18 Building a Relationship
Verbal and Nonverbal Communication

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> We are talking about the *patient-doctor relationship* and its importance for diagnostics and therapy. It is also a thread of verbal and non-verbal messages that must be exchanged between the patient and the doctor if what we call a therapeutic alliance is to develop.
>
> von Uexküll, Wesiack 2011: 37

Abstract: In the first step of the consultation (§ 18.1), a trusting relationship with the patient must be established under various aspects, which must then be further developed and deepened in the subsequent

interaction history. When shaping the relationship, the patient's developments and expectations must be sensitively taken into account, with which the patient must now seek the doctor's professional help following the failure of their own efforts to cope (§ 18.2). Precisely because the first impression is often the lasting impression, mistakes should be avoided as far as possible when establishing a helping relationship. In order to gain the patient's trust, the intimate setting of a one-to-one consultation must first be established, in which the patient can present their personal concerns in a protected space that should be shielded from various types of disturbances if possible (§ 18.3). As in everyday life, certain personal perceptions are already made in the greeting situation, which lead to initial assessments of uncertainty, openness, attentiveness, interest, etc. These perceptions of the other person take place on all verbal and non-verbal communication channels, on which a "normal form" of the other person's communication behaviour is initially assumed (18.4). As in everyday life, the greeting ritual is also part of the medical consultation. Failure to make eye contact or shake hands can lead to irritation, as can an incomplete salutation or personal introduction. Furthermore, in order to create a good atmosphere for dialogue, certain precautions need to be taken to create a dialogue situation that is as comfortable as possible, in which even impaired patients are comfortably seated or can "communicate at eye level" while lying in a hospital bed (§ 18.5). Finally, the question of the extent to which guidance on the function, structure and time of conversations is helpful will be addressed (§ 18.6).

18.1 Manual: Step 1: Building a relationship

The first step in the dialogue is to establish a sustainable relationship with the patient, which should be developed gradually. A number of aspects need to be taken into account when establishing a relationship, some of which are manifested in the doctor's conversational behaviour, some of which play a role before the relationship is established and must be regulated before the first interaction between the conversation partners takes place. For example, the greeting and introduction are part of the perceptible communication, while the precautions taken in advance by the doctor for an "undisturbed" conversation are at best noticeable by the fact that there are no "disturbances". In the following de-

scriptions of the situation, we first assume a "normal case" of a doctor's consultation, in which the doctor is free to choose the conditions he or she prefers for the conversation, and then also refer to "deviating" forms of communication. This includes, for example, consultation communication, in which the institutional conditions of teamwork and shared rooms generally prevent a strictly dyadic dialogue situation. However, the consequences and risks of multi-person communication, as is characteristic of ward rounds, will be discussed separately (§ 24.3). In the following overview of the first step of the consultation (Fig. 18.1), the "normal form" of an initial consultation is assumed, as is usual in general practice (§ 19-23, 25) and should also be aimed for in clinical ward rounds (§ 24).

	1 Building a relationship	[6]2022
Cologne Manual & Evaluation of Medical Communication	1 Framing • Enable confidentiality • Avoid disturbances	0 1
	2 Greeting • Make eye contact • Verbal greetings, shake hands • Address by name	0 1
	3 Introduce yourself • Introduce yourself by name • Communicate function (e.g. ward doctor, surgeon, etc.)	0 1
	4 Situating • Speaking in a sitting position (chair to bed) • Ensure convenience • Coordinate proximity/distance	0 1
	5 Orientation • Structure the conversation • Clarify the goals of the conversation • Communicate time, frame	0 1
[1]1998	**E V A L U A T I O N**	☐☐ 4

Fig. 18.1: Excerpt: Step/Function 1. "Building a relationship"
(The complete manual can be found at the end of the chapter, Fig. 18.5)

In order to better understand the first step of setting the framework for creating a dyadic conversation situation in which the patient can meet their doctor in a protected space of trust, it is useful to be aware of the possible ambivalences with which a patient has decided to seek medical help after their own attempts to cope with the health problems they are experiencing have apparently failed. It is precisely when the patient brings these ambivalences from their previous history to the consultation as *uncertainty* that they are particularly dependent on the doctor's full attention and care from the very first personal encounter.

18.2 The helping relationship

As described above (§ 3, 8), the focus of the conversation between doctor and patient is on establishing and developing a sustainable relationship, which has been characterized from both a psychotherapeutic and (in the narrow sense) a medical perspective as a "helping alliance" or "therapeutic alliance" (Luborsky 1988, Saketopoulou 1999, Street et al. 2009, Wöller, Kruse 2018). In a helping relationship, the patient's skills and resources should be strengthened above all (*empowerment*), which means that "medical help" must be provided as "help for self-help" (v. Uexküll 2003: 1346) (§ 3.1). In order to make use of medical help at all, the patient must be particularly motivated and have high expectations.

18.2.1 Stages and expectations of help-seeking

For the development of the doctor-patient relationship, the organisation of the first meeting is of crucial importance, as this is where the course for the future is set. Mistakes in the initial consultation can have particularly negative effects that are often difficult to correct later. For this reason, particular care is required in the first consultation, which should take patients where they have decided to visit the doctor with their worries and needs. The trust placed in the medical profession is initially based on the patient's own experience of helplessness, from which they turn to a medical helper seeking help. According to Siegriest (2003), four typical *stages of seeking help* can be distinguished (Box 18.1).

Box 18.1 4 Stages of seeking help

Consultation of a doctor is the result of a process of seeking help, which is ideally divided into four stages or decision steps: (1) symptom perception is followed by (2) self-treatment (usually medication), then (3) notification of loved ones. A process of reassurance (e.g. from acquaintances, friends) and counselling leads to (4) consulting a doctor.

Siegrist 2003: 175

The previous history before the visit to the doctor is often made the subject of the consultation itself. As we shall see, patients cite "urgent" advice from partners, other relatives or acquaintances as the motive for their visit to the doctor, often combined with their own or other people's explanations of their experience of illness. According to Siegrist, this so-called "lay aetiology" should definitely be the subject of the doctor's interest in order to find out something about the subjective (e.g. fatalistic) *attitudes* (illness as "fate" or "punishment") or (e.g. causal) *attributions* ("occupational stress") of the patients. We will return to this repeatedly when, for example, the *detailed exploration* (§ 21) deals with the *subjective theories of illness* or when *coordinating the procedure* (§ 22) deals with the patients' *control beliefs*, without the clarification of which the success of the therapy would be jeopardised.

The history before the visit to the doctor is also a history of failure because the lay system, which is orientated towards everyday life, has failed or at least reached its limits. Regardless of how the patient's history developed before their visit to the doctor, in the end it is characterised by a kind of *resignation* because their own *resources* are no longer sufficient to cope with the *crisis situation* they have experienced.

18.2.2 Intimacy of the relationship

A visit to the doctor because of an illness can be experienced as a *humiliation* insofar as the person affected no longer knows how to help themselves and now has to seek outside and professional help. The need to go to the doctor can be seen as a consequence of a growing realisation of one's own powerlessness on the one hand and as a leap of faith towards a potential helper on the other. George Engel (1996) (Box 18.2)

has described this "break" in self-awareness and the trusting turn to the doctor from the patient's dual perspective of developing the *hope of help* in a trusting relationship with the doctor when *losing independence.*

Box 18.2	Hope, confidence and shared privacy

Typically, a patient comes for help because he is experiencing something strange, different, discomforting, or disabling which he does not understand and/or does not know or feel able to handle by himself. At the same time he believes - or hopes - the doctor does understand and does know how to handle the situation. The largest part of what the patient feels disturbed by is known only to himself and will remain so unless and until communicated.
Two considerations loom large in patient's decision to share such information and to entrust himself and his care to the physician. The first is confidence that the physician is competent; the second is the expectation, or at least the hope, that the physician will be understanding and that he, the patient, will feel understood. Thereby is the patient motivated to relinquish autonomy and share privacy, often to degree greater than may be true of almost any other human relationship.

George Engel 1988: 125

This unique *privilege*, which the patient grants by giving up his autonomy and sharing his private sphere with the doctor, is usually granted "tacitly", but occasionally it is also made explicit, for example as the privilege of the doctor's *listener*, who is *told* something *for the first time* that no one else has ever heard in this form (§ 9, 19). One patient emphasizes the doctor's listener privilege by explicitly stating (E 18.1) that she had not even told her husband the following dramatic story.

E 18.1		"I never told my husband" – "deathly bad"	Comment
1	D	this dizziness, did it start when you found out about this diagnosis [=daughter has MS]? .	Exploring details (time, condition) + narrative invitation
2	P	yes, I believe so … once I had something in my head at night, uh … I never told my husband, once at night in my head it was all	Framing, theme Orientation: Listener privilege

weird in my head, deathly bad ... I woke up ... I think: "oh dear, oh dear, what's wrong now?" ... once I got really sick in bed at night ... I fought against it, always did everything at home, took care of the household, until/until it was no longer possible, no ...	Complication: "unheard of Event" Direct speech Evaluation: Mastery *versus* failure, coda

These and other narratives, which are told to the doctor in this form and drama "exclusively", as it were, are analysed in detail in the following chapters (§ 19, 20). Whether conceded directly or indirectly, the doctor-patient relationship is one of the most intimate relationships of all, to the extent of the "sharing of privacy", in which the topic taboos that apply everywhere else for "good" reasons must be lifted in order to ensure successful healing. This objective requires special protection when *setting the framework* for the conversation, in which the patient can open up to the doctor as a helper in confidence without having to fear outside interference in the *dyadic* relationship.

18.2.3 The four-eyes conversation

If possible, protective measures to ensure a disruption-free conversation should be taken before the first patient contact takes place and the first words are exchanged. The effectiveness of the precautions taken when setting the framework is then noticeable in the conversation by the fact that the feared disruptions do not occur or can be quickly resolved, as we will see in a few examples. Firstly, the reasons why patients prefer to have a personal conversation (only) with the doctor they trust should be investigated.

A patient who comes to the doctor expects or at least desires a personal relationship in which private and intimate topics can be discussed without any "publicity". What is said in the medical consultation is generally not tolerated by other listeners. Confiding in another person, especially someone we do not know, requires that we are initially certain that we will only open up to them alone.

