25 Communication in Primary Care

Thomas Reimer, Armin Koerfer

> The quality of the relationship is based on effective communication - the ability of GPs to listen to their patients, to strike the right tone in their exchanges with them and to adequately assess their individual problems.
>
> Hewitt 2001: 143

Abstract: By way of introduction, the manifold tasks that the general practitioner has to face in his daily practice are to be described (§ 25.1). In addition to acute care, which ranges from cuts to heart attacks, the general practitioner is confronted with a variety of physical and mental illnesses of young to old patients, whom he must care for not only in the short term, but also in the longer term in basic psychosomatic care. This requires a psychosomatic approach to conversation that leads from the symptom to the affect to the conflictual relationship as it presents itself outside and inside the consultation (§ 25.2). The specific problems of conducting a psychosomatic conversation in the family doctor's practice are shown in a series of examples of conversations, which are reproduced as transcripts and analysed in detail under verbal and non-verbal aspects (§ 25.3-25.5). If possible, the perspective of the treating doctor's experience should be taken into account in the corresponding sequence analyses. Finally (§ 25.6), problems and suggestions for practice organisation and time management are discussed, which should take into account the different tasks of GP care in a differentiated way.

25.1 Special features of GP practice

General practice is considered the "cornerstone" of the health care system: "Almost half of all outpatient treatment is provided by the family doctor or general practitioner. More than 90 % of those with statutory health insurance say they have a regular family doctor" (Jansen 2009: 63). In this context, the GP practice has to be flexible to "unselected" patients with physical and mental health disorders who have to be cared for in the short and long term and, if necessary, referred to other functional areas and specialties of the health care system (orthopedics,

psychotherapy, clinic, rehabilitation, nursing, etc.) or treated further from there.

Despite or precisely because of these diverse mediating functions, the family doctor retains his central care function for most patients. Those who choose a doctor as their family doctor also invite him or her to their home. As a rule, one is not looking for a specialist, one is looking for a person with expertise in whom one can confide; someone to whom one can admit physical and mental weaknesses and who is able not only to listen, but also to endure and keep what he has been told to himself. Perhaps one also wants an answer to pressing questions, maybe even advice, but certainly not instruction. In any case, one wants help and support with physical and mental complaints, with private and professional relationship conflicts, with dismissal, unemployment or financial hardship, with fear of the future, fear of illness and death. One is not looking for a magician, a priest or a comforting neighbour or friend, but one is looking for a professional, a doctor, who can support one medically in many ways.

25.1.1 The diversity of tasks

In the course of his or her professional life, a family doctor experiences an extraordinarily wide range of clinical pictures. Almost everything occurs. The diagnoses are often not made by the doctor himself. With the lively exchange with and between specialists and clinics that is common today, the diagnostic and therapeutic range is constantly expanding. As a rule, however, patients keep coming back to the family doctor. Not infrequently, they are then overloaded with written and verbal information on diseases and courses of disease or upcoming operations.

Patients are to a large extent at the mercy of the technical language of a wide variety of specialists, which is incomprehensible to the patient. Here, the general practitioner is expected to do a lot of subsequent conversational work (§ 22.3). In part, it is deliberately delegated to the GP by specialists and clinicians. He is supposed to explain the patient in a bite-sized way. Even the communication of serious diagnoses, especially in clinics, is not infrequently geared to legal requirements and only in the rarest of cases corresponds to the situational restrictions on the patient's willingness to be admitted (§ 10, 16, 22). Legal language barriers are then added to the already existing medical language barriers.

Against this background, it is not surprising that the emotional impact that the communication of serious diagnoses can have on the patient repeatedly goes unnoticed and under the table. It should not be assumed that clinics do not try to address the emotional side of patients. But patients are increasingly delegated to a new expert with whom they first have to rebuild a relationship of trust. Long-term effects of diagnoses on the patient's self-esteem and affect regulation are clearly neglected. Here, the family doctor is again called upon (§ 22), who must bring up helplessness, powerlessness, despair and fear of death.

25.1.2 Long-term treatments and relationships

An essential criterion of GP practice is the *duration* of treatment and thus of the doctor-patient relationship. Of course, the relationship aspect is also important for specialists and clinicians. However, special necessities and possibilities arise in the general medical or family doctor's practice. For example, there are relationships that can last not only years but decades, not infrequently even until death (§ 25.5). *Continuity* and joint *profit,* especially in the long-lasting relationship, was already emphasised by Balint from an economic point of view as an essential characteristic for general practice:

Box 25.1	Multiplication of shared capital

The essence of the general practitioner-patient relationship is its continuity, and every treatment, a fortiori a successful one, should be another substantial increase in shared capital in the investing society."

Balint 1964/88: 373

Precisely because a break-off of the relationship would dissolve this investing society with "loss of its common capital and impoverishment of both partners" (ibid.), the relationship should be continued if possible - even if, according to Balint, a separation between doctor and patient can occur for the most diverse, sometimes banal reasons (e.g. moving house).

The *common capital* of the two interlocutors consists above all in the specific cumulative knowledge of long-standing medical histories, as they are often documented in GP medical records. According to Hewitt

(2001), continuity in the relationship often means a lifelong accompaniment of patients that extends "from the cradle to the grave". On this long path of lifelong care, the GP can acquire a "long-term knowledge" of his or her patients (Box 25.2), which gives him or her special insight into their problems and those of their caregivers in the whole *social environment* at any time, which is an essential prerequisite for *holistic* treatment.

Box 25.2 "Long-term knowledge" and "holistic" treatment

A good, long-term relationship with patients is the cornerstone of every GP practice and essential to their very special role in medical care. This is where medical care usually begins and where long-term care also takes place. In the medical records of GPs, it is not uncommon to find medical histories that extend from the cradle to the grave in the truest sense of the word. This "long-term knowledge" and the many years of contact with the patients, their relatives and other caregivers in their social context enables a special insight into the respective problem areas (...) Since they know and naturally include the social environment, they are able to see their patients as whole people and not just as "cases".

Hewitt 2001: 143

On the one hand, this *long-term knowledge* represents a constant resource for current communication in the consultation, in which the knowledge resource is constantly expanded through communication on the other hand. Through the communicatively developed and deepened knowledge of the individual medical and life history of this individual patient in his biographical-social relations, it becomes possible for the general practitioner to provide comprehensive care for the patient at all, as described for the functional areas and working methods in *general practice* (Box. 25.3), which go far beyond the so-called "gatekeeper" function.

Box 25.3 Functional areas and working methods of general medicine

The tasks and functional areas of general medicine are wide-ranging and include considerably more than just "gate keeping". The scope of work of general medicine or GP care includes the basic care of all patients with physical and mental health disorders in emergency, acute and long-term care as well as essential areas of prevention and rehabilitation. General

practitioners specialise in being the first medical point of contact to help with all health problems.
The working method of general medicine considers somatic, psychosocial, sociocultural and ecological aspects. When interpreting symptoms and findings, it is of particular importance to appreciate the patient, his concept of illness, his environment and his history (hermeneutic understanding of the case).

Jansen 2009: 63f.

Although the general practitioner cannot be reduced to the so-called "gatekeeper function", he has to perform a variety of mediation and control functions vis-à-vis various specialists and instances in the health care system. Not only does he initiate many rehabilitation measures, but he also takes over the further treatment of the patients after their completion, whose progress he must track and document in order to be able to initiate corrections in the therapy or further diagnostic steps if necessary. Likewise, after specialist examinations, diagnoses and therapies, patients return to the general practitioner's office for further treatment, where the specialist's treatment concept may be up for discussion again and has to pass the long-term "practical test", and so on.

Overall, the GP practice is the "hub" in the health care system from which patients are further treated in all specialist directions and institutional care areas under differential diagnostic aspects before returning to their trusted GP for long-term treatment. This happens not only in the "regular case", which may be less burdensome, but also in dramatic cases where patients return to the family doctor's practice, for example, with an *inauspicious* prognosis, in which the family doctor must take over the remaining education and practical integration into the patient's living environment. In this context, the GP must not only perform the communicative "translation" of the medical findings into the *language* of the patient and his or her *lifeworld understanding* (§ 10, 22), but often also take over the *terminal* care in the further treatment, which he or she performs in his or her GP practice or through regular home visits (§ 25.6).

During these home visits, the family doctor also acquires special knowledge about the social environment of the patients. On site, he has insight into living conditions, local problems, up to knowledge of stressful neighbourly relations (Cierpka et al. 2001). Here, a non-verbal background knowledge accumulates that forms a matrix for the context of the doctor-patient conversations.

Last but not least, the waiting room of the family doctor can also have a special significance. It is a place where patients meet again and again because of their common long-standing affiliation. The waiting room can become a social meeting place. This is especially true for people who have been left alone and marginalised.

25.1.3 The GP patient population

The family practice is visited by patients of different ages and genders, social and cultural backgrounds, with various problems, complaints and concerns. The spectrum of care ranges from *minor illnesses* ("cough, cold, hoarseness") to uncomplicated cuts that can be treated on an outpatient basis in "minor surgery", to *chronic* illnesses (e.g. CHD, diabetes), which require long-term care (§ 29), and finally to vital threatening *acute cases (e.g.* myocardial infarction), in which patients may have to be cared for as *emergencies* in their own practice or during a home visit, before they can be further treated by the arriving emergency doctor, etc. Here, "primary care" takes on a special meaning, which, however, can be transferred to many other functional areas of general practice.

The diversity of the patient population presents the GP with the challenge of dealing with a wide spectrum of clinical pictures, which can have both a psychological and a somatic origin. However, almost no clinical picture occurs in a pure form. There is no either/or, but a both/and. The spectrum of classic mental and somatic clinical pictures is expanded by the variety of minor illnesses and disorders of well-being. This combination of mild and severe clinical pictures with both acute and chronic courses constitutes the core of GP care practice.

Thus, patients with *mental* and *psychosomatic* health disorders are also treated by the family doctor in *primary care,* as they are otherwise common in the general population: "Depression, anxiety, panic disorders and somatoform disorders occur frequently in the general population and, accordingly, are also often found in GP practices" (Schneider, Szecsenyi 2017: 505). For most of these patients, it can be assumed that they will first present to the GP before they may have to switch to specialist treatment if their own GP resources reach their limits, for example in *basic psychosomatic care* (Fritzsche et al. 2003, Reimer 2017) (§ 15, 42).

Due to *demographic* developments, an increase in older, *multimorbid* patients is to be expected, which has led not least to a "structural and functional change in medicine" (§ 5). Here, *mental comorbidity* can increasingly be assumed, especially among older patients. Furthermore, in an ageing society, not only general physical infirmities but also specific impairments of *sensory functions* (visual and hearing impairments) are to be expected, which can lead not least to social isolation (Schneider, Szecsenyi 2017). Likewise, the GP must care for patients with *cognitive* impairments (up to dementia) or refer them to other functional areas (geriatrics, etc.).

Elderly patients will often have to come accompanied by their relatives, which poses additional problems of communication with third parties (§ 18, 37). This kind of mediation seems to be even easier in the mother tongue that is familiar to all than between different languages, where, moreover, mediation problems may arise between different cultures, in which different ideas of health and illness may also come into play (Nesterko, Glaesmer 2015, Erim, Morawa 2017). In the case of a patient collective that also corresponds to the general population in this respect, the general practitioner must also adjust accordingly to problems of *intercultural* communication (§ 28), regardless of whether the conversation is conducted alone with the patients or with the participation of professional language mediators or "selected" laypersons (relatives, colleagues, acquaintances).

Whenever third parties are involved as "players" (§ 18), it must be expected that they can more or less "consciously" exert influence on the conversation and the shaping of the relationship, which must be more or less "controlled" by the doctor. Although, or precisely because, the GP is also a *family doctor,* he or she must critically weigh up the *advantages and disadvantages of the involvement* of ("intervening") family members, for example, on a case-by-case basis. Thus, even in dealing with *elderly* patients and their relatives, similar risks of "proxy communication" often reveal themselves for the family doctor as already in the treatment of *children* and *adolescents,* where the presence and communicative mediation by third parties (parents, other relatives) (§ 35) often seems unavoidable.

The following examples of conversations with a pre-school girl (§ 25.3) and a schoolgirl (§ 25.4), in which the doctor and the young patients, together with their respective mothers, agree to have a classic *four-eyes conversation* (§ 18.3), which does justice to this literal sense, show that it is possible to do things differently.

A special problem arises from the long-term relationships with individual patients. The daily alternation of mild and severe cases, of acute and chronic courses of illness, not only refers to different patients, but also applies to the individual case. For example, someone may suffer from a moderate hypochondriac disorder for years and then suddenly also suffer from a severe physical illness. Of course, this also applies to the reverse case. Overall, the general practitioner must be prepared for all cases of co-morbidity (§ 29) with basic psychosomatic care.

25.2 Psychosomatic interviewing

In the following, the specific concept of a psychosomatic conversation in the context of basic psychosomatic care will be presented before it is exemplified by a number of empirical examples from GP practice.

25.2.1 Person-centered way of working

The special features of GP care described above require reflection on the significance and connection between conversation and examination, which, although separate, should form a unit. Examinations should always be embedded in conversations (§ 8), so that a circle of pre- and post-conversations can result in a series of examinations.

The examination of the patient is only one essential feature of medical activity. Data should be collected that make a finding describable, which enables the way to a diagnosis. This is an indispensable prerequisite of medical work. The question is, however, how often the same examination should be carried out again on the same patient in the shortest possible time.

