

## 44 Teaching Materials on Medical Communication Appendix of the Handbook

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Communication skills training (CST) remains poorly represented and prioritised in medical schools despite its importance.

Venktaramana et al. 2022: 997

**Abstract:** The following teaching materials on medical communication were developed and tested in the *Cologne Curriculum Communication* (CCC) (§ 2, 13, 14, 17-23). The didactic basis is our *Cologne Manual for Medical Communication* (C-MMC), in which specific anchor examples from real D-P communication are analysed in the empirical part (IV) of the handbook (§ 17-23), which in turn can be used in a multimedia programme for practical exercises (§ 13).

The text boxes often contain longer quotations from *classics* on medical communication research, which should be read in class or as homework in context whenever possible (cf. e.g. below catalogue of *conversation maxims* according to Morgan, Engel, see Box 13.22). The numerous tables and graphics often provide *overviews* and *connections* that can accelerate the teaching and learning process when class time is limited, but should be developed together with the learners whenever possible, for example when *interactive learning media* are used (§ 13).

Since only what has been taught previously should be examined (§ 1-3, 13, 17), teaching must ensure *transparency* of *learning objectives*, the meaning and purpose of which can be checked by all participants in order to adapt or modify the learning objectives to the current level of learning if necessary.

The following (selective) collection of *teaching materials* begins with a table of contents for a comprehensive *learning module* entitled 'Dialogical Medicine' (DiaMed), which was presented in several steps (§ 2-3, 13).

The overview already contains references to the chapters of the handbook in which the 12 learning units can be studied in greater depth (Box 13.6). Here, too, different levels of difficulty must be taken into account, whereby specific *psychotherapeutic competences* (learning unit no. 8) can only be acquired in advanced studies or in continuing education.

In order to ensure the practical use of empirical conversation analyses (especially § 17-25), the purpose of *transcriptions* should be discussed in class in good time using the transcription form, which is therefore included immediately after the statement of Heritage (2013) (Box 2.19) and the empirical example (E 2.2). The collection of teaching materials follows (with a few exceptions) the order of selected chapters. All teaching materials should be considered in the context of the relevant chapters of the handbook and the further reading.

The references at the end of this chapter are only a selection. Further references can be found in other topic-specific chapters and in the comprehensive [bibliography](#) (with around 3,000 references) of the [handbook](#).

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#### Overview – Empirical Example – Transcription Form

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Many years of experience have resulted in a specific *Cologne Medical Communication Training (C-MCT)*, in which the *manual-based learning* (presented in § 13.4.1) is only the introduction to the theory phase of the *Teaching-Learning Spiral (TLS)* (§ 13.3.1), followed by the other circular learning loops (*reflection, training, evaluation* and *theory* again, etc.). As described there, the learning spiral does not necessarily have to be followed in a linear progression, but can be realised by *flexibly switching* from reflection or training phases to the theory phase depending on specific *problem-based* learning occasions.

Accordingly, the learning units presented below can be used in class either in toto or in sub-units, depending on requirements. We are only providing a brief, exemplary overview of the entire "Dialogic Medicine" (DiaMed) learning module here, described in detail above (§ 13).

Here we would like to briefly introduce the topic-specific learning units (LU) that we have gradually developed in our teaching in order to be able to integrate and consolidate them throughout the entire communication curriculum as part of a comprehensive Cologne Learning

#### 44. Teaching Materials on Medical Communication

Module "Dialogical Medicine" (C-LM-DiaMed). An overview differentiates between 12 selected learning modules on a specific dialogical medicine (DiaMed) (Box 13.6) and lists the relevant chapters from the handbook (right-hand column) in which the corresponding topics are dealt with.

In this learning module, a distinction is made between larger and smaller learning units, which are realised with different *scope* and *depth* depending on the *teaching purpose* and *learning level*. Accordingly, different choices will be made from the learning units and their sub-units in the first semester tutorial than in the 4th clinical semester (§ 14), in which the *unity of clinical reasoning and communication* (postulated in § 13.1.3) can already be largely ensured on the basis of *developed* competences.

For example, parts of learning unit 1 ("Biopsychosocial medicine and relationship models") (Box 13.6) can already be used in pre-clinical studies, but the use of learning unit 7 ("Decision Making: SDM") or 8 ("Psychotherapeutic competences") or 12 ("Special competences") is reserved for later semesters.

The selection from the DiaMed learning module is made according to the *degree of difficulty*, because *empathic* communication takes on a *new quality*, for example in dealing with *difficult* patients (§ 34) or with *physically chronically ill* patients (§ 29) or *dying* patients (§ 38), etc. The acquisition of communication competences as *active listening* (§ 19-22) must be promoted throughout all differentiation, which can already be trained in our *Cologne Curriculum Communication* (CCC) (§ 14) in the *preclinical* phase in *role play* or through the use of *Simulated Patients* (SP) in the *clinical* phase (§ 13.5, 14, 41).

Box 13.6 Learning Module "Dialogical Medicine" (DiaMed)

| LU    | Title  | Chapters              |
|-------|--|-----------------------|
| 1 MR  | Biopsychosocial medicine and relationship models | 4, 7, 8, 10, 19-2     |
|       | a. The mind-body problem                         | 4, 8, 10,             |
|       | b. Paradigm shift to biopsychosocial medicine    | 4, 8, 10, 13          |
|       | c. Relationship and communication models         | 4, 7, 8, 10,          |
|       | d. Case study                                    | 4                     |
| 2 EM  | Everyday talk and medical communication          | 1-3, 7, 9, 17-25      |
|       | a. Life world and medicine                       | 1-3, 7, 9, 17-25      |
|       | b. Asymmetry: Institutional Communication        | 5, 7, 9, 17-25        |
|       | c. Dialogical communication and medicine         | 7, 9, 10, 17-25       |
| 3 AL  | Active listening and verbal Intervention         | 3, 8, 9.4, 19.3       |
|       | a. Speaker-listener roles                        | 2.2, 3, 7, 19-22      |
|       | b. Conversational maxims and maxim conflicts     | 2.2, 3, 7, 19-22      |
|       | c. Interrupting speech                           | 3, 9.4, 19.3          |
| 4 NM  | Narrative medicine                               | 9, 13, 19-22, 25      |
|       | a. The psychoanalytic conversation               | 2, 9, 13              |
|       | b. Narration and association                     | 9, 13, 19-22, 25      |
|       | c. Cooperative narration                         | 9, 19-22, 25          |
|       | d. Evaluation of life narratives                 | 9, 19-22, 25          |
| 5 EC  | Empathic communication                           | 3, 9, 20, 21, 24, 25  |
|       | a. Theory  | 3, 9, 20              |
|       | b. Teaching                                      | 3, 9, 20              |
|       | c. Deficits and Practice                         | 8, 19, 20, 21, 24, 25 |
| 7 DM  | Medical decision-making                          | 8.4, 10, 22, 24-29    |
|       | a. Theory (SDM)                                  | 8.4, 10               |
|       | b. Practice                                      | 22, 24-29             |
|       | c. Prescription talk                             | 26                    |
| 8 PC  | Psychotherapeutic competences                    | 14, 15, 16, 29-39     |
|       | a. General practice and psychooncology           | 14, 16, 25, 42        |
|       | b. Psychocardiology & Diabetes education         | 4, 14, 29             |
| 9 FM  | Forms und functions of metaphors                 | 11, 19-22, 25         |
| 10 NV | Nonverbal interaction and communication          | 12, 18, 25            |
|       | a. Theory and Coding                             | 12                    |
|       | b. NV and Relationship Building                  | 18, 25                |
| 11 IP | Interprofessional Competence                     | 2, 6                  |
| 12 CS | Competences in specific fields                   | 5, 14, 24-39, 42-43   |

Box 2.19 We have a microscope. We should use it. Heritage 2013: XI f

The methodological point of a specifically empirically based approach in research and teaching is *expressed metaphorically* by John Heritage, a protagonist of (American) *Conversation Analysis* (CA), in the foreword to the "Handbook of Patient-Provider Interactions" (Beach 2013) (Box 2.19), in which he views the recording procedures in the social sciences in general as the equivalent of a "microscope":

Box 2.19 We have a microscope. We should use it.

Recording technology can, without exaggeration, be described as the social scientist's equivalent of the microscope (...) Conversation analysts, in particular, have always insisted on the value of group work on transcribed materials in the presence of the tape record itself. Anyone who has taught medical students, or trained physicians in CME courses, will be vividly aware of the compelling educational value of real data, in which real clinicians deal with real dilemmas of real patients in real time. Recordings have the power to evoke analysis and reflections that is wide and deep and that is, on occasion, an important stimulus to changes in practice. We have a microscope. We should use it.

Heritage 2013: XI f

This appeal to make greater use of the *microscope* that has long been available is directed both at research, which should develop into an "evidence-based discipline" (ibid.), and at the teaching of doctor-patient communication, to use the "educational value of real data" that has been generated under "realistic" conditions (real conversation partners, problems, time, etc., see above).

We try to meet both requirements here by combining research results, mostly from our own and occasionally other projects, with teaching in order to capture and convey the "reality of conversation" as it took place under real practical conditions. If this is not specifically marked otherwise for *didactic* reasons (e.g. in the case of alternative formulations of medical interventions), our handbook uses directly obtained data of oral communication in the form of recordings and transcriptions of authentic conversations, as is generally done in the tradition of discourse analysis (e.g. Edwards, Lampert 1993, Gee, Handford 2014).

|       |                                  |            |
|-------|----------------------------------|------------|
| E 2.2 | "What are your main complaints?" | Transcript |
|-------|----------------------------------|------------|

At this point, attention should only be drawn to the phenomenon of *eye contact*, which is particularly noted here because of its significance in the context. In the video recording, we see the doctor from behind and have a view of the patient's face and upper body. After the doctor's question about the reason for the consultation, the patient has just started to answer. The doctor interrupts her without need, as soon as she has started. The patient's gaze was directed neither questioningly nor seeking help from the doctor, but "digressively" upwards to the left, which is typical behaviour when one is thinking while speaking (inner concentration) and does not want to be "distracted" from the outside.

| E 2.2 | "What are your main complaints?"   | Comment                                      |
|-------|--|--|
| 01    | D [both sit down]<br>[+] so Mrs A, what brings you here? . [+]   | Opening question:<br>Reason for consultation |
| 02    | P [+] so, in general [-] now um ... [looking up to the left, thinking]                                 | Start of the answer                          |
| 03    | D where are [+] your main problems, what/or main complaints are you coming for? [+] .                  | Early interruption/funneling                 |
| 04    | P I have often experienced heart pain, i.e. stitches in the heart area .                               | Focus: "Main complaints"                     |
| 05    | D since when have [-][TL] [1] you had these stitches? ... [3] ... [1P] [1P scratches her shoulder]     | TL = thoughtful look from P                  |
| 06    | P [-] a little [+] longer, so in 2001 it was really bad, and that's when I had my tonsils removed. [+] | Last sustained eye contact from P to A       |
| 07    | D yes .  | Listener signal                              |
| 08    | P that was still the case with Dr Müller . [+]   | Pre-treatment                                |

With his renewed intervention (03D: "what are your main problems, what/or main complaints, what are you coming for?"), the doctor not only interrupts the flow of speech that has just begun at an early stage, but also quite obviously the patient's train of thought that has just developed ("so, generally now um ..."). (...)

Tab. 2.5 Transcription form

Simultaneous speech by doctor and patient was only taken into account in obvious ("inaudible") cases with square brackets. Since dots are replaced by commas in otherwise normal punctuation and dots are used exclusively as pauses, the corresponding capitalisation after dots is removed. Essentially, the following transcription characters are used:

| Sign             | Transcription explanations                             |
|------------------|--|
| D                | Doctor   |
| P                | patient  |
| MA               | Medical assistant                                      |
| [indicates neck] | Comments (non-verbal etc.)                             |
| here [file]      | Comments (cognitive, meaning: patient file)            |
| Word . Word .    | short pause (no punctuation!)                          |
| Word ... Word    | middle pause   |
| ..... [5] .....  | Pause of approx. 5 seconds                             |
| ähm              | Filled break of the speaker (turn-internal)            |
| hm               | Listening signal (example 1)                           |
| oh               | Listening signal (example 2)                           |
| aha              | Listening signal (example 3)                           |
| yes?             | Listening signal (example 4 with question intonation)  |
| je:sterday       | Emphasised yesterday                                   |
| he/she has       | Self-correction  |
| P [              | simultaneously to speaker D                            |
| D [              | simultaneously to speaker P                            |
| [+]              | Eye contact  |
| [-]              | Eye contact interrupted                                |
| [l-]             | Start "louder" (relative to "normal")                  |
| [-l]             | End "louder" (return to "normal")                      |
| [q-]             | Start "quieter" (relative to "normal")                 |
| [-q]             | End "quieter" (return to "normal")                     |
| [f-]             | Start "faster" (relative to "normal")                  |
| [-f]             | End "faster" (return to "normal")                      |
| [s-]             | Start "slower" (relative to "normal")                  |
| [-s]             | End "slower" (return to "normal")                      |
| (word)           | presumed wording (unintelligible)                      |
| word-            | Contribution/intonation not (yet) finalised/(still)    |
| word=word        | Fast connection  |
| lemme            | Literary transcription (e.g., for dialects) (= let me) |
| gotta            | Literary transcription (= got to)                      |
| etc.             |  |

Table 2.5: Transcription form

# 1 Clinical Communication Education

## Box 1.1 Function of dialogue in medicine (Engel 1988: 121)

The importance of medical communication can be demonstrated with a few (often quoted) figures: Doctors have about 150,000-200,000 conversations with patients in their professional life of approx. 40 years (Lipkin et al. 1995, Kurtz, Silverman, Draper 2005, Morris et al. 2013). Early studies have already shown that 60-80% of diagnoses can be made correctly on the basis of the conversation (Hampton et al. 1975, Lazare et al. 1995, Washer 2009). The frequency of conversations alone, as well as their specific function in making a diagnosis, testify to the particular clinical *relevance* of the doctor's *communicative competence* in dealing with the patient. (...)

