furthermore, ensuring the patients' understanding also is a prerequisite for patient participation in medical decision making (so-called *patient-centered medicine* or *shared decision making*; Klemperer 2003; 2009; Weis/Härter/Schulte/Klemperer 2011).

Concerning the analysis of processes of understanding in doctor-patient-communication in particular, there have been studies analyzing understanding problems caused by professional vs. lay terminology (Bühlig/Durlanik/Meyer 2000; Gülich 1999; Gülich/Brünner 2002; Lörcher 1983), reconstructing the transfer of knowledge within doctor-patient-interactions (Günthner 2006, Lalouschek 2002b, Rehbein/Löning 1995, Sator/Spranz-Fogasy 2004, Spranz-Fogasy/Lindtner 2009 and Spranz-Fogasy 2005; 2010), comparing communicative strategies within therapy planning talks in order to find out which of these strategies lead to a higher or lower compliance of patients (Spranz-Fogasy 1999) or analyzing how bad diagnoses or poor prognoses concerning the chances for a cure are transmitted to the patients (Fallowfield/Jenkins 2004).

Finally, a third big area of research also concerns the analysis presented in this paper: To what extend do patients trust their doctors, their diagnoses and therapy plans and to what extend do doctors simply *assume* trust (or distrust) in contrast to actively reducing distrust and building up trust? These questions have, for example, been discussed by Meyer (2000) in his analysis

of pre-operation discussions. Meyer (2000: 9; my translation) comes to the conclusion that a central function of pre-operation discussions is to enable the patients to make informed decisions: “Legally speaking, after a pre-operation discussion the patients have to decide whether they agree to the proposed operation or not. The doctors have to inform the patients in such a comprehensive way that they can make this decision on the basis of an informed consideration of all relevant aspects of the operation, especially its risks.” Implicitly, the aspect of trust or distrust looms large in these pre-operation discussions: In order for the patients to give an informed consent, they have to feel sure that they have got all necessary information (and, of course, correct information). Meyer (2009: 9; my translation) consequently states that “the mitigation of fear and the establishment of a trusting atmosphere are important functions of pre-operation discussions. These aspects are part and parcel of the demands of cooperation within a clinic.” Spranz-Fogasy (1999), too, proposes similar associations of trust and patient-centered medicine. He found out that there are six basic strategies doctors employ when prescribing medicine to patients: The first one is a simple and straight enjoiner, the second one an enjoiner followed by an explanation, the third the presentation of a recommendation and an alternative offer, the fourth a recommendation and an alternative offer followed by an explanation, the fifth an open offer, which leaves the patient to decide on different ways of medication, and the sixth a ‘granting’ which leaves the patient even to refuse medication. These strategies of prescription are linked to expected actions by the patients: In the case of a simple enjoiner, an (enforced) compliance by the patient is expected, in the case of an enjoiner with an explanation the (enforced) compliance is meant to be supported by an appeal to reason, in the case of the alternative offer the patient can choose between two alternatives (either supported by an appeal to reason or not) and the strategy of ‘granting’ relies on the patients free and informed choice (Spranz-Fogasy 1999: 257). It is easy to see that these expected actions depend on the strength of trust (or distrust) of the patients in their doctors. The less the patients’ trust their doctors, the higher the chance that they oppose the proposed medication. Building trust and reducing distrust, therefore, are prerequisite to all these strategies. And indeed, in all doctor-patient-interactions the negotiation of trust or distrust is a fundamental task that usually accompanies these talks without being explicitly thematized. And at those places in the interactions where trust and distrust become more prominent, even explicit thematizations can be detected and the interactants are then forced to communicate *about* trust or distrust proper.

5. Trust, distrust and medical communication

Of course, trust is central to any type of communication. Within institutional communication in general and doctor-patient-communication in particular, though, it is especially relevant. The reason for the high relevance of trust in these communicative settings is, according to Luhmann (1973: 8; my translation), that trust is a means to reduce complexity:

Wherever there is trust, there are more possibilities of experiencing things and of acting, the complexity of the social system can increase, that is, the amount of possibilities it can cope with, because trust provides a more effective means for reducing complexity.

This explains why trust is so central to institutional communication: There, the possibilities of experiencing things and, along with that, the wide range of possibilities for actions, not only are manifold, but any decision also implies future consequences which cannot be kept track of by the individuals. As a patient, for example, one simply cannot command the same knowledge as a doctor – and, even less so, as the amalgamated expertise of several doctors working together in a clinic. Only by trusting both the individual doctors and the institution of the clinic as a whole is it possible to reduce the complexity of options for action to a tolerable level.

A problem for individuals that is special to medical interaction is that by trusting a doctor or a clinic one has to speculate about future events or results which are vital to one's well-being or even existence: "Those who trust anticipate future. They act as if the future were certain." (Luhmann 1973: 8; my translation). While such a speculation about future events is manageable in everyday interactions and even in most institutional interactions – if you buy a new computer on the internet at a dubious web shop, the worst thing that can happen is that you lose your money – it is not as manageable in many medical circumstances: If worst comes to worst, you will lose your life. In other words: There is too much at stake for the patients to invest easily into the "risky advance payment" (Luhmann 1973: 22) of trust. In the case of a cancer diagnosis and the following suggested therapy the patients face the dilemma of not having enough medical knowledge to act in a completely informed way on the one hand, and of not knowing if and how far to be able to trust the institution of the clinic and the doctors' decisions on the other. Trust in that case has to be spread in a complex manner over both the institution and the single individual doctors the patients get in contact with. According to Luhmann (1973: 4; my translation), trust has to form within an "interactional field that is influenced by psychic as well as social system formations and cannot be allocated to either of these system formations exclusively." Trust in the institution as a whole means trust in the cumulative and for the patient invisible processes of interpreting radiological data, the pathological analysis of tissue probes, the adherence to internationally established routines in gathering and interpreting relevant diagnostic data etc. Trust in single individuals means

that the patient also has to trust the attendant physician who finally brings together all of the previously collected medical data and explains the therapy. In other words: Both the institution as well as the individuals need the “authority of trust in their veracity” (Luhmann 1973: 57; my translation). Such an implicit trust in the veracity of the doctors and the clinical institution demands much and almost automatically provokes its opposite, the emergence of distrust. Distrust can have many origins: Personal knowledge or even stories about the failure of institutions as well as established and medially spread topoi such as *medical malpractice* offer a rich soil on which distrust can grow. Therefore, trust is always accompanied by distrust, which provides an alternative option:

Distrust not only is the opposite of trust, but at the same time a functional equivalent of trust. Only because of this equivalence is it possible (and necessary) to choose between trust and distrust. The qualitative difference and functional equivalence of trust and distrust becomes clear as soon as one focuses on the function of trust. Trust reduces social complexity, simplifying one’s conduct of life through taking a risk. But if there is no willingness to take that risk whenever trust is negated explicitly [...], this will not solve the problem. (Luhmann 1973: 78)

This quote very well describes the patients’ dilemma: Distrust cannot solve the problems posed by lack of medical knowledge and the demand of trust into doctors and clinics – quite on the contrary: Distrust even makes things more complex because a distrusting patient needs to question everything from the diagnosis to the therapy, which opens up countless alternative ways to go. This dilemma cannot be solved once and for all. The only solution is to negotiate trust verbally within the doctor-patient-interactions. Trust needs to be built via verbal rituals. The following excerpt of a therapy planning talk illustrates the importance of such trust-building rituals (two doctors, A1 and A2 and Patient PW take part in this interaction):

example 1:

236 A1 ka i sIEbenundsechzig ist acht proZENT also dann;
 ‘well then ka i sixty-seven is eight percent’
 237 A2 na ALso;
 ‘there we are’
 238 das sind das sind GUte eigenschaften;
 ‘that are good properties’
 239 GOTTseidank das isch-
 ‘thank God that is’
 240 A1 mhm,
 ‘mhm’
 241 A2 JA?
 ‘yes’
 242 PW glück im UNglück?
 ‘lucky under the circumstances?’
 243 A1 mhm,
 ‘mhm’
 244 A2 ja [so was] wir bisher WISsen kann man das so sagen;
 ‘yes regarding what we know so far we can say that’
 245 PW [geNAU;]
 ‘exactly’

246 A2 mhm.
 'mhm'
 247 PW naja GUT;
 'well good'
 248 ich DENke ja ma:l,
 'I guess'
 249 anhand der erFAHrung;
 'because of the experience'
 250 die sie (--) HABen;
 'that you have'
 251 sehen sie ja da SCHON a [bissl] was.
 'you do indeed see some things'
 252 A1 [hm-]
 'erm'
 253 A2 ISCH so isch so.
 'yes indeed, yes indeed'
 254 JA.
 'yes'

The doctors (A1 and A2) refer to the pathological report, quoting the value of the cancer indicator *ki-67* and stating that eight percent is a good sign for this indicator. One of the doctors, A2, delivers a positive evaluation, which is broken off (“thank God that is”; line 239). The patient signals that she understood that it is indeed intended as a good evaluation: She completes the doctor’s broken-off utterance collaboratively with “lucky under the circumstances” (line 242). A1 confirms this interpretation, albeit with a minimal response (“mhm”; line 243), while A2 qualifies the positive evaluation by making clear that a positive development is still guesswork to a certain degree (“yes regarding what we know so far we can say that”; line 244). This qualification is necessary because only during the further treatment will it become clear if the therapy is indeed effective. The patient reacts to this cautious assessment by qualifying, in turn, her own positive evaluation (“well good”; 247) and by referring to the expert knowledge of the doctors: “because of the experience that you have, you do indeed see some things” (line 249-251). The patient thus thematizes the amount of trust that is demanded from her: She not only does not know what the cancer indicator *ki-67* means and thus has to rely on the interpretation of the doctors, she furthermore has to cope with the fact that even the expert doctors cannot give a certain prognosis but have to be only cautiously optimistic at best. Rosumek (1990: 36; my translation) points out that such verbal routines can count as “trust-building measures in the relationship of doctor and patient”. What needs to be done, now, is to find out which verbal routines are used to cope with trust and distrust.

6. The problem of the ‘second opinion’ as a problem of distrust

A recurrent topic which leads to the implicit or explicit negotiation of trust and distrust in therapy planning talks is that of obtaining a ‘second opinion’ regarding the proposed therapy. This topic can either be brought up by patients or by doctors. Chapter 6.1 deals with the patients as initiators of the topic of the ‘second opinion’: How do patients introduce this topic and how do doctors react to it? Chapter 6.2 then deals with doctors as initiators. Doctors either bring up the topic themselves as part of a ‘bundle’ of trust-building measures or they refer to former utterances of their patients where the topic had already been mentioned. Two questions for research have to be posed: On the one hand, it has to be asked which strategies doctors use to evaluate their own proposed therapeutic measures as the best possible ones – and therefore to signal that a ‘second opinion’ is not really necessary. On the other hand, the question is when and how they actively invite the patients to think about getting a ‘second opinion’.

6.1 ‘not that I would distrust there now, or like, but...’: Patients as initiators of the topic of the ‘second opinion’

A general observation – which is supported by previous research on doctor-patient-communication – is that doctors as a rule take a more active role in steering the conversation, while patients (and their companions) take a more reactive position. Usually, patients (or their partners, relatives etc.) thematize the ‘second opinion’ in a ‘roundabout’ way, for example by merely referring to the fact that one has heard about alternatives from acquaintances or got information on the internet. This means that the ‘second opinion’ itself is not thematized explicitly by the patient. Instead, it is usually the doctors who, after the patients have brought up the general topic of alternative therapies, then focus explicitly on the ‘second opinion’. A good illustration for a patient’s ‘roundabout’ strategy is given in the following transcript. The patient (P) has just been informed by the doctor (A) about the planned therapy. She then mentions a well-known alternative therapy on the basis of mistletoe injections:

example 2:

464 P ich hätte jetzt noch ne frage zu ner beGLEITtherapie zum
beispiel mIstelspritzen oder so.
‘I would have a question left regarding a possible accompanying
therapy for example mistletoe injections or something like
that’