If we want to exclude third parties from the communication, we sometimes emphasise this specifically by explicitly saying: "But this remains between us". As we know, the situation we are aiming for here is the "one-to-one conversation", in which *what is communicated* is only

shared *expressis verbis* by two dialogue partners. It is no coincidence that this type of conversation is also called a "dialogue". The meaning and purpose of this type of conversation was described over a hundred years ago by Georg Simmel (1908/1992) in his treatise on the "Sociology of the Senses" in such a general and concrete way (Box 18.3) that the transfer to the doctor-patient conversation is not difficult.

Box 18.3 The four-eyes conversation

For our feelings there is something perverse here, because hearing is by its very nature supra-individualistic: what goes on in a room must be heard by all who are in it, and the fact that one person takes it in does not take it away from the other. This is also the origin of the *special soulful emphasis* that a spoken word has when it is nevertheless *intended* exclusively *for one person.* What one person says to another, countless people would be able to hear sensually if only they were present. If the content of anything that is said expressly excludes this formal-sensual possibility, this lends such a communication an incomparable sociological colouring (...) This is the strangely pointed aspect of the *orally communicated secret*, the *four-eyes conversation*; it expressly denies the sensual character of the sound of speech, which involves the physical possibility of countless listeners.

Georg Simmel 1908/1992: 730f. (emphasis by us)

Even if Simmel's language seems to have "fallen out of time" somewhat "in the digital age", he is highly topical in the matter, according to which the "conversation in private", especially with a "special emotional emphasis", should remain a matter between the two dialogue partners. If the discussion about the handling of digital data in our time rightly refers to the contact details of (telephone) conversations, then their content data is even more subject to special protection. The proverbial *confidentiality* of the doctor *I trust* has a special meaning and purpose in relation to the confidentiality of words spoken in a "dialogue", which should in principle exclude the third party listening in if their role as listener is not expressly permitted.[1]

1 As already mentioned in the introduction (§ 1) and in the presentation of our training concepts (§ 13, 14), we benefit at our clinic from the explicit willingness of patients to make themselves and their interviews available for teaching and research purposes. This also applies to the particularly sensitive type of psychoanalytic conversations, excerpts of which (Koerfer,

From the patient's perspective, direct eavesdropping in the same room is just as often frowned upon as the "eavesdropper on the wall", even if he or she is only a listener in the corridor, in the waiting room or in the next room with the door open, and so on. This is not just a matter of factual eavesdropping, but also of patients' fears that the confidentiality of what they say might not be guaranteed. However, it is also common knowledge among patients that many restrictions are to be expected in practice, some of which are structural (e.g. communication during visits) (§ 25), but which can also be attributed to a lack of caution in taking possible precautions against disturbances of various kinds, which will be differentiated below.

18.3 Protecting the intimate relationship

Overall, the expectations (hopes, fears) of patients with regard to protection from disturbances extend less to the type of short-term *interruptions* (§ 18.3.1), such as those caused by urgent telephone calls or the handing in of documents (files, prescriptions) by team members. More serious are the more or less pronounced forms of *eavesdropping* (§ 18.4.2) and the *involvement of* third parties (§ 18.4.3), which may include more or less "authorised" persons (team members, fellow patients, interpreters, relatives, etc.), which can severely disrupt the "dialogue" between doctor and patient.

18.3.1 Disruptions from outside

Short-term interruptions from outside (team members, telephone, etc.) can usually be dealt with and controlled by the participants in the conversation pausing briefly, as we can see from the following example (E 18.2), in which the doctor routinely deals with the interruption.

Neumann 1982) or the course of therapy (Kächele et al. 2006) have been prepared and analysed for teaching and research purposes with the consent of the patients.

E 18.2		"I'm still talking to the patient"	Comment
01	D	yes .	Listening signal
02	P	and er . ( ) listen to all that and so on . [you just have to ( )	
03	D	[yes yes yes, that's true . there are extremely convinced pump wearers . especially when they realise that this enables them to manage their metabolic disorder better .	LS affirmation Manual: 5.4: Informing about benefits and risks
04	P	hm .	
05	D	in principle there are two reasons ... [disturbance from outside: knock on door] yes please ( ) good afternoon . I'm still talking to the patient . it will take a while ... um . there are two main reasons for a pump from our point of view .	Disturbance from the outside by knocking on the door and opening it, then closing it again from the outside
06	P	hm .	LS
07	D	that either the metabolic control, for example by the basal bolus concept, is not satisfactory.	Continuation of 5.4 Informing about benefits and risks
08	P	hm .	LS

The "troublemaker" is politely invited in and greeted by the doctor conducting the conversation (D 05), but is then "complemented out" in a firm tone. By clearly *marking* that he or she is (not in just *any conversation,* but) in a "*patient conversation*", the special protective character of this type of conversation, which does not tolerate any disturbance here and now, is emphasised at the same time. While the "troublemaker" promptly withdraws, the doctor and patient continue their conversation without further irritation, as if they had not been interrupted.

Brief interruptions of this type can still be *compensated for in actu*, so to speak, if other rules such as the warning light ("Do not disturb") fail or agreements with team members are not honoured - for whatever urgent reasons. However, short-term disruptions can also become a problem as they become more frequent because they interrupt the flow of conversation and can "throw the conversation partners off track", causing them to "lose the thread". The only thing that can help against this is increased monitoring of agreements within the team. For the pa-

tient, the experience of the conversation must be preserved so that they receive the doctor's full attention for a certain "time at a time", who should not give the impression of being "absorbed" by other matters.

18.3.2 Listening through third parties

More problematic than the short-term interruptions from the patient's perspective, however, are the more or less persistent disruptions caused by the actual or merely suspected listening of more or less "unauthorised" third parties, who can disturb in various ways. We have all had the experience of patients more or less "beating around the bush" at the "reception desk" in conversation over the "counter" when they have to explain *coram publico* in the open waiting area with their current complaints why they want to see the doctor so urgently ("blood in the stool", "panic attacks" etc.). Furthermore, people may become "uninvited" listeners if they are in neighbouring rooms (with the doors open) or in "well-lit" (examination) cubicles. In this case, at least the initial consultation and, if possible, diagnosis and therapy conversations should take place in a shielded "consultation room" worthy of the name. Even after examination situations in which other assisting team members are unavoidably involved as more or less "silent witnesses", communication of findings etc. should take place "in private" if possible, in order to be able to (re-)establish the interrupted protection of the "dialogue".

The aforementioned ward round poses a structural problem, as its institutionalised form conflicts with the "dialogue" in several respects (§ 24). Here, the patient is expected to accept specific forms of communication that are due to the *multi-person constellation* (Fig.18.2) For example, the *interprofessional* forms of communication used by team members to communicate with each other can have a disruptive effect, as they often speak "over the patient's head" in a language that the patient cannot or should not understand anyway (§ 10, 24, 27). Here, the patient him- or herself "mutates" into a non-addressed, merely present listener who must experience the exclusion from incomprehensible communication that concerns him as a threat.

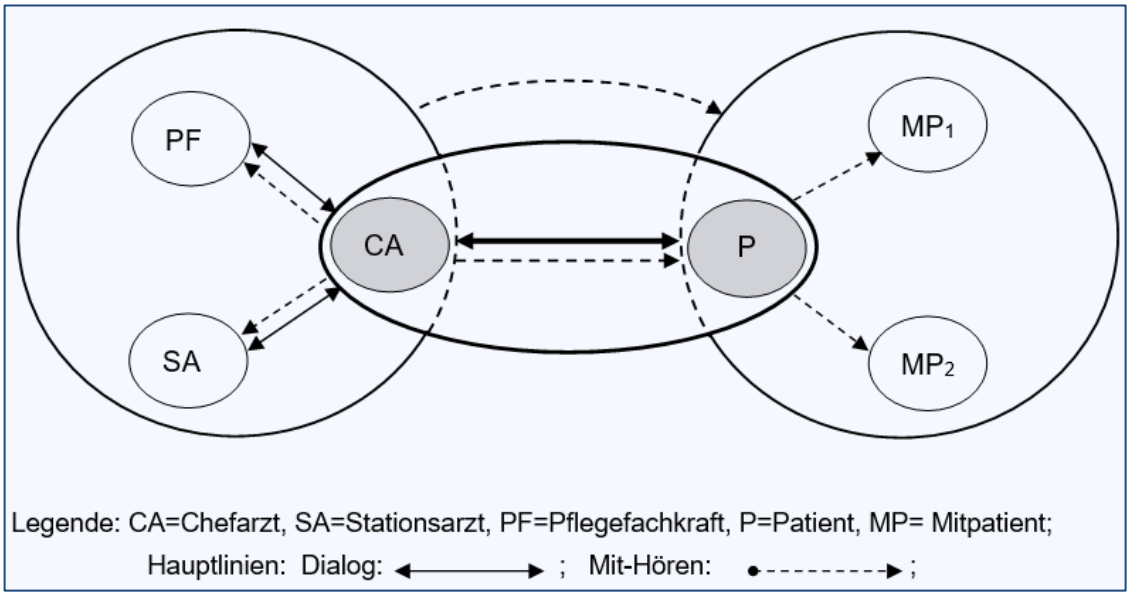

Fig. 18.2: Triadic communication constellation: Example of a visit by the chief doctor. English legend: (CA) Chief doctor, (SA) Ward doctor, (PF) Nurse, (MP) Fellow patient Main lines: Dialog: ◄——►; indirect listening: ●- - - - - - ► (cf. § 24).

From the patient's perspective, however, the typical *coram publico* ward round communication is not only stressful because the patient may have to adapt to changing addresses and dialogue partners from the ward team, but also because fellow patients can disturb the "free speech" as "uninvited" listeners. For this reason, patients repeatedly seek *dialogue* with the doctor elsewhere, if necessary on the empty ward corridor, because this place of conversation appears to be the better alternative to the three-bed room.

It remains to be seen how much relevant information is "concealed" from the medical team on a daily basis during ward rounds because patients do not want to reveal it in a quasi-public space out of shame in front of their fellow patients, etc. Despite all the institutional restrictions in everyday ward life, specific facilities such as a "consultation room" should be considered here, in which patients could, if necessary, have a confidential conversation with the attending doctor/team in a wheelchair or bed without being overheard by others ("unauthorised"). However, restoring dialogue in this way (*dyadic conversation*) would require organizational and spatial changes.