This fundamental function of communicative access to the patient has been repeatedly emphasised by one of the pioneers of *biopsychosocial* medicine (§ 4), George Engel, who will have his say here in detail (Box 1.1). We will refer back to this definition of the basic function of *dialogue* in medicine repeatedly in this handbook, just as the specific functions mentioned by Engel are to be further concretised.

## Box 1.1 Function of dialogue in medicine

Dialogue is in fact the only means whereby the patient can acquaint the physician with those inner experiences which had led him to consider himself ill in the first place, and therefore to solicit medical help. By the same token dialogue enables the physician to reconstruct with the patient a plausible sequence of events ("history") from which hypotheses may be developed, which in turn may be explored by further dialogue and other means (...). As an integral component of the process whereby the clinician gains knowledge of the patient's condition, it is thus clear that *dialogue is truly foundational to scientific work in the clinical realm.*

Engel 1988: 121 (emphasis in original)

Here, a founder of *biopsychosocial* medicine not only conveys to us in a small space the general function of dialogue as "foundational to scientific work in the clinical realm", but at the same time describes the spe-

cific (sub-)functions that the doctor has to perform in dialogue with the patient (...).

Fig. 1.1 Medical Education Learning Spiral (on Windover 2016: 95)

From this "naive" level of learning to a high level of "mastery", there is a long way to go, at the end of which there may also be the ability to teach others as effectively as possible, without ever having "finished learning" oneself. The continuous development in *lifelong learning* can be captured in several learning phases (Fig. 1.1), which build on *each other* with overlaps.

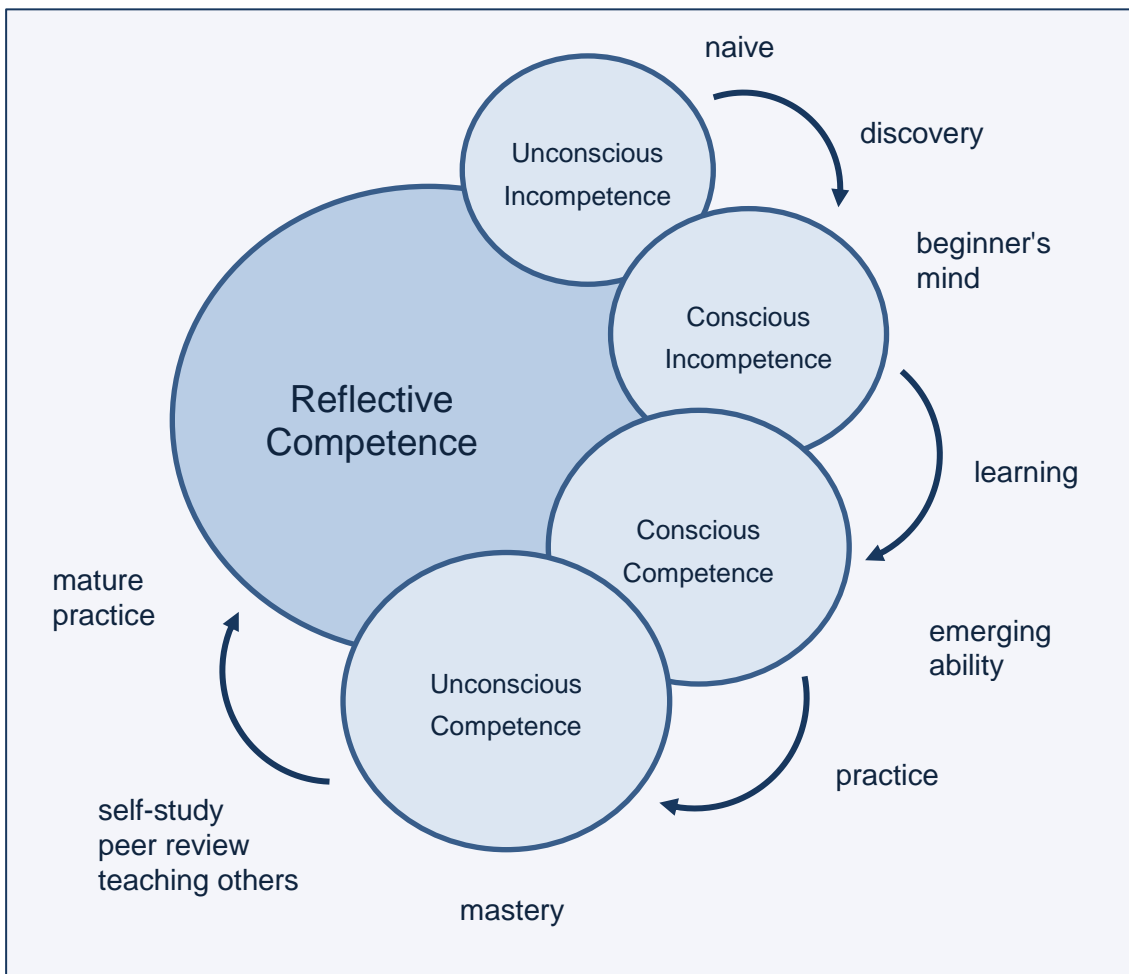


Fig. 1.1: Medical Education Learning Spiral (on Windover 2016: 95)

The *unconscious incompetences* are the starting point of a long, circular learning process, at the centre of which is the development of a *reflexive competence*. According to Windover (2016) (Box 1.8), this *reflexive competence* allows for a constant evaluation, adaptation and creative fur-

ther development of innovative communication techniques in the face of different challenges in the ongoing communication with changing patients, to which the doctor's conduct of the conversation has to *tailor itself* in interaction with clinical competences.

Box 1.8 Reflective competence

*Reflective competence* (...) is characterized by the ability to be mindful of what, how, and why you are communicating in a particular way. Such awareness and reflection allow us to evaluate and refine our communication in an ongoing manner. It also enables us to tailor our communication to each patient, create opportunities to develop innovative communication techniques, and better share the skills with others. It is a vital component in achieving peak performance (...) In a way, reflective competence gives physicians permission to use their clinical judgement and armamentarium of evidence-based skills to decide what language is needed when and where.

Windover 2016: 94

Thus, in order to decide "what language is needed when and where", an interplay of *clinical* and *communicative* competences is required, which are to be alternately applied and further developed (§ 3, 17). This connection is to be further elaborated and deepened beyond Windover (2016) by deriving it from theoretical foundations of a *biopsychosocial* medicine (§ 4), which at the same time sees itself as a *dialogical* medicine (§ 7).

As we will see in detail, with the paradigm shift from a *biomedical* to a *biopsychosocial* approach to care (§ 4), a different way of conducting the conversation is necessary simply because the traditional, *interrogative* taking of medical history proves to be too narrow, which must be replaced or at least supplemented by a *biographical-narrative* way of conducting the conversation (§ 9, 19). This difference between an interrogative and narrative conduct of the conversation is also the subject of critical self-reflection on the part of the doctor.

## 2 Interdisciplinary Research on Medical and Therapeutic Communication

### Box 1.4 Why so little progress?

The benefit of good communication on patient care and outcomes is unequivocal, whereas deficiencies in communication are associated with medical errors and a negative patient experience. So why has there been so little progress over the years?

Levinson, Pizzo 2011: 1802

### Box 2.6 Deficit: Interdisciplinary teams building

Until very recently, researchers have worked in single disciplines rather than on interdisciplinary teams building.

Stewart, Roter (1989: 252)

### Box 2.7 Dilemma: Lack of awareness of what other disciplines are doing

One dilemma facing academics from different disciplines who are in pursuit of health communication is a lack of awareness of what other disciplines are doing.

Parrott, Kreuter: 2011: 4

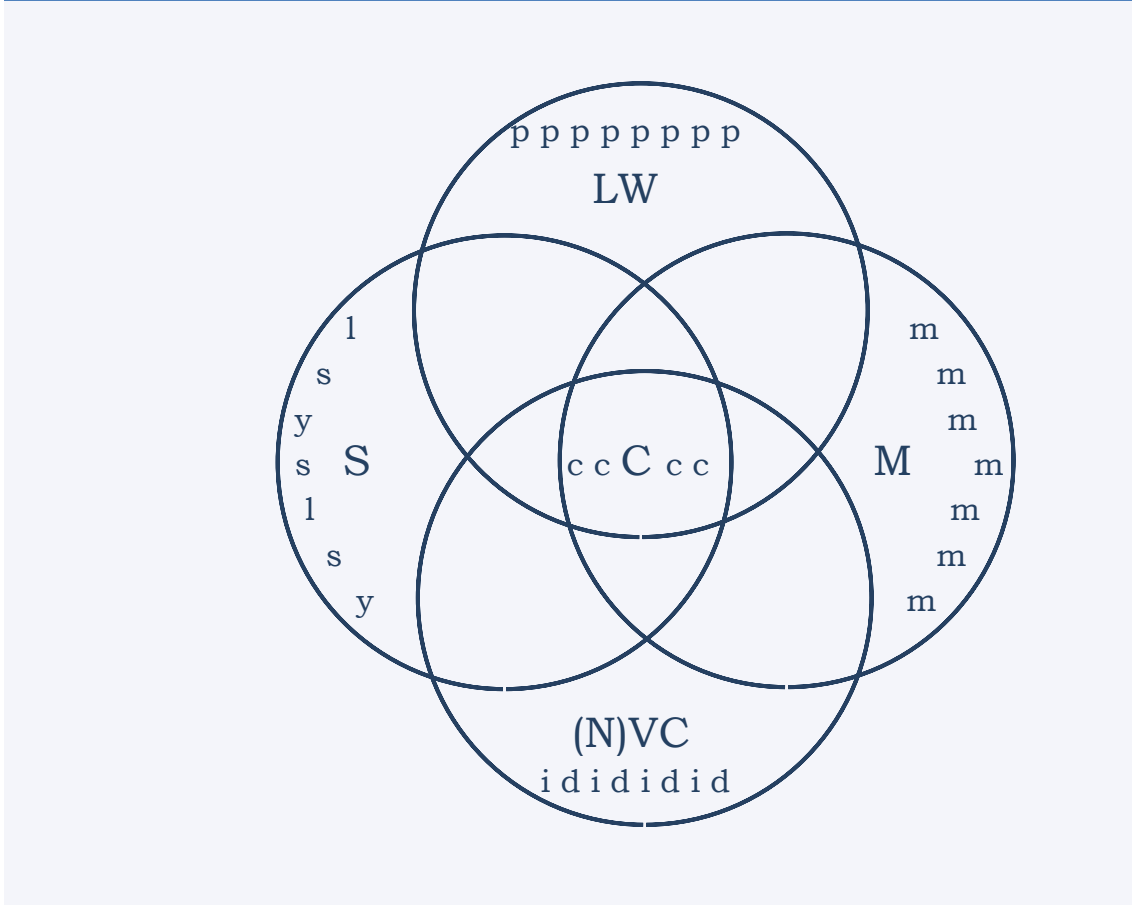
This deficit or dilemma does not appear to have been resolved or eliminated in this decade; according to the latest review by Venktaramana et al. (2022): "A systematic scoping review of communication skills training in medical schools between 2000 and 2020", the deficiency seems to relate not only to *interdisciplinarity*, which is hardly mentioned at all, but the authors also lament a fundamental lack of *communication skills training* (CST) at present (Box 2.8):

### Box 2.8 CST remains poorly represented ...

Communication skills training (CST) remains poorly represented and prioritised in medical schools despite its importance.

Venktaramana et al. 2022: 997

Fig. 2.1 Medical and social science research: sides of the same medals



Legend:

Capital letters: Systems, types

- C Conversation type
- LW Lifeworld
- M Medicine
- (N)VC (Non)verbal communication
- S Social science

Small letters: Individuals, examples

- c Conversation
- p Patient
- m Medical professional
- i Idiolect / d dialect
- l Linguist
- s Sociologist
- y Psychologist

The empirical approach of clinical conversation research soon met with (in the broadest sense) *social science* disciplines (S) (Fig. 2.1), in which conversations (of different types) (C) were examined on the basis of empirical data (exemplary conversations) (c).

The initial focus here was essentially on the differences between *everyday* and *institutional* communication as well as (types of) communication in various institutions, such as schools, universities, courts, tax offices, employment offices, etc. ...

