SAPIENZA
UNIVERSITÀ EDITRICE

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E-ISSN 2724-2943
ISSN 2723-973X

Psychology Hub (2024)
XLI, Special Issue, 117-126

Managing uncertainty in oncology visits: communication practices with ethnically diverse patients in the Italian medical context

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Article info

Submitted: 01 February 2024
Accepted: 07 May 2024
DOI: 10.13133/2724-2943/18417

Abstract

Introduction: In the context of a set of oncological visits carried out by one doctor with Italian and migrant patients, this study focuses on how the oncologist refers to, and how he manages, information, which qualify some events as uncertain or not fully predictable. Examples include the patient's advantage or disadvantage to opt for a certain treatment, the chance to recover from cancer or, on the contrary, the risk of cancer recurrence, as well as the risk to undergo certain side effects of the treatment.

Method: Drawing on results obtained by previous coding of 19 videorecorded doctor-patient consultations with native Italian patients and migrant patients, the study applies Conversation Analysis to analyze two single contrastive cases, respectively, with an Italian patient and a Ukraine patient.

Results: Analyses reveal that, however the oncologist's communication is accompanied in both cases by hedging strategies, uncertainty embedded in cancer issues and particularly, in cancer treatment is discussed in much different way in the case of the Italian and the migrant patient. While the Italian patient is addressed with elaborated and detailed information, cast as objects of considered assessment by both the doctor and the patient, the Ukraine patient is addressed with simpler and generic formulations of uncertainty and eventually offered more constrained treatment options.

Conclusions: The findings emphasize the importance of exploring the oncologists' views and perceptions about matters such as: the significance of shared decision making (SDM) in their own practice, the role of the patient's cultural backgrounds in communicating oncological information, uncertainty and tolerance of ambiguity in the relationship with the patient.

Key words: uncertainty, doctor-patient communication, oncology consultations, conversation analysis, foreign patients

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Introduction

Uncertainty is recognized as a central aspect of medical practice (Montgomery & Harris-Braun, 2008; Han, 2011), necessitating specialized training (Lingard et al., 2003). Whereas medical students may perceive uncertainty as a challenge to be concealed, senior physicians acknowledge and demonstrate methods for handling uncertainty through clinical reasoning (Loftus, 2012; Alby et al., 2015, 2017a; Fatigante et al., 2016). Uncertainty may affect all steps of illness management, including diagnosis, prognosis, treatment plans, illness development and management of everyday life particularly in the case of chronic illness (Mishel, 1999) as in the case of heart disease or Alzheimer (Goldsmith et al., 2006; Stone & Jones, 2009).

Indeed, it is evidenced that effective communication between the doctor and the patient reduces patient's anxiety, and enhances satisfaction, especially in contexts where medical uncertainty is prevalent (Street et al. 2009). Furthermore, examining the impact of uncertainty in communication, Epstein and Street (2007, 2011) underscore the need for physicians to acknowledge uncertainty transparently while maintaining a patient-centered approach. Open communication about uncertainty can contribute to building trust between patients and healthcare providers (Chen & Roter, 2016). Patients often desire honest and realistic information about their conditions, even when the prognosis is uncertain (Epstein & Peters, 2009).

In genetic counseling, Sarangi and Clarke (2002) identified discursive and rhetorical strategies, such as *contrast* and *hedging*, employed by doctors to communicate risk while maintaining a non-directive stance. Contrast is a rhetorical device often deployed in the accounting practices of both patients and doctors to represent the different characters and event involved in the decision-making process. Hedging include verbs (e.g., think, suggest, guess), auxiliaries (e.g., might, may, could), nouns (e.g., estimates), adverbs (e.g., roughly, approximately, about), and so forth, which limit the strength of the speaker's commitment to the certainty of his assertion (see also Brookes-Howell, 2006; and Lehtinen, 2013).

In the specific context of oncology, where uncertainty of therapeutic outcomes is often prominent (Garofalo, et al., 2009), studies by Butow et al. (1996) and Clayton et al. (2005) emphasize the importance of balancing hope and realism in discussions about prognosis and treatment options, considering the emotional and psychological aspects implied in the communication about uncertainty.

Cultural sensitivity is crucial in tailoring communication strategies to meet the diverse needs of patients. Considering cultural factors in the communication of uncertain news, studies by Palmer et al. (2018), Wong et al. (2008) and Lee et al. (2012) delve into the influence of cultural backgrounds on patient preferences for information disclosure (cf. also Fatigante et al., 2020, 2021; Fantasia et al., 2021).

Research conducted in cross-cultural settings has illuminated the intricacies of doctor–patient communication, particularly when the patient is a foreigner, facing linguistic, communicative, interpretative, and relational barriers (Geraci & Hamad, 2011). Investigations into the experiences of migrant patients have revealed the multitude of stressors they encounter in the healthcare system, encompassing challenges in understanding and navigating local healthcare structures, language barriers, and communication difficulties. Disparities in health outcomes among foreign patients are often exacerbated by inaccurate comprehension of diagnosis and treatment, coupled with an elevated occurrence of communicative misunderstandings regarding the causes of cancer (Jacobs et al., 2003; Schouten et al., 2007). This leads to suboptimal long-term health results (Bischoff, & Wanner, 2008; Butow et al., 2011, Pandey et al., 2021), and diminishes quality of life among foreign cancer patients (Hyatt et al., 2017). In investigations conducted in the United States and Canada involving Asian-American and Asian-Canadian cancer patients (both male and female), findings indicate that these individuals were less likely to participate in treatment decisions compared to their white counterparts, with language identified as a primary factor contributing to perceived disparities (Mitchell & Perry, 2020; Palmer et al., 2018; Lee et al., 2012; Wong et al., 2008). On the contrary, foreign patients often express a desire for more information and dedicated time to discuss their conditions with healthcare professionals (Filler et al., 2020).