Redundant examinations are sometimes necessary, but in most cases they are superfluous. They result from redundant symptom descriptions of the patients. If the patient persists in his or her description of symptoms, this results in repeated examinations, despite insufficient findings. The consequences can be iatrogenic chronification processes (Potreck-Rose, Koch 1994). The collection of data for the assessment of findings usually refers only to so-called *hard* somatic facts. The collection of psychological findings is neglected or delegated to the psychotherapist or psychiatrist.

The introduction of *basic psychosomatic care* (Fritzsche et al. 2003) (§ 15, 42) is intended to change this. It is a remarkable institution in the health care system of the Federal Republic of Germany, unparalleled in comparison to other European countries. It offers the possibility to include psychosocial data and facts in the daily routine of medical practice. The work of a general practitioner is not a diluted version of internal medicine or specialist medicine. It is an activity that is primarily oriented towards the person of the patient and only secondarily towards his diagnosis. The doctor's competence consists in dealing appropriately with both the illness and the being ill of his patients as persons. This requires a willingness to listen. He must be prepared to endure the tension that arises between the subjective needs of his patients and the objective demand for treatment that is fair to the guidelines. This requires a critical self-confidence that enables the doctor to take responsibility and endure uncertainties. Psychosomatic competence is required here, which can often only be achieved after many years of further training (§ 15, 42).

This medical qualification is an essential concern of Balint's group work (Balint 1988, Rosin 1989, Adams et al. 2006, Kjeldmand, Holmström 2008). The medical conversation is thus upgraded and the acceptance of mental disorders is significantly increased. Thus, creditable preconditions have been created for implementing psychotherapeutic ways of thinking and procedures, not only as an additional specialisation, but as a basic element in general primary care.

An apparent success is given with the billability of this basic psychosomatic care, which has increased significantly in the last ten years. However, an increase in billing does not at all mean an increase in quality and use of the possibilities offered by this facility. One hurdle for doctors in private practice is still the way in which data on psychosocial indicators are collected. This can only be achieved with a change in the way the conversation is conducted, as will be described below on the basis of the preceding chapters (§ 9, 19) as well as personal experience with a specific *psychosomatic* concept for the GP conversation.

25.2.2 Interrogative versus narrative conversation

In practice, the conversation usually begins with the patient's somatic concerns, which are presented in the form of complaints. In contrast to the traditional, interrogative taking of anamnesis (§ 9, 19), the patient

should now have his or her say in the time available. This means a considerable reduction of the doctor's speaking time (§ 40.2), which should initially be used less for detailed questions and more to promote patient narratives. This is the first and most important prerequisite.

Even this change in the doctor's conversational behaviour initiates a trend-setting change in the usual style of communication between doctor and patient and entails a series of consequences, which in turn affect the entire course of the conversation.

It is not uncommon for older doctors to advise younger colleagues: "Just don't let the patients speak out, once they start talking they won't stop." Doctors obviously have fears about letting patients speak for longer, especially if they use this for patient narratives. As a rule, however, only a small proportion of patients shape the dialogic conversation offer as a monologue. By far the greater part is often initially overwhelmed by the possibility of being able to talk about themselves as a person with individual complaints. Patients usually stop talking very quickly on their own. This leads to pauses in the conversation, which have to be endured by the doctor.

This represents the second significant change step. The patient needs time to *reflect* and *associate* (§ 9, 17), and the doctor must give him this time and allow it. He must defer comments from his medical frame of reference in order to first help the patient to voice his concerns. Helping the patient to speak thus becomes a medical task (§ 9, 19), which should enable the patient to articulate his complaints and concerns as well as the emotions associated with them.

25.2.3 Dynamisation of the complaint reports

In many cases, the conversation simply does not go any further, it comes to a standstill. Initial difficulties can already be overcome with repeated requests to describe the complaint and with encouragement to describe the symptoms more precisely. In the redundancy of the description of the complaint, the multifaceted nature of the symptom opens up and, with rather identical descriptions, gives clues to a somatic background and, with increasing variance in the description, clues to a psychosocial context (Adler 2000).

If the doctor simultaneously perceives non-verbal messages from the patient in the form of gestures, facial expressions, posture, voice pitch and narrative flow (§ 12, 18-19), he gains subjective data about his pa-

tient, which can provide the raw material for formulating hypotheses about the content of the narrative.

If the doctor additionally asks the patient to form his own hypotheses about his complaints, the interaction between the two changes. Now the doctor experiences a patient who tells stories that can be significant for understanding his disease state (Ferro 2009).

The symptom now no longer only has weight in its temporal and topographical dimension, when and where it occurs, but takes on a new quality. It conveys how it is experienced by patients, what it triggers in them and what paths the patient takes to be able to endure it. The symptom conveys subjectivity.

The reduction of the patient's statements to the differential diagnostic considerations of the doctor, and thus the exclusive weighting according to a medical frame of reference, can thus be bridged. Even the symptom, which only appears to be biologically based, now appears in the context of the patient and is thus not infrequently released from its somatic rigidity and begins to move within the framework of a constantly changing description of the complaint, it takes on a dynamic form.

25.2.4 Symptom, affect and relationship

With the dynamisation of the descriptions of complaints, movements from symptom to affect and from affect to relationship are carried out, which not only concern the patient's life situation outside the consultation. Rather, the description of the complaint also brings into play affects and relationships to the doctor as an interlocutor, to whom certain roles (as father, helper, expert technician, partner, friend, etc.) (v. Uexküll, Wesiack 1991) (§ 4.4) are assigned with certain expectations of medical care.

No symptom without affect

The next step in the realisation of basic psychosomatic care is for the doctor to realise that his patients' narratives are always accompanied by affects, which can be congruent but also divergent to the contents (Köhle 2017). The doctor must learn to accept and use these affects as additional sources of information. This applies both to their own affects, but also to those of the patient. The absence or appearance of these affects must be marked in the conversation without immediately giving a con-

crete name in the form of, for example, rage, anger, powerlessness, helplessness, inner emptiness. First of all, it is important that an inner emotion or excitement, or even its absence, is recorded and that the naming takes place only after a joint search movement by doctor and patient.

The doctor must be required to recognise his affects, to manage and control them and not to act them out. This results in a new goal of the conversation. It is not the doctor who explains to the patient what state he is in at the moment, but the patient needs help from the doctor to verbalise his feelings and moods (Parkinson et al. 2000).

The doctor's self-awareness is a necessary prerequisite for achieving greater confidence in dealing with his or her own feelings. The patient in turn needs a counterpart as a competent listener who can read and regulate his own feelings (Koerfer et al. 2010, Obliers et al. 2010). Only then does the patient have the chance to become clear about his or her own thoughts, feelings and inner states.

The doctor's renunciation of causal conclusions in favour of a joint hypothesis formation promotes the formation of a common vocabulary (Hirsch 2002). In this way, narrative units develop that can only be understood in their meaning by the doctor and the patient and form the subject matter for series of conversations (§ 26.2).

No affect without relationship

Through the narrative, the patient's affective experience gains access to the doctor-patient conversation and can be used as an important source of data. It is no longer ignored or overlooked. The affect, in turn, connects with relational episodes that make external conflicts visible, but whose repetitive character also allows first approximations to an unconscious conflict pattern. Affect allows access to the patient's psychic system. The way he regulates it gives the doctor an insight into the stability and coherence of the patient's self-system (Fonagy et al. 2004). It is now clear to the doctor that in conversation and interaction with his patients, he is continuously supporting or stabilising his patient's self-regulation. Lack of attention on the part of the doctor blocks the patient's willingness to open up. However, if he supports him in his stories, he signals affection. The conversation gains depth. The patient's sense of self increases.

Affects, relationship episodes, conflicts can now be linked to each other and can thus be focused into themes. In this way, the conversa-

tion gets a direction. By understanding and listening, the doctor helps the patient to bear and endure affects and thus takes the first steps towards overcoming them.

Therapeutic sustainability does not come from the removal of affect, but from a reflexive working through of its psychogenetic meaning in the context of a competent listener. These required series of conversations (§ 25.5-6) in which the individual narratives can be combined into a supplementary series and placed in a context with the currently triggering complaint situation.

A relationship thus develops between doctor and patient, parallel to the contents of the narrative units, in which both do not unearth or uncover the meaning of the complaints along their own frames of reference, but first construct the meaning in a joint conversation (Brisch 1999).

The reconstruction of this third level is therapeutically effective. Surprisingly, the time factor of the individual conversation seems to play a subordinate role in its generation, whereas the length and intensity of the relationship seems to be more decisive. It is precisely here where the special possibilities of GP activity lie.

25.2.5 Narrative conversation processes

In the following conversation analyses, experiences from practice with different forms of narrative conversation processes are presented on the basis of case studies. All case studies are documented on video. The conversation sequences are reproduced here partly as transcripts, partly as direct or indirect speech. An attempt is made to include elements of transference and countertransference in the case description. In this way, the effects and attitudes of the treating doctor in the aftermath of the conversations will also be taken into account. The methodological perspective is to illustrate the type of psychosomatic conversation described above using a series of conversations as examples, in which the detailed transcript analyses are supplemented as far as possible by the internal perspective of the treating doctor. In this way, the "objective" observation perspective of the conversation, which is equally accessible to all "observers" as a transcript, is to be linked with the "subjective" experience perspective of the doctor participating in the conversation.

The practical possibilities of the narrative are at the center of the conversation analyses. However, due to the size of the interviews, only

excerpts can be given here and analysed under specific aspects. In the first two cases, certain age-appropriate competencies of the child and adolescent patients must also be taken into account.

- ***Conversation with a five-year-old girl***. The first example, a conversation with a child with cancer, illustrates how a series of narratives by the child involves the mother, who was previously sent out by the child, as well as the siblings and finally the attending doctor. With the reflection of the transference event, the child's narratives open up a new level that makes his concern comprehensible in the first place.
- ***Conversation with a pupil***. In the second example, a shy pupil is also asked to describe her complaints without her mother, who is waiting outside as agreed. At first she only manages monosyllables, mainly about her symptoms (nausea, headache). Then a cooperative search develops between doctor and patient for ways to verbalise her complaints. This joint conversation work enables the patient to create a narrative that forms the basis for further series of conversations.
- ***Conversation with a pensioner and couple conversation***. The conclusion is formed by an example from an initially brief conversation with an older patient from a general practitioner's office, in whom a narrative develops following his heart-related complaints about his wife's discharge from hospital. The further couple interviews with the spouses then make this narrative more comprehensible in the context of a symbiotic couple relationship.

The examples illustrate that the patients' primary somatic concern is placed in a new context through their narratives. This new context relativises their objectively describable *illness* to a subjectively experienced *being ill*. This has implications for the diagnostic and therapeutic approaches that usually result.

25.3 Coping with illness

The following conversation with a five-year-old girl is essentially about processing and coping with the "bad" disease "cancer". It is not only the child's own stresses that are discussed, but also those of the family as a

whole. For a better understanding of the conversation with the child, the previous history should be briefly summarised, which begins with the mother's visit to the consultation.

25.3.1 Previous story: The cancer of a five-year-old girl

The case had initially started with the mother's complaint about her headaches. Headaches are one of the recurring treatment concerns of patients in the family doctor's practice. The usual procedure for the doctor is to systematically clarify and rule out possible causes, such as diseases of the teeth, sinuses, cervical spine, eye diseases, vascular diseases, neurological diseases and even tumors. Metabolic disorders and disturbances of the electrolyte balance can also lead to similar complaints.

Mother's burden: from symptom to narrative

If the doctor only refers to the term *headache* when describing the patient's complaint, he is inclined to immediately carry out the differential diagnostic clarification. If, however, he encourages self-representation, there is a chance that the term will become linguistically fluid in a narrative. The term can "dissolve" into a narrative, which then still needs to be examined and understood. The narrative is not an end in itself, but can be understood as a gateway to the patient's subjective reality.

In the present case, the doctor also relies on these differential diagnostic considerations, but first promotes the patient's self-representation, he facilitates a narrative. The mother of three children tells about her five-year-old daughter who is suffering from a complicated cancer. She has already been treated for many months in a university clinic and in an oncology practice. The child is very lively and constantly asks questions, including about the course of her disease.

The doctor suspects that the very caring mother is increasingly overwhelmed. There are not only the many doctor and hospital visits where she constantly accompanies the child, but also two other children and a large house with a garden and a lot of work. Then there are always these questions from the child about her current situation. The mother suffers from unbearable headaches.

Offer to talk to mother and daughter

The doctor offers the patient to come to the practice with her daughter in the hope of talking to the child. The mother readily agreed to this proposal. The mother now comes to the practice today with her child, where she had registered several days ago. Before entering the consulting room, the mother told the doctor, in the presence of her daughter, that they had talked about the doctor at home and that her daughter would now like to talk to the doctor.

Fig. 25.1

First, mother and daughter now take their seats next to each other in the consulting room, with the girl holding a doll in her arms (Fig. 25.1). She wears a cap on her head, probably also to hide the loss of her hair, which can also be perceived directly later in the conversation when she takes off the cap.

25.3.2 Relationship conflict: "Then mum should go out"

Protecting and stabilising, the child continues to hold her doll firmly in front of her, although variations will also be observed. At first it seems as if she is building up the doll between herself and the doctor as a protective shield, which she will only take off later in the conversation.