44. Teaching Materials on Medical Communication

| Phase | Stages in the development of medicine (theories, models) |  |                               | Time   | Exemplary literature (theories, models, didactics)   |
|-------|--|--|-------------------------------|--|--|
| 1     | Doctor-centred model: Authoritarian ethics               | Disease-centred<br>Autonomy & Decision<br>D → P<br>Interrogation                                       | Bio-Medicine                  | ↓  | Traditional medicine (practised before and also after v. Weizsäcker 1940, 1946, Balint 1964, Morgan, Engel 1969, Engel 1977, 1981, 1988, 1997 and others).   |
| 2     | Patient-centred  | First stage: P → D   | Bio-psycho-social<br>Medicine |  | Balint 1964, Byrne, Long 1976, Engel 1977, 1981, 1988, White 1988, Levenstein et al. 1989, von Uexküll, Wesiack 1991, Koerfer et al. 1994, Charles et al. 1997, 1999, Elwyn et al. 1999, Mead, Bower 2000, Koerfer, Albus 2015, 2018, Bruch et al. 2024, Elwyn et al. 2025, Aboushawareb et al. 2025 |
|       | Business: Libertarian ethics                             | P → D<br>Dialogical asymmetry  |                               |  |  |
|       | SDM: Discourse ethics                                    | P ↔ D<br>Dialogical symmetry   |                               |  |  |
| 3     | Relationship-centred model                               | Disease & illness<br>Asymmetrical roles & equal autonomy<br>Narration & SDM (D ↔ P) & Discourse Ethics | Bio-psycho-social<br>Medicine |  | Tresolini et al. 1994, Mead, Bower 2000, MC Beach et al. 2006, Rider, Keefer 2006, Suchman 2006, Kenny et al. 2010, Zhou et al. 2023   |
| 4     | Interactional care model                                 |  |                               |  | WA Beach, Dixon 2001, Robinson 2003, WA Beach 2013   |
| 5     | Partnership & Dialogue-based model                       |  |                               | Pellegrino, Thomasma 1981, Uexküll 1987, 1993, Herzka 1990, Koerfer et al. 1994, v. Kampits 1996, Engel 1997, Anderson 1999, Roter 2000, Olesen 2004, Koerfer et al. 2008a, 2008b, Koerfer, Albus 2015, 2018, Collins, Street 2009, Walseth, Schei 2011, Richard, Lussier 2007, 2014, Chin-Yee et al. 2019 |  |
| 6     | Partnership & Narrative-based model                      |  |                               | Brody 1994, Koerfer et al. 1994, Greenhalgh, Hurwitz 1998, Koerfer et al. 2000, 2008, 2009, 2010, Charon 2001, 2006, Mishler 2005, Goyal 2013, Köhle, Koerfer 2017, Milota et al. 2019, Galvagni 2022, Kirmayer et al. 2023, Palla et al. 2024   |  |

Fig. 2.2: Stages in the development of medicine -  
Modified on Koerfer, Albus (eds.) (2018: 329) (cf. § 3, 9, 10, 13, 17-23).

## Box 2.2 Dialogue-centred medicine

Olesen 2004

The associated *asymmetry* in the relationship, which can lead to the disempowerment of the physician, should be abolished in a *dialogical model*, which was formulated early on by Pellegrino, Thomas (1981, 1988) and later justified in many variations from different perspectives, in which the *dialogical principle* in the sense of Buber (1954/1986) is also applied to the doctor-patient relationship and communication to be evaluated within the framework of *discourse ethics* (cf. v. Uexküll 1987, 1993, Gadamer 1993, Koerfer et al. 1994, 2008, Kampits 1996, Ritsert 1992/2004, Kettner, Kraska 2009, Koerfer, Albus 2015, 2018) (§ 7, 10 of the handbook). According to this view, the two conversation partners, doctor and patient, meet in their own way as experts who engage in dialogue in the interests of both parties, which was summarised by Olesen (2004) in a short editorial as an essential interim conclusion of the discussion (Box 2.2).

## Box 2.2 Dialogue-centred medicine

In conclusion, the way forward lies in accepting that a good consultation is a meeting between two different experts: the patient and the doctor. These experts should realise that they each have a unique expertise, and from this position they should build common ground for their interaction. This demands that the doctor preserves his/her professional integrity and that the two parties respect each other's positions and are, indeed, willing to interact. The tool they should use in this process is dialogue, i.e. an exchange of thoughts and ideas and a discussion staged to come to agreement on a topic (...) The time may thus have come to stop focusing on the concept of patient-centred medicine and to go for developing a concept of balanced, dialogue-centred medicine.

Olesen 2004: 194

With this model of *dialogue-centred* medicine, the social roles of patient and physician (already described by Parsons 1951/1970), whereby the patient seeks out the physician in the role of professional helper due to their need for assistance, remain unchanged, as does a significant asymmetry in communication. This asymmetry is *constitutive* for doctor-patient communication ...

Fig 2.3 Power/control-shift models (mod. after Koerfer, Albus 2018)

In the practice of dialogue-based decision-making, it will rarely be possible to assume one universally valid ideal model (Koerfer, Albus 2015, 2018) (§ 10, 22). As in everyday life, the same applies in medical care practice:

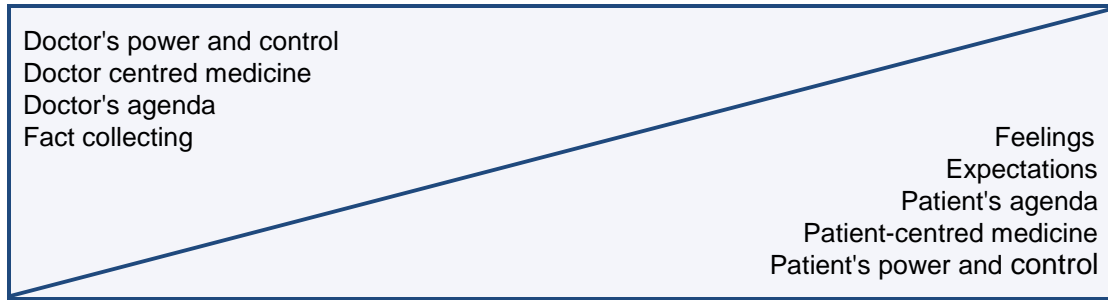
- *One shoe doesn't fit all.*

With this plausible proposition, a number of models are ultimately differentiated in order to be able to select a suitable model for different types of decision-making situations (Lussier, Richard 2008, Epstein, Gramling 2013, Keller, Sarkar, Schillinger 2014). Overall, a broad spectrum of models and their variants can be assumed, with fluid transitions. In order to capture this plurality typologically, numerous distinctions have been made in research on decision-making, e.g. four models (Emanuel, Emanuel 1992, Peters 2015) or six models (Kettner, Kraska 2009) or nine models (Sandman, Munthe 2010, Sandman et al. 2012). Without any claim to completeness or selectivity, the following models can be distinguished in a loose list, the validity of which is quite plausibly justified in research on decision-making:

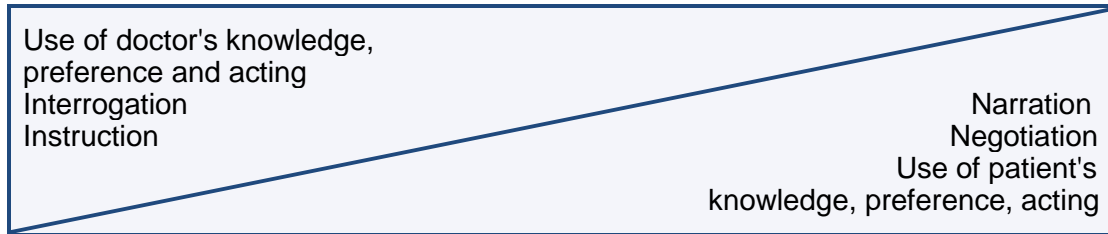
- Paternalism model
- Interpretation model
- Deliberation model
- Information model
- Business model ("service")
- Prevention model
- Agent model
- Contract model
- Cooperation model ("shared decision making") (SDM)
- Partnership model
- etc.

The variety of models is difficult to classify comparatively and to evaluate critically for practice, especially since there are also superordinate relationships and mixed forms. We have attempted (in § 10) to depict the different variants in a power shift/control model (Fig. 2.3), in which selected literature from five decades is taken into account and previous theoretical considerations (§ 7-10) and empirical analyses of conversations (§ 17-25) can be summarized.

A: Power and control



B: Knowledge, preference, acting



C: Verbal Gradation

|   |  |  |  |  |   |   |
|---|--|--|--|--|---|---|
| Doctor makes decision and instructs the patient | Doctor makes decision and announces it | Doctor sells his decision to the patient | Doctor presents tentative decision subject to change | Doctor presents problem, seeks suggestion & makes decision | Doctor defines limits and requests the patient to make decision | Doctor permits patient to make his/her decision |
| 1   | 2                                      | 3  | 4  | 5  | 6   | 7   |

D: Medical ethics framework

|   |   |  |
|---|---|--|
| I   | II  | III  |
| Paternalism   | Shared decision making  | Service  |
| ←-----→   |   |  |
| Authoritarian ethics                                      | Discourse ethics  | Libertarian ethics                                       |
| Information one way                                       | D & P Shared information  | D Offer-advertisement                                    |
| D Decision  | D & P Shared decision   | P Decision   |
| D Autonomy<br>D Responsibility<br>P External control by D | D & P Autonomy: Symmetry<br>D & P Shared Responsibility<br>D & P Shared control | P Autonomy (D)<br>P Responsibility (D)<br>P Self-control |

Fig. 2.3: A-D: Power/control-shift models

cf. Byrne, Long 1976, Pendleton 1983, Koerfer et al. 1994, Elwyn et al. 1999, Charles et al. 1997, 1999, Roter 2000, Tate 2004, Koerfer et al. 2005, 2008, Koerfer, Albus 2015, 2018

Fig 2.4

Learning goal taxonomy

(mod. after Koerfer, Albus 2018)

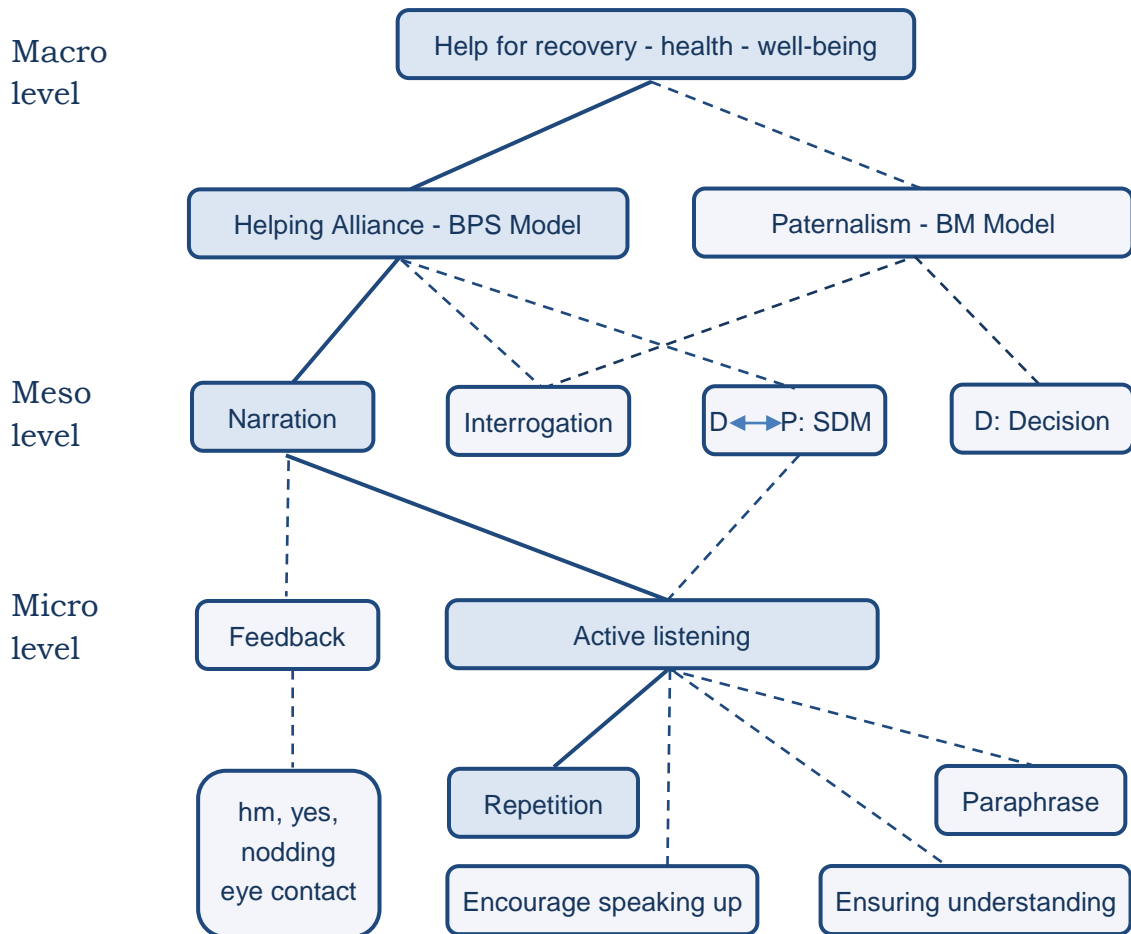


Fig. 2.4: Learning goal taxonomy (mod. after Koerfer et al. 2008, Koerfer, Albus 2018); Selection: Exemplary path for intervention type "Repetition"

The complex, competence-based learning goal taxonomy distinguishes between *macro*, *meso*, and *micro* learning goals in a standardized form that allows for *operationalization* down to the level of *manifest* communicative (partial) actions or nonverbal conversational behavior (gaze, position, gestures, etc.) in order to be able to initiate targeted and differentiated training of communicative competences and individual sub-competences after an evaluation of relevant deficits ...