A previous study applied a recently developed coding system (ONCode, Alby et al., 2021; Marino et al., 2023)on a corpus of 19 oncological consultations videorecorded in two Italian hospitals, involving both native patients than non-native patients. ONCode examined different communicative dimensions (e.g. misalignments between doctor and patient, accountability and expressions of trust, markers of emotions, patient's initiatives), including, markers of uncertainty in doctor's talk. This dimension, showed to obtain lower scoring in the case of visits with non-native patients, as compared to visits with native ones.

Prompted by the studies surveyed so far, we comparatively examine here different ways to deal with uncertainty in two visits, respectively, with an Italian and a non-native patient. Particularly, we aimed at examining how reference to uncertainty appears in the oncologist's discourse in a specific stage of the visit, i.e., the treatment recommendation stage. Here, in fact, reference to certainty/uncertainty regarding the beneficial effects of the treatment and prognosis overall, may affect the likelihood that the patient accepts or rejects the treatment. In turn, doctor's moves may be tailored accordingly to what he anticipates that the patient can understand and /or resist over the proposal.

Analyses ground on Conversation Analysis (Schegloff, 2007), a methodological approach based on the close examination of the sequence of conversational -turns, transcribed in detail (including gaze, posture, facial expressions, hand movements, gestures, co-occurring with talk), which allow to analyze how participants at talk display each other, and gain, a mutual understanding of the specific actions they accomplish in interaction, how implicit rules and cultural preferences are indexed through linguistic and discourse moves, how context and identities are made relevant by sequential and formal aspects of conversation.

Data and Method

We selected the two cases from the corpus of overall 19 videorecorded oncological consultations, which constituted the set of data inspected by ONCode in the previous study. This included 15 first time post-surgical visits, and 4 follow-up consultations; visits involved 3 different doctors (one senior oncologist, working in a middle size hospital, and a set of 1 senior and 1 junior doctor, resident in oncology, working in a University hospital), 10 Italian patients, and 9 non-native patients. Analyses here only included visits led by one senior oncologist, working in the middle size hospital. This choice was made, after having identified features (type, length, overall structure of the visit), which were comparatively similar across visits, this allowing to examine specifically which features of the cultural and language identity of the patient were made relevant by language and discourse choices of the doctor.

The two patients, an Italian and a Ukrainian patient, had both a breast cancer diagnosis, and were accompanied, respectively, by the husband and a (Italian) friend.

Like all other patients in the study, they were invited to participate in the study while waiting for their appointment. Those who agreed to participate were asked to sign a written informed consent form to take part in the study and allow video recording of the visit. A video camera was placed in the examination room, focusing on the patients and physicians (and companions, if present) interacting. The visit video-recordings were fully transcribed according to conversation analytic conventions (cf. Figure 6).

Results

Examples 1 and 2 illustrate how treatment recommendation unfolds in the oncological visits. Both examples start as the doctor has completed to review the patient's record (including histological exam, and other tests useful for the diagnostic assessment), and has stopped to write down the information on his own medical (hospital) record. We put them one after the other, to capture similarities, and differences (cf. Figures 1 and 2).

Fig. 1. (Example 1a)

Participants: 62 yrs old Italian woman with breast cancer (PAT), companion (COM, husband), onologist (ONC, M)

```
1. ONC     =premessa, (.) lei dovrebbe fare la radioterapia.
           =provided that, (.) you should do radiotherapy.
2. PAT     eh sì=
           uh right=
(....)
5.  ONC    quello che è un pochino più difficile,
           what is a little bit more difficult,
6.  PAT    eh,
           uh
7.    (.)
8.  ONC    è  decidere, se fare anche un trattamento medico,
           is to decide, whether to do also a medical treatment,
9   PAT     ((lifts her eyebrows, as to express misunderstanding))
10  ONC    cioè una pasticca,
           I mean a tablet,
11  PAT    ah,
           uh
12  ONC    oppure no.
           or not
13  PAT    mh.
```

Fig. 2. (Example 2a)

Participants: 46 yrs old woman from Ukraine, fluent in Ukrainian, with Italian proficiency at conversational level (PAT). She has breast cancer, companion (COM, Italian friend), oncologist (ONC, M).

```
1 ONC      a:llora.  vediamo se riesco a spiegarmi. =
           so:. let's see if I can make myself clear.=
2   PAT    ((nods))
3   ONC    =lei co:munque dovrà fare la radioterapia. =
           =you will have to do radiotherapy in any case.=
4   PAT    ((nods))
5   ONC    =*perché la radioterapia la devono fare tu:tte le donne,
           =because the radiotherapy needs to be done by a:ll women,
6   PAT    *((continues nodding))
7 ONC      (.) che- (0.4) hanno avuto un intervento parziale.=
           (.) who-(0.4)  have undergone a partial surgery.=

8          =quindi quella=là, la deve fare di sicuro.
           therefore that=one, you have to do it for sure.
9 PAT      (0.5) ((nods firmly))
10  ONC    .h il colloquio che oggi, (.) lor signore, *hanno con me,
           .h the meeting that today, their madames, have with me,
11  COM                                               *((smiles at ONC))
12         è inteso a stabilire, se lei si può, giovare,
           is aimed at agreeing upon, whether you can, benefit,
13         se può convenire, di fare qualche terapia, per ridu-
           if it can be worthwhile, to do some therapies, in order to redu-
14         preventiva, per ridurre il suo rischio.
           preventively, in order to reduce your risk.
15         (1.0) ((PAT looks unmovable at ONC))
16 ONC     n'a capito.
           you didn't understand.
15  PAT    ntz ((shakes her head and turns to the companion))
16  COM     ((smiles and bends toward the patient))
17         la radio-
           the radio-
18  ONC    allo-
           so-
19  COM    no prego
           no go ahead ((she returns to her previous position))
```

In both examples the oncologist formulates, prior to the delivery of the treatment recommendation, what he will undertake together with the patient: similarly to what we have observed across the corpus, he anticipates and *frames* (Goffman, 1974) the main task that the participants have to engage: a decision -making process. Further, in both examples, the oncologist sets forward a scenario, introduced by the conjunction "whether" (line 8 example 1, line 12 example 2), in which the patient is faced by the chance to consider certain factors and information, to make up her mind toward an option or another.