465 A mhm,
‘mhm’

466 P sieht man da ne MÖglichkeit bei diesem?
‘does one see a possiblilty with this’

467 A ja des isch ein ganz klares NEIN.
‘yes that is a very clear ‘no’’

468 das sollte man bei dEr art von erkrankung NICHT machen weil man
nicht weiß wie diese mistel in das immunsystem eingreift und

- die lymphzellen irgendwie vielleicht beeinflusst in schlechtem sinne.
 'with this type of disease it shouldn't be done because it is not known how that mistletoe extract interferes with the immune system and maybe influences the lymph cells'
- 469 P oKAY.
 'okay'
- 470 A was die KRANKheit betrifft.
 'regarding the disease'
- 471 P hat man da erFAHRungen?
 'does one have experience there'
- 472 A ja.
 'yes'
- 473 P HAT man.
 'one has'
- 474 A da wird also tatsächlich EINdeutig davon abgeraten.
 'it is indeed strongly advised not to do this'
- 475 P hat das jetzt was mit der bestimmten erkrankung des lymphOMS zu tun oder mit-
 'does that now have to do with the special disorder of the lymphome'
- 476 A generell lymphOM,
 'lymphomes in general'
- 477 generell lymphOMerkrankung ja ehm genau.
 'lymphome diseases in general, yes, erm, exactly'
- 478 was solche beGLEITtherapien betrifft da haben wir-
 'regarding such accompanying therapies we have'
- 479 kann ich ihnen auch ANbieten mal einen termin auszumachen mit unserer ehemaligen kolLEgin,
 'I can also offer to arrange a meeting with our former colleague'
- 480 die anthroposophisch verSIERT ist und jetzt auch in XX hat in ner anthroposophischen klinik.
 'who is anthroposophically experienced and now also has in an anthroposophical hospital in XX'
- 481 ham se vielleicht schon einmal geHÖRT.
 'maybe you happen to have heard about it'
- 482 P ich KENN die;
 'I know her'
- 483 ja.
 'yes'
- 484 A die is dort Oberärztin.
 'she is a senior physician there'
- 485 Ang sie ist antropoSophin; ((Angehöriger über die Patientin))
 'she is an anthroposophist' ((relation of the patient talking about the patient))
- 486 P nein ich bin nicht antropoSophin aber ich bin so orientiert.
 'no I'm not an anthroposophist but I am oriented to anthroposophy'
- 487 Ang im erGEBnis schon. ((an die Patientin gerichtet))
 'for all intents and purposes you are' ((talking to the patient))
- 488 A und die macht zum beispiel diese ganzen MISTeltherapien.
 'and she offers, for example, all these mistletoe therapies'
- 489 P sie sind unter ();
 'they are under'
- 490 A die kommt aber die war ja bei uns n paar JAHre,
 'she comes but she has been with us for several years'
- 491 und die KOMMT einmal in zwei wochen,
 'and she comes here once every two weeks'
- 492 und da könnte man ihnen auch mal n terMIN vermitteln um mit der zu sprechen was die vielleicht sonst noch für ideen hat außerhalb.

493 'and there a meeting could also be arranged for you to talk
 to her about what other ideas she might have besides'
 da gibts ja noch viele ANdere dinge außerhalb von misteln.
 'there are many other things besides mistletoes'

The opening question nicely illustrates the ambivalence of questions concerning alternatives to a proposed treatment: First, the patient introduces her question in a very cautious and non-committal way by using the conjunctive mood (“I would have a question left”; line 464). Phrases such as “I’ve got a question” constitute so-called “pre-sequences” (Jefferson 1972) which are usually placed before potentially face-threatening activities or activities which demand some action from the person addressed. Pre-sequences, for example, occur regularly before requests, where they ‘warn’ the recipient that some demand on him or her will follow. If a pre-sequence such as “I would have a question left” is used, this can mean – in certain contexts – that a potentially problematic, for example face-threatening, question will follow. This is a first strategy used by the patient to signal that the topic of the ‘second opinion’ is a problematic one. The second strategy is not to refer directly to getting a ‘second opinion’ but to ask in a general way about an “accompanying therapy”, which is furthermore modalized by several “hedges” (Lakoff 1973) such as “for example” and “or something like that” (line 464). The use of specialized vocabulary (e.g. “accompanying therapy”) and the knowledge that a mistletoe treatment involves injections (and not, for example, pills) clearly indicates that the patient has already looked after a ‘second opinion’ – if only by informing herself on the internet. Nevertheless, by using hedges she introduces this topic in a very vague, non-committal and therefore for the doctor face-saving way.

The doctor uncompromisingly refutes the possibility of a mistletoe therapy (“that is a very clear ‘no’”; line 467) and offers a plausible and well substantiated explanation for this rejection, namely that with that type of cancer a mistletoe treatment can interfere with the conventional therapy and “influence the lymph cells” (line 468). Furthermore, he supports his assessment by claiming that his evaluation is based on medical experience. By using the passive voice in line 474 (“it is indeed strongly advised not to do this”) he makes it clear that his advice against a mistletoe therapy is not based on his knowledge alone but on *general* medical knowledge. What is positive in regard to establishing maximal freedom of decision and giving the patient as much information as possible is his following offer to help the patient get a ‘second opinion’: Even though the accompanying therapy the patient has in mind does not work, there may be other alternatives, which can be discussed with an anthroposophically oriented doctor (lines 479f.). The ‘roundabout’ initiation of the patient thus lead to the doctor’s thematization of getting a ‘second opinion’. This pattern, by the way,

occurs regularly in the data: While patients introduce the topic very cautiously and accompanied with many hedges, the doctors always react in a very open and supportive way, showing – at least on the surface – no problems with a patient’s wish to get a ‘second opinion’ (see chapter 6.2, though, for a discussion of the strategies with which doctors establish their diagnoses as well-founded and, thus, imply that a ‘second opinion’ is not necessary).