18.3.3 Participation of third parties

Another structural problem for which there are often no patent remedies is communication with participating third parties in the function of *intermediaries* of different types. This applies, for example, to *intercultural communication* (§ 28), in which both professional and lay mediations can lead to "distortions". Here, doctors often have to find the difficult balance between *direct* communication with the patient or *indirect* communication via interpreters or relatives, which can also lead to misunderstandings in both cases (§ 28). In the case of mediation by relatives, more or less pronounced "vested interests" in the course of communication are also to be expected, as they can "come through" in all communication involving relatives. This must also be taken into account when communicating with *young* patients (§ 35) with the involvement of *parents*, but also when communicating with *elderly* patients (§ 37), where *relatives* (partners, children) often mediate or even instruct the communication.

Pre-exclusion of the third party

Experienced doctors know that the presence and participation of relatives can not only be helpful, but also problematic, because those involved can be subject to (self-)censorship, and therefore try to carefully sound out and take into account the wishes of "their" patients with regard to their preference for a "dialogue" in good time. In the following interview (E 18.3) with a pupil, it is already clear in the opening sequence that prior agreements have been made between the participants to initially conduct the interview in pairs.

E 18.3		" the two of us are going to try it ."
01	D	[Doctor and patient come in together and sit down] yes, please come [first name] . sit down ..... (5) ..... tell . mum is so worried that you won't say everything .
02	P	[laughs softly, embarrassed] .
03	D	now the two of us are going to try it .
04	P	Yes, sometimes I feel a bit sick .
05	D	yes .

06	P	and I also have a headache .
07	D	yes .

Here, the invitation to tell (01 D: "tell ...") is justified with reference to the mother's obviously previously discussed "worries" that her daughter "might not be able to tell everything". After the patient's embarrassed reaction, the doctor again encourages her to continue talking by emphasising the commonality of the attempt, which also establishes the "togetherness" of the conversation ("the two of us"). As the further course of the conversation shows, which has been analysed in detail elsewhere under various aspects (Koerfer et al. 2010, Kruse, Tress 2010, Szirt, Langewitz 2010, Obliers et al. 2010), it can be reasonably assumed that the conversation would have been different in the direct presence of the mother. Before we return to the main parts of the interview (§ 25.3), it should be noted in advance that the "exclusion" of the mother from the interview was later "cancelled" by mutual agreement.

Ad hoc exclusion of the third party

If, in this case, specific arrangements have been made for the "dialogue" based on the previous history, this can also be established proactively and spontaneously later in the conversation situation that has already begun with the three of them. Relatives who are initially still present are often "invited out" at the start of the conversation or later, which can lead to irritation. However, the primary concern here is the well-being of the "index" patient, who enjoys a preferential right that must be taken into account even in the case of immaturity. For example, a 6-year-old patient suffering from leukemia wants to continue the conversation without her mother (E 18.4), apparently because she has something to say that only the doctor should hear.

E 18.4		"Mum should go outside"
01	D	I think you want to ask me something? . what do you want to ask me? .
02	P	mum should go outside .
03	D	Mum should go outside . leave the door open or close it?
04	P	close .
05	D	close completely .... [the mother leaves the room] ....

06	P	my nerves are going crazy and I'm scared .
07	D	yes . that's nice how you can say that .
08	P	sometimes I don't dare to say that ...
09	D	what are you afraid to say? .
10	P	that my nerves are going crazy and I'm scared .
11	D	then you are really scared .
12	P	[nods] .

At the beginning of the consultation, the mother and child and the doctor are still sitting together "amicably" and the doctor opens the conversation with a kind of *small talk* in which he enquires about the place of origin ("Yes, where do you come from now?"). After a brief exchange (keywords: injections, chemo, etc.), the doctor first addresses the first question to his patient in an *indirect* form (01 D: "I think you want to ask me something"), then in a *direct* form (01 D: "What do you want to ask me?"). In this example, which is followed up elsewhere (§ 25.3), the young patient (aged 6) makes very impressive use of her right to a *one-to-one conversation* with the doctor. The doctor immediately *cooperates appropriately* by affirmatively repeating the content of the request (03D: "Mum should go outside") and specifying it with a question, the answer to which is also intended to regulate the degree of *closeness/distance* to the mother (03 D: "Leave the door open or close it?"). Here, the doctor is apparently supposed to explore the opportunities and dangers of listening, which, depending on the young patient's perspective of experience, can involve different active to passive participation roles by the mother, which may range here unspoken from *threat* to *protection* (in each case of the child by the mother) to *protection* (of the mother by the child).

The child's wish, however motivated, to continue the conversation in the absence of the mother is tacitly respected by the mother, is "tacitly" respected by her by leaving the room without further ado, so that the patient and her doctor are finally "among themselves" as desired. It is only through this dialogue framework initiated and jointly created by the patient that it is possible to open the "actual" conversation with a *dramatic* topic (06 P: "my nerves are going crazy and I'm scared sometimes"). This problem, which the patient apparently only "dares to say" (08 P) in the protection of the one-to-one conversation, is then worked on further between the doctor and his or her patient in the subsequent conversation with many topic variations, until finally the mother is asked to join in again by mutual agreement at the end of the conversation. As the further description and analysis of the conversation shows

(§ 25.3), it could not have taken place in this form if the mother had been present. On the contrary, the development of the confidential *dialogue* between doctor and patient would have been completely prevented or at least severely "disturbed".

Overall, doctors should actively counter the different types of disruptions, which can range from (excessive) telephone calls etc. to "unauthorised" listeners (fellow patients etc.) and (unwanted) intermediaries (interpreters, relatives etc.) in the patient's experience of the conversation, in advance. Where disruptions cannot be adequately anticipated, they should be recognised in the ongoing interaction as early as possible and sensitively "remedied" or at least "mitigated" in their effects through appropriate negotiations with the respective "index" patients.[2]

In the two previous cases (Box 18.2, 18.2), the verbal agreements or spontaneous explanations were decisive for the exclusion of a third person. As the further conversation analyses will show (§ 25), in these cases the protection of the *intimate, dyadic relationship* was more important than the assistance of a parent, who was thus not ignored, but only temporarily suspended. In both cases, the mothers were subsequently involved again. In other cases, triadic communication is indispensable, for example in pediatric consultations (Winterscheid 2018) (cf. § 28).

Triadic communication

The concept of triadic communication is ambiguous. On the one hand, a broad term can be used to describe institutional communication conducted by two or more people in front of a more or less large audience (e.g. university, court, talk show) (cf. Koerfer 2013). On the other hand, triadic communication is possible in smaller groups, as in the ward round, the constellation of which has already been described above (Fig.

2 Sheeler (2013) discusses the certainly controversial case of sending parents out if there is a suspicion that a young woman could be pregnant and certain examinations (involving x-rays) or medication would be risky. "The ideal in such a circumstances is to have the parent leave the room (...) In this setting, one delicately asks the question - and I found the best thing to do is to focus intently on the young women's face for nonverbal clues" (2013: 238). It remains to be seen to what extent the (perception of) nonverbal communication can also be "deceptive".

18.2). Here, the primary conversation between doctor and patient is often integrated into the team communication, which can also be followed by fellow patients (§ 24). Conversations can also be held in medical tandem with a patient, which can have advantages and disadvantages (Baldt 2022).

Intercultural communication often requires linguistic mediation, which can be carried out by a professional or a relative or acquaintance (§ 28). In addition, communication can also be conducted with two or more patients, not least in couples or group therapy. It is also sensible and common to have a triadic conversation in a GP practice, especially if both conversation partners are known to the doctor as patients. For example, an elderly couple with whom the GP has known for a long time and whose shared life and medical history he knows in full came to the consultation together (§ 25). In this case, the consultation was preceded by a conversation with the husband, during which a follow-up consultation with the couple was explicitly arranged.

During the preceding individual consultation, it had become clear that the husband was more concerned about his wife and her care than he initially expressed verbally. In many cases, doctors must first explicitly state their impressions of patients and their emotions (concerns, fears, anxieties) before they become an explicit topic of conversation (§ 19, 20, 25). In doing so, doctors are often guided by an overall impression, the main source of which is their specific perception of non-verbal communication, which does not necessarily have to be congruent with verbal communication.

18.4 Verbal and nonverbal communication

As discussed above, the concept of communication can be defined in different ways, either narrowly or broadly (§ 7, 12). This applies to both verbal and non-verbal communication, which often unfold their effectiveness in specific combinations. This will first be illustrated using constructed examples of medical communication as it might also be perceived from the patient's perspective:

- For example, a doctor can receive his/her patients in the consulting room behind the large desk by greeting them "grumpily" verbally ("hello") and barely taking his eyes off his monitor and then initially remaining silent for longer before turning to the patient.

- Similarly, a doctor can talk to a patient during a ward round while standing and "with arms folded" and "from above" or exchange technical comments with his colleagues in a whisper, which the patient should not hear (§ 24).

Before we continue with empirical examples from the practical chapters on consultations and ward rounds (§ 19-25), a broad *definition* of nonverbal communication should be given first. A common distinction is between *nonverbal communication* (NVC) and *nonverbal behavior* (NVB). The terms are just as often considered interchangeable: "Researchers have come to use the terms NVC and NVB interchangeably much of the time, as we do in this review" (Hall et al. 2019: 273). With regard to the criterion of intentionality mentioned by Hall et al. in this context, reference can only be made here to the discussion of the broad concept of communication by Watzlawick et al. (1967/2011), according to which, as is well known, not only language but "all behavior is communication" (§ 7.4).

Without repeating the discussion here, it should only be noted in passing that language can also have unintended effects, such as when a listener feels hurt, provoked or threatened by a statement, even though this may not have been intended by the speaker. Whether intended or not, the power of the doctor's words can also be so strong that they have a harming effect on the patient, as we have already pointed out with examples (§ 17.1).[3]

Regardless of the question of intentionality, a broad definition of non-verbal communication should be given here before we turn to examples of specific communication modalities. A pioneering work on "body language", presented by Julius Fast (1970/79) in his book of the same name, is often referred to, for example by Matsumoto et al. (2013) in their subsequent broad definition of non-verbal communication (Box 18.4), which includes many modalities and phenomena that go beyond body language:

3 Hall et al. (2019) give the well-known example of the criterion of intentionality in non-verbal communication: "e.g., is a yawning sender telling me she is bored, or is she simply tired?" We refer to the detailed discussion of the concept of communication and intention in Ch. 7 on "Dialogic Communication and Medicine".