Radiotherapy is pronounced in both cases as not a matter of consideration: the way in which the recommendation toward radiotherapy formulated as a "premise" for subsequent arguments rules it out of debate. Yet, it can be noted that, in the first example, the oncologist mitigates (Caffi, 1999) the strength of certainty in his recommendation, by using the conditional (*you should do*) instead of the imperative (*you will have to do*) used in example 2.

On the contrary, the medical treatments, or, preventive therapies are qualified as a matter of debate: something, which is cast (example 1) as imbued with difficulty (*is a little more difficult*), and involving shared judgment (*decide whether to,* example 1; *agreeing upon,* example 2) between the doctor and the patient (and her companion, invoked line 10 example 2, *Miladies*).

As regards differences between the two cases, we summarize a few, up to this point:

0) clearly, the patient's understanding is something, which the doctor makes relevant more prominently in example 2 than example 1 (line 1 *let's see if I can make myself clear*); 2) in example 2 and not example 1, the doctor provides an explanation for how the radiotherapy is commanded to the patient (lines 5-8) and repeats his pronouncement as implication of that, after which the patient displays acceptance; 3) in example 2 and not example 1, the framing formulation about the medical therapies includes a reformulation (*can benefit* .. to *be worthwhile,* line 12 and 13) and a self-repair (*to reduce..* to *preventively reduce*, line 14), which work as repeated attempts

to make information increasingly more specific and reasoned; 4) in example 2, the doctor explicitly addresses both the patient and the companion as official recipients of his talk.

All these indexes highlight the increased effort made by the oncologist to secure the patient's understanding in a case, where there is no shared language background.

Both patients in the two examples respond to the introductory preface – regarding the need to carefully consider medical therapies- with a nonverbal reaction of non -understanding (line 9, in example 1; line 15, example 2). This is immediately cleared in the first example, where the doctor's exemplification of what he means obtains that the patient confirms immediate comprehension (line 11). In the second example, the patient's behavior conveys striking evidences that she got lost in the explanation: she remains silent, stops nodding, looks unmovable at the doctor. Taken altogether, these signals are interpreted as displays of non-understanding by the doctor, who comments outload about the patient's lack of comprehension (line 16), and, halting the companion to repair to the misunderstanding herself, returns to the very first beginning of his assertion (line 18).

This has great consequences on the sequential development of the recommendation.

From line 14 in Figure 3, the Italian patient is addressed with a rich explanation, which also includes recall of scientific literature, and which is produced making extensive reference to specific quantification of the advantages and risk:

Fig. 3. (Example 1b)

14	ONC	.h l'ultimi::ssimo lavoro,
		.h the ve::ry last work,
15		che è stato pubblicato,
		that has been published
16		l'ha scritto (Fisher),
		was written by (Fisher),
17		è stato pubblicato sul Lancet,
		it has been published on Lancet, ((turns to the computer))
18		*((PAT and COM turn their gaze in the direction of the computer screen))*
19		mi pare che da- dar- darebbe un piccolo vantaggio, .h
		I believe that it wo- would gi- would give a small advantage, .h
(...) few lines omitted		
22		quello che si tratterrebbe di capire se ci può convenire dare
		what one would need to understand is whether it could be convenient for us to give
23		questa pasticca, come sorta di, prevenzione per il tumore controlaterale,
		this tablet, as a sort of , prevention for the contralateral tumor,
24		perché le donne che hanno avuto un t*umore da una parte,
		because women who had a tumor on one part,
25	PAT	*points to her left breast, then to the right one and opens her mouth
26	ONC	non è che lo devono avere per forza
		it's not like they must inevitably have it
27	PAT	↑però può-
		yet it can -
28	ONC	rispetto alla popolazione normale,
		as compared to normal population,
29	PAT	si, si=si, ho capito.
		yes, yes=yes, I understood.
30	ONC	hanno un incremento, seppur lieve,=
		have an increment, however small, =
31	PAT	m=mh
32	ONC	=di rischio.
		of the risk.
33	ONC	a:llora. il problema è questo. se noi, (.) vogliamo,
		therefore. the problem is this. if we, (.) want,
34		decidere di fare l'ormonoterapia,
		decide to do hormonetherapy,
35	PAT	mh,
36	ONC	.h a parte che
		.h provided that
37		l'ormonoterapia, la potremmo fare anche dopo la radioterapia,
		we could even do hormonetherapy after radiotherapy
38		perché siccome in qualche re- reference, c'è scritto, che:
		because given that in some re-reference, is written, that
39		l'ormonoterapia, col tamoxifene insieme alla radioterapia,
		hormonetherapy, with tamoxifen together with radiotherapy
40		aumenta un pochino la fibrosi post attinica,
		increases a little bit post actinic fibrosis,
41		siccome c'ha un rischio praticamente zero,=
		since you have a risk practically equal to zero,=
42	PAT	mh=mh,
43	ONC	=.h gliela facciamo dopo,=
		=.h we do it later,=
44	PAT	certo. certo.
		sure. sure.
45	ONC	=tanto non succede niente.
		=for in any case it does'n happen anything serious.