Expectant tension of the doctor

Due to the mother's advance notices, the doctor is in expectant tension. He does not yet know how to open the conversation with a five-year-old child with this serious illness. He is afraid that he will not be able to cope with the conversation.

It spontaneously occurs to him that it might be important to know when the last chemotherapy for the child took place, and he tries to clarify this situation. Although he initially addresses his question to the young patient with a kind of *small talk* ("Silke, where did you come from?"), the rest of the conversation, which is reproduced here in abbreviated form (E 25.1), turns into a question-answer pattern between doctor and mother.

E 25.1		"Silke, where have you come from now?"
01	D	[all seated] Silke, where have you come from now?
02	P	from [place name] .
03	D	[...]
04	M	[Mother themed to include: outpatient treatment, injections, chemotherapy, etc.] .
05	D	[...]
06	M	[...]

The doctor quickly realises, however, that he is slipping into his old, *interrogative* questioning pattern with the mother and thus trying to avoid a possibly stressful conversation with the young patient. Therefore, he tries a kind of new start in which he turns again to the girl who is supposed to be his primary interlocutor today. This leads to a surprising turn in the conversation situation, which was previously determined by the special triangular relationship between the doctor, the young patient and the mother, who was and is also his patient.

One-to-one conversation and medical listening privilege

Even with the GP, who is often at the same time the *family doctor,* the presence of family members can disturb the direct communication between doctor and patient, who should then better retreat to the classic one-on-one conversation (§ 18.3). In this case, a possible *relationship conflict* between mother and daughter is acted out directly in the consultation in actu before the doctor. The example is strong evidence of the doctor's *listening privilege*, which is granted to the doctor's "stranger" rather than to familiar persons, especially in the case of "difficult" or "sensitive" topics (§ 20, 21), even if or precisely because they are family members. It is quite astonishing how self-confidently and single-mindedly the five-year-old is able to claim the professional role of the doctor for herself, with whom she obviously seeks to enter into an exclusive relationship alliance.

E 25.2		"then mum should go out"
07	D	I think you want to ask me something . what do you want to ask me? .
08	P	then mum should go out .
09	D	Mum should go out . leave the door open or close it? .
10	P	close .
11	D	completely close ... [P nods].

With this kind of "solution" to a possible conflict situation, it must remain open whether the child seeks the one-on-one conversation with the doctor primarily to "spare" the mother or to create a "sanctuary" for himself in front of the mother, although both motives can of course coincide, as suggested by the further course of the conversation.

At first, the doctor is surprised himself and seems to have to ascertain the extent of the consequences: After the literal repetition, he then puts the remaining alternatives up for discussion ("leave the door open or close it") in order to clarify a possible consequence ("completely close?") by asking again, despite the patient's clear answer ("close"), which is confirmed non-verbally by nodding. Thus "complimented", the mother, who seems somewhat irritated but immediately rises as if she agrees, leaves the consulting room, which the young patient now shares with her doctor alone.

Fig. 25.2

Fig. 25. 3

In the moment when the mother is outside and the door is closed, the child's gaze, which was initially directed at the mother walking out (Fig. 25.2), turns to the doctor and he notices a fleeting relaxed, hopeful smile (Fig. 25.3). Then the "real" conversation begins with a restart, where the patient immediately goes into medias res.

25.3.3 Self-exploration: "My nerves are getting the better of me"

As soon as the strictly dyadic conversation situation desired in this way is established, the general topic for the consultation is briefly and succinctly formulated by the patient without further introduction under two aspects, which turn out to be *thematic openers* for the whole conversation, in which they are taken up again and deepened by both conversation partners.

E 25.3		"My nerves get the better of me and I'm scared sometimes"
12	P	my nerves get the better of me and I get scared sometimes .
13	D	yes that's nice . how you can say that .
14	P	sometimes I don't dare to say it ...
15	D	what don't you dare to say? .
16	P	that my nerves are getting the better of me and I'm scared .

This introduces the two main thematic aspects, which are further elaborated in the course of the conversation with reference to various actively and passively involved family members. While "fear" refers to an "inner" feeling, the "nerves" that are "getting the better" of the patient describe an outwardly "directed" feeling, which is later also referred to the parents and siblings in its *aggressive* orientation ("anger"). Although both thematic aspects ("affects") are repeatedly brought together in the further conversation, a choice must first be made between the two alternatives at the beginning.

The emotional content of the thematic lead

With both thematic openers ("My nerves get the better of me and I'm scared sometimes"), the emotions are addressed at the same time, which are further processed in the joint conversation work between doctor and patient. The direct and open formulation, delivered almost in the style of an adult, also surprises the doctor. This five-year-old girl openly presents her whole inner situation with a clear formulation. It is possible that she has taken the formulation from reproaches or comments of the parents, which she is quoting in a certain way. This would also make the motivation of her request more understandable again,

not to talk about the topics formulated in this way in the presence of her mother, but with the doctor alone.

The doctor thinks about how difficult it is to get to the core of their problems with adults and what difficulties they sometimes have in formulating this directly. This child amazes him all the more. He immediately reflects back to her this extraordinary ability to say clearly what is bothering her and why she comes to him with an *empathic* feedback of recognition (§ 20.5). The child takes his feedback ("nice how you can say that") in a relativising way by emphasising the limitation of her ability: "Sometimes I don't dare to say that." So she is often in a state of inner turmoil and great anxiety without being able to talk openly about it with anyone.

Fig. 25.4

Not only does she know the condition, but she can already establish it linguistically, describe it and convey it with coherent formulations. She directly contacts her doll and lifts the doll's head under her chin in what the doctor sees as a protective gesture (Fig. 25.4). However, she is not yet able to say specifically what she is afraid of, which subsequently becomes clear when she answers the doctor's question (21D) with not knowing (22P: "I don't know"). As the conversation progresses, however, it becomes clearer and clearer what she is afraid of.

Fear of death as fear of separation

After the doctor has first expressed his appreciation ("it's nice how you can say that"), the *fear topic* is continued, which is *upgraded in relevance* by being *taken up again* (17D: "you're really scared then") and *empathic* feedback (19D: "that's a nasty feeling") (§ 19, 20). To clarify the question of the reason or object of the fear, it takes two attempts by the doctor (21D: "What are you afraid of?" - 23D: "How do you notice it?") before the fear is specified primarily as *separation anxiety* (24P - 28P), which is thematised as separation from the parents (25D: "going away"). The doctor is of course aware of the patient's serious illness, to whose child-oriented ideas of illness he reacts appropriately without overburdening her.

E 25.4		"Anxiety" as fear of loss and separation
17	D	you are really scared .
18	P	[nods] .
19	D	that's a nasty feeling . you already know that .
20	P	[nods] .
21	D	what are you afraid of? .
22	P	I don't know .
23	D	You don't know that. How do you notice the fear? ...
24	P	that mum and dad should stay with me .
25	D	are you afraid they will leave ? . and that you will be alone? .
26	P	[nods] .
27	D	then you're all alone and you're afraid mum and dad will leave.
28	P	[nods] .
29	D	now you have sent mummy away . well done . now alone with me . you can do that very nicely .
30	P	[Puts doll, which she has been holding in her arms, away to the side] .

When the doctor asks her how she notices the fear (D23), she thinks hard. She thinks about it. Mum and dad should stay with her. She is afraid that her parents might leave. It understandably occurs to the doctor that she is afraid of a threatening course of the disease, whatever the child's idea of death and dying might be. Perhaps she expresses fear of her own leaving, of her own dying, as a fear, a projection about her parents leaving. At this point he considers whether she wants to talk to him about it, whether that is the real reason for her visit. Does she want to talk to him about death, about dying?

At the same time, the doctor recognises how competently the young patient can already deal with separation. She is afraid that the parents might leave her, but in the present situation she has sent the mother out. She has actively brought about the separation from the mother. The doctor conveys to her that she can already handle separation very well (D29). This intervention triggers a startling non-verbal action in her. She now also detaches herself from her doll and puts it aside next to her on the chair (Fig. 25.5). She puts down her transitional object in a clear-

Fig. 25.5

ly recognisable way. Now nothing stands between doctor and patient, both interlocutors are in direct contact. For a moment she seems embarrassed and disoriented, but immediately resumes contact with the doctor.

The "scary" topics that are latent (*death*) or manifest (*separation*) in the conversation space seem to have lost their threatening nature in the relationship with the doctor, at least for the moment, because the patient's own resources were strengthened despite all remaining ambivalences.

In studies on the child's concept of death, the ambivalences of children are expressed, for example, by a six-year-old girl who has lost her mother in a traffic accident: "That mummy is dead and won't be around anymore, I understand that well. But why doesn't she come in the evening to kiss me goodnight anymore?" (Huppmann, Wilker 1988: 136). In other children's concepts of understanding, death is also presented as more or less "final" or mediated by transitional phases.

Thus, the fear of death is not addressed directly by the five-year-old patient in this conversation either, but mainly as a *fear of separation and loss*, which seems to depend above all on the behaviour of her parents (24P: "That mummy and daddy should stay with me"). Apparently, the patient fears that her parents will not behave as they should from the child's perspective of wishes and expectations. This is where the other thematic aspect, already introduced by the patient at the beginning of the conversation, comes into play, namely that the patient herself is behaving "inappropriately" (12P: "my nerves are getting the better of me"), which apparently makes her fear corresponding "sanctions" (*leaving*, etc.) by her parents. This thread is first pursued before the doctor turns again to his patient's subjective ideas about her illness.

Loss of control: "then I get crazy"

After the doctor had expressed his appreciation for the patient's short-term, current separation from her mother (29 D: "you're very good at that") and the patient had put her doll aside as an "auxiliary object", the doctor leaves the subject of anxiety for the time being, but it is immediately taken up again by both interlocutors. The doctor first addresses the other aspect of the initial topic ("nerves ...") of his patient, to which she then willingly responds after further enquiry by giving her "affect" a dialectal "name" in her language (34 P: "then I get crazy [jeckig]"). The patient characterises herself as so "crazy" that she apparently loses con-

trol (34 P: "and don’t know what I’m saying"), which is further *upgraded in relevance* (§ 17, 19) by the doctor qua *repetition* (35 D: "you don't know what you're saying anymore").

E 25.5		"then I get crazy"
31	D	and then your nerves get the better of you, right? .
32	P	[nods] .
33	D	what's it like when your nerves get the better of you .
34	P	then I get crazy and don't know what I'm saying.
35	D	you don't know what you're saying anymore, do you? .
36	P	[nods] .

Not knowing what to say anymore is an expression of a "loss of control", which both partners can apparently derive in their own way from an overriding understanding of the illness. In any case, the patient is able to integrate the subsequent doctor's topic initiative, which may seem surprising at first, well into her own subjective ideas of her (basic) illness, the meaning of which ("bad illness") both conversation partners can quickly agree on.

The "bad" disease "cancer“

The doctor comes back to the patient's illness. She knows that she is ill, she knows that she has cancer. What might the child mean by cancer? The doctor asks several times. His verbal escalations ("sick", "very sick", "bad illness") obviously fit the patient's self-perception of her illness, whose name (42P: "cancer") she can then pronounce herself, before the doctor then begins to cautiously inquire about her "subjective ideas of illness".

E 25.6		The "bad" disease "cancer“
37	D	I think you're sick, yeah? .
38	P	[nods, nods] .
39	D	are you very ill? .
40	P	[nods several times] .
41	D	do you have a bad illness? .
42	P	[nods] cancer .
43	D	you have cancer . what do you think it is, cancer? .

44	P	yes, that my hair will fall out .
45	D	yes ...
46	P	that I get medication .
47	D	yes ...
48	P	that I sometimes become weak .
49	D	really weak . then you have no more strength at all .
50	P	[nods] .
51	D	then you're just tired . then you feel like you're getting crazy, yeah .
52	P	[nods] .

With the name of the disease ("cancer") the "cue" has been given with which possible "taboos" can now finally be "broken" by both conversation partners openly talking about details and accompanying signs of the "bad" disease and its treatment ("hair loss", "medication", "weakness", "tiredness" etc.) in the further (here abbreviated) conversation. In this developed explanatory context of the serious illness, the questionable behaviours are repeatedly placed in between, which are described in a differentiated way in the already familiar expressions ("nerves are getting the better of me", "crazy"), but also in different variants ("grumpy") in a joint emotional work.

25.3.4 Emotion work: fear, craziness, sadness, joy

In their joint emotional work, doctor and patient develop an extremely differentiated vocabulary of emotions, which is reciprocally initiated, resumed and continued by both, so that a common thread of conversation gradually emerges with thematic key words, whose *individual meanings* are sometimes subjected to fine-tuning.

Fear and craziness towards parents

For example, following the expression "jeckig" (crazy), not only is the *quality* of the feeling asked for in the sense of *detailed exploration* (§ 21) ("What does that mean?"), but also the *conditions* of its occurrence ("Does it go away or does it come back?"), whereby the doctor again initiates the topic of the *presence* versus *absence* of the mother or parents with his enquiry (61D: " ... is it better then?").

E 25.7		"Fear" and "craziness“
53	D	what does that mean .
54	P	grumpy .
55	D	so grumpy, yes?
56	P	[nods] .
57	D	I can imagine that very well.
58	P	[nods] .
59	D	does it ever go away again . or does it come back? .
60	P	goes away too .
61	D	goes away too ... and if the mummy is with you, is it better then? .
62	P	I'm only scared when they're gone, but my nerves get the better of me even when they're there .
63	D	(...)
64	P	(...)
65	D	you have to endure a serious illness .
66	P	I had cancer twice .