Box 18.4 Definition of nonverbal communication

We also define nonverbal communication as the *transfer and exchange of messages in any and all modalities that do not involve words* (…) our definition of nonverbal communication implies that it is more than body language. It can be in the distance people stand when they converse. It can be in the sweat stains in their armpits. It can be in the design of the room. Nonverbal communication is a broader category than nonverbal behaviors, encompassing the way you dress, the placement of your office within a larger building (…) The exact boundary of nonverbal communication, as part of communication, is a point of contention.

Matsumato, Frank, Hwang (2013: 4) (emphasis there)

Without going into the contested boundaries in more detail here (cf. § 7, 12), the relevance of a number of modalities of nonverbal communication in medical communication will be exemplified. The more or less conscious, reciprocal perceptions of the conversation partners play a role here, in which the decisive course for the further conversation can already be set at first glance.

18.4.1 The first moment

The first moment between doctor and patient often sets the course for the further development of the relationship between the two interaction partners. As is well known, the *first* impression is often the *lasting* impression (Box 18.5), which is difficult to correct.

Box 18.5 The first impression

On first contact with a person, we form an image of the other person from a small number of characteristics such as appearance, demeanour, manner of speaking (...) The first impression is decisive for the further development of the personal relationship, as it creates a "frame of reference" right at the beginning, into which later impressions are fitted. It is difficult to correct an image once it has been created.

Schmielau, Schmielau-Lugmayr 1990: 323

In the greeting situation, the level of attention is particularly high if both partners are strangers to each other, which is the case in the initial consultation between doctor and patient. They initially meet as strangers and must first establish a *content-filled "We"-relationship* (Schütz 1932/74). With a particularly sharpened perception of the person, both partners seek to gain information about the other partner in order to compare this with their expectations and to be able to adapt better to the other (Argyle 1969/1972, Argyle 1975/1992, Delhees 1994). In this respect, the doctor is initially no different from the patient as an everyday person.

Both conversation partners try to gain social orientation and thus security in the new situation. In addition, both encounter each other in their respective social roles in specific ways. For example, the patient will check whether the doctor meets their expectations of help, and the doctor may use the first encounter with the patient to gain initial diagnostic impressions. The impressions of both interaction partners will be formed from different sources of personal perception.

> If you do not pay attention to the nonverbal behavior there is a great chance that you are missing much of what it actually being communicated by the other person. Thus, while active listening is always good, observation is also necessary.
>
> Matsumoto, Frank, Hwang 2013: 12

18.4.2 (Non-)verbal communication and observation

The mutual perception of persons and their behaviour extends to various *verbal* and *non-verbal* modes of communication. The special features of non-verbal communication between doctor and patient have already been explained in detail (§ 12). The problem of *reflexive* self-observation and observation of others in the ongoing interaction between doctor and patient was also discussed there. The aim here is merely to demonstrate the opportunities and limitations of observation using a report on a case study. This example should first provide an insight into the differentiated observation spectrum of non-verbal com-

munication that George Engel gives us in his detailed report on a case with a patient who initially behaved very withdrawn before he was able to open up emotionally. The focus of the report (Box 18.6) here is only on Engel's observations of selected phenomena of non-verbal communication.

Box 18.6 Observations of nonverbal communication in a ward round

First, while actively engaged in dialogue, I was at the same time monitoring the likelihood of his crying. This I did by paying attention to signs known to presage crying, such as facial expressions (e.g., angling of the upper lid), gestures (e.g., helplessness), body movements and positions (e.g., sagging of his shoulders), behaviors (e.g., bringing a finger to his eye), and what he was having to say and how (e.g., sad content, a catch in his voice) (...).
Second, I watched and listened for indications of physical and emotional movement toward or away from me, as sustaining or breaking eye contact, including his body toward or away from me, or sharing or withholding intimacies.
Third, I noted his responses to my behavior, as when I moved closer, spoke more softly, or indicated sympathy with the plight.

George Engel (1988: 129)

What Engel reports here using a case study is the self-perception and external perception of an experienced professional with many years of professional experience. Beginners in particular should not overstretch themselves when observing their own consultation practice. Because the self-reflective attitude always involves the risk of disturbing spontaneous behaviour, directing attention to specific non-verbal phenomena is only possible for a limited period of time. A "spotlight technique" is required here (§ 12.4), with which doctors can focus their observation on specific non-verbal phenomena for a short time without being "absorbed" by the ongoing conversation for too long.

This also applies to verbal forms of communication: Anyone who repeatedly observes "suggestive" forms of questioning in themselves or is made aware of them by others in external observation may lose their "usual" rhythm of communication in the meantime. The change from an *interrogative* to a *narrative* interview style (§ 9, 19) cannot be achieved without "breaks" in routine behaviour that can no longer withstand critical self-reflection. Temporary irritations of this type must, however, be

accepted if the self-reflective competence of the meta-doctor, as described above (§ 3.2) by Uexküll and Wesiack (1991), is to be further developed in order to achieve long-term changes in the way doctors conduct conversations. However, since it is not possible to observe and control everything at the same time, a selection must always be made, which depends not least on the interest that must first be awakened in *problem-orientated* teaching and further training (§ 13, 14-16) in medical dialogue.[4]

18.4.3 Typology of communication modalities

In order to be able to make better reference to individual verbal and non-verbal phenomena in conversations between doctor and patient, a typological overview (Fig. 18.3) will provide an essential distinction for further orientation in medical communication theory.

This overview, which is intended to serve practical teaching purposes with a didactic reduction, in no way assumes that a standardised typology and terminology can be claimed based on the current state of research.[5] Rather, the aim is to promote awareness of the multidimensional interaction of verbal and non-verbal elements in communication and personal perception between doctor and patient.

---

4 For specific problems of teaching non-verbal communication in medicine (e.g. OSCE), see Ishikawa et al. 2006, 2010, Hall et al. 2009, Collins et al. 2011, Sheeler 2013.

5 Our overview of different modes of communication (Fig. 18.3) was partly based on Helfrich, Wallbott (1980). Such an overview must remain simplified and incomplete insofar as sweat, for example, can be perceived by different sensory organs (visual, olfactory, gustatory, tactile). For further orientation, please refer to overviews and basic literature and edited volumes: Argyle 1972, 1992, Scherer, Wallbott (eds.) 1984, Delhees 1994, Nöth 2000, Ekman 2004, Bührig, Sager (eds.) 2005, Matsumoto et al. (eds.) 2013, Burgoon et al. (eds.) 2021; specifically on non-verbal communication between doctor/therapist and patient: Hall et al. 1995, Schmid Mast 2007, Makoul et al. 2007, Henry et al. 2012, D'Agostino, Bylund 2014, Schmid Mast, Cousin 2014, Little et al. 2015, Gumz, Strauß 2023. Hall et al. (2019) provide a review on nonverbal communication, while Patterson et al. (2023) criticize "four misconceptions about nonverbal communication". Otherwise, we refer back to the literature cited in § 12 as well as to the arguments cited there in favour of using the term *nonverbal interaction* instead of the term *nonverbal communication*, which is often already associated with *awareness* and *intentionality*.

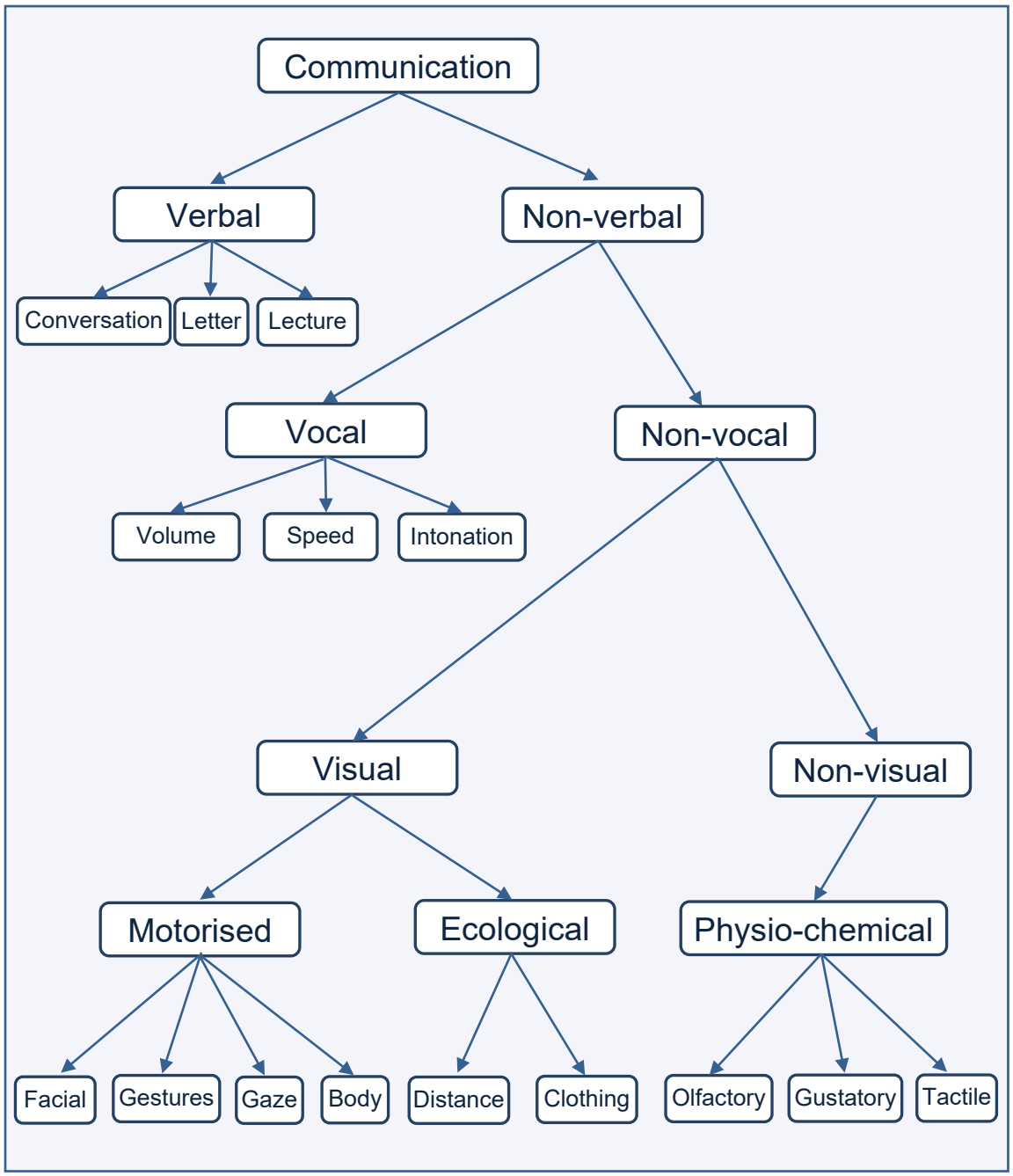

Fig. 18.3: Verbal and non-verbal communication modes

Firstly, a distinction must be made between the *verbal* mode of communication, which can be *written* (letter) or *oral* (conversation), *dialogue* (letter, conversation) or *monologue* (lecture, essay), and the *non-verbal* mode of communication, which in turn can be differentiated into a *vocal* and *non-vocal* mode. In the non-vocal mode, many phenomena are accessible to *visual* perception (facial expressions, gestures, clothing, etc.),