Firstly, noticeable here is that the doctor at line 16 refers to an authoritative source of knowledge, the scientific reference, ascribed precisely to a certain author, who – however probably meaningless for the patient – we know (from other instances of the oncologist's talk, interviews with him and verification on medical database) is very influential in the field of oncology. The reference, then, to impersonal, validated knowledge strengthens the doctor's reliability. Given this, the doctor uses *hedging* strategies to introduce the next information, firstly by the expression "I believe" and secondly, by the use of the conditional tense, strategies, which together weaken his full commitment in the propositional content of what he refers (Fraser 2010). This way, the doctor works two jobs in a time: on one hand, he projects himself as an expert of the subject, a reliable and trustworthy interlocutor; on the other, he socializes the patient to understand that predictions in oncology always rely to uncertainty and, as such, it always opens up a space for a (shared) consideration.

Another hedging strategy is used rhetorically at line 20 (i.e., the conditional mood in "*what one would need to understand*"), which limits the oncologist's commitment in the illocutionary force (Austin, 1962) of the action he is presenting while, at line 21, he uses the propositional hedge ("*a sort of*"), which conveys the sense of semantic approximation of what is saying. Besides the differences existing between the different hedging strategies, what we can say is that the oncologist is building, little by little with this patient, the pre-conditions for the patient and him consider together the recommendation as the result of a cautious choice , which could finally consist in the selection of one treatment over others or, over non -treatment (in this case): see lines 23-24, *if we want to decide to do hormonotherapy*. Suspending the formulation of this logical proposition, the oncologist inserts a parenthetical element, where, provided that hormonotherapy would be pursued as an option, other considerations open up for the doctors, making it possible to postpone its administration. Here again, he refers to scientific literature, which would support the considered option. The use of an elaborated, specialistic code (evident in the use of a medical lexicon: *tamoxifen, post actinic fibrosis*, the use of English term *reference*, instead of the Italian "riferimento" or "articolo", which indexes the doctor's identity as not only a clinician but also an academic scholar) contributes to ground the recommendation toward hormonotherapy onto a distributed, collective, knowledgeable subject (line 33, *h gliela facciamo dopo*) that has righteously weighed *pros* and *contras* of the treatment before expressing a definitive opinion.

In any case, the doctor does not yet conclude the recommendation, whereas, he resumes the provisional character of the option that they are considering, and refers to two other elements, which are able to loosen the force within which the recommendation may be delivered at this moment: firstly, he begins to portray the possible collateral, noxious effects coming with the hormonotherapy, which may influence the patient's willingness to comply with the proposal; secondly, he shares with the patient that he needs more information, specifically, whether her tumor is hormone sensitive (something, which can only be revealed by the histological test as he will clears off at the end of the sequence) , thus showing that the choice of the treatment is never so straightforward but always conditional to certain evidence (cf. Figure 4).

Fig. 4. (Example 1c)

```
46 ONC      .h allora però,
            .h in any case though,
47          se noi dobbiamo fare la radiotera- la- l'ormonoterapia,
            if we have to do the radiothe- the - the hormonetherapy,
48 PAT      mh,
49 ONC      prima, io le devo raccontare quali sono gli effetti tossici della
            medicina,
            first, I have to tell you what are the toxic effects of the medicine
50 PAT      m=mh,
51 ONC      che lei prende
            that you take
…
55 ONC      .h secondo, devo avere l'informazione,
            .h secondly, I need to have the information
56          devo avere l'informazione dai colle- lì, se i recettori ormonali,
            I need to have the information from colleag - there, whether the
            hormonal receptors
57          come è verosimile che siano, sono positivi.
            as they plausably are, are positive
58 PAT      ho capito.
            I got it.
…
64 ONC      questo se decidiamo di fare il trattamento,
            this is, if we decide to do the treatment
65  PAT     certo
            sure
66 ONC      perché se decidiamo di non farlo,
            because if we decide not to do it,
67 PAT      è inutile
            it's useless
68 ONC      e tanto è tutt'uno.
            for anyway it comes as a whole
….
((ONC explains all the toxic effects and formulate them as very rare or, something that can
be mobitored))

80  ONC     io direi questo. che è molto più equilibrato.
            I would say this. that is much more balanced.
81 PAT      mh sì.
            mh yes.
82 ONC      lei, intanto, ce pensa su.
            in the meantime, you think about it.
83 ONC se ci pens- tanto lo facciamo dopo la radioterapia.=
            if you thin- anyway we do it after the radiotherapy
84 PAT      sì
```

Overall, the oncologist dedicates quite a lot of time and explanations about variables which can influence the patient (and the doctor)'s decision to opt for the hormone therapy treatment, or to rule it out. The patient is driven into a journey, in which, the more uncertainty is acknowledged and not concealed or blurred, the more the decision is secured as the most correct and reliable.

Finally, the doctor leaves the patient with the open question and suggests that she takes her time to consider both options, while she will engage in radiotherapy (something, which is instead maintained as mandatory).

Contrasting this scenario, the treatment recommendation with the Ukraine patient unfolds in much different way (see Figure 5). Halted by the patient's display of non-understanding, he repeated the first pronouncement regarding radiotherapy (line 20), this way recovering immediately the patient's display of understanding and acceptance of the proposal (line 22).

Across the whole doctor's explanation, the patient has signaled constant and repeated nods. The series of embodied display of understanding, in this action environment, allows the doctor to add increasing pieces of information, and scaffold not only the patient's comprehension but, concurrently, also her acceptance and adherence to the treatment(s)' formulation. This includes firstly the recommendation for hormonotherapy and lastly, the recommendation for chemotherapy, which is commonly met by patients' resistance and perception of threat (Lorusso et al., 2017; Alby et al., 2017b; Fatigante et al., 2020).