The cooperation between doctor and patient is already extraordinarily successful here. The young patient has a *self-reflection competence* that the doctor knows how to challenge through conversation. This is followed by a classification of the feelings that arise above all in the *presence* ("nerves are getting the better of me", "crazy" ["jeckig"], "grumpy") and *absence* ("fear") of the parents (P62). After the doctor's renewed acknowledgement of the stress caused by the "serious illness" (D65), an intensive "feelings work" (§ 20) then takes place in the interview passages omitted or shortened here, which expands the spectrum of feelings discussed so far in various positive and negative directions, in which both the patient's stresses and resources are expressed.

Sadness and bravery in illness

Whereas up to now the two themes of "fear" and "craziness" were in the foreground in connection with the basic illness ("cancer"), the doctor now opens up thematic opportunities for other emotions of the patient. Already following the "seriousness" of the illness and its accompanying signs, the doctor not only acknowledges his patient's "narrative competence" (71D: "you can tell me that very nicely"), but also praises her *bravery* in coping with the illness (75D: "enduring very bravely"), which, however, also recognisably reaches its limits in the consultation.

E 25.8		"brave" and "sad"
71	D	I think you can tell me this very nicely ...
72	P	sometimes when I get the drugs, sometimes I get sick .
73	D	then you don't feel good at all .
74	P	[nods] .
75	D	I also believe that you are seriously ill . and you are also enduring this very bravely .
76	P	[nods] ...
77	D	but it's hard ...
78	P	[nods, wipes her eyes] .
79	D	do you ever get sad? .
80	P	[nods several times] .
81	D	then what makes you so sad? .
82	P	that I always have to get sick and the other siblings don't .
83	D	they are healthy yes . and they can .
84	P	[nods] .
85	D	and they can do everything and you can't do everything.
86	P	[nods] .

With the contrast relation (75D: "very brave" - 77 D: "but it is hard"), the doctor addresses the limits of the young patient's resilience, who agrees by nodding, but also seems overwhelmed by her rising feeling, which is initially expressed non-verbally by wiping away the rising tears with her hand (P78). In the sense of *scenic understanding* (§ 9, 20), the doctor perceives the patient's rising feeling, which he verbalises in question form on behalf of the patient (79D: "do you ever get sad"). Asked about the reason for the sadness (81D), the further contrast relation to the healthy siblings is then established in narrative sequences (82ff.), who are experienced in short narratives as competitors in a rival relationship, as it were, because they already go to or come from school, can ride a bicycle, etc., i.e. "can do everything" and above all "can play everything", which can later also lead to "anger" on the part of the patient.

In the further course of the conversation (omitted here), the patient also talks about her dreams, which are "sometimes bad", so that she cannot sleep well, etc. There are also disturbances during (falling) asleep due to the siblings making noises etc.

As the relative detailing of the narrative sequences already suggests, these adverse conditions during falling asleep seem to preoccupy the

patient a great deal. The doctor understands the phase of falling asleep as a transitional space to the unconscious, a phase in which the defence functions are weakened, in which fears arise and she has to relinquish control.

Fig. 25.6

When talking about her problems during this phase of falling asleep, the patient surprisingly lifts her head covering (Fig. 25.6). The bald head with a slight fuzz becomes visible, but this is not discussed further by the interlocutors. Obviously, however, the patient confides in the doctor non-verbally in a way that makes her feel defenseless and exposed. The doctor sees this as a more or less conscious appeal to continue to address her defenselessness and helplessness and not to end the conversation yet. However, at this moment the doctor is not yet sure how to continue the conversation, which has already been very stressful for both partners.

Joy and fun with health

After so much stress, the doctor looks for the patient's resources. What could bring her joy or fun? Again, the patient differentiates very thoughtfully in the further course of the conversation and does not let his intervention stop her. In response to the doctor's subsequent question (113D), who "actually" does not want to pursue any special intentions with clarification of nuances with his doubling of "joy" and "fun" on his part, the young patient gives him an extremely differentiated and "instructive" answer in two parts before both conversation partners then head towards the end of the conversation.

E 25.9	"Joy" and "Fun"
113 D	what do you really enjoy and have fun doing? .
114 P	joy when I am healthy . no longer sick .
115 D	yes .
116 P	fun- .
117 D	that's nice (...) the thought that you will get well again .
118 P	and fun for me . when I can do everything again .
119 D	that you can play with the others again, yes? .
120 P	[nods] .
121 D	and now it doesn't work like that, does it? .

122	P	[shakes head] .
123	D	and that hurts somewhere when you can't do that .
124	P	[nods] .

Although the patient is formally "interrupted" by the doctor, she does not let herself be distracted from her flow of thoughts and speech, which she elegantly continues after the interruption (116P: fun-") by resuming "as if uninterrupted" (§ 19.3, 40.2). After her impressive "teaching" about the difference between *joy* and *fun* from the life-world perspective of a young patient, the conversation seems to be saturated, nearing its end after 12 minutes after all.

Call termination

The end of the conversation is announced several times in the sense of "opening up closings" (§ 23). The doctor is already talking retrospectively in the past (125D: "... that you wanted to talk to me") and the patient "can't think of anything else" (P126), which the doctor repeats paraphrasing (127D: "you don't know anything anymore") and which the patient confirms again by nodding. The topics seem to have been sufficiently exhausted and there is a lull in the conversation, which corresponds to emotional exhaustion. The young patient now seems tired and the doctor also feels exhausted.

E 25.10	"I can't think of anything else"
125 D	I think it's so nice that you wanted to talk to me .
126 P	I can't think of anything else.
127 D	you know nothing more.
128 P	[shakes head] .
129 D	have you said everything you wanted to ask me? .
130 P	[nods several times] .
131 D	would you like to come to my place again? .
132 P	[nods several times] .
133 D	(...) [as the doctor rises and goes out to bring the mother in, the young patient begins to spin gleefully on her patient chair as if on a merry-go-round] .

Although the end of the conversation seems to have been more or less clearly reached, the doctor's *closing routine* (§ 23) is also maintained in

the conversation with the very young patient, in that the doctor asks the *standard question* about questions that are still open in a child-friendly form (D129) and offers the prospect of a follow-up conversation (D131) with the patient, who nods several times in agreement.

Fig. 25.7

In the unobserved situation in which the doctor goes out to fetch the mother from the waiting room, one can still see in the (moving video) image (Fig. 25.7) how the patient turns back and forth on the patient chair as if on a merry-go-round. Obviously, the conversation with the doctor "did her good" if she can try out her self-efficacy in such a pleasurable way on the "strange" swivel chair.

Conversation balance: Scenic storytelling and understanding

The conversations first with the mother and then with her daughter are characterised in a special way by *scenic narration* and correspondingly *scenic understanding* (§ 9, 19, 20). First of all, there is the mother with her headache, for which she comes to the consultation. In an attempt to clarify the headache, a narrative about her daughter with cancer emerges. In a first hypothesis, the doctor suspects excessive demands as the cause of the complaints and invites the daughter for a talk. In this initial conversation with the family doctor, the sick child opens up and confides in the doctor to the exclusion of the mother. At first, the conversation develops satisfactorily for both of them, but in the meantime the conversation falters and there are longer pauses. The doctor feels increasingly strained and overwhelmed. Although he is not prone to it, he also gets a headache. Thus he gets into a similar situation as the mother of the child.

The child is now in a doubly difficult situation. Once it notices that its parents, who are very caring, are overwhelmed. The child feels that despite all the exemplary care, it is no longer being sustained. It feels increasingly alone and lonely, especially when the parents are absent. It panics internally. The child describes this state as crazy.

In the conversation with the doctor, the feeling of not being endured is repeated for the child. The doctor now experiences this unbearable situation in which the child continuously finds itself at home. In an unconscious enactment, the child has succeeded in transmitting its inner distress, which can no longer be expressed in words. If the doctor deals

with this situation self-reflexively, he has the possibility to also feel and understand the child's difficulties. He can achieve a container *function* for the child by being prepared to accept the feelings that are unbearable for the child and, without acting on them, also to endure them. The child can thus feel accepted again and is relieved, which in turn makes the situation more bearable for the mother, whose headaches finally subsided.

The conversation with the daughter, which lasts 12 minutes, is characterised overall by continuous *cooperation* between the young patient and her doctor, who in his *midwifery function* (§ 9.5) is able to help her well in verbalising her problems. The *dialogue* between the two interlocutors takes place at a high (self-)reflexive level, at which the five-year-old patient, with the verbal help of the doctor, can also express her *emotions* in a differentiated way when dealing with and coping with her "bad" illness. The doctor himself was impressed by the reflexive and linguistic competence of the very young patient, whom he repeatedly praised explicitly in between (71D: "I think you can tell me that very nicely") in order to animate her to further, partly narrative self-exploration.

In their joint *emotional work,* both conversation partners can verbalise and evaluate the patient's multi-layered emotions both in her self-experience of the "bad" illness and in her behaviour towards her parents and siblings. The wide spectrum of directly verbalised emotions is summarised again here: *Fear, craziness (nerves), bravery, sadness, anger, joy, fun.* Indirectly, the narrative sequences about school attendance and the games of the "others" also address *envy*, with reference to the "rival" children who "can do everything" that the patient "cannot". However, she will have the associated "fun", which she threatened to lose in the meantime, again when she is healthy again, which in turn would trigger "joy", etc. Here, in the *linguistic and lifeworld* perspective of a five-year-old, the connection between *health*, *self-efficacy* and *joy of life* is impressively established in the simple words of a child.

Some of the young patient's linguistic forms may seem "precocious". Even the opening statement ("My nerves are getting the better of me") may be a reflection of statements made by older caregivers (parents, siblings), who may have expressed themselves in a similar way in certain family conflict situations, either directly to the patient (e.g. "Silke, you're getting on my nerves") or in the third person (e.g. "The little one is getting on my nerves again"). Thus, this self-critical perception of the patient may also be a reaction to the reaction of her environment, which

she reproduces linguistically as a pattern of action in the consultation as a "quotation" without having to fully understand the meaning.

In the conversation, all relevant illness-related problems and areas of the patient's life were addressed. Apparently, the patient was also able to use the conversation with the doctor in its catharsis *function* and strengthen her *resources.* In between, the patient had gotten rid of both her doll (as an "auxiliary object") and her cap (as a "visual protection"), so that one can also perceive the loss of her hair. To be able to "give herself away" at all in both cases is just as much a testimony to the growing *confidence* and *self-confidence* of the young patient still in the ongoing conversation with her doctor as the amusing carousel ride on the swivel chair after the end of the conversation.

Catamnesis

A few months later, the chemotherapeutic treatment showed a surprising improvement in the somatic findings. The mother herself immediately calls the doctor after the treating pediatric oncologists had informed her of the result and shares the joyful news with him. After about half a year, the condition worsened again, with a considerable proliferation also of the myocardium. This necessitated renewed chemotherapeutic treatments. This treatment lasts more than ten years in total and takes place in the oncological children's department of the nearby university hospital. During this time, further consultations with the family doctor take place regularly. Today, the patient is considered cured. She continues to be under the care of her family doctor.

25.4 Fear of failure and loss

In the following conversation, a pupil also comes to the GP's practice with her mother because she is "worried" about her 13-year-old daughter who already goes to school in the morning with "indisposition" or "nausea". The conversation is again first conducted with the pupil alone and is later continued with the mother after about 7 minutes. After a brief description of the background, the conversation is analysed in se-

lected sequences, focusing in particular on forms of *cooperative narration* (§ 19, 20).[1]

25.4.1 Nausea and headaches of a pupil

The pupil is already known to the doctor as a child and he has examined her several times. Lower abdominal complaints always play a role. Since the pupil is very shy, the doctor has not yet been able to have a one-to-one conversation with her. When picking up the patient from the waiting room, the mother wants to take part in the conversation again. She fears that her daughter will not be able to present her complaints adequately. This time she follows the doctor's request to talk to her daughter alone first, which the doctor alludes to right at the beginning of the conversation.

E 25.11		"I feel sick sometimes ... and I also have a headache"
1	D	yes please come Julia . sit down . [D+P come in together and sit down] ..... [5] ..... tell . your mum is worried that you won't tell everything .
2	P	[P laughs softly; embarrassed] .
3	D	now we two try this . right .
4a	P	yes, I sometimes feel a bit sick .
-	D	yes .
4b	P	and I also have a headache .
-	D	yes .
4c	P	and when I got up this morning, I immediately felt sick.
-	D	yes ...
4d	P	and um, today at lunch time . when I ate something . I was totally sick . and then I always feel sick and tired in between at school

1 The interview has already been analysed in a multi-method perspective with different approaches (Discourse Analysis (DA), Roter Interaction Analysis System (RIAS), Structural Analysis of Social Behaviour (SASB), Heidelberger Struktur-Lege-Technik (SLT), which we will return to with a summary presentation of the results in the *evaluation* (§ 40.2) (Koerfer et al. 2010, Szirt, Langewitz 2010, Kruse, Tress 2010, Obliers et al. 2010). The entire conversation is documented as a transcript (Köhle et al. 2010). A detailed movement analysis of the interaction between doctor and patient has been carried out by Lausberg elsewhere (2011) and in this handbook (§ 12) using an exemplary sequence from this conversation.

		.
-	D	yes .
4e	P	and then, as I said, the headaches .
4f	D	yes .