Box 2.5 Learning goal taxonomy for "Listening to concerns"

The doctor practices a *biopsychosocial* approach to care

- by taking a *biographical-narrative anamnesis*
  - by *listening* to the patient's concerns
    - by starting the conversation openly
      - by asking about the motive for consultation
      - or by asking about the patient's well-being
      - or by offering himself as a helper ("What can I do for you?").
    - and by *promoting the patient's narrative*,
      - by giving listening signals (*nodding, hm*)
      - by avoiding interruptions
      - by tolerating breaks
      - by allowing a free development of topics
    - and by active listening (verbal support)
      - by encouraging speaking up: "and then?"
      - by repeating statements verbatim
      - by open follow-up questions: "How did that come about?"  
etc.

Further learning goal *formulations* follow the six steps/conversational functions in our *Cologne Manual of Medical Communication (C-MMC)*, which can also be used to determine the learning content and sequence of learning units in the classroom (§ 3, 13, 17) (cf. appendix in this chapter). Since the preceding definition of competence cited by Epstein and Hundert (2001) proved to be quite complex and comprehensive, there are certain consequences for evaluation, which must also take into account certain levels of development in competence development, as already addressed (in § 2.2.4: topic focus 13 ("Education and Evaluation")) and now to be further elaborated ....

|         |                                   |                    |
|---------|-----------------------------------|--------------------|
| Box 2.9 | Without a problem, no observation | (Popper 1972/1994) |
|---------|-----------------------------------|--------------------|

The spontaneous reactions of students often make it clear that *merely observing* an object does not necessarily lead to an *awareness* of the *problem*. Rather, according to Karl Popper (Box 2.9), the problem must precede observation.

|         |                                   |
|---------|-----------------------------------|
| Box 2.9 | Without a problem, no observation |
|---------|-----------------------------------|

My thesis is that every scientific development can only be understood in terms of its starting point being a problem or a problematic situation, i.e., the emergence of a problem in a specific situation within our overall knowledge (...) This can be easily demonstrated by the following thesis: *without a problem, no observation*. If I ask you to “Please observe!”, you should ask me, in accordance with common usage: “Yes, but what? *What should I observe?*” In other words, you are asking me to specify a *problem* that can be solved by your observation (...) But if I pose a very trivial *problem* to you, then the situation is different.

Popper 1972/1994: 19 (*italics there*)

The question of the relationship between problem and observation leads directly to the didactic issues surrounding *problem-oriented learning* (POL), which has already been mentioned and is dealt with in detail in the didactic chapters (§ 3, 13, 14). A *good starting point* for a *teaching-learning spiral* is usually a critical theoretical text that can be used to create *problem awareness* and overcome *naive incompetence* (in the above sense of Windower 2016).

At an advanced stage of development, we chose a *comparative* approach as a further starting point, in which extremely *poor* (interrogative) conversations are *contrasted* with extremely *good* (narrative) conversations in direct observation, which usually requires a certain awareness of the problem, which can be promoted by reading critical texts on communication theories and models in medicine (§ 13). ...

Box 2.10 Translation between Medicine and Lifeworld (Mishler 1984: 172)

Applying Habermas' (1981, English 1985) fundamental distinction between the *lifeworld* and the *system*, Mishler distinguishes in his (transcript-based) studies between *medicine* (as a system) and the *lifeworld* (of patients) and draws the conclusion from his empirical conflict analyses that the "voice of the lifeworld" should be given more weight and validity than the "voice of medicine". Contra factually eliminating or at least reducing the prevailing dominance of medicine would be possible in principle simply by ensuring that doctors have both *medical* and *everyday language competences*, enabling them to speak both the everyday and medical codes, as Mishler pointedly described in his summary:

Box 2.10 Translation between Medicine and Lifeworld

The aspect asymmetry of the medical interview is that physicians are communicatively competent in both codes. They can speak in either the voice of the lifeworld or of medicine, but the patient is competent only in one (...) For this reason, the burden of translating falls primarily on the physicians. For communication to produce mutual understanding, physicians must provide equivalences in meaning between statements in one voice and the other and explain differences between alternative contexts. In other words, physicians must translate patients' lifeworld statements into medical terms, and medical statements into patients' terms.

Mishler 1984: 172

The key findings of his conflict analyses, which Mishler aptly characterises in the subtitle of his book as "Dialectics of Medical Interviews", will also be used here to develop an expanded concept of *medical communication competences*, which will be established in several steps and finally presented and discussed in summary form with a *taxonomy of learning goals* (§ 2.3.9).

Table 2.2 Comparison of the conversational maxims of Freud (1913) Grice (1975)

First, knowledge must be acquired about the differences and similarities between everyday communication and medical communication, to which different conversational maxims apply. The differences can be worked out in class (in excerpts) through a critical comparison of theories in the context of Freud's formulation of the *psychoanalytic* basic rule for the patient (1913) and Grice's *everyday* conversational maxims (1975), which can also be condensed into a table (Table 2.2).

| Freud (1913)  | Grice (1975)  |
|---|---|
| Whereas otherwise you rightly try to hold the thread of the connection in your presentation,                          | Be relevant;<br>Be orderly  |
| and reject all disturbing ideas and secondary thoughts,   | Be orderly  |
| in order to avoid, as they say, going from the hundredth to the thousandth, you should proceed differently here (...) | Avoid overinformativeness   |
| You will be tempted to say to yourself: this or that does not belong here, or it is quite unimportant (...)           | Be relevant   |
| Never give in to this criticism (...) So say everything that crosses your mind.                                       | Make your contribution to the conversation as required by the accepted purpose (...). |

Table 2.2: Comparison of the conversational maxims of Freud (1913) and Grice (1975)

Freud's message to the patient reads like an anticipation of a *negation* of the *maxim catalog* that the philosopher of language Grice formulated fifty years later (1975) for *everyday* communication. These everyday maxims are now to be *suspended* in conversation with the therapist or doctor in favor of the *association* rule—contrary to all habits of everyday communication (cf. Koerfer, Neumann 1982). With such a *comparative* perspective, the *specific learning goal* to be pursued (§ 2.3.10) is that Freud's *rule of association* should be applied *moderately* (sic) in medical communication in order to promote the corresponding patient *narratives* in *dialogical medicine* (§ 2.2.3), which open up space for the patient to express their complaints, suffering, and life stories (§ 9, 19).

Table 2.3 The dosage problem – recommendations and warnings

The art of medical communication lies precisely in striking a *balance* between the two extremes of misdosing, which should be warned against in teaching, preferably using negative anchor examples (§ 13, 19). It has already been explained (in § 2.3.3) why medical communication training should not be confused with *rhetoric training*, in which the use of listener signals, word repetitions, or paraphrases is practiced, which can lead to the inappropriate *inflation* of these forms of communication without meaning or purpose and can even become counterproductive: The mere accumulation of listener feedback such as word *repetitions* can be perceived as parroting, just as the physician's prolonged *silence* can be interpreted as embarrassment or helplessness, or sustained *eye contact* can be perceived as threatening control (§ 17-19).

| Recommendations   |  | Warnings                 |
|---|--|--------------------------|
| Less of the same  | More of the same   | Too much of a good thing |
| Doctors' speaking<br>Interrupting<br>Information questions<br>Suggestive information questions<br>Ignoring emotions<br>Rebuking<br>Teaching<br>Instructing<br>Change of topic | Silence (= letting the patient speak)<br>Eye contact<br>Listener feedback ( <i>hm, yes, okay, nodding, etc.</i> )<br>Active listening (repetitions, paraphrases)<br>Comprehension questions<br>Addressing emotions<br>Commendation<br>Enlightening<br>Counseling<br>Topic reactivation |                          |

Table 2.3: The dosage problem – recommendations and warnings

Accordingly, teaching must convey that the shift from interrogative to narrative medicine postulated in research (§ 2.1 and 2.2) can only be understood as a *shift in focus*, in which dosage problems must also be taken into account. A doctor who merely listens silently without empathic feedback to a dramatic patient narrative can cause just as much irritation to the patient as a doctor who asks only suggestive information questions or funnel questions (§ 19, 21).

Table 2.4 Professional Medical Competence

The following summary also refers to a *tabular overview* (Table 2.4), which is then commented on by way of example. A *multidimensional* concept of professional medical competence was developed and justified in advance (§ 2.3.2-8), which will be summarized and differentiated here in three steps (cf. Table 2.4):

### 1. Clinical and communication competences

The professional competence of physicians consists of traditional clinical competence (2A-B) and dual communication competences (2C-E), comprising everyday (naturally acquired) communication competence (4C), which we all possess as participants in the world we live in, and specific medical communication competence (4D-E), which is divided into knowledge competence (6D) and action competence (6E) and is taught in medical training through the teaching of theory (8D) and training (8E).

### 2. Translation and fitting competences

With *dual* medical communication competences, specific *translation* competence (5C-E) must also be developed in order to anticipate and, where possible, minimise or compensate for potential problems and conflicts between *medicine* as a system and the *lifeworld* (of patients). The choice of both instrumental (diagnostic, therapeutic) actions and communicative actions is made on the basis of *fitting* competence (7A-E), which must be used in a patient-oriented and context-sensitive manner.

### 3. Meta-competences

Communication between doctors and their patients should be *evidence-based* insofar as *instrumental* action (B8-9) and *communicative* action (E8-9) are continuously subjected to *rational control* and, if necessary, *correction* from the perspective of *self-reflective meta-competence* (1), in line with the current state of scientific development. Meta-competence is divided into *clinical* (3A-B) and *communicative reflection* competence (3C-E), which is used to reflect on the extent to which the *translation* between *medicine* and the *lifeworld* has been successful, the appropriate level of narrative self-expression by patients has been found, gaps in the medical history still need to be filled, etc.

|                                 |                                    |  |   |  |   |  |
|---------------------------------|------------------------------------|--|---|--|---|--|
| 1                               | Meta-Competence of the good doctor |  |   |  |   |  |
| 2                               | Clinical competence                |  | Dual communication competence   |  |   |  |
| 3                               | Clinical reflection competence     |  | Communicative reflection competence   |  |   |  |
| 4                               | Medicine as system                 |  | Lifeworld   | Medical communication competence   |   |  |
| 5                               | Doctor & Team                      | Doctor   | Doctor's translation competence   |  |   |  |
| 6                               | Knowledge Competence               | Acting (IAC) competence  | Everyday competence   | Knowledge competence   | Acting (CAC) competence   |  |
| 7                               | Fitting competence                 |  |   |  |   |  |
| 8                               | Theory                             | Training   | Natural P & D   | Theory   | Training  |  |
| Professional medical competence | a                                  | Nosology/<br>Diagnostics<br>–Disease<br>–Illness<br>–Well being<br>History taking:<br>–Life story<br>–Details: pain, etc.<br>–Medication, etc. | Physical Examination<br>–Palpation<br>–Auscultation<br>–Measuring blood pressure etc. | Knowledge/<br>Acting   | Manual* C-MMC   | Examples:  |
|                                 |                                    |  |   | Grice's Maxims:*<br>Cooperation principle:<br>Be relevant<br>Be orderly<br>Be brief, avoid ambiguity, etc. | Special Maxims:*<br>Freud's Therapeutic Association Rule:<br>Moderate application in medicine | Allowing/<br>providing (P's) unstructured associations: P may be disordered, unclear, irrelevant, etc. |
|                                 | b                                  | Specific diagnostics<br>–Diabetes*<br>–Depression*   | ECG<br>Radiation<br>Pain scale<br>Questionnaire                                       | General maxims<br>turn taking:<br>Symmetrical  | Specific maxim:<br>turn taking<br>preference for patient                                      | Preferred choice<br>P → D → P<br>P's turns "as if uninterrupted"                                       |
|                                 | c                                  | Therapy<br>–primary care<br>–surgery   | Medication<br>Physiotherapy<br>Operation  | Nonverbal<br>–eye contact<br>–mimics   | Face to face<br>Reducing<br>PC work   | Sorry, I just have to enter the data ...   |
|                                 | 9                                  | Psychotherapeutic Knowledge  | PT- Instrumental acting (IAC)   | Informal talk<br>small talk  | Institutional talk<br>Manual* C-MMC   | Functions/<br>Steps 1-6 *  |
|                                 | a                                  | Psychodynamic defense:<br>–rationalization<br>–denial, etc.  | Questionnaire<br>–Pain<br>–Anxiety<br>HADS-A  | Greeting<br>Topic flow<br>Closing up   | 1 Relation<br>–Greeting<br>–Situating<br>–Orientation   | Hallo Mrs. A.<br>I'm Dr. B.,<br>please sit down and ...  |
|                                 | b                                  | KA Menninger:<br>Transference<br>Counter-transference  | –Manual DD*<br>Diabetes &<br>Depression*<br>–HADS-D                                   | Reporting:<br>Concerns<br>Listening  | 2 Listening to Concern<br>–Feedback<br>–Listening signals                                     | Opening question:<br>What can I do for you?  |
|                                 | c                                  | Interview styles:<br>C Rogers: directive vs. nondirective  | Personality tests:<br>–FPI  | Questions<br>Signals of Understanding  | –D → P<br>–Free choice of topic   | Encourage<br>Speaking up:<br>And then?   |
|                                 | d                                  | George Engel:<br>Interrogation vs. Narration   | –MMPI<br>–Neo PI-R  | Narration<br>Illness story<br>Life story   | 3 Eliciting Emotion<br>NURSE  | Naming an emotion after a narration  |
|                                 | e                                  | KA Menninger:<br>Interpretation:<br>Tentative vs. Confrontational  | Information aids<br>–Sheets<br>–Multimedia  | Advice<br>Reject<br>Negotiating<br>Decision  | 5 Decision Model<br>Paternalism<br>Business<br>SDM D ←→ P                                     | Present options,<br>benefits, risks<br>Discussing<br>Informed consent                                  |
| f                               | Topics (follow up)                 | Coding – data  | Say goodbye   | 6 Resume   | Next meeting  |  |
|                                 | A                                  | B  | C   | D  | E   |  |