while others can only be perceived through the sense of touch or smell. For example, a doctor who is already sensitised to the phenomena of non-verbal communication will be able to make the following observations during the first encounter with the patient and use them for initial diagnostic purposes.

Visual communication modes

The doctor may notice features of *visual* behaviour (Box 18.7) such as the dark clothing and *rigid facial expression* of the grieving patient or the *tortured smile* (Ekman 2004) of the anxious patient or the *stooped posture* of the back pain patient who is already visibly "carrying his back". When the doctor picks up the patient from the waiting room to greet them (§ 18.6, 25), a conspicuous "body language" can be perceived as soon as they enter the consulting room.

Box 18.7 Visible behaviour

Visible behaviour refers to all behavioural expressions that can be perceived visually by other people: Among other things, the way someone moves around the room, the position they take up in the room and in relation to other people, posture and all kinds of body movements. Some are specifically communicative - including gestures and facial expressions - while others are less so, such as changes in posture or movements in connection with a task. A person's outward appearance, physiognomy, clothing and appearance are also part of visible behaviour.

Kendon 1973/1984: 203f

Later, the doctor may notice *helpless gestures*, such as those made after dramatic narratives, for example when a patient expresses his or her resigned exhaustion (§ 19.7). Likewise, an attentive doctor can recognize from the averted gaze of patients during the narrative that they want to continue, so that they should not be interrupted. As will be shown by empirical examples, gaze behaviour is essential for the organization of the speech change.

Vocal communication modes

Doctors can also notice *paralinguistic*, i.e. speech-accompanying features such as the sluggish or quiet *speech* of the depressed patient, just as they can perceive other emotions such as fear or suppressed or open anger by listening to the patient's voice (Table 18.1).

Voice and emotion	
Suppressed anger	High and loud voice, rapid speech, loss of voice
Open anger	High and loud voice, fast speech, hardly any interruption of speech
Fear	Increased cancellations (in quick succession), fast and incoherent speech, many slips of the tongue
Depression	Reduced volume, lack of high overtones, falling pitch
Contempt	Emphasise slow speech
Serenity	Lower voice pitch (except when played)

Table 18.1: Voice and emotion (on Delhees 1994: 142ff)
(cf. Frank, Maroulis, Griffin 2013, Guyer et al. 2021)

While the "loud" sounds cannot be "overheard" anyway, particular attention should be paid to the "quiet" phenomena, such as hesitant pausing or "fidgeting" before significant "revelations" that were initially left out as taboo subjects.

The speaker change can also be organized via the vocal communication mode. When taking over, the new speaker may become louder in competition with the current speaker. To mark the end of his or her speech, the speaker can lower his or her voice or raise it with a questioning intonation when he or she concludes with a so-called tag question ("right?"), combined with eye contact (§ 18.4.6).

Body movement and bodily contact

Furthermore, during the greeting and the first direct contact with the patient, the doctor can already perceive the limp handshake of the seriously ill patient or the moist hand of the anxious patient during the

handshake, i.e. the first clinically relevant impressions (Box 18.8). As the first physical contact, the handshake has a high conventional significance (§ 18.4.5), so that an omission or "fleeting" execution is perceived as particularly conspicuous. During and after the corona pandemic, the ritual of shaking hands is suspended, but many doctors resume it. A completely different type of physical contact, which can be experienced as an imposition despite all professionalism, is the medical examination, which should be announced verbally, commented on if necessary and carried out as carefully as possible.

Box 18.8 Clinical cues right from the greeting

When greeting the patient, the student [the doctor] extends his hand, or if the patient is seriously ill, he can place his hand on his arm or shoulder. In this way, he establishes physical contact and expresses his sympathy. The patient's reaction to the presentation and handshake often provides important clinical clues. Examples: the cold, damp hand of an anxious person, the weak handshake of a seriously ill person, the hearty handshake of someone who trivialises their suffering, the distressed impression of a person with dementia.

Morgan, Engel 1969/77: 34

As we will see from empirical examples, the spectrum of relevant phenomena in communication and especially in the perception of persons is so diverse and complex that they can easily escape spontaneous observation, although they are "effective" in the joint interaction. Just as the doctor forms an initial impression of the patient in the opening situation, the patient will also form an initial impression of the doctor: The latter may appear "distracted" or "attentive", "grumpy" or "friendly, "dismissive" or "welcoming" to him or her, to which he or she in turn reacts with *reticence* or *openness,* etc., depending on the situation.

Both partners will interpret their behaviour as a *sign of the relationship* and continue to act according to their interpretations (Goffman 1974: 255ff). If, for example, the doctor greets the patient only casually and shakes his or her hand only briefly or not at all, barely rises from his or her chair and immediately buries him- or herself in the files again, only to "shoot off" with the first question as soon as the patient has taken a seat, it should not be surprising if he or she gives the patient the impression of an "absent" or "hurried" doctor, to whom the patient is best prepared "briefly and succinctly" in the further conversa-

tion. In order to avoid the mistakes that "set the tone" in the opening situation of a conversation, critical self-observation should begin with the greeting ritual, whose "conditioning potential" (§ 9, 19) for the subsequent course of the conversation cannot be overestimated.

18.4.4 Greeting and introducing yourself

Although the greeting situation is ritualised, it is structured in a highly complex way, so that many verbal and non-verbal elements must work together in coordination with the other person if the interactions are to succeed and a "satisfying" feeling of the encounter is to arise, on which both parties can build for the further development of their relationship. Greetings are rituals which, in the encounter between doctor and patient, take on a particular form of the general *social function* which, according to Erving Goffman (1974) (Box 18.9), regulates the degree of *accessibility* between the parties involved.

Box 18.9 Greetings and farewells as "accessibility rituals"

Greetings and farewells are the ritual brackets for a variety of joint activities - punctuation marks, as it were - and should therefore be seen together. To express the matter more generally: greetings denote the transition to a state of increased accessibility, farewells the transition to a state of decreased accessibility. The following definition is therefore possible, encompassing both greetings and farewells: they are ritual proclamations that mark a change in the degree of accessibility. I propose to call such forms of behaviour "accessibility rituals" (...) As with other arrangements in the field of public order, the expectation of the performance of an accessibility ritual by a particular person at a particular moment establishes a time-person expectation system, on the basis of which everything that is emitted at that moment can be understood as a functional equivalent of an accessibility ritual. Thus, physical gestures can of course be used instead of words.

Goffman 1974: 118ff

In our culture, greetings consist of verbal and non-verbal sub-actions, which will be briefly differentiated here in order to recognise possible "failures" (see Fig. 18.4 below). Although the verbal greeting formula is central to our culture as a standard formula or in whatever dialectal

variants (German: "Guten Tag", "Grüß Gott" etc.), greeting on first contact in certain contexts, especially institutional contexts, is closely linked to the mention of a name, which is often *explicit* ("XY, my name"). In the following example (E 18.5), the interlocutors even repeat the greeting ritual in the consulting room (albeit without an "official" verbal greeting ("Good day"). They had obviously already met briefly outside and the doctor already knew the patient's name (from the records), as can be seen from the patient's form of address ("Mr Müller") right at the beginning.

E 18.5		"Ahrens, my name"	Comment
01	D	[knocking] in! ..... (5) ..... Mr Müller ... Ahrens is my name again .	1.2 Greeting with salutation 1.3 Presentation
02	P	Müller [handshake] ...	1.2 Greeting with a handshake
03	D	take a seat, please . well, Mr Müller, you've had to wait a long time, I'm sorry ...	1.3 Situating + regret
04	P	yes, a bit, hours or something like that .	
05	D	Mr Müller! . what brings you to us? .	2.1 Opening question (reason) with salutation
06	P	type 1 diabetes	Reason for consultation
07	D	yes .	Listening signal

In this example, which we will return to repeatedly as the conversation develops, names are mentioned five times right at the beginning, twice in the function of *self-introduction* and three times in the function of *address*. By mentioning names, the dialogue partners enter into a commitment that goes beyond mere politeness, as is the case elsewhere in the social world. While I greet my neighbour, whom I only know briefly by sight, with a standard greeting ("Hello") in passing without introducing myself by name, introducing myself by name is part of the greeting ritual in consultation hours and ward rounds for good reason. Both parties want and need to know who they are entering into a personal relationship with and, above all, who they will be dealing with in the near future, namely Mrs Lehman or Mr Schulz etc., so that a "face" can final-

ly be "associated with a name". This *mutual* identification by name has various social and practical reasons:

In addition to the documentary-record function, the identification of persons by name serves the subsequent reference to third parties ("As already discussed with Dr Lehman yesterday ..."). In addition, knowing a person's name allows them to be *addressed* personally by name, which not only signals personal recognition when greeting them in subsequent conversations, but also *marks changes of topic*, often associated with specific types of action (announcements, warnings, decisions, etc.) as *relevant* in the ongoing conversation, as in this conversation (E 18.6), in which the doctor introduces the therapy suggestion *by addressing them by name.*

E 18.6		"Yes, Mr Müller, of course we can..."	Comment
01	D	yes, Mr Müller, of course we can try it out . the important thing is that I first have to collect the materials for you .	5.4 Planning therapy: discussing chances and risks
02	P	hm .	LS
03	D	to get you started, so to speak, so that you can try it out . in advance I want to say . (...)	5.4 Planning therapy (continued)

Although introducing each other by name seems self-evident in the dyadic dialogue situation, it is often neglected in multi-person communication during *ward rounds* (§ 24). Here, as there, the introduction of the doctor by name should ideally take place at the same time as the naming of the *function,* whereby attention should be paid to generally understandable explanations, if necessary in everyday language ("ward doctor", "anesthetist", "gastroenterologist", "consultant as ..." etc.). Overall, the naming of names and functions is particularly important for further orientation in the hospital, because patients are confronted with a double-digit number of relevant reference persons with different functions on the very first day. It is therefore important for them to find out who will be the "contact person" for their concerns and needs here and now and in the near future.