Both treatment proposals are presented as certain: in Stivers et al.'s (2018) terms, it is delivered in the present tense, as *pronouncement*, something for which the speaker is ascribed full commitment and authority, and no choice or preference is (linguistically) anticipated by the addressee. Also, this deontic authority is allocated to a collective subject of medical professionals who will administer the medical therapies to the

Fig. 5. (Excerpt 1b)

```
20  ONC     la [radi*otera↑pia, la deve fare.
            with reg*ard to radioth↑erapy, you must do it.
21                *(( PAT turns to ONC, smiling))
22 PAT      (0.8) ((displays a firm nodding))
23 ONC      però questa malattia, anche se lei è guar*ita,
            yet this illness, despite you are healed,((gestures with hands opened
toward the patient))
24 PAT                                         *nods
25          è pos:*sibile che negli anni success*ivi, rito:rni.
            it is possible ((hand gesturing)) that in the following years,
             returns. ((hands opened toward the patient))
26 PAT      nods
27 ONC      a::nche da altre parti.
            also in other parts.    ((lifts and moves his left hand in the air))
28 PAT      nods
29  ONC     all↑ora per ridu:r*re questo rischio,
            th↑erefore to redu:ce this risk, ((closes his hands in fists, moving
            them closer to his breast))
30 PAT                     * repeated nods
31          noi le dobbiamo fare delle cure mediche.
            we have to do some medical therapies to you. ((hands opened toward the
            patient))
32          (1.0) ((PAT nods))
33 ONC      allora, la CUra più importante per lei, è l'o:rmonoterapia.
            so, the most important cure for you, is ho:rmonetherapy.
34          (1.0) ((PAT nods))
35  ONC     cioè deve prendere una past*icca ogni cinque anni.
            that is you have to take a tablet every five years.
36 PAT                              * repeated nods
37  ONC     pe:rò, (1.0)
            but, (1.0) ((ONC moves his index fingers, lifted, in circle three times))
38 PAT      nods
39 ONC      però io a lei          vorrei fare=      a:nche la chemioterapia.
            but I ((lit. to you)) would like to do  also chemotherapy
            but I would like to prescribe also chemotherapy for you    ((points with
            both index fingers to PAT))
40  PAT     ((looks unmovable at ONC))
41          (1.2) ((ONC remains with both index fingers pointing to PAT,  glances
            at COM, then at PAT again))
```

patient (*we have*, line 31). At line 32, authority and certainty is utmost strengthened via *assertions* (Stivers et al., 2018): *the most important cure for you is… that is the most important ever,* which cast the treatment as universally valid and, as such, unquestionable. The second type of treatment, chemotherapy, which, more than hormonotherapy, implies burdening collateral effects, is presented as solely dependent from the doctor's will, and cast with a *hedging* (line 39, *I would like to prescribe also chemotherapy for you*). The doctors' explanations throughout the sequence are accompanied by ostensive hand gestures, which give emphasis to verbal communication. As the doctor explicates his intention to prescribe the patient the chemotherapy, he points to the patient with index fingers of both hands, and keeps them in that position across lines 39-42. Such a gesture, coupled with the left dislocation "a lei" ("to you", line 39), which emphasizes that the proposal is targeted for the patient as a particular addressee, strengthens the deontic authority of the doctor over the patient herself. This latter does not provide any reaction (line 40): a pause follows, which alerts that a potential misalignment is developing between the doctor and the patient. This is also exhibited by the oncologist's conduct (he rapidly glances at COM before turning again to PAT; he starts his turn by inhaling, line 42), who then starts to account for the proposal, something which obtains that the patient shows – by nodding (Steensig, 2012) alignment again. Differently from what happened in example 1, where the oncologist referred to scientific evidence to support his recommendation, here the account roots in the doctor's individual expertise in drawing relevant implications from the clinical examination of the tumor.

Tab. 1.

48	ONC	la chemioterapia è quella che fa cadere i capelli.
		Chemotherapy is that which causes hair loss. *((looks at PAT))*
49		(0.6)
50	PAT	starts nodding
51		ne ha sentito parlare?
		Did you hear about it?
52	PAT	°sì°
		°yes°
53	ONC	mh. LEI ACCEtta di farsela?
		Mh. Do you accept to do it?
54	PAT	(.) ↑eh sì,
		eh yes, *((looks away from ONC, lifts her shoulders))*
55		(se serv)-
		(if it is use-)
56	ONC	brava.
		Well done. *((stretches his arm and makes a halt hand gesture toward PAT))* okay.
57	ONC	occhei.
		Ok[ay.
58	PAT	[sì
		yes
59	ONC	= siamo d'accordo.
		We agree. *((turns to COM))*

In this second example (see Table 1), the oncologist speeds up (in comparison to example 1) the process of decision making: he restricts to a minimum the description of side toxic effects of the chemotherapy (contrary to what he did for hormonotherapy proposed to the patient in example 1, lines not shown), and, once secured that the patient is aware of what is the most common and also the most dreadful effect commonly perceived among female cancer patients, hair loss (McGarvey et al., 2002), he solicits the patient to express straightforwardly acceptance of the treatment recommendation: his question incorporates, indeed, a preference for a yes- response (Heritage and Raymond, 2021), which the patient does, obtaining a clear positive assessment (line 56), paired with a gesture, which appears to inhibit further elaboration, and the resurgence of potential uncertainty and resistance from the patient. As a matter of fact, the whole sequence in this final stage is formatted similarly to the IRE format (Initiation – response -Evaluation; Sinclair and Coulthard, 1975; Mehan, 1985), a triplet, which incorporates the expectation that only one option is the right answer. Considering all these evidences, it appears that the entire activity of treatment proposal with the non-native patient involves the doctor – and the patient – in a fully-fledged pedagogical sequence, where the doctor's contributions scaffold (Wood, Bruner, Ross 1976) the patient's comprehension, while leading her toward the acceptance of the proffered solutions. We need to add to this analysis the evidence that the companion is involved at several points in the delivery of treatment proposal. Despite the fact that the doctor always targets the patient as legitimate addressee and respondent, he also appears to turn to the companion as invoking her own confirmation of understanding or, approval (line 59), *vis -à-vis* the risk that the patient's autonomy and agency may by threatened by her vulnerability in communicative competence.