The narrative invitation has a special function right at the beginning ("tell"), which naturally applies to the whole conversation and is later supplemented by other forms of invitation to the patient's active cooperation (D: "try it" - D: "think about it"). These repeated invitations to cooperative conversation work are later accepted by the patient on further topics that gradually broaden the narrow focus of her initial symptom descriptions ("headache", "nausea", "tiredness" etc.). In the process, the two interlocutors move through a thematic change from "pressure" (in the case of headaches) (Fig. 25.8) to "being depressed" to "being under pressure", which is later linked to the topic of "anxiety". We can only rudimentarily trace this *thematic change of form* over the course of the conversation.

At the beginning of the conversation, the patient's utterances are initially *minimalistic* (04P: "I feel a bit sick sometimes (...) and I also have a headache") (Fig. 25.8). In this first phase of the conversation, the doctor fears that the pupil might fall silent again immediately after each utterance. He tries to encourage her to speak at greater length about her condition.

Fig. 25.8

However, there is no real flow of speech; the pupil can initially only be persuaded to make symptom-oriented statements about her complaints such as *headaches*, *nausea* and *tiredness*. In this first phase of the conversation, the doctor pays close attention to her gestures and facial expressions as well as the way she verbally describes her symptoms ("such a pressure", "I feel sick"). In doing so, he follows the guiding principle already mentioned: "No symptom without affect" (§ 25.2.4). When the patient tries to express a disturbance in her state of mind ("I feel sick") when asked by the doctor, and she repeatedly fails to find the words, she reaches for her neck with her hand as a substitute for this deficiency (Fig. 25.9). During his repeated enquiries ("there is such a feeling"), this non-verbal behaviour is more or less consciously mirrored by the doctor, who in turn almost touches his neck (Lausberg 2011) (§ 12). The patient answered the doctor's other questions ("is something constricting you or do you have the feeling that you have to vomit?") in the affirmative, but put them into significant perspective ("yes . I have . but then it never happens"). Apparently it is a *feeling of "as if"*. Further attempts at description and explanation initially remain relatively vague until a new thematic form develops, which is accompanied by a change in meaning (from "pressing" to "depressed"), which is carried out in the joint conversation work of *cooperative storytelling*.

Fig. 25.9

25.4.2 Dialogue roles of doctor and patient

Before this specific form of cooperative narration takes place, the further thematic development of the conversation cannot be followed in detail here, but only in an overview of the entire conversation, which is then to be deepened with exemplary excerpts of the conversation. This involves reconstructing the interactive and thematic forms of participation of the two interlocutors. In a formal procedure for depicting the *dialogue role structure* of speaker and listener, which is justified and described in more detail elsewhere in the handbook (§ 17, 19, 40),[2] it is

2 At this point, for methodological reasons, it should be noted again that mere feedback from the listener ("yes", "huh"), which allows the speaker to

possible to see at a glance (Fig. 25.10) which interlocutor speaks when and for how long, and in which phase of the conversation he or she has his or her specific focal points of speech, while the interlocutor listens more closely.

According to this procedure, the conversation is divided into four phases in which each partner has his or her own speech domains, each of which can be used for specific purposes. The patient has two, i.e. a total of four longer (asterisked) contributions in each of her two speech domains (I, III), which are at a critical threshold of about 60 words. The patient can speak in one piece without being interrupted by the doctor in any relevant sense.

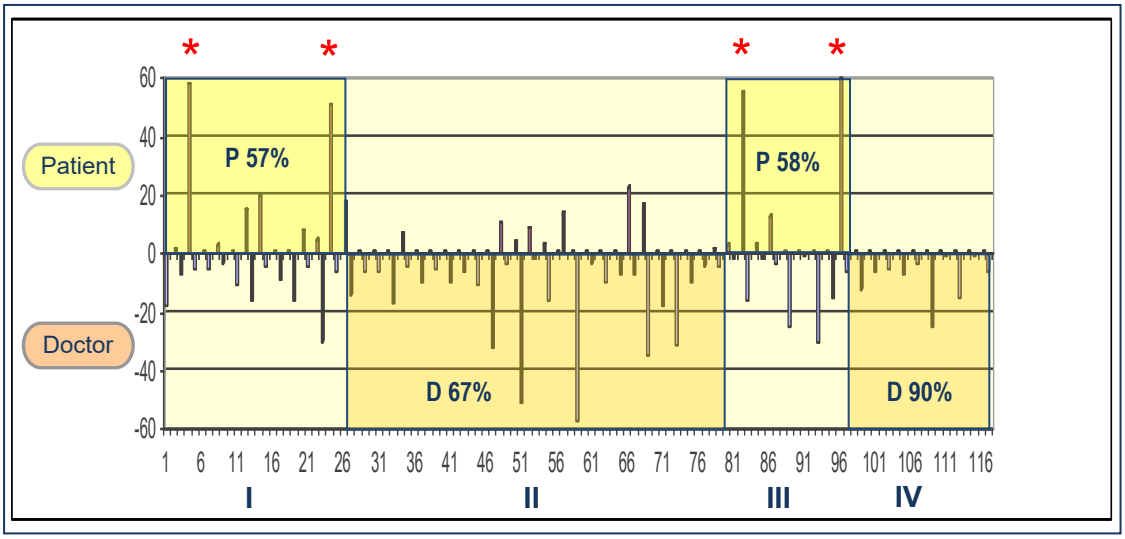

Fig. 25.10: Dialogue role structure (phases, domains) (on Koerfer et al. 2010)

Under an *evaluative* aspect of *participation,* these opportunities to speak at length can already be considered formal-dialogical indicators of the quality of the conversation. The fact that patients more often have their say in detail is a necessary, though not sufficient condition for patient-centered conversation, whose interactive and thematic granting and use of opportunities must then be examined in detail.[3]

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continue "as if uninterrupted", is not counted as "independent" speech contributions in this specific procedure (cf. § 17.3, 40.2).

3 The fact that patients cannot exceed a threshold of 30 words during the whole conversation was shown by the "interrogation conversation" (19.6), in which the doctor nipped all the patient's speech and topic initiatives in the bud with an interrogative style of conversation.

In this context, the longer patient contributions are methodologically a good starting point for further conversation analysis, because the core themes of the conversation are usually developed here (§ 17, 40). In a second step of analysis, the *contexts* of the longer, often narrative patient contributions are then to be examined, in which the development of such speech contributions is favoured (Koerfer et al. 2000, 2004, 2005, 2010). In this way, medical (key) interventions can be identified at the same time, whose effects and ranges can then be empirically proven in the conversation.

In the present conversation, the first two longer contributions of the patient still serve entirely the *symptom-oriented* description of complaints (*headache, tiredness, nausea*), while the two longer contributions from the third phase of the conversation lead to a conversation climax with a *narrative self-exploration* of the patient. On the way there together, the original patient offer undergoes a change of meaning, in which the doctor with his interventions as a "co-constructor" in *cooperative narration* plays a considerable role.

25.4.3 Cooperative storytelling: "Then I'm just scared ..."

The importance of narratives has also been recognised in medicine as an elementary form of communicative understanding (§ 9, 19). The *biographical-narrative* approach is based on the insight into the *closeness to everyday life* of this form of communication, in which in a specific way individual experiences of patients can be conveyed as *stories of suffering*, which are told as part of a *life story. The* present conversation is about a looming crisis in the patient's student biography, which gradually emerges on the surface of the conversation.

Thematic shape change

Here we can only focus on the highlights of the conversation, which both partners work towards together in their own way. After the doctor's softening interventions (D 73-79), both conversation partners cooperate in a two-paragraph narrative in which the patient's *fear of failure at* school and her *fear of separation* (from losing friends) are expressed.

E 25.12		"and then I'm just scared..."
73a	D	yes . now at the moment I can't sort it out . but I have the feeling that there is something, as if something is pressuring you . yes? .
-	P	hm [agreeing] .
73b	D	but you can't express it.
74	P	[Nodding, confirming several times] .
75	D	yes . and then you just feel bad . that kind of thing .
76	P	[Nodding, confirming several times] .
77	D	do you think that's possible? .
78	P	could be .
79	D	Is something bothering you? .
80	P	hm [laughing sheepishly, with hunched shoulders] . except maths .
81	D	the school .
82a	P	yes, that's in maths. I've had two fives in the first half of the year and a three afterwards. (German grading system: 1 is best, 6 is worst grade)
-	D	yes .
82b	P	now in/the second half of the year the first exam I also had again five .
-	D	yes .
82c	P	and then I'm just afraid that I might get left behind.
83	D	aha ... [crosses arms, puts hand to mouth] that's a good reason ..... [5] ..... would it be bad if you had to repeat a grade? ...
84	P	for me it is .
85	D	yes ... why? .
86	P	yes because I have/ because I have my friends in class .
87	D	you'd lose them? .
88	P	yes .

Entirely in the spirit of a *dialogical* and *narrative* medicine (§ 7, 9), this is a special form of cooperative narration, described with Brody (1994) as "joint construction of narrative" (§ 9, 19). The joint construction efforts of doctor and patient can be recognised by a traditional method of text structure analysis based on shift, addition and omission samples (§ 17, 19, 40), the results of which are finally checked for their coherence of meaning (Tab. 25.1, right column).

Doctor		Patient
79 Is something bothering you?	→	80 except maths (that depresses me)
81 the school	→	82 Yes, it's in maths ... I've had two fives in the first half-year and a three afterwards ... now in the second half-year I had another five in my first exam ... and then I'm afraid that I could be left behind.
83 That's a good reason. Would it be bad if you had to repeat a grade?	→	84 (that would be) already (bad) for me
85 why?	→	86 because I have my friends in class
87 you would lose them?	→	88 yes (which I would then lose)

Tab. 25.1: Cooperative storytelling

To illustrate the procedure with the preceding conversation sequences: The doctor's question (83D: "would that be bad if you had to repeat a grade?") is fully attributed with its proportional content to the patient's elliptical short utterance (84P: "for me it would"), so that she is allowed to answer as if in the whole sentence: "(that would) be (bad) for me (if I had to repeat a grade). Likewise, the content of the doctor's utterance (87D: "you would lose your friends") is integrated into the patient's affirmative answer, so that she responds not only with "yes", but again in the whole sentence, whereby the "yes" could also be deleted: "yes (I would lose my friends)".

Subsequently, if at all necessary, smaller units of communication (*and, because, but, therefore,* etc.) can be supplemented or deleted with another sample of meaning after the transformation of the dialogue into a quasi-monological narrative form; in short: In a multiple controlled procedure of sense-making, the propositional contents of the doctor's interventions are productively attributed to the patient contributions and the whole text construct is tested for its coherence of meaning as a narrative (by reading only the right-hand column of the patient utterances in Tab. 25.1 one after the other). In retrospect, the doctor's utterances (on the left-hand side) seem dispensable, but without them the

narrative would not have come into being. Figuratively speaking, however, the doctor as midwife becomes dispensable only *after* the birth. In his function as *obstetrician,* the doctor proves to be a co-constructor of patient stories in a *maieutic* conversation (§ 9.5), which he helps to verbalise.

Thematic shape closure

The previous verbalisation of the patient's story is continued in another variant of cooperative storytelling. Here, the guiding principle described above (§ 25.2.4) comes into play again: "No affect without relationship". Although the *fear of failure* at school precedes the *fear of separation* (loss of school friends), the two aspects of fear cannot be separated psychologically. From the patient's subjective perspective of experience, her current distress under both aspects becomes clear when "fear" and "pressure" are mentioned below.

E 25.13		"this depresses me quite a bit"
89	D	I can understand that very well. Yes, I can understand that very well. What do you mean now? Do you think we are there / could it have something to do with that? .
90	P	could have .
91	D	you think? .
92	P	hm [agreeing] ...
93a	D	Let's pursue this idea further. . eh, but I still suggest that we don't forgo the blood test either .
-	P	hm .
93b	D	that we also take a look at it .
94	P	hm .
95	D	but the others / maybe that's also so that you have fear there too yes .
96a	P	yes, that is / that is also the case . that depresses me quite a bit, because I think .
-	D	yes .
96b	P	always about the exam, too - when I'm getting a five.
-	D	hm .
96c	P	then I have to repeat a grade or something.
-	D	hm .
96d	P	and then I'm totally scared somehow and then I make so many mistakes.

-	D	yes! .
96e	P	that's what my mother says too.
-	D	yes .
96f	P	I make so many mistakes.
97	D	there's pressure on you.
98	P	yes .

Towards the end of the conversation, the doctor and the patient have adapted to each other in cooperative narration to the extent that they recognizably "speak the same language", which manifests itself in a common *vocabulary of emotions* that they adopt mutually (*scared*: 82 P, 95 D, 96 P, 109 D; *pressure/pressed*: 79 D, 96 P, 97 D). At the same time, this closes the thematic arc of the conversation, which extends from initial *physical* symptoms (04 P: "totally bad", 08 P: "such a pressure") to the patient's *psychological* experience (96 P: "that depresses me quite a bit", "totally scared", 97 D: "pressure on you"). This closure of the conversation allows for a résumé at the end of the decision-making process, in which the perspective for a follow-up conversation can be sketched out at the same time.

25.4.4 Decision-making: "We'll check it out"

After the further physical clarification (93 D: "blood test") had already been determined in advance, an action perspective for the follow-up conversation is drafted at the end of the conversation: When topics ("bad", "fear") are taken up again, the relational pattern of a cooperative conversation is to be used again, in which above all *hypotheses* (§ 1, 8) are to be tested together (105D: "let's have a look", 107D: "think about it and pay attention", 113D: "we'll check it out"). The hypothesis testing should not only be rhetorically assumed (D113), but seriously pursued with the active *participation* of the patient, who is addressed specifically as a person with a specific task until the next conversation imperatively (*think about it, pay attention*).