Table 2.4 Professional Medical Competence –

\*Manuals & Maxims see Appendix of this chapter 2 (cf. § 3, 13, 14, 17-23, 29, 30)

Fig. 2.6 Simplified flow chart for professional competence

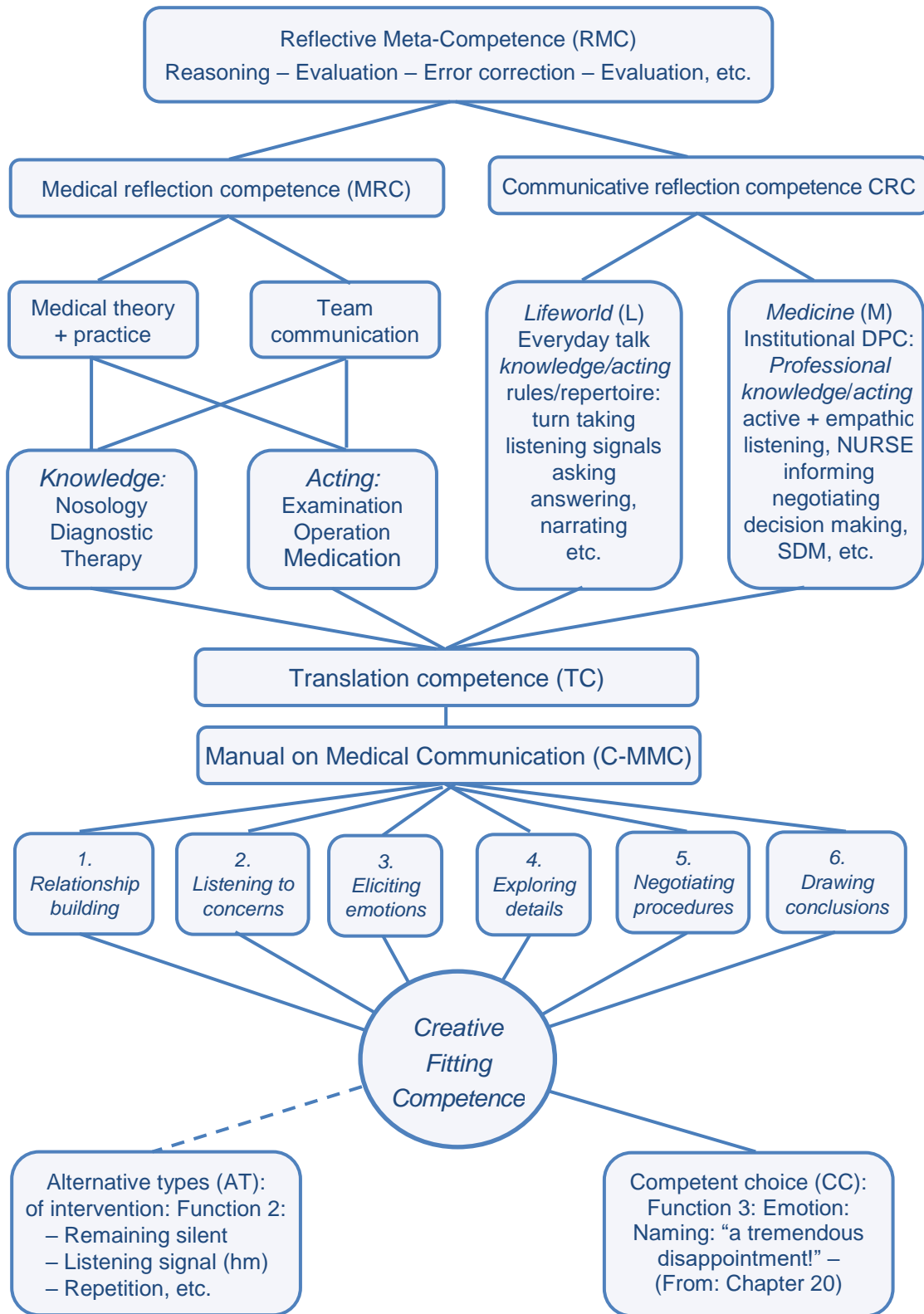


Fig. 2.6: Simplified flow chart (key and sub-competences) for professional competence (see this example in context: Chapter 20, transcript E 20.18)

Below are two examples of learning goal formulations in abbreviated form, which may need to be further differentiated in class if a new learning focus requires it.

---

Box 2.15 Specific learning goal: Narration versus Interrogation

---

Learners

- are *knowledgeable* about the differences (in the rules) between *everyday* communication and *therapeutic* communication (§ 2.2.3, § 9) and
- *can moderately apply* Freud's *association rule* in *medical* communication,
  - by *practicing* a moderately *narrative* interview style instead of a merely interrogative one (§ 19),
  - by *promoting* patients to tell their *stories*,
  - by *actively listening* to them and *encouraging* them to continue talking and
  - by responding to their narratives with *empathetic feedback* and, where appropriate, *interpretations* (§ 20, 25),
  - to initiate a further dialogical *new construction* of the narrative for *therapeutic* purposes (§ 19, 20, 25).

---

Box 2.16 Specific learning goal: Decision making

---

Learners

- are *knowledgeable* about the key differences between *paternalistic*, *libertarian* and *discourse-ethical* decision-making *models* and their variants (§ 10) and
- *can promote patient participation* wherever possible, depending on the situation (§ 10, 22),
  - by establishing a *translation* between medicine and the patients' lifeworld,
  - by exploring patients' *information needs* regarding diagnostic findings and treatment options (§ 10, 22, 25) and
  - by proactively involve their patients in decision-making (§ 10, 22, 25) based on their explored ideas and preferences
  - so that the result is not *confused consent*, but *informed consent* (§ 10, 22).

|           |   |
|-----------|---|
| Table 2.5 | Cologne Communication Curriculum (CCC)<br>(Overview, selected literature) |
|-----------|---|

As the emergence and development of communication curricula is considered in other recent reviews (e.g. Bachmann et al. 2022, Venktaramana et al. 2022), we will limit ourselves here to an overview of the *Cologne Communication Curriculum* (Table 2.5, cf. § 13, 14). Since the mid-1990s, a research focus and a study reform with new teaching and examination formats have been established at the University of Cologne.

The paradigm shift from biomedicine to biopsychosocial medicine described above (§ 2.1 and § 2.3) and the parallel shift from paternalistic and directive medicine to partnership-based and dialogue-oriented medicine has been taking place in Cologne since the mid-1990s, when the curriculum reforms were underpinned by accompanying scientific research (see Table 2.5).

Not only were new learning concepts such as problem-oriented learning in small groups and learning through role-playing and, since 1998, with simulated patients tested, but new content (disease, illness, salutogenesis, etc.) and relationship and communication models (narration, participation, NURSE, BBN, SDM, etc.) were also taught. In addition, new methods of empirical conversation analysis were used (§ 2.4), which enabled the development of new evaluation tools (rating, coding) based on the observation of recorded doctor-patient conversations (§ 2.6. and § 40-43).

The specific communication curriculum was developed in cooperation between the *Dean of Studies* (under the direction of Jürgen Koebke, Stefan Herzig, Christoph Stosch) and the *Department of Psychosomatics*, which took the lead in research, teaching and evaluation in the development of communication competences for students (*training*) and doctors (*continuing education*), initially under the direction of Karl Köhle and from 2005 under the direction of Christian Albus.

The *scientific foundation and accompanying research* of the new curriculum was ensured on an *interdisciplinary* basis through the involvement of staff from various disciplines (medicine, psychology, linguistics, media studies, etc.).

Since the 2000s, reform developments have been driven by increasing interdisciplinary cooperation between various pre-clinical and clinical disciplines. A variety of *interdisciplinary projects* were developed at

the University of Cologne (between psychosomatics, medical sociology, medical psychology, surgery, dermatology, pharmacology, medical ethics, dentistry, etc.). The results of the interdisciplinary projects have been continuously integrated into the *Cologne communication curriculum* (CCC) (§14), which has been structured

- interdisciplinary
- competence-based,
- circular,
- longitudinal

The reforms of the Cologne curriculum have been described in numerous publications (Table 2.5). Stosch et al. (2000, 2001, 2008), Zims et al. (2019) provide an overview of the Cologne Curriculum as a whole. The developments, functions and structures of the *Cologne Communication Curriculum* (CCC) are described in detail in the relevant chapters of the handbook (§ 3, 13, 14, 16, 40, 41, 43), so that we can limit ourselves here to a synoptic presentation, in which we also list references for the *scientific and interdisciplinary foundation* as well as the *accompanying research* of the *communication curriculum* (Table 2.5).

#### 44. Teaching Materials on Medical Communication

| Cologne Communication Curriculum (CCC) |                                |   |   |   |          |
|--|--------------------------------|---|---|---|----------|
|  | Research & Education           | Disciplines & Topics                                | References<br>Selected literature   | Ch.   |          |
| I                                      | Scientific foundation          | Institutional Communication                         | Koerfer 1994/2013, Koerfer et al.1994, 2008, Koerfer, Albus 2015, 2018  | 5<br>7  |          |
|  |                                | Relationship models                                 | Koerfer et al. 1994, 2008, Koerfer, Albus 2015, 2018  | 7<br>10   |          |
|  |                                | Communication theories & BPSM                       | Koerfer 1994/2013, Koerfer et al. 1994, Koerfer, Koerfer 2018, Koerfer, Albus 2018  | 4<br>7  |          |
|  |                                | Narratology<br>Psychotherapy & BPS-Medicine         | Koerfer, Neumann 1982, Koerfer et al. 1994 2000, 2010, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2017, Koerfer, Albus 2018        | 9<br>19<br>20   |          |
|  |                                | Emotion & Empathy                                   | Koerfer, Obliers, Köhle 2004<br>Neumann, Obliers, Albus 2012  | 20<br>25  |          |
|  |                                | Decision making<br>BBN & SDM<br>Palliative medicine | Hauser et al. 2015, Koerfer et al. 2008, Vitinius et al. 2013, Obliers, Köhle 2017, Köhle 2017, Koerfer, Albus 2015, 2018         | 10<br>16<br>22  |          |
|  |                                | Discourse ethics                                    | Koerfer et al. 1994, 2005, 2008, Koerfer, Koerfer 2018, Koerfer, Albus 2015, 2018   | 7<br>10   |          |
| II                                     | Inter-disciplinary cooperation | Surgery   | & Psychosomatics  | Eggers et al. 2007, Bollschweiler et al. 2008   | 39       |
|  |                                | Pharmacology  |   | Hauser, Koerfer, Kuhr, Albus, Herzig, Matthes 2015, Hauser, Koerfer, Niehaus, Albus, Herzig, Matthes 2017 | 10<br>26 |
|  |                                | Dean of Studies                                     |   | Herzig ... Schmeisser, Koerfer 2006   | 6        |
|  |                                | Dentistry   |   | Haak, Rosenbohm, Koerfer et al. 2008  | 40       |
| III                                    | Education & Didactics          | Competence- & Problem-based                         | Köhle et al. 1999, Antepohl, Herzig 1999, Koerfer et al. 1996, 1999, 2008   | 13<br>14  |          |
|  |                                | Manual-based learning                               | Köhle et al. 1997, 1998, Koerfer et al. 1999, 2004, 2005, Albus 2020, 2022  | 17<br>-23   |          |
|  |                                | Role-playing<br>Simulated P                         | Koerfer et al. 1994, 1996, 1999, 2008, Obliers, Koerfer, Albus 2018   | 13<br>40  |          |
|  |                                | Multimedia:<br>Training/ & patient information      | Koerfer et al. 1999, 2008, Eggers et al. 2007, Bollschweiler et al. 2008, Chon et al. 2018, Koerfer, Albus 2018, Zims et al. 2019 | 13<br>39  |          |
| IV                                     | Evaluation                     | Training, PJ<br>OSCEs (SP)<br>Rating                | Koerfer et al. 1994, Neumann, Obliers, Schiessl, Stosch, Albus 2011, Obliers, Koerfer, Albus 2018                                 | 13<br>14<br>41  |          |
|  |                                | Continuing educ:<br>Rating, Coding                  | Köhle et al. 1995, 1996, 2001, Kaerger 1999, Vitinius et al. 2013, David et al. 2025  | 40<br>43  |          |

Table 2.5: Cologne Communication Curriculum (CCC) (Overview, selected literature)