Discussion and conclusions

The aim of this article was to conduct a qualitative examination of oncologist- patient talk in the context where uncertain information needs to be delivered: this reveals to be often the case in oncological consultations and particularly, when discussing treatment options. Solicited by previous quantitative insights, which reported low reference to uncertainty by oncologists who interacted with non-native patients, we conducted a single-case Conversation Analysis on two instances of treatment recommendation delivered to, respectively, an Italian patient and a Ukrainian patient. We found that, whereas initially shaped in similar manner, the treatment recommendation in the two cases evolve much differently: whereas the Italian patient is led to consider *pros* and *contras* of the treatment choice, being exposed to highly detailed consideration of uncertain terms within which this choice will be made whatsoever, the foreign patient is more constrained to consider choices that are selected and supported by the medical's opinion and authoritative own voice.

The in-depth sequential analysis of the second case make us contend, though, that it is not the status of "foreigner" *per se* that caused the doctor to simplify the explanations and to opt for a more persuasive approach toward the patient. Rather, it was the patient's overt display of misunderstanding of his formulation at the beginning of the sequence, the trigger for his remedial action. Further, we need also consider that the recommended treatments are different in the two cases, with the foreign patient in case 2 being recommended a combination of hormonotherapy and chemotherapy. This also reveals that she might be in a more serious, possibly life-threatening condition, which may have urged the doctor to solicit her adherence to the treatment more convincingly than in the case of the first patient.

That is, the cultural and linguistic identity of the patient certainly plays a role in the content and style of talk that the doctors use with them, and in the degree to which shared decision making is implemented, as also the literature shows (Mitchell, & Perry, 2020; Palmer et al., 2018; Lee et al., 2012; Wong et al., 2008).

At the same time, our study shows the advantage to look in detail at the constraints which may influence gaps in shared understanding and mutual trust between the foreign patient and the doctor.

Factors such as the breadth and complexity of the information the doctor must convey, the assumption of the patient's limited comprehension or health literacy, the concern that thorough communication may provoke patient anxiety, and the extent to which the communication of more burdensome diagnoses and treatment recommendations may affect the oncologist's emotional state, may deter the doctor from providing extensive explanations and references. This, in turn, may result in the treatment of uncertainty in a more superficial and residual manner. Conversely, these factors may also encourage the doctor to convey to the patient that he bears the primary responsibility for delivering the best available treatment.

Further studies could complement the analysis of the interaction with measures of doctors' prejudice, doctors'

tolerance of uncertainty and ambiguity, measures of the patient's language competence and health literacy, and the patient's preferences, to identify more specifically what difference in talk and management of uncertainty can be specifically and uniquely ascribed to cultural difference.

Further, studies informed by CA methodology could help consider the contribution of the patient's companion in the occasions when the doctor discuss uncertainty with both Italian and foreign patients.

Moreover, while the study differentiates between native and non-native Italian patients, delving deeper into specific cultural backgrounds within the non-native group could yield more comprehensive insights into how diverse cultural factors influence communication.

In conclusion, ongoing research in the field of communicating uncertain medical information underscores the delicate and multifaceted nature of this process. Doctors face several communicative challenges related to the balancing of transparency, patient-centered approaches, cultural sensitivity, and patients' involvement in treatment decision making processes.

Fig. 6. (Transcription conventions)

Transcription Conventions

Symbol	Meaning
.	The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence.
?	The question mark indicates rising intonation, not necessarily a question.
,	The comma indicates "continuing" intonation, not necessarily a clause boundary.
:::	Colons indicate stretching of the preceding sound, proportional to the number of colons.
-	A hyphen after a word or a part of a word indicates a cut-off or self interruption.
word	Underlining indicates some form of stress or emphasis on the underlined item.
WOrd	Upper case indicates loudness.
° °	The degree signs indicate the segments of talk which are markedly quiet or soft.
> <	The combination of "more than" and "less than" symbols indicates that the talk between them is compressed or rushed.
< >	In the reverse order, they indicate that a stretch of talk is markedly slowered.
=	Equal sign indicate no break or delay between the words thereby connected.
(( ))	Double parentheses enclose descriptions of conduct.
(word)	When all or part of an utterance is in parentheses, this indicates uncertainty on the transcriber's part.
( )	Empty parentheses indicate that something is being said, but no hearing can be achieved.
(1.2)	Numbers in parentheses indicate silence in tenths of a second.
(.)	A dot in parentheses indicated a "micropause", hearable but not readily measurable; ordinarily less than 2/10 of a second.
[	Separate left square brackets, one above the other on two successive lines with utterances by different speakers indicates a point of overlap onset.
hhh	letter "h" indicates hearable aspiration.
→	marks the line with focal phenomenon.
*	indicates gesture or gaze turns, which happen concurrently with the speaker or some co-participant's talk

Ethical approval

The study received approval from the Ethical Committee of the hospitals involved.

Data availability statement

The data are not publicly available due to the participants' privacy.

Funding/Financial Support

This study was financially supported by the University of Rome La Sapienza (2013–2021) as regards the collection and analysis of the data.

Authors' contribution

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

Declaration of Conflicting Interests

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

References

Austin, J. (1962) *How to do things with words*. Oxford: Oxford University Press

Alby, F., Zucchermaglio, C., Baruzzo, M. (2015). Diagnostic Decision Making in Oncology: Creating Shared Knowledge and Managing Complexity. *Mind Culture & Activity, 22,* 4–22.

Alby, F., Zucchermaglio, C., Fatigante, M. (2017a). Communicating Uncertain News in Cancer Consultations. *Journal of Cancer Education, 32,* 858–864.