E 25.14	"we are checking"
99	D	yes, I think we're on the right track, yes? .
100	P	hm [nod] .
101	D	Shall we keep it up? .

102	P	[Nod] .
103	D	are you coming back next week? .
104	P	yes .
105	D	Let's see how it is.
106	P	yes .
107	D	think about it, will you? .
108	P	hm .
109	D	and pay attention to the symptom, yes, whether there is something behind the "sick", whether there is such a fear of school or not being able to attend school, whether that could be behind it.
110	P	[Nod] .
111	D	yes? .
112	P	hm .
113	D	we check it, if it's wrong, it's wrong, but maybe it's right .
114	P	yes .
115	D	yes? ...
116	P	OK .
117	D	can you send the mother in? .
118	P	yes .

Moreover, the "we" in these doctor's remarks is not used as a *pluralis majestatis,* as is often still the case in medical conversation, but as if in an appeal to the reason and (self-)reflection competence of both conversation partners, who are to embark on a joint search process to clarify the patient's complaints for the next conversation.

At the end of the current conversation, the young patient, as a learning subject, will be sufficiently familiar with this type of medical conversation as it was practised here: In the 7.30 minutes of the conversation so far, she will have learned that the doctor will continue to depend on her active cooperation in order to be able to help her. [4]

4 For the sustainability of this learning process from the patient's subjective experience perspective, please refer to the contribution by Obliers et al. (2010), in which the patient was interviewed about her experience of the conversation, among other things. For further multi-method analyses of the conversation with Julia, reference is again made to other contributions (Koerfer et. 2010, Szirt, Langewitz 2010, Kruse, Tress 2010, Lausberg 2011) and the following summaries of the results (§ 40.2).

Catamnesis

Regarding the *catamnesis,* it can be briefly reported that the physical examinations did not reveal any significant findings. As agreed, the topic of school anxiety was taken up again and dealt with in further conversations, as was the importance of her school friendships. After several weeks, the patient's symptoms improved and she was promoted and continued to attend school successfully.

25.5 Heart complaints and hopelessness

In everyday conversation with patients, narratives always arise spontaneously. No sophisticated psychotherapeutic technique is needed to make them possible. Often it is enough for the doctor to allow the spontaneous patient narratives, not to suppress them or limit them prematurely. Sometimes, however, he has to stimulate patients to tell stories, as proved necessary in the present case, in which the doctor offers his patient a storytelling opportunity after a minute of conversation, which the patient then willingly accepts.

The patient narratives arise from an inner pressure. The patients tell what is "on their mind". However, such stories are not always immediately comprehensible. They often require a supplementary series in which further narratives take on a meaningful overall shape. Since this can go beyond the time frame of a single conversation, new appointments are necessary in which further narratives can be brought up. Only by linking them do they become more comprehensible. This will be illustrated by the third case study, which is initially a conversation with a pensioner, which is later continued with his wife as a couple's conversation, in which the initial narratives of the worried husband acquire their full meaning.

25.5.1 The first minute with Mr. J: "ECG again?"

Mr. and Mrs. J and their daughter are already "regulars" at the GP's practice. Mr. J is now a pensioner and has been receiving treatment for decades (e.g. cardiovascular). The patient comes regularly for check-ups because of the known complaints. Today he comes without an appointment, he is classified as an "urgent" case by the doctor's assistants and has to be "inserted" into the current appointments in view of the well-

organised practice procedure (§ 25.6). The entire conversation with the patient takes 6 minutes and 14 seconds and can be divided into two conversation phases of different lengths. First, the first conversation phase is reproduced here in one piece in the transcript, which lasts 59 seconds, before the step-by-step conversation analyses follow.

E 25.15		"Should we do the ECG again?"
01	D	come, take a seat, make yourself comfortable ... Mr. J ...
02	P	I think it would be better .
03	D	it would be better? .
04	P	yes .
05	D	what is better? .
06	P	here with the ... with the pump (=heart) . sleep is also possible, I can now get to 2, 3 or 4 o'clock ...
07	D	yes .
08	P	I can get there .
09	D	yes .
10	P	should we do the ECG again? .
11	D	yes . we can do it again .
12	P	and blood pressure again .
13	D	and test your blood pressure again ... what else do you feel now? ...
14	P	every now and then ... it's up to above here . a bit of a tug . and then it goes away again quickly .
15	D	yes .
16	P	and when I lie on my back in bed .
17	D	yes .
18	P	then I feel it . but if I lie left and right, then it is good .
19	D	then it is all right so far.
20	P	then it is all right .
21	D	yes .
22	P	yes, shall we do that? ...
23	D	yes ... let's do it .
24	P	ECG again ...
25	D	let's do another ECG, let's do another check .
26	P	and the blood .
27	D	yes ... we'll take your blood pressure again .
28	P	no . also draw, let's say, also control it .
29	D	yes . we can do it . yes .
30	P	yes ...

In the following, parts of the transcript are repeated again and supplemented by non-verbal parts of the conversation (pictures) and by comments also from the observation and experience perspective of the treating doctor. First, the alternation between the patient's descriptions of complaints and his wishes for an examination is described, which leads to an ambivalent relationship between doctor and patient. The two interlocutors carry out a latent relationship conflict, which becomes manifest on the linguistic surface as a misunderstanding. Only after an interactive-thematic turn in the conversation can the relationship stabilise again as a *helping relationship* (§ 3, 8).

25.5.2 Complaints and examination requests

The first sound and image sequences represent the welcoming scene. The patient is not yet in the consulting room but is first called in by the doctor from the waiting room. An ambivalent tension becomes recognisable, which can be seen in the facial expression of the first images of the patient. The initially trusting and hopeful look changes into an uncertain, sceptical, doubting expression. Later, the suspicion of an ambivalent-uncertain attachment pattern arises.

Opening the conversation and describing the complaint

It is part of the practice ritual (§ 25.6) that patients are called in from the waiting room, greeted there of course and then led into the consulting room, so that here the greeting could not be "recorded". Although not yet in the picture, both conversation partners can be heard coming closer. After the patient has accepted the doctor's invitation to "make himself comfortable" (D01) and has taken a seat, eye contact is made immediately. The doctor continues his introductory words with a typical opening form of encouraging address (§ 19.2), leaving the opportunity to speak to his interlocutor at his own disposal by mentioning his name.

Fig. 25.11

In the first section of the conversation, the patient describes symptoms, he describes them in the way doctors often wish. Clear, short, concise descriptions, no elaborate explana-

tions, practical treatment requests. He emphasises complaints in the heart region with vigorous gestures (Fig. 25.11). After just one minute (E 25.15: 01-30) the patient's concern and the treatment request to the doctor seem to be sufficiently clarified. Both could part again with a satisfied feeling. Up to this point, therefore, it is a classic example of "one-minute medicine", which would still undercut traditional *five-minute medicine* by far. However, if one takes a closer look at the course of the conversation so far, as the doctor himself does during the conversation, one realises that the patient is concerned about other things than his previous complaints and examination requests suggest.

Complaints and ambivalences

The next sequence of conversations (04-06) gives the first description of the patient's complaints. The immediate beginning of the descriptions of the complaints is striking. There is a clear gap between the textual content and the visual impression. The picture impression without sound suggests a more violent description of pain and discomfort than the verbal presentation and description of everything that had "improved". The ambivalence that was already apparent when contact was made at the beginning of the conversation is now further intensified in the discrepancy between the picture and the sound.

The doctor initially reacts to his patient's statements with an *echo-like* feedback (§ 19, 20). However, he has to ask further (05D: "what is better?") because the mere repetition (03 D: "it would be better?") does not lead to the intended goal of the patient's further speech, who merely answers sparingly (04P: "yes"). The doctor's question (05: "what is better?") is answered by the patient in an "organ-related" way (06: "here with the ... pump"), but at the same time he taps his right hand heavily on the area around his heart (fig. 25.11), with a facial expression that signals anything but an "improvement" not only in the freeze frame but also in the short image sequence as a whole. The whole scene is still unclear to the doctor: the patient says he is "better", but his mimic and gestural expression give a contrary impression.

When the patient makes further announcements about the quality of his sleep immediately afterwards (06P: "Sleep is also possible"), the doctor cannot remember at the moment that the patient had also complained about sleep disturbances. The doctor senses slight anger arising within himself. The patient pushes himself into the practice routine like an emergency, just to say that he is feeling better? The doctor feels

pressured by the patient, especially as the patient is now taking the initiative for his *direct* demands for examinations.

Examination desires and relationship conflicts

In the further sequences of the conversation (P10ff.) the patient expresses his wishes for examinations so energetically and resolutely that they seem like *direct* requests, which in their abbreviated form (12P: "and blood pressure again") already seem borderline *impolite* (§ 7.3). Image and sound are more in agreement again, but there is now a change in the doctor's counter-transference. The doctor feels uncomfortable with the patient, becomes increasingly annoyed and wants to end the relationship as quickly as possible, at least for today. The inner contact between doctor and patient begins to diverge. In the hope that the patient will not notice the doctor's emerging anger, the doctor quickly agrees to the patient's request ("ECG") (11D: "yes . can we do it again"). Obviously, however, the patient has more wishes and needs for further examinations, which the doctor tries to meet quickly in order to be able to pursue further objectives of the anamnesis.

The doctor first steers the conversation away from the requested examinations, which he has already conceded, and towards further exploration of the complaints. With his subsequent question for specific *detailed exploration* (13D: "what else do you feel now?"), the doctor wants to record the *quality* of the complaints (§ 21.4) more concretely.

E 25.16		"what else do you feel now?"	Comment
09	D	yes .	Handset signal [=LS]
10	P	should we do the ECG again? .	Further examination request
11	D	yes . we can do it again .	Consent
12	P	and blood pressure again .	Right hand towards the heart
13	D	and take your blood pressure again ... what else do you feel now? ...	Consent + detailed exploration: Quality
14	P	every now and then ... it's up to above here . a bit of a tug . and then it goes away again quickly .	Right hand again in the direction of the heart

15	D	yes .	HS
16	P	and when I lie on my back in bed .	Conditions
17	D	yes .	LS
18	P	then I feel it . but if I lie left and right, then it is good .	Conditions
19	D	then it is all right so far .	Paraphrase
20	P	then it is all right .	Reconfirmation through resumption
21	D	yes .	Reconfirmation
22	P	yes, shall we do that? ...	wish repetition with "we"!
23	D	yes ... let's do it .	Consent

The patient follows the doctor's topic focus and comes back to his complaints. Before answering, his first reaction to this question is to reach towards his heart as he did at the beginning of the conversation (Fig. 25.11), only then does he begin to talk. Now, however, he no longer speaks of an improvement, but describes his pain sensations more concretely (14P: "a bit of a tug") (§ 33). Image, content and sound reinforce each other. The patient seems to want to do massive persuasion work, as if an inner withdrawal of the doctor should be prevented by factual arguments.

The doctor takes the further somatic patient offer with differential-diagnostic considerations and examination plans (*ECG, chest X-ray, laboratory,* etc.) seriously, but inwardly now thinks of ending the conversation soon with a transition to his own examinations and even of a referral to a cardiologist - on the one hand for mutual safety, on the other hand in order to be able to "shorten" the conversation contact in this way.

The patient reacts with verbal and gestural attenuations of his statements (14P: "now and then" - "a bit" - "goes away quickly" - 18P: "(...) then it's fine") before both conversation partners can agree on a common denominator with alternating reconfirmations (19D: "then it's all right so far" - 20P: "then it's all right"). With these alternating reconfirmations, all communication difficulties between doctor and patient seem to be resolved, but they then become manifest through a misunderstanding about the blood pressure measurement or blood test.

E 10.9		"... also control"	Comment
23	D	yes ... let's do it .	Consent
24	P	ECG again ...	Examination request 1
25	D	let's do another ECG, let's do another check .	Consent
26	P	and the blood .	Examination request 2
27	D	yes ... we'll test your blood pressure again .	Agreement; misunderstanding
28	P	no . also draw, let's say, also control it .	Outraged correction of the misunderstanding
29	D	yes . we can do it . yes .	Agreement (+ "displeasure")
30	P	yes .	Reconfirmation

Obviously, the doctor's agreement was initially based on a misunderstanding. The patient had presented his request for an examination in an incomplete formulation (26P: "and the blood"). The doctor now believes that Mr. J, as already decided, would like to have his blood pressure measured, as can initially be inferred from the corresponding doctor's consent (27D: "test blood pressure again"). The patient indignantly tries to clarify his wishes, whereby the *direct* form ("28P: no . also draw ...") again borders on *rudeness* in the doctor's experience (§ 7.3). The doctor again formally agrees (29D: "yes, we can do that"), but feels the temptation to break off the conversation here. There are sufficient clinical reasons to begin or initiate examinations immediately, especially since this is also the patient's wish. Continuing the conversation does not seem to be very productive for collecting further "hard" clinical data.