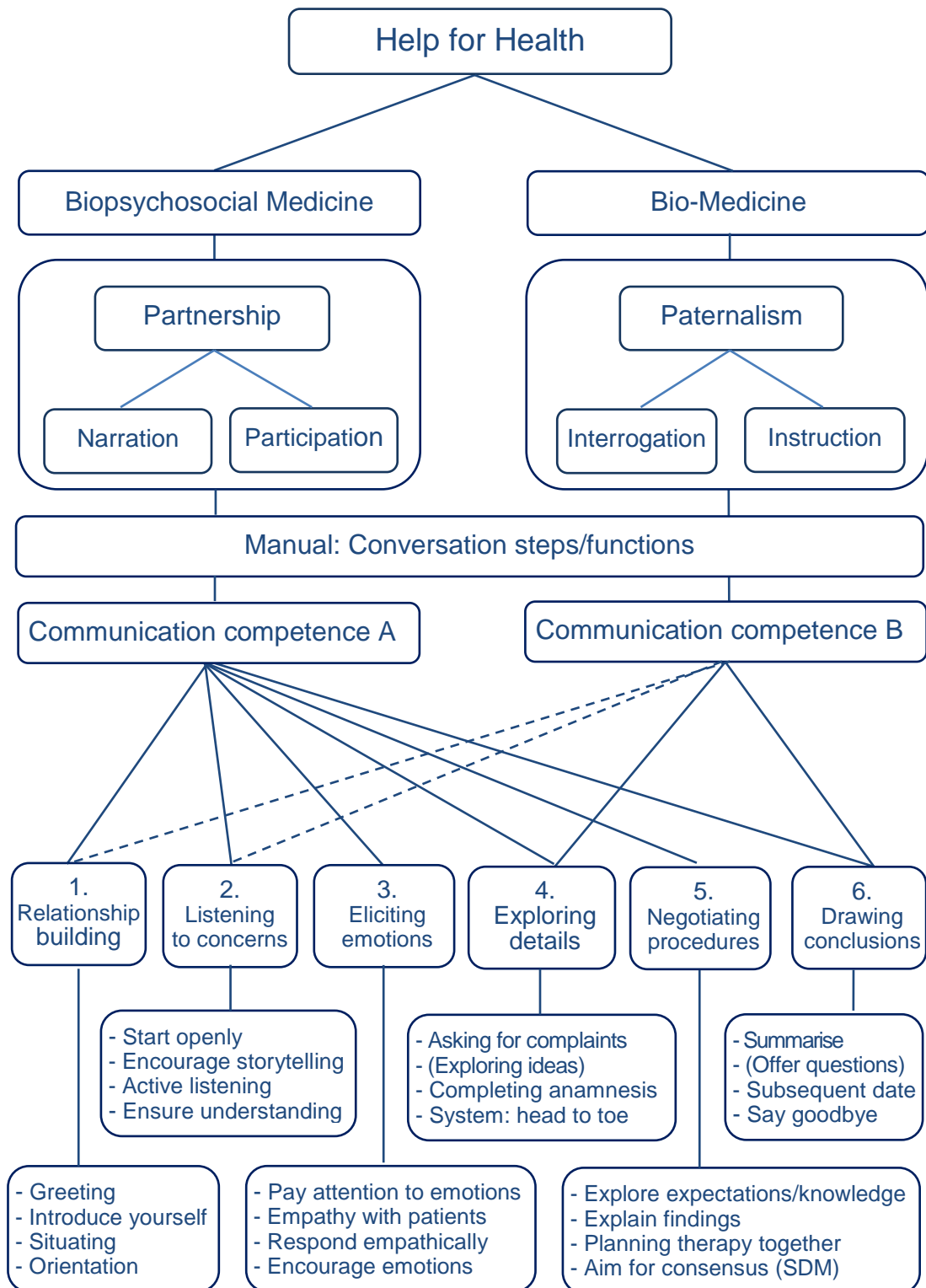


Fig. 2.7: Alternative relationship and communication models in medicine (cf. Cologne Manual of Medical Communication (C-MMC) (cf. Fig. 13.11))

Fig. 2.8 Hexagram of medical communication

If doctors here are willing to respond *flexibly* to spontaneous patient initiatives, this often results in a certain ‘deviant’ (*non-linear*) conversation structure, in which the middle conversation steps or functions (2-5) are realised in *circular*, possibly repetitive and redundant conversation sequences with specific *conversation dynamics* (§ 17-23). The potential and then manifest conversation dynamics can be taken into account using the *hexagram* representation of medical conversation (Fig. 2.8), which eliminates the *linearity* of a manual and allows *circular*, criss-crossing or retrograde connections to be taken into account.

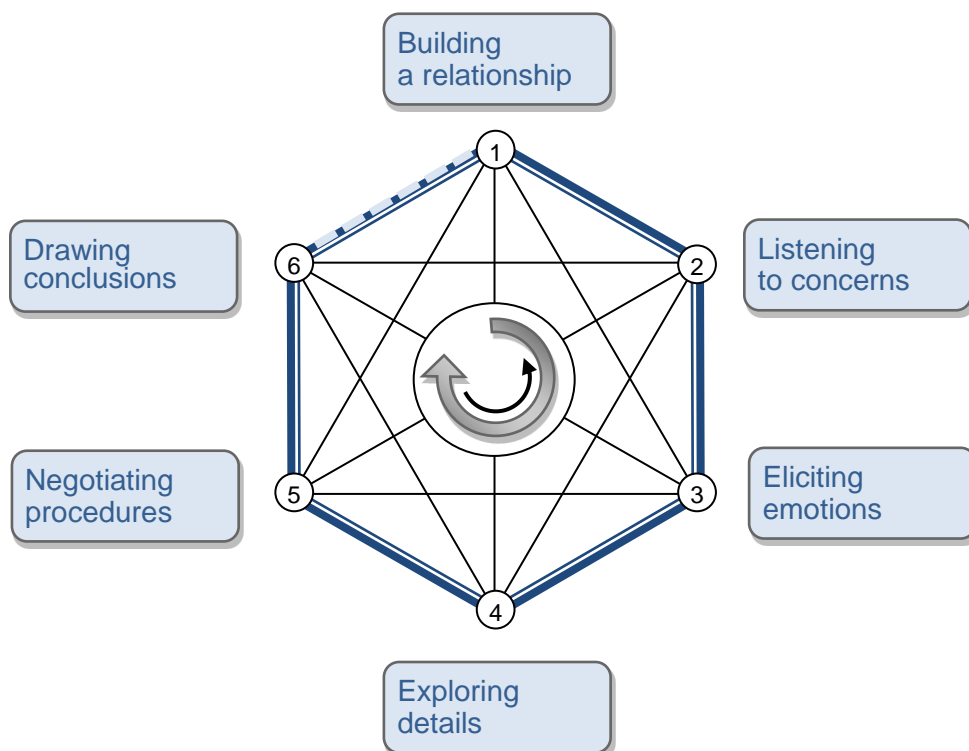


Fig. 2.8: Hexagram of medical communication  
(modified on Koerfer, Albus 2018: 765)

This hexagram representation captures the main structures in the development of a conversation, which are rarely or never realised in the assumed ideal-typical sequence (outer ring 1-6). The dotted line/edge marks the transition from step/function (6) of one conversation to step/function (1) of a subsequent conversation. If this representation initially assumes a ‘uniformity’ in the weighting of steps/functions, this

is also an ideal-typical assumption that may not apply in the initial conversation, ...

While the *alternative* decision paths were previously differentiated in an *ideal-typical process model*, in which a choice must be made between *paternalistic* and *partnership-based* communication (§ 2.5.2), a *hexagram* of medical communication was used to illustrate the potential process structures that can be *flexibly* implemented in individual consultations. At the same time, the *limits* of the *manualisation* of medical communication became clear. Like all manuals, our *Cologne Manual on Medical Communication* (C-MMC) can at best be a *structuring aid* that can give learners initial orientation. In practice, the *balancing act* between *structuring* and *flexibility* remains, which Silverman described as a paradox (Box 2.22).

Box 2.22 Paradoxically, structure sets us free

Without some form of structural model, it is all too easy for consultations to be unsystematic or unproductive and for experimental communication teaching to appear random and opportunistic. Paradoxically, structure sets us free – it provides us with an awareness of the distinct phases of the interview as we consult and the flexibility to move away from a fixed path when appropriate, with the security of understanding how to return to our structure in due course.

Silverman 2018: 8

This *balancing act* between structure and flexibility can only be taught using *practical* cases in which doctors make more or less competent decisions that need to be evaluated through critical reflection. Here, too, a distinction must be made between *strong* and *weak* conversation developments, because, for example, a doctor may have started the conversation well by opening up sufficient space for the patient to tell their story, but then ‘took a wrong turn’ because they interrupted the patient's narrative flow too early with their detailed questions (about the course, duration and previous treatment of the illness). In contrast, there are *ideal-typical* cases in which the *narrative* medicine approach was consistently pursued from start to finish in initial consultations, but also in follow-up consultations without restrictions.

See variants of the hexagram in § 13.

**3 Learning Goal Communication Competence**

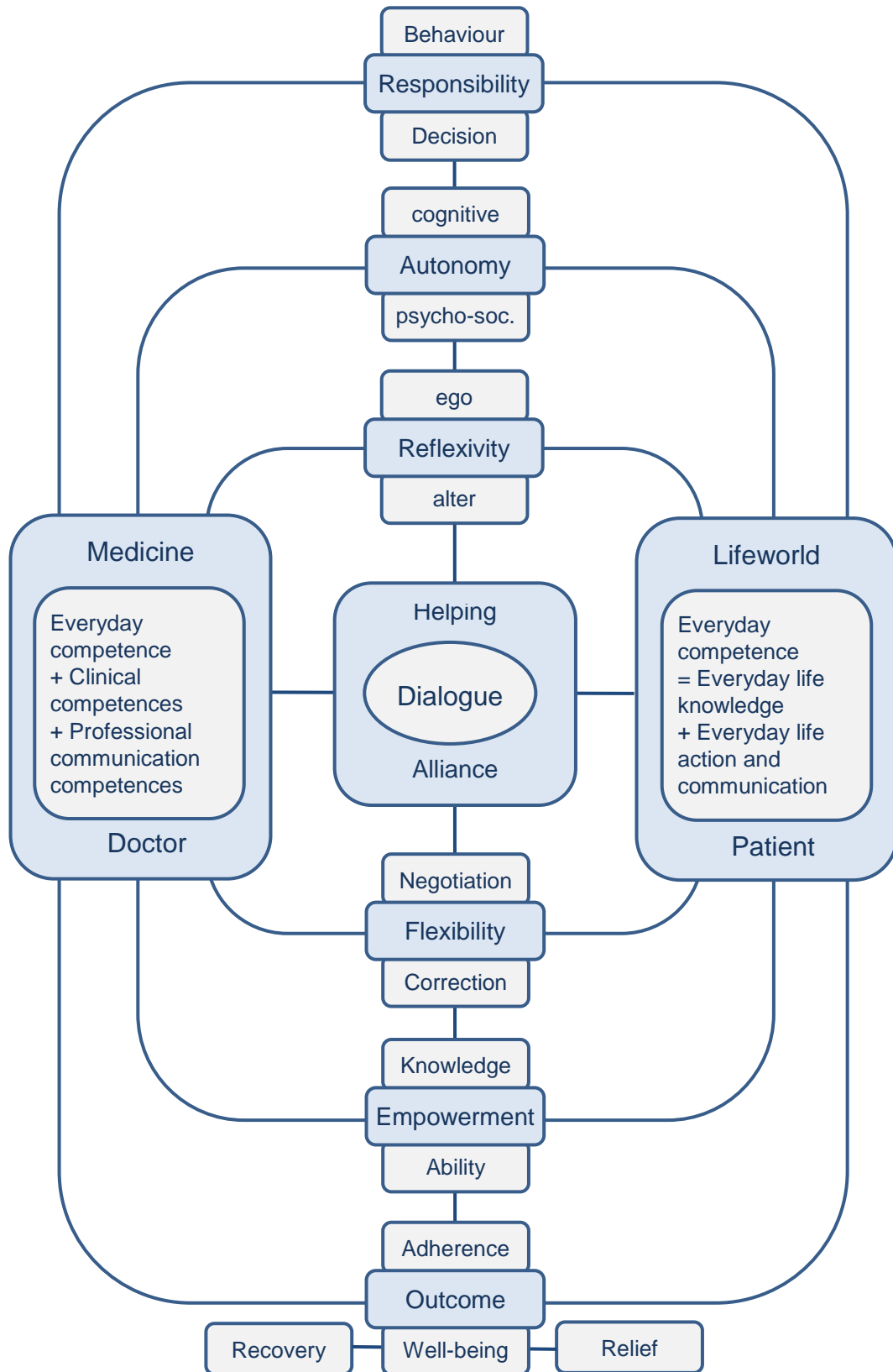


Fig. 3.1: Interdependence model of professional and everyday communication skills