Alby F., Fatigante M. Zucchermaglio C. (2017b). Managing risk and patient involvement in choosing treatment for cancer: an analysis of two communication practices. *Sociology of Health and Illness*, vol.39, n.8, pp. 1427-1447. DOI:10.1111/1467-9566.12598.

Alby, F., Lauriola, M., Marino, F., Fatigante, M., & Zucchermaglio, C. (2021). A coding system for doctor-patient communication in oncological consultations - ONCODE. *TPM Testing, Psychometrics, Methodology in Applied Psychology* , *28*(3), 287–311. https://doi.org/10.4473/TPM28.3.2

Bischoff, A., Wanner, P. (2008) The Self-reported Health of Immigrant Groups in Switzerland. *Journal of Immigrant Minority Health*, 10: 325–335. DOI: 10.1007/s10903-007-9089-z

Brookes-Howell, L. C. (2006). Living without labels: The interactional management of diagnostic uncertainty in the genetic counselling clinic. *Social Science & Medicine,* 63: 3080–3091. doi:10.1016/j.socscimed.2006.08.008

Butow, P. N., Kazemi, J. N., Beeney, L. J., Griffin, A. M., Dunn, S. M., & Tattersall, M. H. (1996). When the diagnosis is cancer: patient communication experiences and preferences. *Cancer,* 77(12): 2630-2637. https://doi.org/10.1002/(SICI)1097-0142(19960615)77:12<2630::AID-CNCR29>3.0.CO;2-S

Butow, P.N., Sze, M., Dugal-Beri, P., et al., Psycho-Oncology Co-operative Research Group (PoCoG). (2011). From inside the bubble: Migrants' perceptions of communication with the cancer team. *Supportive Care Cancer*, 19: 281–290. DOI: 10.1007/s00520-010-0817-x

Caffi, Claudia (1999). «On Mitigation». *Journal of Pragmatics,* 31: 881-909. https://doi.org/10.1016/S0378-2166(98)00098-8

Chen, J. Y., & Roter, D. (2016). Exploring the relationship between U.S. and Chinese patients' information orientation and provider-patient communication: Two-world view. *Health Communication,* 31(8): 1035-1043. DOI: 10.1007/s00520-012-1641-2

Clayton, J. M., Butow, P. N., Arnold, R. M., & Tattersall, M. H. (2005). Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer*, 103(9): 1965-1975. doi: 10.1002/cncr.21011.

Epstein, R. M., & Peters, E. (2009). Beyond information: exploring patients' preferences. Journal of the National Cancer

Institute. Monographs, 2009(44): 66-69. DOI: 10.1001/jama.2009.984

Epstein, R. M., & Street Jr, R. L. (2011). Shared mind: Communication, decision making, and autonomy in serious illness. *Annals of Family Medicine*, 9(5): 454-461. doi: 10.1370/afm.1301

Epstein, R. M., & Street, R. L. (2007). *Patient-centered communication in cancer care: Promoting healing and reducing suffering*. National Cancer Institute, Bethesda, MD, 07-6225.

Fantasia, V. , Zucchermaglio, C., Fatigante, M.; Alby, F. (2021).'We will take care of you': Identity categorisation markers in intercultural medical encounters. *Discourse Studies*, 23, 451–473.

Fatigante, M., Alby, F., Zucchermaglio, C., Baruzzo, M. (2016). Formulating treatment recommendation as a logical consequence of the diagnosis in post-surgical oncological visits. *Patient Education & Counselling, 99,* 878–887.

Fatigante, M., Heritage, J., Alby, F., & Zucchermaglio, C. (2020). Presenting treatment options in breast cancer consultations: Advice and consent in Italian medical care. *Social Science & Medicine*, *266*, 113175. https://doi.org/10.1016/j.socscimed.2020.113175

Fatigante, M., Zucchermaglio, C., & Alby, F. (2021). Being in place: A multimodal analysis of the contribution of the patient's companion to "first time" oncological visits. *Frontiers in Psychology*, 12, Article 664747.

Filler, T., Jameel, B., Gagliardi, A.R., (2020) Barriers and facilitators of patient centered care for immigrant and refugee women: A scoping review. *BMC Public Health 20:*, 1013. https://doi.org/10.1186/s12889-020-09159-6

Fraser, B. (2010). «Pragmatic Competence: The Case of Hedging». In Kaltenböck, G. (ed.), *New Approaches to Hedging*. England: Emerald, 15-34

Garofalo, J. P., Choppala, S., Hamann, H. A., & Gjerde, J. (2009). Uncertainty during the transition from cancer patient to survivor. *Cancer nursing*, 32(4): E8–E14. https://doi.org/10.1097/NCC.0b013e31819f1aab

Geraci, S., El Hamad, I, (2011). Migranti e accessibilità ai servizi sanitari: Luci e ombre. *Italian Journal of Public Health,* 8: 14–20.

Goffman E. (1974) *Frame analysis. An Essay on the Organization of Experience*. Harper Torchbooks

Goldsmith D.J., Lindholm K.A., Bute J.J. (2006) Dilemmas of talking about lifestyle changes among couples coping with a cardiac event. *Social Science and Medicine*, 63:2079–90. doi: 10.1016/j.socscimed.2006.05.005.

Han, P. K. J., Klein, W. M. P., & Arora, N. K. (2011). Varieties of uncertainty in health care: A conceptual taxonomy. *Medical Decision Making: An International Journal of the Society for Medical Decision Making*, 31, 828–838. doi:10.1177/0272989X10393976

Heritage, J., & Raymond, C. (2021). Preference and Polarity: Epistemic Stance in Question Design. *Research on Language and Social Interaction,* 54(1): 39-59. doi:10.1080/08351813.2020.1864155.

Hyatt, A., Lipson-Smith, R., Schofield, P., et al. (2017) Communication challenges experienced by migrants with cancer: A comparison of migrant and English-speaking Australian-born cancer patients. *Health Expectations,* 20: 886–895.