Nevertheless, the doctor decides to continue the conversation, which he initiates with a *key intervention* that leads to an interactive and thematic *turn* in the further course of the conversation, which takes on a new *quality on the content* and *relationship level.*

25.5.4 Narrative turn of conversation: "I don't have any more hope"

In order to understand the development of the conversation from the doctor's perspective, we will first draw an interim balance of the conver-

sation, in which the ambivalences of the doctor himself are summarised, who wavered between breaking off the conversation and continuing it or the current relationship with the patient here and now. After clarifying the misunderstandings in the meantime (26-30), a *consensus* is marked by the doctor's agreement and the patient's reaffirmation, with which a certain saturation of topics ("lull in conversation") had initially occurred.

This "lull in conversation" could easily be used for good reasons to end the conversation by carrying out or initiating the examinations desired by the patient and now consented to. The doctor's relationship with the patient was not only reduced to a mere *echo* in the verbal feedback (§ 19, 20), but also resigned in his momentary inner concept of action according to the motto: "Let the patient get what he wants, I don't know what he has." The inner breakdown of the relationship between doctor and patient threatens to increase further and lead to the termination of the conversation, which seems to have fulfilled its purpose.

Despite his own "displeasure", the doctor's attentive observation of the patient's non-verbal behaviour had not escaped him: Compared to the preceding conversation sequences, the patient now seemed more powerless to the point of resignation. Although the patient had successfully "pushed through" the examinations he wanted and could be "satisfied", the patient now appears even more worried to the doctor.

In view of this impression, however, the situation remains unclear for the doctor. Mr. J seems helpless and worried. His gaze now goes nowhere. The doctor still does not understand what the patient is "actually" concerned about. In order to find out exactly this, the doctor decides to continue the conversation despite his displeasure.

New content and relationship aspects

The doctor evaluates the feelings, thoughts and fantasies rising in himself in the sense of an extended clinical data collection about the patient. He experienced as critical the patient's staging of urging the doctor to examine him and his own impulse, which was lastly also increased by the anger about the misunderstanding with the patient, to respond to his unconscious staging.

The doctor can re-establish inner contact with the patient by not evaluating his *demanding* and *indignant* request for an examination exclusively in a medical context, but can also understand it on the relational level as an expression of *fear* and *despair.* The tension already

described in the opening sequence breaks down again in the following course of the conversation. If the build-up of tension at the beginning meant a deterioration of the relationship, it now means the re-establishment of contact, as it had been in the trusting and hopeful look at the very beginning of the conversation, before the further course of the conversation was dominated by "worried" facial expressions and gestures, which could easily appear "aggressive" in the "demanding" examination requests.

Instead of ending the conversation - as was already planned - the doctor chooses to continue it with an intervention which, due to its open stimulation function, can prove to be a *key intervention* not only in this conversation situation. In the sense of a new start, the doctor takes the initiative in the conversation with a new topic focus that moves the conversation in a qualitatively different direction. With an *open topic invitation* ("what else?"), as is also realised in other languages with equivalents ("something else?") (§ 21.2.7), the doctor tries to pick up where the contact left off.

In order to capture the patient's verbal and non-verbal reaction, the transcript will first be reproduced in the context of the preceding sequence as well as with a comment column and then with two still images (Fig. 25.12-13), from which the non-verbal interaction sequence at this turn in the conversation can be halfway concluded.

E 25.17		"how is everything else going?"	Comment
29	D	yes . we can do it . yes .	Agreement (+ "displeasure")
30	P	yes .	Reconfirmation
31	D	what else is it like, how is everything else going? ...	Open question as a narrative invitation
32	P	yes . Doctor, I want to tell you honestly now . I have no more hope ... for my wife ... it's hard ... it's hard ... it's bitter .	Direct salutation + Expression of sincerity + Expression of emotion
33	D	why do you have no more hope? .	Exploratory question (reason)
34	P	yes . because she can no longer walk .	Justification

Nonverbal response	Turning the conversation around
 Fig. 25.12	31 D: what else is it like? how is everything else going ... The patient literally slumps down. He looks as if he has been hit, lowers his head and closes his eyes. There is a pause, which is obviously used as a "thinking break".

Nonverbal response	Beginning of the narrative
 Fig. 25.13	32 P: yes . Doctor, I want to tell you honestly now . I have no more hope now ... for my wife ... it's hard ... it's bitter . The patient seems isolated, no longer has eye contact 33 D: why do you have no more hope? . 34 P: yes, because she can no longer walk.

As can often be observed, at the beginning of the story, the patient concentrates on his "inner" story, which he perceives and recalls with a "digressive" gaze in front of an "inner eye", which is why eye contact with the partner is often omitted, not only in the sensitive initial phase of the story (§ 18, 19). This is followed by a dramatic narration by the patient about the illness of his wife, who is unable to walk after several strokes to the brain, is in a wheelchair, will soon be discharged from hospital and, because of her need for care, will be particularly dependent on his special help. In order to tell this story in detail and vividly and to work out its individual meaning for the patient step by step in cooperation with the doctor, it now takes another five minutes of conversation for

Mr. J. In these five minutes, the drama of the patient's current situation with his oppressive worries and needs becomes clear.

His narrative opens the door to his "individual reality" (v. Uexküll, Wesiack 1991, 2011) (§ 4.4) and allows an insight into his world of problems and difficulties, which also make his concerns (investigations) more understandable. He has to worry not only about his own health, but about the health of his wife, whom he has to take care of once she is back home. Thus, he suffers not only from his own burden of illness, but also from the expected burden of taking care of his wife on a daily basis, which he may not be able to cope with himself for health reasons.

This experiential perspective of a stress story, developed narratively in the 5-minute conversation, sheds light in retrospect on the first minute of the conversation, the latent meaning of which can only become manifest after the key intervention of the doctor.

Exploration of biographical narrative meaning

The difference between the first minute of the conversation and the further course of the conversation in the following five minutes is striking. At the same time, the risks of missed opportunities for narrative self-exploration on the part of patients become clear if the medical interview were to be limited to purely organ-related descriptions of complaints during the anamnesis according to a *biomedical* model (§ 4).

After just under a minute of conversation, in which both interlocutors have switched thematically back and forth several times between "physical complaints" and possible or required "examinations", a floodgate is now opened with the specific doctor's question ("how is everything else going?"), which allows a broad thematic spectrum for *perspectivisation* (§ 21.2.7), through which a completely different, namely *narrative* access to the patient as a person can be opened up. The relevance of the following topic is already announced by the adoption of the speech, in which the introductory "yes" and the personal address ("Doctor") seem like a "shock sigh". The affirmation of the *honesty* of the announced statement (32P: "I want to tell you honestly now") represents a further *relevance upgrade* (§ 7, 17) on its own account. Here, the further *content* and *relationship aspects* (§ 7.4) of the utterance, which impresses with the specific way of announcing (32P) the relevant content, complement each other:

Those who affirm their own honesty in this way before continuing to talk mark not only the relevance of the content of the now expected

statements, but also the *personal esteem* of the interlocutor, to whom one can address oneself openly and confidently after addressing him personally ("Doctor ... tell you"). This example is further evidence of the medical *listening privilege* (§ 19) usually granted by patients, which often manifests itself in the corresponding *formulas (to say* something *openly, honestly, only to you, only between us,* etc.).

In this case of an "honest" statement, the new general theme is dramatically expressed by the patient right at the beginning: "I have no more hope". Although the hopelessness is specified in the following clause ("for my wife"), the hopelessness for his own person already becomes clear here, which then becomes more and more apparent in the further course of the conversation. The patient presents the worries about his wife, who is in need of care and will soon be discharged from hospital, as worries about her lifelong care, which could possibly overwhelm him for health reasons.

As a life narrative, his biography experiences an *anti-climax,* as it were (§ 9, 19), because a fall from formerly hopeful heights into unexpected depths threatens. The prospect of a peaceful, shared old age for the couple fades away, which is already expressed in the *evaluative lead* directly following the "hopelessness": (32P: "it's hard . it's hard . it's bitter"). This evaluation is impressive not only because of its content, but also because of its repetition and paraphrase, which rhetorically heightens the drama of the experience in the communication to the medical listener.

The patient could hardly have given this kind of information at the beginning of the conversation. Obviously, "hopelessness" in a "difficult" and "bitter" situation is not a good topic candidate for a conversation starter. In this case, too, the patient had to solve a different kind of *entry ticket* to open the conversation (§ 18, 19), namely on the topic of his physical complaints. In order to bring up his "hopelessness", it took a diversion, which both partners took with a certain impatience, before another ("real") topic emerged.

The *organ-related* complaints that the patient presents at the beginning cannot be dismissed out of hand and should be taken seriously. The patient's fear that he will not be able to cope with the new challenge of caring for his wife is also "organ-related" in the sense that "his heart might not be able to cope". Thus, a multi-layered fear about his own health, which seems to be exposed to a threatening strain, finally drives him unannounced to the consultation, in which he had to be "inserted", as it were, as an "emergency" in between. Right in the first minute of the

conversation, the previously familiar, *helping relationship* (§ 3, 8) between doctor and patient threatens to topple over, and they eventually become entangled in the clarification of misunderstandings.

From the doctor's reconstruction perspective, the termination of the conversation by initiating examinations inside and outside the practice was already seriously considered, although he too obviously suspected more behind the descriptions of the complaints than was initially "visible" and "audible" on the surface of the conversation.

The narrative turnaround in the conversation, which manifests itself at the same time on the *content* and relationship level, is only initiated by the doctor's open perspectivisation question ("How is everything else going?"), which in the further course of the conversation leads to specific *patient narratives* (§ 9), in which the patient *narratively* elaborates on the perspective, whereby it is worth recalling once again the preceding *evaluative lead of* the narratives (32P: "no more hope" (...) "it's hard" (...) "bitter"). This lead had also been understood by the doctor as a kind of maximum relevance rating in the sense of an alarm signal, which is why he had asked his exploratory question about the reason for the hopelessness, so that the patient had finally been given license to tell.

The patient's narrative activities have at the same time made the doctor sensitive and open again to the relationship with the patient, which had been put to the test in the initial phase. Now contact has been re-established and the doctor can tune into the patient's perspective of suffering and empathically resonate with his narratives. Thus, through *active listening* (§ 19) and *empathic feedback* (§ 20), the doctor can help the patient to *verbalise* his *emotions*, which are placed in the context of possible relational conflicts in the care situation. In further narrative phases of the conversation, the patient's *affects* (fears, anxieties, feelings of guilt, etc.) concerning himself and the couple relationship then come to light to an extent that far exceeds the *emotional* content of the original *descriptions of complaints* (heart, sleep) from the first minute of the conversation. However, this *narrative surplus* was only available at the "price" of extending the 1-minute conversation by another 5 minutes for Mr. J.

25.5.4 Symbiotic couple relationship and non-verbal interaction

At the end of this two-part conversation, a unity of meaning becomes recognisable, which was developed conversationally between doctor and

patient. In the process, the "individual reality" of the patient was transferred into the "common reality" of both interlocutors, from which a common perspective of action can now be gained (Uexküll, Wesiack 1991, 2011) (§ 4.4). In this case, a further continuation of the conversation could be chosen, which lent itself to the specific function of the family doctor as family physician. Without wanting to cast doubt on the perceptible and comprehensible despair of the patient who has "no more hope" in the 5-minute conversation, the doctor perceives a specific opportunity for conversation for the further clarification of the patient's worries and fears, which he can use precisely as a family doctor.

Since the patient's wife is also a patient of the GP, he suggests a couple's consultation at the end of the conversation, which can then also take place here in the GP's practice close to the time of the wife's discharge from hospital, because both spouses have readily agreed. The doctor has not seen the patient for months after he admitted her as an inpatient due to syncopal seizures. In the meantime, the patient was thoroughly examined. As there were no cardiological findings that could be explained, she was examined in two different neurological departments of different hospitals for further clarification. She is now in a wheelchair without a solid somatic explanation having been found. She is therefore to be discharged back home. This was the background of the husband's narrative from the previous conversation.

At the new appointment, the doctor calls both of them from the waiting room as usual. The woman is sitting in a wheelchair. They both walk two or three metres together and he helps her to take a seat on the chair in the consulting room. The conversation lasts a total of about 20 minutes, which is allotted for this type of conversation (§ 25.6). The patient begins to tell her story of suffering from the point when she was last in the surgery. She keeps having dizziness and then suddenly falls over. She does not mention the numerous examinations that were carried out on her, nor that they were concluded without results. The falling over comes out of the blue for her and frightens her. She vividly describes that she can no longer do anything in everyday life on her own, not a single step. She is constantly dependent on the help and support of her husband. In these descriptions, both in the narrative flow and in the pauses in the conversation, the synchronous movements (Fig. 25.14; Fig. 25.15) of the spouses are striking.

Fig. 25.14

Fig. 25.15

The patient clings to her husband. In impressive gestures, she uses her arms to illustrate the clasping of her husband, who follows these movements synchronously. The doctor remembers that the husband had already shown a gesture of clasping in the narrative from the individual conversation (Fig. 25.16).

Fig. 25.16

Only now does this embrace become more understandable when he also experiences the wife's condition and the changing interaction between the couple in the consulting room. For the doctor, a mutual dependence of the spouses becomes apparent, bordering on a symbiotic relationship from which there seems to be no escape for either partner.

At the same time, the doctor now asks himself whether there are autonomous impulses in the wife that he could support in the context of further treatment. He had noticed that the patient appeared surprisingly stable and secure when she moved from the wheelchair to the chair in the doctor's office. The doctor wants to clarify what the patient can still do independently and asks her about her mobility. To his great surprise, the patient alternately lifts both legs up to above the desk of the practice (Fig. 25.17). He uses this scene to ask her to try another unassisted walk. The patient's facial expression brightens. She is obviously surprised that the doctor thinks she can do it. She therefore makes sure once again that she should really try to stand up on her own.