While example 2 shows that a patient’s referring to tentative own knowledge can lead to the ‘second opinion’ being thematized by the doctor, this, of course, does not happen automatically. In the following transcript, the partner (LG) of the patient (P) refers to some superficial knowledge she has regarding the type of cancer that is discussed there. In that case, this does not lead to the doctor’s (A) thematization of a ‘second opinion’, but is treated as a mere information sequence:

example 3:

503 LG .hh ähm (.) des gibt verschieDene KREBSarten,
 ‘erm there are different types of cancer’
 504 hab ich mir SAgen lassen;
 ‘I have been told’
 505 also ve? verschiedene GRAdE der- (--)
 ‘well dif different degrees of’
 506 der erKRANKung oder de?-
 ‘of the disease or the’
 507 des KREBS,
 ‘the cancer’
 508 .hh äh- [hh]
 ‘erm’
 509 A [er] hat ein aDEnokarzinom.
 ‘he has an adenocarcinoma’
 510 LG und WA:S?
 ‘and what’
 511 A das ist der STANdardtumor;
 ‘that is the standard tumor’
 512 der hÄUfigste tumor im DARMBereich.
 ‘the most common tumor in the intestinal regions’
 513 P mhm.
 ‘mhm’
 514 LG mhm-
 ‘mhm’
 515 oKAY,
 ‘okay’
 516 A über den ich jetzt auch geSPROCHen habe.
 ‘about which I have been talking just now’
 517 LG mhm-
 ‘mhm’
 518 P [mhm]-
 ‘mhm’
 519 A [ja,]
 ‘yes’
 520 und weil sies vom AUSbreitungsgrad haben,
 ‘and as you mention the degree of spreading’
 521 da meinen sie SICHERlich den streUgrad über den kÖrper?
 ‘you surly mean the degree of spreading across the body’
 522 LG ja oder die TIEfe des-
 ‘yes or the depth of the’

523 es soll verschiedene TIEFwerte beim- (---)
 'there are said to be different low values with'

524 A da MEInen sie (--) polyPen,
 'there you are referring to polyps'

525 LG (XXX)

526 A die mehr oder minder KRANK sind und in die dArmwand einwachsen.
 'which are more or less diseased and grow into the intestinal
 wall'

527 P mhm;
 'mhm'

528 LG das kann [SEIN] ja:;
 'that is possible yes'

529 P [ja.]
 'yes'

530 mhm.
 'mhm'

531 [ja ja.]
 'yes yes'

532 A [das IS:]-
 'that is'

533 LG [ich-]
 'I'

534 A [is:-]
 'is'

535 das ist schon überSCHRITTen;
 'that already has been crossed'

536 weil es schon geSTREUT hat.
 'because it has already spread'

537 LG ach so oKAY.
 'oh, I see, okay'

Here, too, the topic of other views and opinions is introduced with a variety of strategies with which to mark a dispreferred action: The patient's partner first uses hesitation signs such as breathing in, a filled pause and a micropause (line 503) and she names the source of her information very vaguely as "I have been told" (line 504). At the same time, and in contrast to example 2, she shows that she is insecure in using specialized vocabulary: First, she speaks of "types of cancer" (line 503), then of "degrees" (line 505), and she switches from "disease" (line 506) to "cancer" (line 507). The doctor therefore interprets this passage not as a roundabout introduction of the topic of a 'second opinion' but as a mere 'fishing' for further information about the cancer: He first gives the accurate name ("adenocarcinoma"; line 509) and then, after LG signals that she does not understand what this means ("and what"; line 510), he offers an explanation ("that is the standard tumor, the most common tumor in the intestinal regions"; line 511-512). Only then does he take up the key word "degrees", offering an interpretation of what LG might have meant: "you surly mean the degree of spreading across the body" (line 521). This interpretation is not accepted wholeheartedly, though. On the surface, LG accepts the reformulation with "yes", but then she goes on referring to the "depth" of the cancer or the "low values" (lines 522-523), without specifying exactly what she means. The doctor tries another interpretation with "there you are referring to polyps" (line

524), which is cautiously accepted by LG (“that is possible yes”; line 528). After that confirmation, the doctor finishes the sequence rather abruptly by saying that the cancer has already “crossed” that line and “spread” through the body. LG accepts this information (line 537) and the doctor does not thematize possible alternative treatments or the option of a second opinion, i.e. the sequence is treated as a mere request for clarification, not as a covert attempt to ask after alternatives. This shows that the topic of the ‘second opinion’ has indeed to be ‘talked into being’ by both parties, patients (and relatives) and doctors. Covert thematizations have the disadvantage that, if the doctor does not take the initiative, the topic of the ‘second opinion’ may actually not be talked about.

While patients and relatives, as has been mentioned several times now, often use ‘roundabout’ strategies to thematize the question of a ‘second opinion’, there are of course also instances where they use more direct strategies, as in example 4:

example 4:

1314 P ehm EIne frage hätt ich jetzt noch;
 ‘I would have one question left’
 1315 ehm nicht dass ich jetzt da misstrAUen würde oder so,
 ‘erm not that I would distrust there now or like’
 1316 aber es ist ja grundsätzlich auch so eine frage zweite MEInung.
 ‘but there generally comes up that kind of question concerning
 a second opinion’
 1317 KLAR das is erst sicher dann sinnvoll nAch der bekanntgabe der
 endgültigen befunde;
 ‘of course that certainly makes sense only after we have the
 final medical results’
 1318 A würde ich so SEhen.
 ‘I would see it that way’
 1319 ja.
 ‘yes’
 1320 P keine FRAge.
 ‘no question’
 1321 ehm stehen sie dem OFFen gegenüber oder sagen sie da warum soll
 das;
 ‘erm are you open-minded concerning a second opinion or do you
 say what’s the point’
 1322 das ist doch alles ganz KLAR.
 ‘everything is totally clear’
 1323 A nein GUT dass sie es ansprechen,
 ‘no good that you mention it’
 1324 wir stehen dem sehr OFFen gegenüber_ne,
 ‘we are very open-minded concerning a second opinion, aren’t
 we’
 1325 also das befürworten wir aktIV und das machen sie wenn sie das
 bedürfnis haben unbedingt.
 ‘I mean that we actively endorse it and you should definitely
 do it if you feel the need for it’
 1326 sie kriegen da von uns auch alle UNterlagen die sie brauchen um
 diese zweitleinung einzuholen_ne,
 ‘in that case you get all documents which you need to ask after
 a second opinion from us’
 1327 und das macht schon SINN.
 ‘and it does make sense’