Jacobs, E., Agger-Gupta, N., Chen, A., Piotrowski, A. et al (2003) *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*. The California Endowment: Los Angeles, CA

Lee, S., Chen, L., Ma, G. X., & Fang, C. Y. (2012). What Is Lacking in Patient-Physician Communication: Perspectives from Asian American Breast Cancer Patients and Oncologists. *Journal of behavioral health*, 1(2), 10.5455/jbh.20120403024919. https://doi.org/10.5455/jbh.20120403024919

Lehtinen, E. (2013). Hedging, knowledge and interaction: Doctors' and clients' talk about medical information and client experiences in genetic counseling. *Patient Education and Counseling*, 92, 31–37. doi:10.1016/j.pec.2013.02.005

Lingard, L., Garwood, K., Schryer, C. F., & Spafford, M. M. (2003). A certain art of uncertainty: case presentation and the development of professional identity. Social science & medicine, 56(3): 603-616. https://doi.org/10.1016/s0277-9536(02)00057-6

Loftus, S. (2012). Rethinking clinical reasoning: time for a dialogical turn. *Medical education*, 46(12): 1174-1178. DOI: 10.1111/j.1365-2923.2012.04353.x

Lorusso, D., Bria, E., Costantini, A., Di Maio, M., Rosti, G., Mancuso, A., 2017. Patients' perception of chemotherapy side effects: expectations, doctor–patient communication and impact on quality of life – an Italian survey. *European Journal of Cancer Care*, 2 (26): 1–9. https://doi.org/10.1111/ecc.12618.

Marino, F., Alby, F., Zucchermaglio, C., Scalisi, T. G., & Lauriola, M. (2023). Navigating Intercultural Medical Encounters: An Examination of Patient-Centered Communication Practices with Italian and Foreign Cancer Patients Living in Italy. *Cancers*, *15*(11), 3008. https://doi.org/10.3390/cancers15113008

McGarvey, E.L., Baum L.D., Pinkerton R.C., Rogers, L.M. (2002). Psychological sequelae and alopecia among women with cancer. *Cancer Practice,* 9(6):283–9. doi: 10.1046/j.1523-5394.2001.96007.x.

Mehan, H. (1985). The structure of classroom discourse. In T. A. van Dijk (Ed.), *Handbook of discourse* analysis: V*ol. 3, Discourse and Dialogue*. London: Academic Press, 119–131

Mishel M. H. (1999). Uncertainty in chronic illness. *Annual review of nursing research*, 17: 269–294. PMID: 10418661

Mitchell, J.A., Perry, R. (2020) Disparities in patient-centered communication for Black and Latino men in the U.S.: Cross-sectional results from the 2010 health and retirement study. *PloS ONE 15*, e0238356.

Montgomery, K.K., Harris-Braun, E.K. (2008) Information is not enough: The place of statistics in the doctor-patient relationship. *Cancer Treatment Research,* 140: 29–43. https://doi.org/10.1007/978-0-387-73639-6_3

Palmer, N.R., Gregorich, S.E., Livaudais-Toman, J., et al. (2018) Racial and Ethnic Differences in Prostate Cancer Survivors' Perceived Engagement in Treatment Decision-Making. *Journal of racial and ethnic health disparities,* 5(6): 1273–1283. https://doi.org/10.1007/s40615-018-0475-0

Pandey, M., Maina, R.G., Amoyaw, J. et al. (2021) Impacts of English language proficiency on healthcare access, use, and

outcomes among immigrants: a qualitative study. *BMC Health Service Research* 21: 741. https://doi.org/10.1186/s12913-021-06750-4

Sarangi, S., & Clarke, A. (2002). Zones of expertise and the management of uncertainty in genetics risk communication. *Research on language and social interaction,* 35(2): 139-171, DOI: 10.1207/S15327973RLSI3502_2

Schegloff, E. A. (2007). Sequence organization in interaction: A primer in conversation analysis. Cambridge University Press. https://doi.org/10.1017/CBO9780511791208

Schouten, B.C., Meeuwesen, L., Tromp, F., Harmsen, H.A. (2007) Cultural diversity in patient participation: The influence of patients' characteristics and doctors' communicative behaviour. *Patient Education and Counselling* 67: 214–223.

Sinclair, J. M., Coulthard, R. M. (1975). *Towards an analysis of discourse: The English used by teachers and pupils*. Oxford: Oxford University Press.

Steensig, J. (2019). Conversation Analysis and Affiliation and Alignment. In *The Encyclopedia of Applied Linguistics,* C.A. Chapelle (Ed.). https://doi.org/10.1002/9781405198431.wbeal0196.pub2

Stivers, T., Heritage, J., Barnes, R.K., et al. (2018) Treatment recommendations as actions. *Health Communication* 33: 1335–1344. https://doi.org/10.1080/10410236.2017.1350913.

Stone A.M., Jones, C.L. (2009) Sources of Uncertainty: Experiences of Alzheimer's Disease. *Issues in Mental Health Nursing*, 30:11, 677-686, DOI: 10.1080/01612840903046354

Street, R. L., Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? Pathways linking clinician–patient communication to health outcomes. *Patient Education and Counseling,* 74(3), 295-301. DOI: 10.1016/j.pec.2008.11.015

Wong, S.T., Chen, W., Bottorff, J.L., Hislop, T.G. (2008) Treatment decision making among Chinese women with DCIS. *Journal of Psychosocial Oncology, 26*: 53–73. doi: 10.1080/07347330802359594.

Wood, D., Bruner, J.S., Ross, G. (1976). The role of tutoring in problem solving. *Journal of Child Psychology and Psychiatric*, 17(2): 89-100. doi: 10.1111/j.1469-7610.1976.tb00381.x.