In *general practitioner* or *specialist* care, the name and function may already be known from signs outside the practice or consulting room, but here too there are good reasons for introducing people *by name*: firstly, patients always need to be reassured that they are not dealing

with substitute colleagues. Secondly, in our culture, politeness demands that we introduce each other by name as part of the greeting ritual, if only for reasons of social symmetry. Omitting to introduce each other by name and mentioning the doctor's function can lead to irritation, as can omitting to shake hands or failing to make eye contact.

18.4.5 Handshaking

The act of greeting is very complex. It is only successful when several sub-actions interact, which increases the susceptibility to disruption when establishing a relationship in face-to-face situations. The complex act of greeting can be summarised in the sense of a structural tree (Fig. 18.4) into the following verbal and non-verbal sub-actions, which can be broken down into further elements, such as the handshake.

By analysing the breakdown into sub-actions, the susceptibility to disruption can also be revealed in detail under the psycho-social aspect of the relationship design. This will be analysed in more detail using the partial actions of the *handshake* and eye contact. If, for example, the handshake is broken down into *rhythm*, *duration* and *pressure*, etc., which can be perceived by the interaction partner as finely grained as skin temperature or skin moisture (see Box 18.8 above), the significance of a change or omission of the (partial) action itself may be recognised.

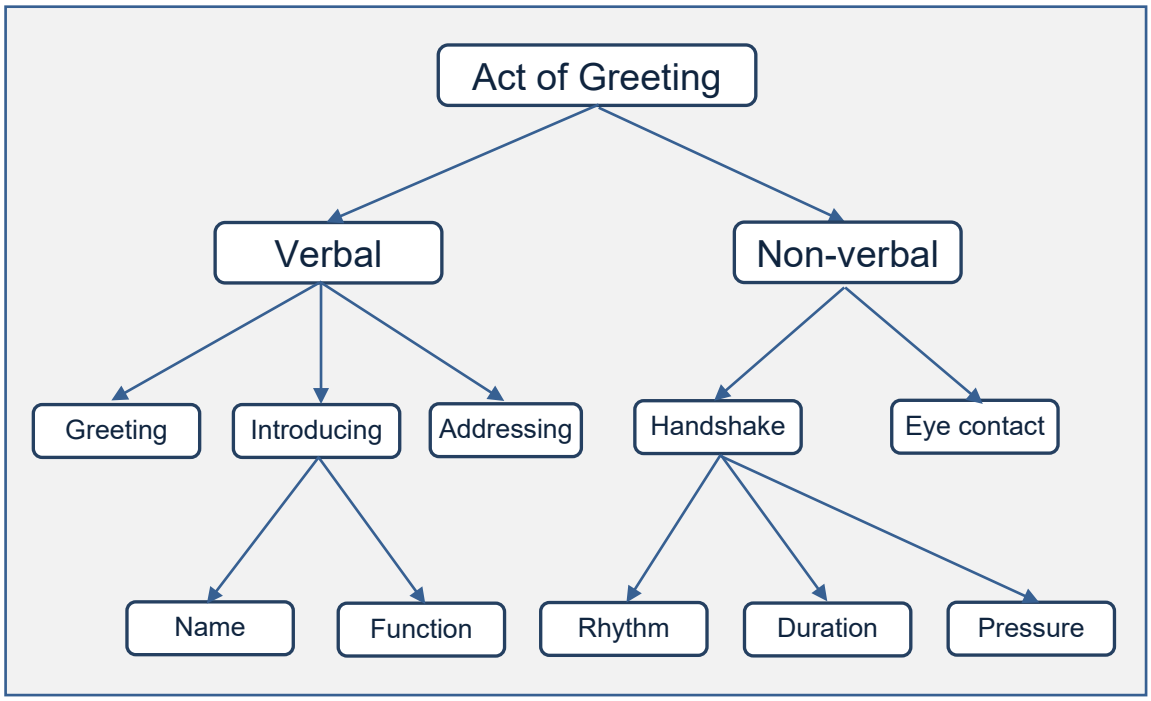

Fig. 18.4: Sub-actions of the complex greeting action

As part of the greeting ritual, the handshake is generally expected by the patient and also realised by the doctor. According to Morgan, Engel (1969/1977) (see Box 18.8), doctors should use the handshake with the patient to make an initial diagnosis, and patients also interpret the way the doctor greets them with a handshake as the first *sign of a relationship.* Accordingly, the greeting tends to be experienced as "fleeting" or "cordial". Due to its manifold significance for the doctor-patient relationship, the doctor's handshake is often considered indispensable when greeting the patient (Makoul et al. 2007) – especially at the *first contact* and despite all hygienic reservations. Failure to take the initiative to shake hands, and even more so refusal, will cause irritation when establishing a personal relationship.

18.4.6 Gaze behaviour and eye contact

Further disturbances in establishing a relationship can occur right at the beginning when *greeting with the eyes* as well as in later *gaze behaviour,* which has already been discussed above (§ 12.2.3) and which is repeatedly referred to in our empirical conversation analyses. The avoidance of eye contact can certainly be perceived as meaningful, for example in the case of lowering the gaze when feeling insecure, embarrassed or ashamed. The same behaviour can be interpreted differently depending on the role of the participant.

What may be interpreted as shame, shyness or insecurity on the part of the doctor in the case of the patient's avoidance of looking, may in the other case be interpreted by the patient as disinterest on the part of a doctor in a hurry, who does not even take the time to look up from his or her files when greeting the patient, so that a dialogue situation "face to face", as should be sought precisely when establishing a relationship between doctor and patient, is made more difficult or even prevented.

Before we continue to investigate the gaze behaviour of the conversation partners in empirical conversation analyses, we should first raise awareness of the special role of the gaze, as it also comes into play between doctor and patient. Georg Simmel, who in his treatise on the "Sociology of the Senses" (1908/1992) (Box 18.10) very impressively described the "unique sociological achievement" for which the eye is "designed", will first have his say here.

Box 18.10 "The eye unveils the soul to the other ..."

Among the individual sensory organs, the eye is designed for a completely unique sociological achievement: the linking and interaction of individuals, which lies in looking at each other. Perhaps this is the most direct and purest reciprocal relationship that exists (...) In the gaze that takes in the other, one reveals oneself; with the same act in which the subject seeks to recognise its object, it reveals itself to the object. The eye unveils to the other the soul that seeks to unveil it. Since this obviously only takes place in the direct gaze from eye to eye, the most perfect opportunity in the entire field of human relationships is created here (...) The gaze of the other not only serves me to recognise the other, but also him to recognise me; on the line that connects both eyes, he carries his own personality, his own mood, his own impulse to the other (...) The person is by no means already completely there for the other when the other looks at him, but only when he also looks at him.

Georg Simmel 1908/1992: 723ff

It is only through eye contact that the presence of the participants is mutually confirmed before the exchange of souls can begin on the line between the two pairs of eyes, along which personality, moods and impulses are transmitted. While from a sociological point of view, considerations on the non-verbal *transfer relationship without words* are still being stimulated here, the observations on empirical research into eye and gaze behaviour relate to a range of aspects in different social and cultural contexts. Depending on the situation, the more or less sustained gaze can fulfil very different functions (Box 18.11), especially if various other "body language" behaviours are involved in different contexts (Eibl-Eibesfeldt 1972, Argyle 1975, 1992, Doermer-Tramitz 1990, Ekman 2004). For example, we raise our eyebrows in a greeting and usually associate this behaviour with a friendly smile, etc. However, the same behaviour as raising our eyebrows can occur not only when we greet someone, but also when we are displeased or indignant, etc.

Box 18.11 "Eye contact triggers ambivalent reactions"

There are cultural differences in the readiness with which people greet others with eye contact (...) The quick raising of the eyebrow is primarily a yes to social contact. We observe it when greeting, flirting, bantering and thanking, also when affirming and agreeing and when emphasising a

statement (...) Eye contact triggers ambivalent reactions. You have to look at a fellow human being to let them know that you are interested in communicating, but you must never do it for too long, otherwise the gaze becomes a stare, which has a threatening effect (...) We also raise our eyebrows when we are displeased, for example when we are indignant about a person's behaviour (...) When expressing pride, raising our eyebrows becomes a signal of social rejection.

Eibl-Eibesfeldt, Hass 1994: 1-5

The duration of the gaze can also have different functions and trigger different reactions depending on the situation. It is well known that the gaze between mother (father) and child, as well as later between lovers, can last a "little eternity" without the participants being irritated. With less familiar people, on the other hand, a prolonged gaze can be perceived as staring and this staring can be interpreted as *dominance* or *aggression*.

In addition to these socio-cultural functions, gaze behavior takes on specific *regulative* functions in the *speaker-listener exchange*, which we will return to separately in empirical conversation analyses.[6] The systematics of gaze behavior during speaker changes has already been described in early studies, the main results of which are still relevant today (Box 18.12).

Box 18.12 Speaker change and gaze behavior

The previous results support the assumption that the relationship between the speaker's gaze behavior and his utterances influence the interlocutor's behavior. By looking away, the speaker makes clear his intention to continue speaking and thus avoids interruptions by his partner. Briefly looking at the listener while he is speaking also signals that he wants to continue speaking. However, if the listener receives a long look at the end of the speaker's utterance, he knows that he can now begin his answer.