1328 find ich SCHON wenn sie das bedürfnis haben machen sie das_ne,
 'I do think that if you feel the need you should do it, don't
 you'
 1329 P gut.
 'good'

Again, the potentially face-threatening and problematic character of the question after a possible 'second opinion' is marked verbally. The patient (P) uses a typical pre-sequence signaling a problematic next action ("I would have one question left"; 1314). This is followed by an explicit, metacommunicative hedging (Lakoff 1973) with which she directly refers to the problem she thinks this question may touch upon: It may be interpreted as an expression of distrust ("erm not that I would distrust there now, or like"; line 1315). A third strategy the patient uses to tone down the thematization of the 'second opinion' is to take herself back as the initiator and to refer to the question of the 'second opinion' as a question which is routinely to be expected in therapy planning sessions ("but there generally is that kind of question concerning a second opinion"; line 1316) and therefore need not be taken personally. A last strategy is to put the final decision into the hands of the doctor: "are you open-minded concerning a second opinion or do you say what's the point, everything is totally clear" (line 1321-1322). This implies that the question of a second opinion is not meant as an indication of distrust. Quite in contrast to the elaborate attempts of the patient to thematize a second opinion, the doctor (A) reacts not only without showing any problems but with actively supporting the patient's wish to get a second opinion. This supportive attitude, as has been mentioned before, is indeed typical for the therapy planning talks. It becomes clear that the problem of distrust concerning the 'second opinion' is actually a problem that exists in the perception of the patients, who seem to expect that asking after a second opinion more or less automatically is interpreted as a signal of distrust. From the perspective of the doctors, in contrast, getting a second opinion is simply part of an established routine and is supported without reservations. This is one of the findings that have to be communicated to patients: They may thematize the 'second opinion' without any misgivings.

Yet, in spite of the fact that doctors support the patients' wishes to get a second opinion, they nevertheless invest verbal 'work' to present their diagnoses and therapy plans as not needing a second opinion. How these strategies work will be discussed in the following chapter.

6.2 "or you say I want to seek for a second opinion at some other place": Doctors as initiators of the topic of the 'second opinion'

That doctors know that they have to cope with patients' distrust can be seen in the following transcript. The patient (PW) just been told the diagnosis of breast cancer. She starts sobbing

and breaks down in spite of the fact that the doctor (A1) has just told her that she only has a very mild and easily to cure form of breast cancer:

example 5:

050 A1 ECHT;
 'really'
 051 es is NIX schlimmes;
 'it's nothing bad'
 052 das ist-
 'it is'
 053 PW <<weinend> das SAgen sie bloß nur;>
 'you're saying it just so'
 054 A1 warum soll ich das bloß nur SAgen?
 'why should I say that just so?'
 055 PW ((schluchzt; ca. 2 Sekunden))
 '((sobs for about 2 seconds))'
 056 A1 frau ((Name)) wie kommen sie denn DA drauf?
 'Mrs. (name) where did you get that idea?'
 057 [meinen] sie ich lüg sie AN?
 'do you think I'm lying to you?'
 058 PW [<ha ja-] <weinend>>
 'well yes (crying)'
 059 NEIN des nicht aber-
 'no, not that, but'
 060 A1 natürlich ist das ein bösartiger Tumor;
 'of course that is a malign tumor'
 061 aber das ist KEI:N tumor,
 'but that is no tumor'
 062 der wirklich bösartig IST,
 'that is truly malign'
 063 der schnell WÄCHST,
 'that grows quickly'

The doctor tries to explain to the patient that the diagnosis of breast cancer in her case does not mean catastrophic news. Before the transcript starts, she presents the therapy (based on taking pills only, with no operation, radiation therapy or chemotherapy involved) as a comparatively easy one without expected complications. Furthermore, the chances of success were presented as very high. The patient refutes this positive evaluation in line 053 with “you’re saying it just so”, implicitly evoking the widespread topos of doctors keeping back the true diagnosis or prognosis for the sake of their patients’ mental well-being.¹ The doctor reacts by first asking for a reason why she should not tell the truth and, as the patient does not answer, she expands her question first by marking the patient’s assumption as unusual (“where did you get that idea”; line 056) and then by countering with a highly save-threatening question: “do you think I’m lying to you?” (line 057). To allege someone to accuse oneself of lying is a socially highly dispreferred action and the patient is more or less

¹ See Peters (2015: 49-50), who cites studies which show that until the 1960s more than 90 percent of doctors in the USA decided to leave their patients in the dark concerning their cancer diagnosis. Only since the end of the 1970s a general change of thinking has started, resulting in the full information of the patients. The ‘old’ strategy of concealing bad diagnoses for the sake of the patient, though, still lives on as a kind of lay concept in the minds of many patients.

forced to go back on her words. Her reaction demonstrates that nevertheless she is not yet convinced: She first affirmatively answers the doctor's question ("well yes"; line 058) and then seems to realize that this is a very face-threatening and dispreferred act: She repairs her affirmative answer by producing a very strongly accented "no", making clear that she does not think the doctor is lying to her in the prototypical sense of a lie. The following qualification ("not that, but"; line 059) then lays open that she is obviously thinking of a 'white lie', i.e. the concealment of a negative prognosis by the doctor for the sake of the patient. The doctor nevertheless is satisfied with having – at least tentatively – established trust again and goes on to explain why in the patient's case the diagnosis of cancer is indeed not a catastrophic one. The patient finally accepts the positive interpretation of the diagnosis and trusts the doctor's words.

This passage quite well illustrates the potential for distrust in therapy planning talks: The patients do not command the expert knowledge which helps them understand medical reports and interpret types of cancer and their respective chances of getting cured. They depend on the doctors telling them the truth (and, of course, on the doctors themselves having enough expert knowledge to come to the right conclusions).

How wide-spread patients' distrust is can be seen by the number and range of 'safeguarding strategies' doctors use in these talks. With 'safeguarding strategies' I will refer to verbal strategies with which doctors – usually in an anticipatory manner – validate their diagnoses, therapy suggestions and prognoses regarding a successful cure by referring to collective decision-making, expert colleagues who share their opinion, the orientation to internationally established standards of treatment, the participation of patients in supervised studies etc.