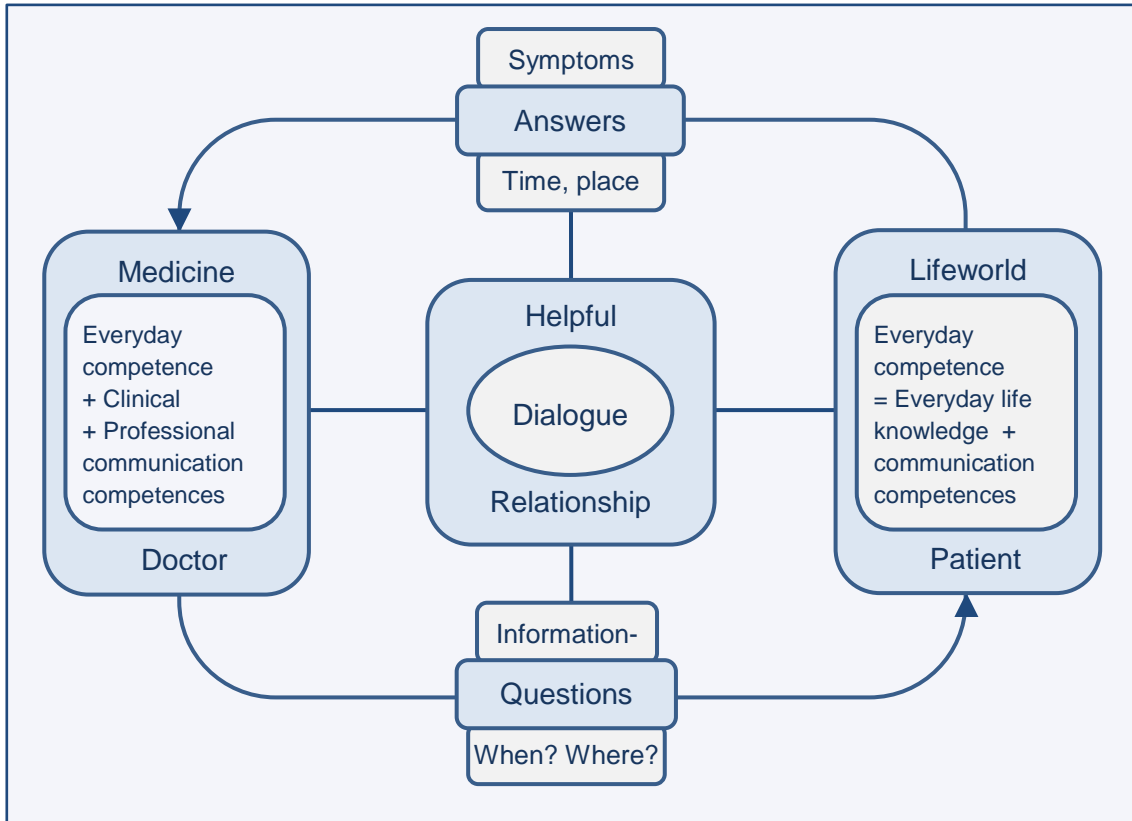


Fig. 3.2: Interrogative communication pattern

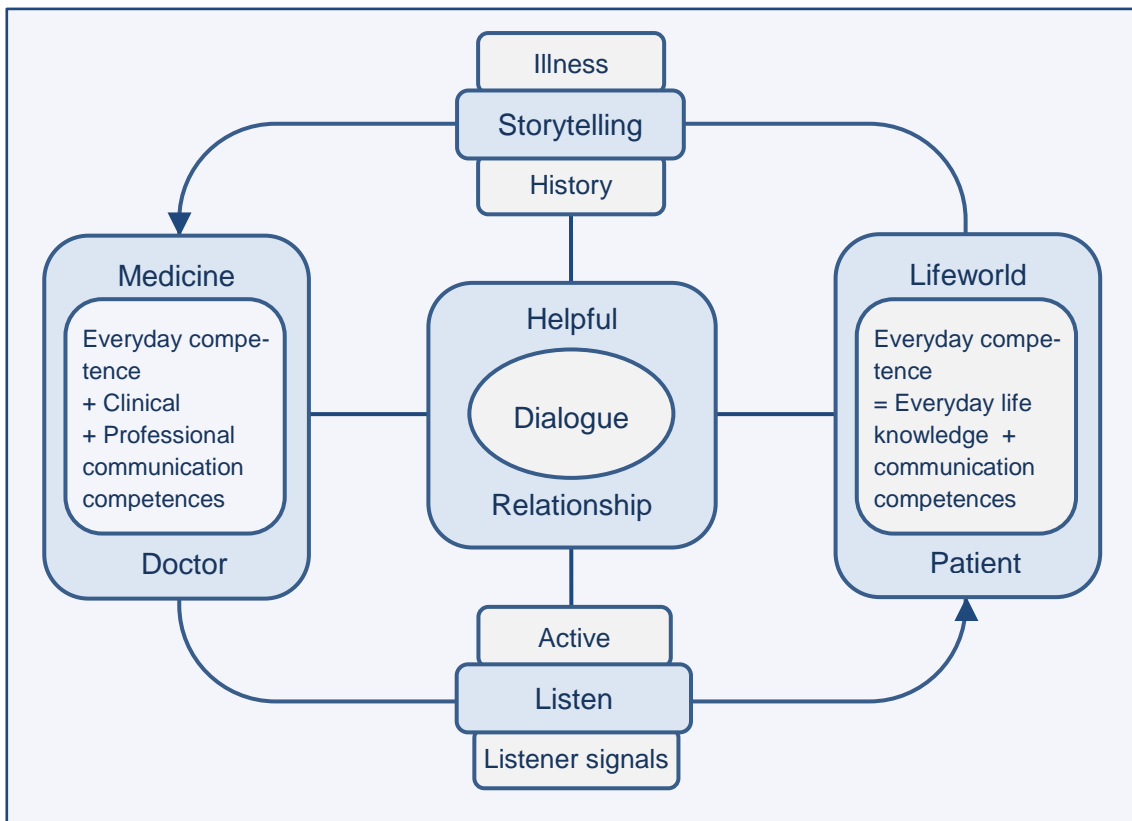


Fig. 3.3: Narrative communication pattern

44. Teaching Materials on Medical Communication

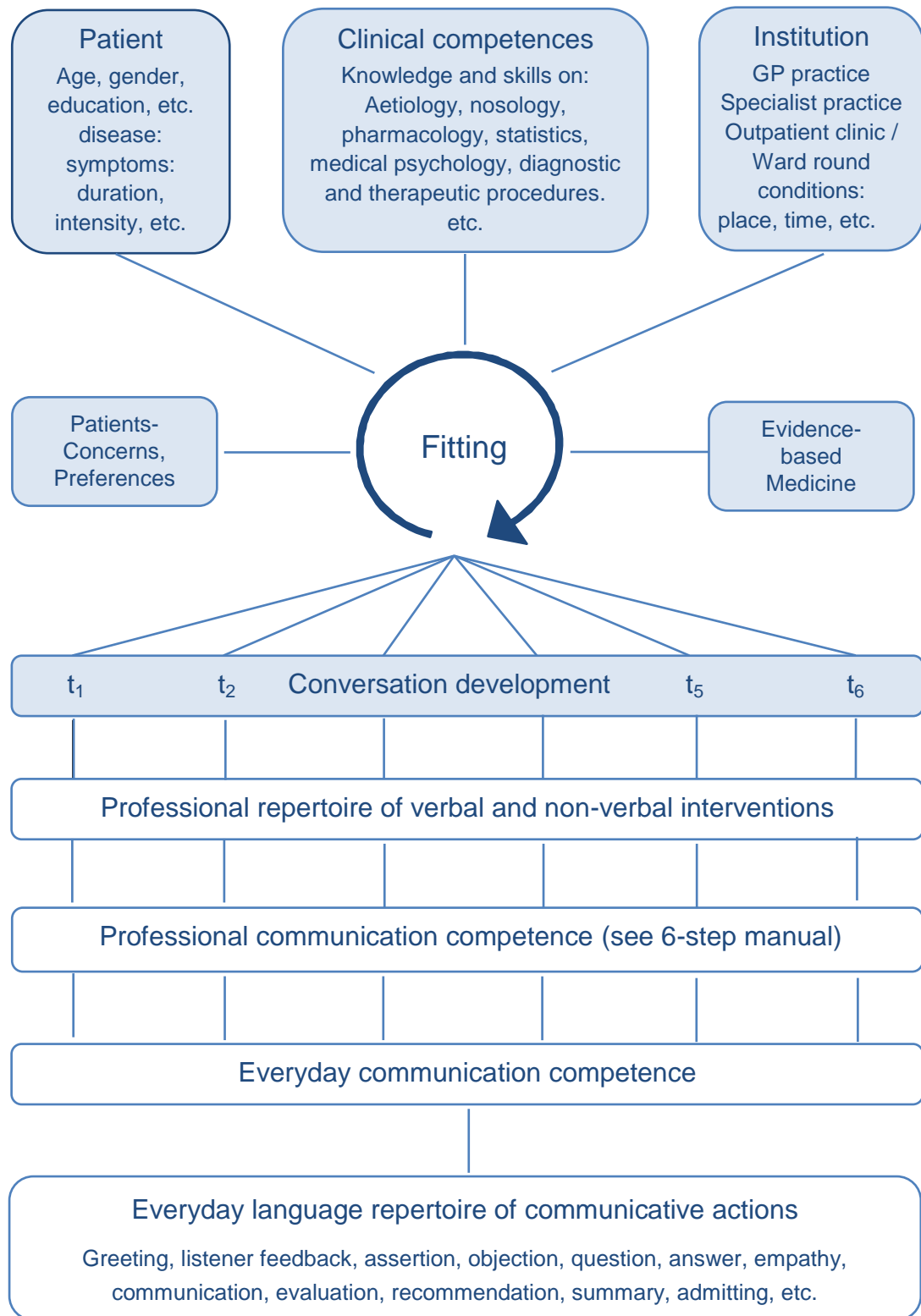


Fig. 3.6: Fitting model of key medical competencies

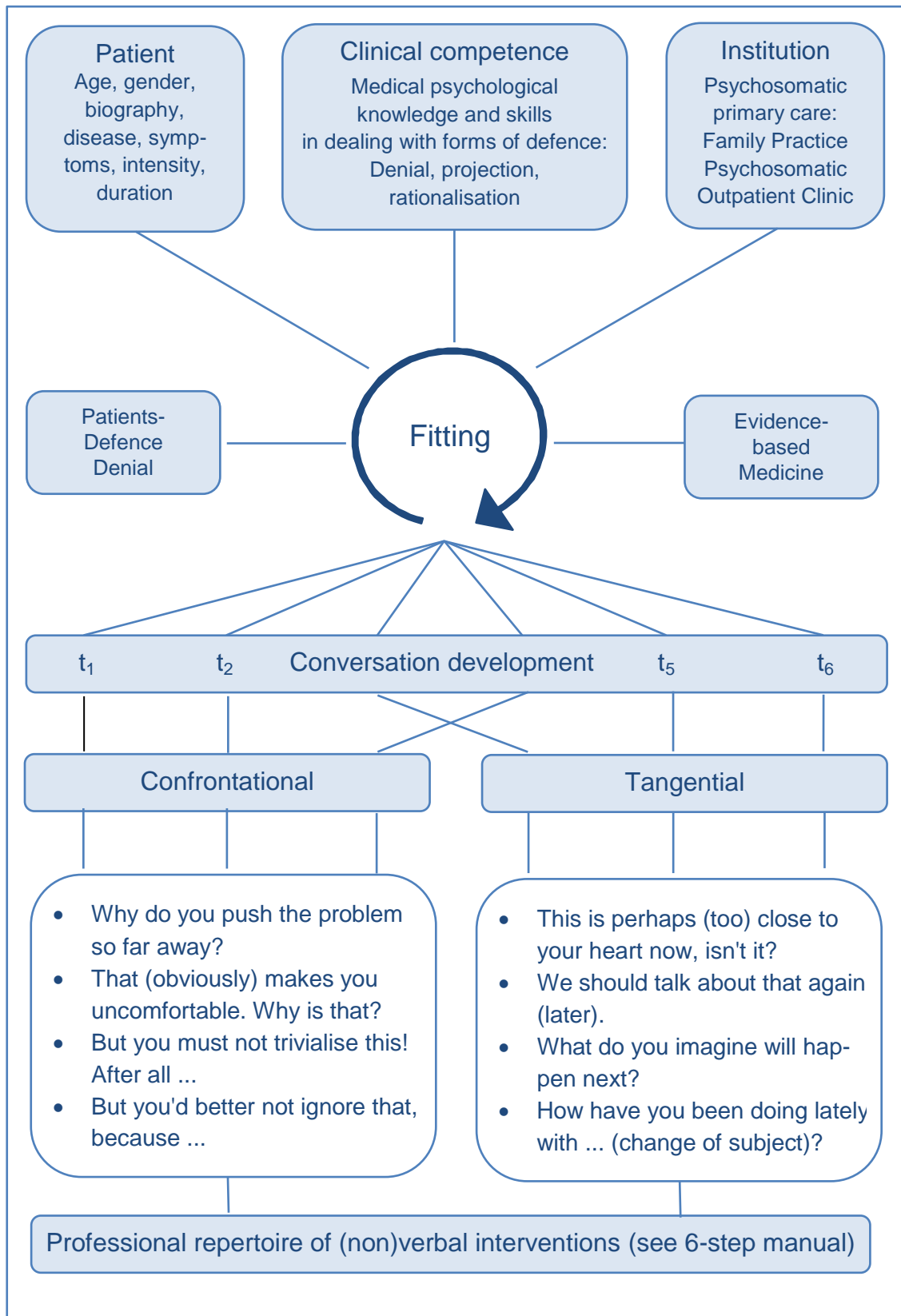


Fig. 3.8: Confrontational vs. tangential interviewing for defensive behaviour

Box 3.12 Medical competences in risk communication

A prototype for the communication service to be provided by the doctor here is *risk communication* (Box 3.12), because here a particularly large number of doctor competences must be applied in a bundled manner in order to achieve, for example, an appropriate risk understanding among patients for their diseases and treatment options.