Kendon 1973/1979: 229

6 In addition to the above-mentioned literature on non-verbal communication, examples of gaze behaviour are listed below: Eibl-Eibesfeldt 1967/1972, Kendon 1967, 1973/1984, Ekman 2004, Doermer-Tramitz 1990, Streeck 2004 (207ff, specifically on greetings in therapy), Weiß, Auer 2016 and Gorawara-Bhat, Cook 2011 on "Eye contact in patient-centered communication".

In empirical conversation analyses we will focus on the interactive phenomenon that patients often avert their gaze when speaking in order to concentrate on a narrative of an "inner" story, for example, in which the doctor should not interrupt with verbal interruptions if possible (§ 19, 20). Here is a brief example from the beginning of a conversation in which the doctor interrupts the patient as soon as she has taken the floor.

E 19.33		"Where are your main complaints?" (Part 1+2)	Comment
01	D	[both sit down] so Mrs A, what brings you here? . [+]	Manual 2.1: Opening: Reason for consultation
02	P	[-] so [+] [-], in general now um ... [Looking up to the left, thinking]	Start of the answer with thinking
03	D	where are [+] your main problems, what/ or main complaints, what you come for? .	Manual 2.2: Early Interruption/ Funneling
04	P	I have often had heartaches, i.e. sharp pains in the heart area. [+]	Focus: "chief complaints"
05	D	since when have [-] you had these pains? ... [3] ... [-] [P scratches shoulder]	4.1 Exploring details (time, start); Patient: Contemplative gaze of P
06	P	for a little [+] longer, so in 2001 it was really bad, and then I also had my tonsils removed . [+]	Last sustained eye contact from P to D
07	D	yes . [+]	Listener signal

Transcript: eye contact (+) or not (-)

The patient is about to answer the doctor's opening question while she looks to the side, thinking, when she is interrupted after a few words by the doctor, who narrows the initially general topic to a new focus with a doubly corrected opening question (1: "main problems", 2: "main complaints"). The patient then follows the new *biomedical focus* with a suitable answer ("heartaches"), to which the doctor can in turn respond with closed detailed questions (onset, duration, etc.).

The early use of the tunnel technique initiates an interrogative interview that both partners can no longer escape during the course of the

short conversation. We will analyze this and other conversations in contrast in order to work out the essential differences between interrogation and narration (§ 19, 20). For the preceding beginning of the conversation (Box 18.12), the better alternative is to be anticipated, according to which the doctor should have listened until the patient had finished the turn she had begun ("so, in general now um ...") and looked at him silently and expectantly at the end. For the time being, the first of many maxims of medical conversation (§ 3, 17) can be formulated, namely that patients who are looking away should not be interrupted prematurely while talking.

While the avoidance of eye contact by the speaking patient is quite functional here, the patient's refusal to make eye contact should be recognised by the doctor as a particularly conspicuous feature when greeting the patient.[7]

18.5 Situating and comfort

After both partners have greeted each other appropriately and got to know each other, they must create a dialogue situation that does justice to both of their roles. The doctor does not have to give up certain habits and privileges, but he or she should ensure that the patient is sufficiently comfortable, which contributes to a trusting dialogue. This includes

- on the one hand, that the doctor ascertains the relative physical comfort of the seated or lying patient.
- that, on the other hand, he or she strives for the best possible exchange of speech in which both partners are in an approximately symmetrical speaking position

Both are made more difficult or impossible if, for example, the doctor talks to the patient "from above" while standing at the hospital bed, who tries to straighten up and support him- or herself with his arms in order to reduce the distance to his dialogue partner with great effort. Such an asymmetrical speaking situation can often be observed during ward rounds, not only when the doctor conducts the conversation standing up, but also when the whole team talks "over the patient's head" (§ 24).

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7 For the specific function of turning the head away or refusing eye contact, especially in psychotherapy, see Scheflen (1964/1976) and Streeck (2004), who also discusses conspicuous greeting situations.

Regulating the distance

This can usually be easily remedied by the doctor conducting the conversation adjusting the head section of the bed or supporting the patient with a pillow, for example, and above all by "lowering" themselves to the patient. They can either pull up a chair or - with the patient's permission - sit on the edge of the bed. In this way, the doctor creates a dialogue situation that we are used to from everyday communication, at least in our culture. In this situation, we fulfil our need for closeness without being "pushed too close". Depending on our familiarity with the person we are talking to and the situational, social or cultural conditions of the conversation, we regulate *proximity* differently (Box 18.13). Depending on the conditions, we prefer a distance of between 50 cm and 150 cm in a face-to-face conversation, which we do not perceive as too far or close enough.

Box 18.13 Spatial proximity

Whenever two people enter into a social relationship, they have to decide to what extent they want to get physically closer to each other. The lower limit corresponds to physical contact, the upper limit is set by factors of sight and hearing (...) in the case of "casual personal" distance (about 1.5 meters), sight and hearing are used, in the "intimate" area smell, feeling and even taste play a role, sight loses importance (...) What determines how close someone gets to another? Factors such as sight or hearing, smell etc. are of course important (...) someone who is hard of hearing or short-sighted, for example, is more likely to seek greater closeness. There are also cultural factors - whether our perceptions are sought or avoided, for example. Physical proximity varies with social conditions. At a crowded party, people stand closer together, partly to understand the other person, partly to show who they are interacting with.

Argyle 1969/1972: 93ff

When regulating body distance, we usually endeavour to ensure that we all speak either sitting or standing wherever possible so that we can communicate at approximately the *same eye level*, which can also be achieved during the ward round with the chair provided. In the consulting room, the distance should not be unnecessarily increased by an excessively large desk. The view of the patient should also not be artificially obstructed by other obstacles. For example, the doctor should not

"hide" behind a monitor or a pile of books or files, but should keep a clear view of the patient and vice versa.

Invitation to comfort

An alternative to the traditional sitting arrangement, in which the desk is facing the dialogue partners, can be *sitting across the corner,* although this should not be too close ("knee to knee"). In any case, patients should be allowed to make themselves "comfortable", which they can be "invited" to do both with the usual space available (E 18.7 and 18.8) and also explicitly (E 18.9).

E 18.7		"Please take a seat"	Comment
01	D	please come in .	Invite in
02	P	yes .	LS
03	D	hello .	1.2: Welcome
04	P	hello .	Greeting
05	D	[Introduction: Attribution] ..... (7) ..... please take a seat .... (4) .... [P becomes visible in picture] . what is your name?	1.3: Presentation 1.4: Situating: Convenience; [Name?]
05	P	[calls his name] [sits down]	Attribution
07	D	tell me about it .	2.1: Opening: Narrative invitation
08	P	uh . and that's . um . uh ... a nervous thing so . I was (...)	Start narrative

E 18.8		"Take a seat here, please"	Comment
01	D	come on, take a seat here, please . so take a seat here ... [both become visible in the picture and sit down] ... yes Mr F, what's up? .	1.4: Situating: Convenience; 2.1: Opening question: Concern
02	P	so the following complaints, uh . probably stomach, intestines [made gesture with interlocked hands] .	Patient offer: Complaints

E 18.9		"Make yourself comfortable, Mr Z"	Comment
01	D	take a seat, make yourself comfortable. Mr Z .	1.4: Positioning: Convenience
02	P	[Patient sits down] ( )	
03	D	soo . Mr Z, what brings you to me? .	2.1: Opening question: reason for consultation
04	P	yes . I had the accident with my bike on Wednesday 8 days ago, I passed [name] here .	Patient offer: Narrative: Accident history
05	D	yes .	2.2: Active listening: Listening signal
06	P	and so in slow motion I rolled over and couldn't get off the pedals (...)	Narrative: Accident story

While the greeting in example (18.6) takes place entirely in the consulting room (and could therefore be "recorded"), in many other examples the greeting and introduction is already carried out outside the consulting room. There are good reasons for this, because many doctors pick up their patients personally from the waiting area and accompany them into the consulting room, not only out of politeness, but also to gain a first impression of the patient (sitting in the waiting room, standing up, walking into the consulting room, etc.). In the first two examples, a seat is formally offered, which in the third example (18.8) is combined with the reinforcing invitation to make oneself comfortable.

Reinforcing the invitation to feel comfortable

In the previous examples, a seat is formally offered, which in the following example is combined with the reinforcing invitation to make oneself comfortable. If sensitive doctors notice that their patients are becoming more restless, they can also extend this invitation later, as happens in the following example (E 18.10) after more than a minute.

B 18.10		"Make yourself comfortable while telling the story"	Comment
01	D	(...)	
02	P	(...) but I dismissed it . didn't think it was that important .	Patient offer
03	D	why don't you make yourself comfortable ... yes, while telling the story ... yes ...	1.4: Positioning: Convenience
04	P	yes ... yes . I'm . n . nervous ... ehm ... I actually have a question first (...)	Patient question

The doctor evidently notices the patient's nervousness, which she then addresses herself ("I'm nervous"), and tries to counteract this by explicitly asking her to make herself "comfortable". The doctor's perceptions (of her "nervousness") are part of a "scenic understanding" (§ 9.2), which is indirectly expressed here. As we will see later with other examples of empathic understanding and responses, doctors can of course also intervene directly here ("You seem very nervous/ worried/ concerned" etc.). At this early stage, the doctor favours an indirect form by combining the invitation to be comfortable with an invitation to tell ("comfortable with telling"), which the patient then accepts after her emotional self-revelation ("nervous").

The doctor's behaviour can help to create a relaxed *atmosphere during* the initial *consultation.* They can often observe the success of their efforts themselves. The video shows that patients who initially sit on the edge of the chair and clutch their belongings ("just in case") become increasingly relaxed as the consultation progresses: They place their glasses, handbag, file etc. on the table or empty neighbouring chair, lean back and cross their legs – in other words, they no longer behave "as if on the run", but have finally "arrived" at the consultation. The doctor may be able to "read" this "arrival" more or less directly not only from their "body language", but also from their "tone" and "content" when patients "start talking" because they feel "invited" to do so by their doctor.

18.6 Orientation: Goals, time, frame

The question of the type and scope of *orientation* before and during conversations is not easy to answer. As already conceded above (§ 17.3.1), we have not been able to agree on uniform positions in research and training groups at our clinic. This is due to the different experiences that colleagues have had with patients in their field of work.