The following transcript illustrates several of these strategies. Before the transcript starts, the doctor (A) told the patient (P) the diagnosis of a chronic type of cancer which for a long time, and possibly even during the rest of the patient's life, needs to be treated with tablets. After that information the patient asks after the possibility that the cancer may vanish and that he may at some point in the future therefore no longer need to take tablets. The doctor answers with a long explanation, validating his prognosis:

example 6:

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324  A      und sie haben RECHT es besteht die chance,
        'and you are right there is the chance'
325  P      (3.0) ((räuspert sich))
        '(3.0) (clears his throat)'
326  A      dass im besten fall (2.0) sie (---) in (3.0) zwei drei jahren
        (.) KEIne tabletten mehr nehmen müssen im besten fall.
        'that, in the best case, you will not need to take any more
        pills in two or three years' time, in the best case'

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- 327 DAS ist genau der moderne stand der wissenschaft und ehm diese
frage ist Unbeantwortet;
'that is exactly the modern state of science and erm this
question is unanswered'
- 328 oKAY,
'okay'
- 329 u::nd-
'and'
- 330 P ((räuspert sich))
'((clears his throat))'
- 331 A aber wir behandeln natürlich UNsere patienten nach dem besten
stand der wissenschaft,
'but of course we treat our patients in accordance to the best
scientific standards'
- 332 so auch SIE,
'this also holds true for you'
- 333 u::nd für SIE:: bedeutet das (--) dass wir beide ihnen (1.5)
empfehlen an einer sogenannten behandlungsstudie teilzunehmen.
'and for you this means that we both recommend you to take part
in a so-called treatment study'
- 334 (3.0)
- 335 A stUdie hört sich jetzt für sie vielleicht KOMisch an aber das
ist der begriff der medizinischen wissenschaft;
'study may sound strange to you but this is an expression
within the medical sciences'
- 336 (2.0)
- 337 in studien (-) behandeln wir patiEnten nach BESTmöglichem
standard und gehen bestimmten wissenschaftlichen fragen nach;
'in studies we treat patients according to the best possible
standards and answer certain scientific questions'
- 338 ja?
'yes'
- 339 und ehm die behandlung ist also (-) europaweit verEINheitlicht.
'and erm the treatment is standardized within the whole of
Europe'
- 340 oKAY?
'okay'
- ((2 minutes))
- 378 A .h und diese studie (--) führt auch MIT sich,
'and this study implies'
- 379 dass sie MAMaximal überwAcht sind;
'that you are under maximal surveillance'
- 380 das ist alles GA:NZ stark standardisiert und das wird ihnen
frau x ja nachher noch erklären;
'everything is very strongly standardized and this will
explained to you later by Mrs. X'
- 381 das ist unsere studienärztin die beschäftigt sich (---) im
prinzip mit NICHTS anderem als sOlchen (---) studien_okAy?
'who is our study doctor who basically does nothing else but
look after those studies, okay?'
- 382 die ist da ganz TIEF im thema drin;
'she is very deep into that topic'
- ((5 minutes, during which the doctor explains the methods with which the
cancer cells can be detected in the blood; at the end of that explanation
he concludes that during the treatment there may come the point at which
even highly sensitive detection methods cannot find cancer cells any more.
This leads back to the patient's question whether it is possible that the
therapy may be stopped at some time in the future.))
- 489 A ja ja also das ist-
'yes yes well that is'
- 490 ja das is (--) MÖglich und entspricht dem stand der (.)
behAndlung.

'yes that is possible and corresponds to the current state of treatment'

In order to support his assessment concerning the results of the proposed therapy, the doctor presents a range of 'safeguarding strategies' which may anticipate possible questions and possible sources of distrust of the patient: First, the doctor points out that the fact that he cannot give a clear answer is something that is not due to his fault but that this represents the "modern state of science" (line 327). Implicitly, he thus tells the patient that he is informed and up to date with current developments regarding the cure of this chronic type of cancer. He further builds up trust when he tells the patient that he will be treated according to the "best scientific standards" (line 331). The second strategy is to position oneself as part of an expert collective: The doctor uses the third person pronoun *we* (e.g. line 331) to signal that the proposed therapy is not the result merely of his own expertise but that of the collective of doctors working in the oncological departments (in some instances the doctors explicitly refer to the 'tumor boards', i.e. the meetings of all cancer specialists in the clinics, who always have to decide collectively whether a proposed therapy will be finally performed. Therapies are never decided upon by a single individual). A third strategy, when possible, is to refer to the chance of taking part in a treatment study and to the advantages this has for the patient, namely that a board of independent doctors again evaluates the medical report, the diagnosis and the therapy, that the therapy is conducted according to the most modern standards in medicine and that the patients in these studies are "under maximal surveillance" (line 379). A fourth strategy is to present the therapy plan as an established, well-known and acknowledged routine. This is often done by presenting the steps of the plan using the indefinite pronoun *man / one* or by using the passive voice (in another example the doctor presents the therapy plan saying: "for you this means that one recommends several steps in the treatment. [...] The first step would be that one removes the original tumor..."). The fifth strategy is to praise one's colleagues at the clinic ("our study doctor who basically does nothing else but look after those studies, okay? she is very deep into that topic"; lines 381-382). Praising one's colleagues establishes a general trust into the institution of the clinic as a whole from which the individual doctors then in turn may profit.

All of the phenomena described so far – how doctors deal with openly or covertly shown distrust and which strategies doctors use to validate their diagnoses, therapy plans and prognoses in advance – concern the question of the 'second opinion' only indirectly insofar a patient who does not trust a doctor may feel more inclined to get a second opinion than a patient who trusts his doctors, who is convinced that his therapy meets international standards,

who is supervised in a study and knows that a whole collective of doctors has considered his case. Nevertheless, in all of these cases there has been no explicit thematization of a ‘second opinion’.