But when she tries to do so, the husband jumps up worriedly and tells the doctor that his wife is not able to do so (Fig. 25.18). Looking at her husband, the patient breaks off her attempt to stand up accordingly. The emotional involvement in this (inter)action is "written on the face" of both spouses in their own way, although the attribution of their respective specific emotions should remain in the eye of the beholder.

Fig. 25.17

Fig. 25.18

The unconscious dependence of the two spouses becomes impressively visible for the doctor's eyes. In the further course of the conversation, the doctor works out a *subjective theory of the illness* with the couple. The syncopal seizures had been preceded by a series of loss events on the patient's side. In the course of a year, four close relatives died suddenly. She sees her husband as the only support in this situation. She clings to him. She fears that he too could die suddenly.

Conversation balance: Five minutes for Mr. J's narrative

In doctor-patient communication, both interlocutors meet each other in their own way as *experts* (§ 10). The patient provides data of various kinds, the content of which the doctor cannot simply ask for. The patient discloses it due to a trusting conversational atmosphere without pressure. What is told is expressed more or less spontaneously or actively stimulated by the doctor, in any case it is motivated by inner suffering. Here the patient speaks as an expert for his own subjectivity.

We have to weigh up the relevance of what is somatically and psychosocially significant. On the one hand, we now have to weigh up between symptom descriptions of heart complaints that may be based on an organic cause - for this, the *doctor* as expert is called upon. On the other hand, the *patient* as an expert introduces a stressful relationship conflict with a wife who may be seriously ill for the rest of her life and

who may be "conversion neurotically" warding off an overwhelming mourning process into the data collection of the findings.

For the doctor it could be a temptation to interpret the "data" introduced by the patient even without dialogical understanding, i.e. to construct a causal connection between psychosocial stress and heart complaints without the patient's participation. However, the patient remains the expert for his subjectivity, which is essentially reflected in the form of the narrative in the consultation, in which the doctor can prove to be a good *listener* and, if necessary, a *co-constructor of* a *new story* (Brody 1994) (§ 9, 19). Once doctor and patient have agreed on the essential problems and conflicts from their respective expert perspectives in a common language, they can also jointly attempt a relevance negotiation of possible solutions.

In the present case, the successful communication between doctor and patient was already endangered in the course of the first minute of the conversation, if there had not been an extension of 5 minutes, in which the patient could then narratively "bring up" what had previously remained "*hidden*" as an *agenda* (§ 18-20). If both interlocutors had immediately "fled" into the examinations, essential "data" of the biopsychosocial anamnesis would have remained "undiscovered".

The fact that things turned out differently is due to the doctor's reflexive observations of the patient's ambivalences and non-verbal communication, from which he drew the right conclusions in time for the continuation of the conversation in the sense of a new thematic start. This new start was initiated by the key intervention of the open perspectivisation question ("How is everything else going"), which invited the patient to *freely choose a topic* (§ 9, 19). The *narrative surplus* reveals itself for both interlocutors in the shared knowledge and recognition of the burdens of the wife's illness, whose need for care seems to endanger the spouses' previous life narrative, which had hoped for a "carefree" retirement. Nevertheless, realistically adjusting to the new life situation as a joint challenge was the topic of many further individual and couple conversations, in which the doctor stood by his two patients in a supportive manner.

Catamnesis

The patient's current concerns about his own health could also be alleviated by the fact that the patient could also understand his "symptoms" as a stress reaction. Further conversations with the couple con-

tinue to take place as individual and couple conversations for years, both in the practice and during home visits, until the patient finally dies of kidney failure. His wife also remains a patient at the practice until her death. Likewise, the daughter remains a patient for many years, with whom the "difficult" life of the parents is often a topic in the consultation. Here, the daughter's burden due to the parental care situation is also an integral part of the care provided by the general practitioner, who is also the family doctor for all involved.

25.6 Practice organisation and time management

Doctors would like to give the conversation more space in their everyday practice, but in their experience, the time available does not allow this. Lack of time is still the most frequent counter-argument. In the GP practice where the preceding interviews were conducted, an attempt was made to find a solution to this problem in a professional life spanning more than 30 years. In the following, results of this experience are presented in the form of an organisational plan, which has also proven itself for more than 20 years (Reimer 2017). It must be emphasised that it is not the form of organisation that is decisive. The greatest difficulty arises for the doctor himself to also end the conversation after ten minutes or the agreed time. Here, however, organisational planning is again helpful. A conversation can also be ended after ten minutes in a relatively emotionally charged situation if the patient can also be offered a follow-up appointment for the next day or the day after.

25.6.1 Treatment events

The organisation of daily practice processes is of particular importance, as it must guarantee the central importance and fixed time frame of the conversation, so that the conversation, in addition to its counselling and clarifying function, can always also fulfil its relational-diagnostic and therapeutic tasks. In contrast to psychotherapy, where the organisation focuses exclusively on the conversation, the daily routine of integrated medicine must always take into account potentially vital, somatic events.

The immediate availability of the doctor for serious but also banal treatment concerns of his patients, in constantly changing forms of in-

teraction, such as emergency treatment, examination, during telephone calls or home visits, represents a characteristic of care medicine, whose diagnostic and therapeutic potency in relation to affects, relationships and attachment behaviour must be utilised.

All doctor-patient encounters, inside and outside the consulting room, are therefore understood as *treatment events*, which are grouped into two different categories according to comparability. A separate setting is defined for each category. In organisational terms, this is expressed in a special setting for registered patients and a different setting for unregistered patients. The setting for registered patients includes initial consultations, follow-up consultations and series of consultations. The setting for unregistered patients includes spontaneous visits to the practice, telephone calls, home visits and emergencies.

Registered patients

Registered patients select the time span for the conversation with the doctor themselves, with a choice between five and 25 minutes. If the practice is overloaded, such as during flu epidemics or at the beginning of a quarter of the year, this selection frame can be narrowed down to ten minutes at short notice. Over the course of more than ten years, this time frame was most frequently chosen by patients. The ten-minute conversation thus became a permanent fixture and today forms the backbone of the entire organisation. Series of talks are also geared to this time frame.

Apart from the time frame, other setting criteria include the way of greeting, situating, opening and ending the conversation. For example, patients are not called, but are met personally by the doctor in the waiting room. Conversations and physical examinations take place in separate rooms.

By entering the consulting room, the patient knows that this is a place to talk, that the doctor is exclusively available to him and his concerns, that the conversation will take place in a protected, undisturbed setting without external interruptions from telephone calls and helpers, and he knows that the conversation will also be ended promptly after the agreed time.

Since the entire organisation of the day depends on not exceeding the given time frames, this point is already pointed out during registration.

The affective state of a patient at the end of a ten-minute conversation is basically no different from that of a 50-minute psychotherapy session. The patients' emotional states can range from feeling relieved, feeling understood, being very upset, feeling abandoned and let down. In any case, they must be discussed or at least addressed. If there is an urgent need for discussion, the patient is given a follow-up appointment, if necessary the next day.

In this way, time overruns are usually avoided. Normally, the time available is even experienced by the patient as sufficient and not infrequently subjectively perceived as much longer than it actually ran.

Unregistered patients

Patients who spontaneously visit the practice are not "pushed in between" or placed in a buffer time, but are allocated fixed blocks of time at the beginning or end of the consultation time (see Table 25.2). Since these spontaneous treatments can reveal a great deal of information about the subjectivity and inner conflicts of the patient, these encounters are used as an important source of data for later, but then fixed-time conversations. Even if a sufficient ad hoc conversation cannot take place at the moment, there is always enough space to address the patient's need for clarification, to focus on it and to combine it with a new conversation agreement. This applies to prescription orders as well as to urgent requests for examinations, which, not infrequently presented in an urgent manner, can reveal not only fear and insecurity, but also anger and manipulation as behavioural patterns of the patient, which represent an important information background at the next appointment and can be addressed.

Emergencies and initial consultations

Emergencies are understood to be situations that require immediate action and do not allow for any delay. For these situations, 2 × 25 minutes are available daily. In retrospect, with over 30 years of practical experience and considering anesthesiological and emergency medical competence, such emergencies have occurred on average only once or twice per quarter, which does not significantly disrupt the organisation of the schedule. However, if the emergency occurs, the schedule is shifted accordingly. The time frame set aside and scheduled for this purpose every day is therefore predominantly used by initial consultations, so that two initial consultations of 25 minutes each can take place every day in normal daily routine.

Tab. 25.2 shows the distribution of these time blocks over a morning and afternoon. These time blocks serve the medical assistants to distinguish and categorise patients when they enter the practice.

Phone calls

Telephone consultation refers to all callers who expressly wish to speak to the doctor. This concerns not only patients but also colleagues. Calls are only forwarded by the assistants in the designated time slot. This arrangement has proven to be particularly effective, as the available conversation time is not interrupted by telephone calls or the doctor's assistant.

Morning Mon-Fri			
Blocks	Number of patients	Call duration	Time
1	6-15	2-5 Minutes	07.30 - 08.00
2	6-18	5-15minutes	08.00 - 09.30
Break		5 minutes	09.30 - 09.35
3	1	25 Minutes	09.35 - 10.00
4	6-18	5-15minutes	10.00 - 11.30
5	1	25 minutes	11.35 - 12.00
6	6-15	1-5 minutes	12.00 - 12.30
7	1-6	Telephone consultation	12.30 - 13.00

Afternoon Tue and Thu			
Blocks	Number of patients	Call duration	Time
1	1-3	Home visits	15.00 - 15.30
2	1-2	50 minutes or: 2x 25	15.30 - 16.20
Break		10 minutes	16.20 - 16.30
3	6-15	2-5 minutes	16.30 - 17.00
4	6-18	5-15minutes	17.00 - 18.30
5	6-15	2-5 minutes	18.30 - 19.00
6	1	50 minutes	19.00 - 19.50

Tab. 25.2: Time grid for the morning (Mon-Fri) and afternoon (Tues and Thurs)

25.6.2 Talk series

These are fixed follow-up talks of ten minutes each. The frequency of these talks is not uniform, it is individually adapted to the patient and is firmly agreed between doctor and patient.

Depending on the treatment concerns, several appointments per week or even only once per quarter can be arranged. On the one hand, this leads to a reduction in the number of patients who spontaneously visit the practice with complaints; on the other hand, it enables the doctor to observe the patient's constantly changing level of suffering as it progresses and to address this in turn.

The series of talks incorporate experience from the psychotherapeutic competence of the practice owner, but they are not psychotherapy in the sense of standard care. However, this means an advantage in practice. The patient's threshold fear is reduced and loosens their unconscious defense against the effectiveness of conversations.

The short but regular conversation time also enables, with the patients' unconscious fear of dependence and loss of autonomy, a secure control over the regulation of the closeness and distance barrier. It makes it easier for both the large group of patients with functional

complaints, but also patients with a primarily serious somatic diagnosis, such as heart attack or cancer, to enter into a medical working relationship.

In the context of these series of conversations, the patient experiences that, in addition to the usual conversations about prescriptions and examination results, there is always enough room for difficult personal problems. He experiences that he retains control over the choice of topics and that he is not devalued due to a lack of physical findings or pushed to unpopular topics of conversation, but that he determines a focus (Strupp 1991) for a series of conversations together with the doctor.

Against this background, even with a group of patients who are primarily hostile to therapy, issues of affect management, relationship problems as well as conscious and unconscious conflicts can not only be addressed but also deepened.

These series of talks are the main focus of the practice. However, since depth psychotherapy is also offered at the same time, it is possible to combine these ten-minute talks with the setting of short-term and long-term therapy. However, the possibility of linking probationary sessions of 25 or 50 minutes with the series of ten-minute talks for each patient has proven to be particularly advantageous.

Given the fundamental limitations of these series of talks, there is a great variability, both for the treatment frequencies and for the duration of the individual talk. These series of talks are not limited to supportive interventions. They are usually very limited in time and narrow in focus, but also allow for working through regressive phases (Jaeggi, Riegels 2008). These series of talks are designed for a long-term doctor-patient relationship. Within the framework of GP care, conversation developments and processes can take place that can range from the development of the disease to its management, but also in the form of end-of-life care up to death.

25.7 Further information and references

Well-understandable overviews of the functions and communication in family practice are given by Hewitt (2001) and Jansen (2009), who bases his presentation on: German Society for General Practice and Family Medicine (DEGAM; Deutsche Gesellschaft für Allgemeinmedizin und

Familienmedizin). (Resolution of the Annual General Meeting of 21.09.2002,). The specific approach of *integrated psychosomatics* in general practice is described in Reimer (2017). Specifically on the medical interview in the anamnestic initial interview, reference should be made here once again to the recommendations of the DEGAM (2022). A systematic review (on "Barriers and facilitators to GP-patient communication about emotional concerns in UK primary care") is provided by Parker et al. 2020.

Other chapters of the handbook deal with approaches of *biopsychosocial* medicine (§ 4) and *biographical narrative* anamnesis (§ 9, 19). Many of the examples from the chapters on the manual (§ 18-23) come from the same general practitioner's practice as the examples of conversations documented and analysed above, which are characterised by the approach of psychosomatic conversation described here. For further training and evaluation in psychosomatic primary care, please refer to the topic-specific chapters in the handbook (§ 15, 42).

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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