The problems of (over- or under-)*structuring* that can arise when *setting* or developing an "*agenda"* are also controversially discussed in research (Silverman et al. 1998, Tate 2004, Roter, Hall 2006, Boyd, Heritage 2006, Cole, Bird 2014, Gobat et al. 2015, Windover 2016, Langewitz 2017). This is about the risks of a hasty, premature setting of a (first-best) "agenda", which sets a thematically and temporally restrictive framework that counteracts a free development of the conversation, in which the agenda can be negotiated jointly between the two dialogue partners (*shared agenda setting*), i.e. can also be changed.

Structuring and flexibility

A lack of flexibility here increases the risk of discrepancies between the doctor's and patient's agenda (Box 18.14), which can ultimately prove unproductive and lead to wasted time not only for the doctor, but for both parties.

Box 18.14 "Flexibility of agenda"

Flexibility of agenda concerns the physician's adaptation of his or her agenda to fit with the patient's agenda. The highly skilled physician takes care to identify the underlying concerns and expectations that prompted the patient's visit (...) For reasons that may be unconscious, these true concerns are often not expressed by the patient right away. If underlying concerns are not identified and responded to, the patient may be dissatisfied and subsequently uncooperative. In effect, the doctor's time will have been wasted.

Cole, Bird 2014: 289

If there is a lack of cooperation, both dialogue partners are threatened with a loss of interactive and thematic coherence, so that they end up going their separate ways, constantly misunderstanding each other and

consequently systematically talking past each other. The dialogue partners allow themselves to be guided by different relevancies, from which they can no longer escape once they are set (§ 7, 17). The relevance problem already arises here with the opening of the conversation (§ 19.2), with which the further thematic development of the conversation can be "conditioned" in one direction or another. From the doctor's point of view, it must be taken into account that patients often buy "*tickets of entry*" (Roter, Hall 2006: 7) due to their uncertainty in assessing relevance, which do not necessarily correspond to their main concern, which often has to be "*elicited*" (§ 19) with great effort in the further course of the conversation. Precisely because the patient's concerns can initially remain hidden (*hidden agenda*), the fixation on a first-best agenda often proves to be unsustainable because it is deceptive in the long term.

Topic chances and time frame

To illustrate the problem of premature fixation on an agenda in advance, two different types of conversations are given. In the first example (E 18.11), the patient seems to have a clear idea (02: "I can tell you ...") after the doctor's opening question (01: "er . Mrs X, what brings you to see me today?") of what brings her to the doctor "today".

E 18.11		"Three initial symptoms"
01	D	Mrs X, what brings you to see me today? .
02	P	I can tell you: nausea, dizziness, when I breathe deeply, my shoulder blade hurts at the back right .... then I've had a swollen foot since . thursday, friday, saturday, sunday, jo for 4, 5 days . which also hurts me . yo, that's it . in principle .
03	D	er ... three initial symptoms, you'll have to explain them to me again, nausea and .
04	P	dizziness, and, and uh . yes . claustrophobia I don't want to say uh . oh, I, I don't know, so I have the feeling . as if I'm going through a phase of menopausal symptoms again at the moment .
05	D	can you explain what you mean by that?
06	P	yes . how should i say . mfhh [exhales air] . how should i express that . hot . yes bad . closer to crying than anything else, sometimes, not always . logical . uh . uh . i just don't know, i, well, i didn't have that for a long time .

07	D	hm . you don't feel well? .
08	P	nope, so at lunch today (...)

Although the patient already sets a kind of "final point" at the beginning (02: "yo, that's it . in principle"), the "agenda" is by no means exhausted. As can already be concluded from this opening sequence, the medical interventions of various types (§ 19-22), with which the patient is invited to further (self-)exploration, lead to further complaints and concerns, which gradually establish a complex *biopsychosocial* thematic development that goes far beyond the "three initial symptoms" (e.g. menopause, abdominal pain, fear of cancer, desire for clarification by CT, etc.) (§ 22.4). While the "agenda" only gradually develops in this conversation, there is an *abrupt* change of topic in the following conversation (E 18.12) after the doctor has already recognisably initiated the end of the conversation (*opening up closing*).

E 18.12		"the head is not okay either?"
01	D	otherwise you are not taking any medication? .
02	P	yes I have to (drug name X) uh . must/ (drug name X) I already said . (drug name Y) because of the high cholesterol .
03	D	yes, well, we'll have a look at you now . [A disappears from the picture]
04	P	and the head, that's not okay either .
05	D	the head is not OK either? .
06	P	no [laughs] .
07	D	what's wrong with the head?
08	P	[laughing] it’s awful . sometimes is (...)

In both examples (E 18.11, E 18.12) the history taking develops differently, in the first case *continuously*, in the second *abruptly*, in that the patient has to assert a further, central topic against the doctor towards the end, after the doctor has already concluded the conversation interactively. In the first case (E 18.11), the doctor promotes the full development of the range of topics through his types of intervention, which need to be discussed in more detail; in the second case (E 18.12), the patient first has to make herself heard against the doctor with her concerns. In this case, the doctor should have opened up further opportunities to speak and discuss topics earlier or at least before the end of the conversation, for example by asking whether there are any other

problems or unanswered questions (§ 23). However, both cases illustrate in their own way the risks that lie in prematurely fixing a topic with a substantive agenda.

The first risks for interactive and thematic restrictions can already arise *formally* with dedicated time specifications, especially if these are understood differently than they may have been intended by the doctor. Since time is generally still limited, especially during ward rounds (§ 24.4), an explicit reference to this would possibly be counterproductive. Subjectively, specific times are often estimated to be much shorter than the corresponding period of time is actually experienced. A precise time orientation within the framework of the usual ward round ("We now have 4 minutes") could cause the patient to fall silent from the outset or tempt them to adopt a conversational attitude of leaving the initiative to the doctor and answering the doctor's questions "deliberately", i.e. "concisely and succinctly", without asking, commenting and/or even arguing their own concerns.

Since, according to Martin Buber (1954/86), "real" conversations cannot be *pre-planned* (§ 7.5), thematic guidelines or tasks can also lead to considerable restrictions on the patient's room for manoeuvre, who would then also remain stuck in a passive participation role in this respect. The active participation of patients requires that their opportunities to discuss topics are kept open for as long as possible and are not obstructed by an agenda that is set (too) early and restricts a free choice of topics in the sense of interactive and thematic "conditioning" (§ 9.4).

Initial and follow-up conversations

However, thematic focussing seems to be understandable for both parties if, for example, the ward round is a specific follow-up consultation with a doctor as consultant, whose task was already introduced in the welcome situation by mentioning their name and function (as "anesthetist", "gastroenterologist" etc.) (§ 18.4). Similarly, we had already made a fundamental distinction between *initial consultations* and *follow-up consultations*, in which structural *focal points* may be *formed* depending on the preliminary examinations and agreements made, because this is part of the expectations of both interaction partners (17.3.2).

For example, after a blood test, the corresponding announcement ("We need to discuss your cholesterol values today and consider a possible therapy (diet, medication)") would not be surprising, but part of a

previously agreed "agenda" that is to be "worked through" together. Due to his professional competence, this agenda must be pre-structured by the doctor in ongoing consultations and gradually agreed with the patient, especially towards the end of the consultation, when the further procedure (§ 22) is determined and the tasks for the follow-up consultation must be specified in a summary (§ 23).

Before this can happen, however, an *open* initial consultation must be conducted, which should also be under less time pressure if possible. This may require a special *practice organisation*, which will be discussed separately from a GP's perspective (§ 25.6). In terms of content, the doctor should comply with the traditional anamnesis scheme during the initial consultation, which allows for corresponding detailed explanations (§ 21), but otherwise initially "let the patient have the floor" in order to "bring up" their concerns. This "agenda" is best explained to a "new" patient in such a way that the doctor wants to take "enough" time to "get to know" him or her. The phrase "to get a picture first" is also frequently used in relation to the patient. Specific examples of this can be found in the following chapter (§ 19), in which the doctor's invitations to the conversation are used in connection with narrative invitations.

18.7 Further information and references

For further reading on *non-verbal* communication, please refer to the relevant chapter (§ 12) and in this chapter (§ 18) to the specific literature cited in notes 2-6. The book by Michael Argyle (2013) on "Bodily Communication" should be mentioned as a "classic" and "introduction" (first published in English in 1975). For further orientation, please refer to basic literature and edited volumes: Argyle 1972, 1992, Scherer, Wallbott (eds.) 1984, Delhees 1994, Nöth 2000, Ekman 2004, Bührig, Sager (eds.) 2005, Matsumoto et al. (eds.) 2013, Hall, Knapp (eds.) 2013, Burgoon et al. (eds.) 2021; specifically on non-verbal communication between doctor/therapist and patient: Hall et al. 1995, Schmid Mast 2007, Makoul et al. 2007, Henry et al. 2012, D'Agostino, Bylund 2014, Schmid Mast, Cousin 2014, Little et al. 2015, Gumz, Strauß 2023. Hall et al. (2019) provide a review on nonverbal communication, while Patterson et al. (2023) criticize “four misconceptions about nonverbal communication”. For criticism of an (overly) broad concept of

communication, see the chapter on "Dialogic communication and medicine" (§ 7), which also deals with the concept of intention.

For specific problems of teaching non-verbal communication in medicine (e.g. OSCE), see Ishikawa et al. 2006, 2010, Hall et al. 2009, Collins et al. 2011, Sheeler 2013. We will return to the problem of setting or developing an "agenda" (§ 18.7) in the manual step "Drawing Conclusions" (§ 23), which is why we refer again to the relevant literature at this point (Silverman et al. 1998, Tate 2004, Roter, Hall 2006, Boyd, Heritage 2006, Cole, Bird 2014, Gobat et al. 2015, Windover 2016, Langewitz 2017). Different types of conversation openers and opening questions are discussed below (§ 19) with reference to empirical examples and further literature.

The complete *Cologne Manual & Evaluation of Medical Communication* (C-M+EMC) can be found at the end of this chapter (see also § 17.5 on practical application in teaching and examination). Further empirical anchor examples are analyzed and discussed in the other practical chapters (Part IV) (§ 19-25) of the handbook.

References

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

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Cologne Manual & Evaluation of Medical Communication see next page.

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

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

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

Fig. 18.5: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)