This, of course, does not mean that doctors do not thematize that topic. One way the ‘second opinion’ is thematized is a rather common one. Often, the doctors assume that patients have already informed themselves through the internet, by buying advice booklets or by asking friends, relations or even other doctors. This is possible because even though the patients do not as a rule know for certain the details e.g. about the grade and depth of the cancer they suffer from, they at least now which type of cancer is suspected. Especially the internet has become a quick and easy – although often unreliably – source of information. The internet as an origin of a ‘second opinion’ (or, more often than not, of dozens of opinions) is well known to the doctors, who assume as a matter of fact that patients did some research on their own before coming to the therapy planning talk:

example 7:

265 A oder wie wir auch in den letzten jahren sagen können eine
kombinierte CHEmotherapie.
'or what we can say since the last few years a combined
chemotherapy'

266 ich weiß nicht inwiewei? inwieweit sie schon nochmal irgendwie
bereits was NACHgeguckt haben im internet,
'I don't know how fa how far you already have searched the
internet'

267 oder ob sie DA schon n bisschen was-
'or whether you already have a bit'

268 oder haben sie sich jetzt erscht emal bissl bedeckt gehalten
mit dem recherCHIERen;
'or have you so far abstained a bit from researching on your
own'

269 P nee ich hab mich jetzt noch überHAUPT noch gar nicht;
'no so far now I haven't at all'

270 A oKAY.
'okay'

In the middle of explaining the therapy plan to the patient (P), the doctor (A) interrupts himself and asks the patient whether he already did some research on his type of cancer. If that had been the case, the doctor could, for example, skip some explanations or thematize alternative treatment options discussed on the internet. In that case, though, the patient deliberately refrained from getting a ‘second opinion’ via the internet.

Finally, doctors also initiate the topic of a ‘second opinion’ explicitly. In the following transcript the doctor (A) has just finished his explanation of the therapy plan and, without further introduction, brings up the topic of the ‘second opinion’, which, in this case, had

obviously been breached upon at some time before the therapy talk, maybe during some of the previous examinations.

example 8:

- 835 A würden wir uns schon WÜNschen eh (--) dass wir das betreuen dürfen.=
 'we would wish for ourselves erm that we were allowed to look after this'
- 836 =<<all> sie hatten ja auch ganz offen nach ner zweiten MEInung gefragt;>
 'you had also asked quite frankly after a second opinion'
- 837 das is noch THEma?
 'is that still on the table'
- 838 P mhm.
 'mhm'
- 839 A gut.
 'good'
- 840 ja.
 'yes'
- 841 ehm der ARZTbrief ist jetzt noch (.) auf den aktuellen stand zu bringen natürlich_ ja,
 'erm the medical report now is still to be put up to date of course, isn't it'
- 842 und das macht frau x aber und dann KRIEgen sie das und dann wenden sie sich an ein zEntrum ihrer wahl; (---)
 'and this is what Mrs. X will do and then you will get it and then you turn to a medical center of your choice'
- 843 vermutlich liegt die universität X da nah oder Y; (---)
 'probably universities X or y will be an obvious choice'
- 844 ich WEIß nich an wen sie DENken?
 'I don't know whom you have in mind'
- 845 P eher im beKANNTenkreis;
 'I rather thought about someone I know'
- 846 jemand der sich da gut AUSkennt;
 'who is well-versed in that'
- 847 A ja GERne okay;
 'yes, you're welcome, okay'

In line 835, the doctor finishes his description of the proposed therapy with a wish that he (and his colleagues at the clinic) would be glad to treat the patient. Directly after this wish, and latched onto the previous utterance, he follows up with a thematization of the 'second opinion' the patient obviously had brought up some time before the therapy planning talk. Even though doctors usually are much more 'relaxed' about that topic, the verbal formatting of the utterance nevertheless shows that there still is some aspect of a 'problematic' topic associated with the 'second opinion': First, the doctor introduces the topic speaking very quickly and, second, he characterizes the way the patient asked after a 'second opinion' as "ganz offen" / "quite frankly" (line 835), which is a phrase that is regularly used to mark face-threatening and problematic utterances (Stoltenburg 2009). But this is the only place where the potentially problematic nature of this topic can be glimpsed. After the patient affirms her wish for a 'second opinion', the doctor in a matter-of-fact way deals with the technical issues

(putting the medical papers in order) and closes the sequence shortly after with “ja GERne okay / yes, you’re welcome, okay” (line 847).

In most cases, though, when doctors thematize the ‘second opinion’, this happens without any use of contextualization cues referring to a potentially problematic topic. The following transcript illustrates such an unproblematic thematization where the doctor even brings up the topic without any previous initiation by the patient. After the doctor (A) has told the patient that he just fixed “good early date” (line 494) for the patient to start with the chemotherapy, he himself gives the patient do decide whether this date is okay or whether a ‘second opinion’ is wished for:

example 9:

- 494 A und des is schon n ziemlich GÜter früher termin.
 ‘and that really is quite a good early date’
- 495 wenn sie sagen das REICHT mir nicht,
 ‘if you say that is not enough time’
- 496 oder sie sagen ich will noch eine zweite MEInung mir irgendwo
 anders einholen,
 ‘or you say I want to seek for a second opinion at some other
 place’
- 497 P mhm,
 ‘mhm’
- 498 A ja des is wahrscheinlich der FALL;
 ‘yes that probably is the case’
- 499 oder viELLEICHT der fall,
 ‘or maybe the case’
- 500 P also ich hab im HINterkopf,
 ‘well I have at the back of my mind’
- 501 das sag ich jetzt einfach ganz OFFen,
 ‘I say that now simply quite frankly’
- 502 A ja ja,
 ‘yes yes’
- 503 P natürlich mich noch mal also einfach ich WEIß jetzt noch nicht
 in welcher form,
 ‘of course again well simply I don’t know in what way’
- 504 ich möchte auf JEDen fall mit meinem hAUarzt rücksprache
 halten und mit ihm dann noch mal drüber sprechen.
 ‘in any case I want to talk with my family doctor and to
 discuss it with him’
- 505 A geNAU.
 ‘exactly’
- 506 ja.
 ‘yes’
- 507 P und dann dass wir zweimal überLEgen ob es sinn macht noch ne
 zweite mEInung oder nicht,
 ‘and then that we think twice about whether it makes sense
 maybe to seek for a second opinion’
- 508 also dass ich dann EINfach dann noch n bissl-
 ‘well that I then simply then a little bit’
- 509 A mhm,
 ‘mhm’
- 510 P also ZEIT in anführungsstrichle haben mir da.
 ‘well have quote time unquote there’
- 511 A oKAY also ich glaub bei unter medizInern ist das jetzt wirklich
 ne völlig EIndeutige sache.

- 'okay well I think among medical practitioners this really is a completely unequivocal matter'
- 512 P mhm,
'mhm'
- 513 A wo keine zweite meinung unbedingt [NOTwendig ist,]
'where no second opinion is absolutly necessary'
- 514 P [NOTwendig ist;]
'is necessary'
- 515 A aber wir sind da VOLLkommen offen.
'but we are completely open there'
- 516 P mhm.
'mhm'
- 517 A und wenn des für sie ein beDÜRFnis darstellt,
'and if this is your wish'
- 518 dann ist das überhaupt GAR kein thema,
'then it is no question at all'
- 519 und SO viel zeit hätten sie auch noch ja;
'and that much time you would also have yes'
- 520 P also im im prinZIP ist mein beDÜRFnis des also mein beDÜRFnis
sehr groß nach all also nach zusätzlichen alternativen zu
schauen.
'well in principle my wish is well my wish is to search for all
well to search for additional alternatives is very great'
- 521 A mhm.
'mhm'

As the patient might feel forced to act against her wish because of the fast succession of diagnosis, presentation of the therapy and an already fixed date for the start of the treatment, the doctor 'pedals back', making clear that the date is not that fixed that it could not be postponed (or even canceled). He builds the patient's trust by offering her the opportunity and time to get a second opinion (lines 495-496). The patient then affirms that this is indeed something she had already thought about and that she at least wants to talk to her family doctor about the therapy. The doctor states that according to his view a 'second opinion' is not really necessary in that case – again by using the strategy of placing himself within the collective of “medical practitioners” who all would agree that it is a “completely unequivocal matter” (line 511) – but then goes on to support the patient's wish unconditionally (“but we are completely open there”; line 515). This gives the patient the full control over the decision of the proposed therapy.

7. Trust and distrust in therapy planning talks: a conclusion

The analysis showed that the possibility of distrust is omnipresent in therapy planning talks and that the negotiation of trust and distrust needs to be done verbally. Distrust can emerge because patients do not have the expert knowledge of the doctors and, consequently, cannot judge (i) whether and to what degree the diagnosis and therapy plan are correct and justified, (ii) whether the proposed therapy is the best possible one and conforms to current international standards of treatment, (iii) whether the doctor is truthful about the state of the

disease or conceals some negative aspects for the sake of the patient and (iv) what the chances of a successful cure are. This already difficult situation is further aggravated by the fact that often the therapy and its surroundings are associated with uncertainties which cannot be solved at all: Sometimes there are optional examinations which are not absolutely necessary but advisable to a certain degree. In one therapy planning talk, for example, the doctor proposes a bone-marrow puncture. The patient says that he does not want to do it and the doctor then concedes that he himself cannot recommend this puncture whole-heartedly but that it is simply the routine procedure. In other cases there is a choice between different therapy plans, each of which has advantages or disadvantages, such as a longer time of treatment in exchange for fewer side effects. Here, patients have to decide on the basis of their meagre knowledge about cancer therapies. In some cases even the basis of the diagnosis is not fully clear, which means that one has to operate with probabilities, not with certain facts (for example, if a tumor may or may not turn out to be aggressive, which only time will tell).

Another source of insecurity has to do with the fact that patients often inform themselves through the internet, where they are confronted with many, often contradictory, pieces of information. Furthermore, there is the tendency that only negative stories turn up in weblogs or forums on cancer, which distorts the picture regarding conventional cancer therapy.

All of these aspects have to be negotiated by the doctors in order to make sure that the patients accept and trust in the proposed therapy. It could be shown that an important measure of building trust is the use of anticipatory ‘safeguarding strategies’ by the doctors: By referring to international standards of treatments, collectively made decisions, patients’ participation in supervised studies or excellent colleagues at the clinic trust is built up. Another strategy to build up trust is to take a positive and supportive position regarding the patients’ wishes to get a ‘second opinion’. This is a strategy that can be observed throughout the analyzed talks: Be it in reaction to the initiation of the topic of the ‘second opinion’ or in the context of an initiation by the doctors themselves: The wish to get a ‘second opinion’ is always actively supported. This is a very effective combination of subjective and objective parameters of trust and distrust, in the terms of Luhmann (1973: 83; my translation):

The problem is that trust and distrust, as we could see, are symbolically transmitted, generalized actions which do not co-variate together with specific objective causes but are steered by subjective processes of a simplified coping with experiences.

This means that objective aspects such as standardized treatment procedures, the collective expertise of a clinic or the participation in studies are, of course, important, but that their main importance is in establishing the *subjective* assessment of the doctor as trustworthy by the patient. Therefore, it is important that doctors actively deal with the patients’ pre-knowledge

about their disease and thematize the ‘second opinion’ as something that is not face-threatening but a normal and necessary part of a therapy planning talk.

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Appendix: Transcription conventions according to GAT 2 (Couper-Kuhlen/Barth-Weingarten (2011)):

Sequential structure

01 each line represents a single intonation phrase and is marked at the end regarding final pitch movement (see below)

[]

[] square brackets signal simultaneous talk

Final pitch movements of intonation phrases

? rising to high

, rising to mid

– level

; falling to mid

. falling to low

Pauses and lengthening of sounds

(.) micro pause, estimated, up to 0.2 sec. duration appr.

(-) short estimated pause of appr. 0.2-0.5 sec. duration

(--) intermediary estimated pause of appr. 0.5-0.8 sec. duration

(---) longer estimated pause of appr. 0.8-1.0 sec. duration

(2.5) measured pause of appr. 2.5 sec. duration

:

lengthening, by about 0.2-0.5 sec.

::

lengthening, by about 0.5-0.8 sec.

:::

lengthening, by about 0.8-1.0 sec.

In- and outbreaths

°hhh inbreath, increasing number of h indicates longer inbreath

hh° outbreath, increasing number of h indicates longer outbreath

Accentuation

SYLlable focus accent

sYllable secondary accent