Box 3.12 Medical competences in risk communication

Risk communication brings together a particularly large number of clinical-statistical-communicative competences (Elwyn et al. 2005, Steckelberg et al. 2005, Gigerenzer 2013, Wegwarth 2013), which doctors must communicate skillfully when talking to patients:

- Specific *clinical* knowledge competences on a particular disease pattern and the associated risks in treated and untreated disease courses.
- Specific *clinical* knowledge skills on treatment options and their risks
- specific *risk competences* (statistical competences) in dealing with *relative* and *absolute* risks (for diseases, (preventive) examinations and treatment methods, etc.)
- Specific *comprehension competences* to anticipate and control possible (mis)understandings of facts and figures.
- Specific *formulation competences* to illustrate relative and absolute risks in a patient-friendly way using a mix of figures, charts, tables, fact boxes, etc.
- specific *empathic* competences, for example when certain (life-) threatening risks as well as "number confusion" lead to emotional-cognitive blockades in the patient, etc.

*Well-dosed* information in the language of the patient is an elementary prerequisite for the promotion of patient autonomy, which in turn is an integral part of a self-determined decision. However, this decision should not be made "unqualified" just because the medical information was incomplete or the patient "broke off" because it became "too much" in the meantime ...

Box 3.13 Fitting of key medical competences

In summary, the *competent* doctor must have a number of *key competences at his or her disposal* which, in the ideal case of application (performance), he or she adapts to changing conversational conditions in a combined, context-sensitive and creative way (Box 3.13). In order to perform this adaptation, the competent doctor must develop a fitting competence as a self-reflective meta-competence that allows him or her to continuously monitor the conversation in the mode of critical self-observation and make any necessary corrections.

Box 3.13 Fitting of key medical competences

Overall, doctors must have a range of key competences and be able to adapt these to changing (social, cultural, individual, disease-specific, etc.) conversational conditions in practice in a *combined, context-sensitive* and *creative* way with their self-reflexive *fitting competence*:

- Medical fitting competence  
as a self-reflexive meta-competence
- Clinical competences for
  - Aetiology
  - Nosology
  - Pathogenesis
  - Statistics
  - Diagnostics
  - Therapy
  - etc. for internal, psychosomatic, orthopaedic, gynaecological, etc. diseases
- General communication competences for
  - Relationship building
  - Anamnesis
  - Provision of information (education)
  - Decision-making
- Specific communication competences
  - Listening competence
  - Comprehension competence
  - Questioning competence
  - Formulation competence
  - Empathic competence
  - Intercultural competence
  - etc.

Fig. 3.9 Cologne Manual of Medical Communication (C-MMC)

In the ideal case of a doctor guiding a conversation, six conversation steps can be distinguished in a certain sequence structure, in each of which certain communicative functions are to be perceived, which are further differentiated at the level of observable conversation behaviour, for example, to *active listening* (Fig. 3.10), which can be realised as *verbatim repetition* or as *paraphrasing*.

| <b>F U N C T I O N S</b>  |                            | <sup>6</sup> 2022           |
|---|----------------------------|-----------------------------|
| <b>Cologne Manual &amp; Evaluation of Medical Communication</b> | 1 Building a relationship  | <input type="checkbox"/> 04 |
|   | 2 Listening to concerns    | <input type="checkbox"/> 10 |
|   | 3 Eliciting emotions       | <input type="checkbox"/> 08 |
|   | 4 Exploring details        | <input type="checkbox"/> 12 |
|   | 5 Negotiating procedures   | <input type="checkbox"/> 12 |
|   | 6 Drawing conclusions      | <input type="checkbox"/> 04 |
| <sup>1</sup> 1998   | <b>E V A L U A T I O N</b> | <input type="checkbox"/> 50 |

Fig. 3.9: Cologne Manual of Medical Communication (C-MMC) and Cologne Evaluation of Medical Communication (C-EMC)

In this way, a taxonomy of learning objectives emerges in which macro-, meso- and micro-learning objectives of conversational guidance can be



## 4 Biopsychosocial Medicine

### Box 4.1 Divisible body and indivisible mind – Descartes

It encompasses such diverse theoretical and empirical sciences as philosophy, theology, sociology, psychology, biology, medicine, etc., which, despite all attempts to distance themselves, cannot escape the theme of a dualism of whatever kind (v. Uexküll, Wesiack 1991, 1997, Uexküll 1995, Fuchs 2000, Langenbach, Koerfer 2006, Beckermann 2011, Tress 2011, Herrmann-Lingen 2012, Langewitz 2022). Overall, a number of pairs of opposites are often linked to the mind-body problem, of which the essential difference between body and spirit in the relationship between part and whole is already discussed in Descartes as a prominent example (Box 4.1).

### Box 4.1 Divisible body and indivisible mind

Now, first of all, I notice here that there is a great difference between spirit and body insofar as the body, according to its nature, is always divisible, whereas the spirit is absolutely indivisible. For indeed, when I consider this, i.e. myself, inasmuch as I am only a thinking being, I cannot distinguish any parts in myself, but recognise myself as a thoroughly uniform and whole thing. And although the whole spirit seems to be connected with the body, yet I recognise that if one cuts off the foot or the arm or any other part of the body, nothing is therefore taken away from the spirit. Nor may one call the faculties of willing, feeling, cognition, etc., its parts, for it is one and the same spirit that wills, feels, and cognizes. On the contrary, I cannot think of any corporeal, i.e. extended thing, which I could not easily divide into parts in thought and thereby recognise as divisible, and this alone would be sufficient to teach me that the spirit is entirely different from the body, if I did not already know it sufficiently from elsewhere.

Rene Descartes 1641/1960: 76f

Not only since Descartes, the following pairs of opposites have played a role in the discussion of the mind-body problem with a long tradition, which have become significant for different sciences to varying degrees:

- Mind - Body
- Part - Whole
- Outside - Inside
- Cause - Effect
- Freedom - Bondage
- Finitude - Infinity
- Mortality - Immortality etc.

Fig. 4.1 Three Worlds Theory by Popper

There and in a later work with the programmatic title "How the Self Controls Its Brain" (1994), in which the central control function of the self vis-à-vis the brain is elaborated, Eccles explicitly draws on Popper's *three-world theory*, which he has presented several times in clear diagrams (Fig. 4.1).

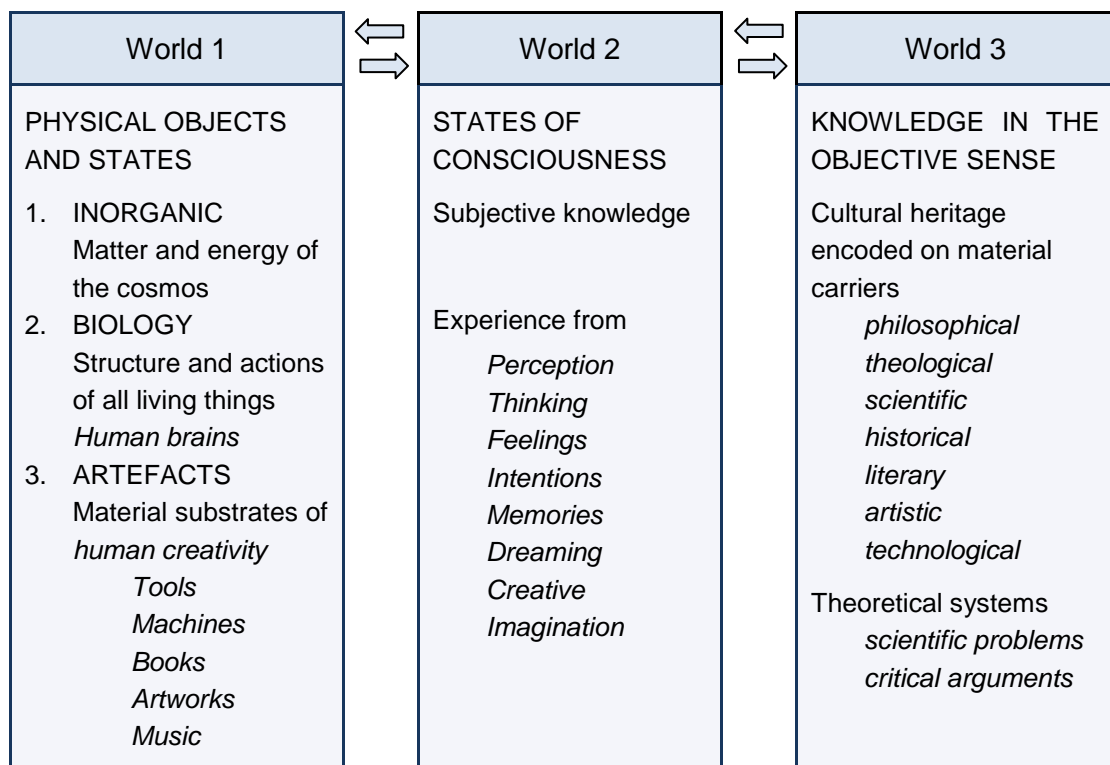


Fig. 4.1: Three Worlds Theory by Popper  
(Illustration according to Popper, Eccles 1989: 433, Eccles 1994: 17).

In their joint work, but also separately, both authors have dealt with numerous alternatives and variants to their dualistic interactionism as well as with the criticism of their associated epistemological position ("objectivism", "scientism"), to which we can only refer here. In this context, we are particularly interested in the aspect of interaction, which even biopsychosocial medicine (§ 4.2) will not be able to avoid.

Fig. 4.2 Dual and integrative medicine (overview)

For easier understanding, we have therefore compiled the differences between *somatic* and *psychological* medicine in a contrasting representation, which can also be used as a blackboard illustration in teaching (Fig. 4.2). Our tabular presentation follows easily understandable texts (v. Uexküll 1991, 2001, 2002), which in our experience have also proven their worth in teaching under the aspect of didactic reduction.


What is initially still listed separately in this representation (Fig. 4.2) under the metaphor of care by "hand" or "word" is now to be brought together in an *integrated* medicine that considers all bio-psycho-social aspects relevant to the disease and healing in both diagnostics and therapy.

First of all, to avoid possible misunderstandings: The *paradigm shift* from biotechnical to *biopsychosocial* medicine called for by George Engel (1981, 1979, 1996) as well as Thure v. Uexküll (1995), Thure v. Uexküll and Wolfgang Wesiack (1991, 2011) does not mean neglecting or even ignoring the modern biomedical achievements and the resulting diagnostic and therapeutic possibilities, but rather achieving integration at all levels of knowledge and treatment.

The medically indicated treatment with the "hand" (bypass surgery, medication) is carried out just as unrestrictedly as the treatment with "words" is continued with an "organ-healthy" patient who, after thorough examination and diagnosis "without organ findings", regularly complains of "heart pain" in the consultation hour. The patient with "high blood pressure" is treated "with medication", while at the same time his personal possibilities for changing his "risky" lifestyle are "discussed" together with the doctor in the consultation.

The patient with diabetes mellitus (type 1) who is already "well controlled" can nevertheless make a change of treatment forms ("injections" versus "pump") the subject of conversation, in which doctor and patient jointly "discuss" the advantages and disadvantages of the two treatment alternatives in view of the patient's personal motives ("injection phobia" as a "mental problem") and his life circumstances (profession), to which we will return in detail with a concrete consultation analysis (§ 22.5).

|                            | <b>Dual medicine</b>   |   |
|----------------------------|--|---|
|                            | Somatic medicine   | Psychological medicine  |
| Terms/Metaphors            | "Hand"<br>Mechanical action                                      | "Word"<br>Psychological intervention  |
| Disease theory             | Spatially localisable<br>disturbance in technical<br>structures  | Result of an individual<br>socialisation failure  |
| Subject                    | Open system:<br>"trivial machine"                                | Closed system:<br>"non-trivial machine".  |
| Example                    | Valve defect in the heart<br>Enzyme defect<br>in the liver       | Obsessive-compulsive<br>avoidance reaction  |
| Discipline                 | Surgery,<br>cardiology, etc.                                     | Psychoanalysis,<br>behavioural therapy, etc.  |
| Treatment/<br>Intervention | Manual interventions:<br>direct: surgical<br>indirect: medicinal | Have a conversation:<br>Coping through biograph-<br>ical (self-)education, be-<br>havioural suggestions |
| Destination                | "Repair"   | "Problem solving"   |
| Reduction/consequence      | Medicine for:<br>"Bodies without souls"                          | Medicine for:<br>"Souls without bodies"   |



|   |
|---|
| <p><b>Integrated medicine</b><br/>Biopsychosocial model</p> |
|---|

Fig. 4.2: Dual and integrative medicine (overview of tables compiled by us according to texts by v. Uexküll 1991, 2001, 2002, v. Uexküll, Wesiack 1991, 2011).

Fig. 4.3 Hierarchical system representation of the biopsychosocial model

To overcome the dualism between a somatic "medicine for the body" and a psychological "medicine for the soul" with all the associated dichotomies (Fig. 4.2.), a biopsychosocial medicine has to achieve an integration of different hierarchical levels in theory and practice, even if this may be more or less successful according to the state of the art in each.

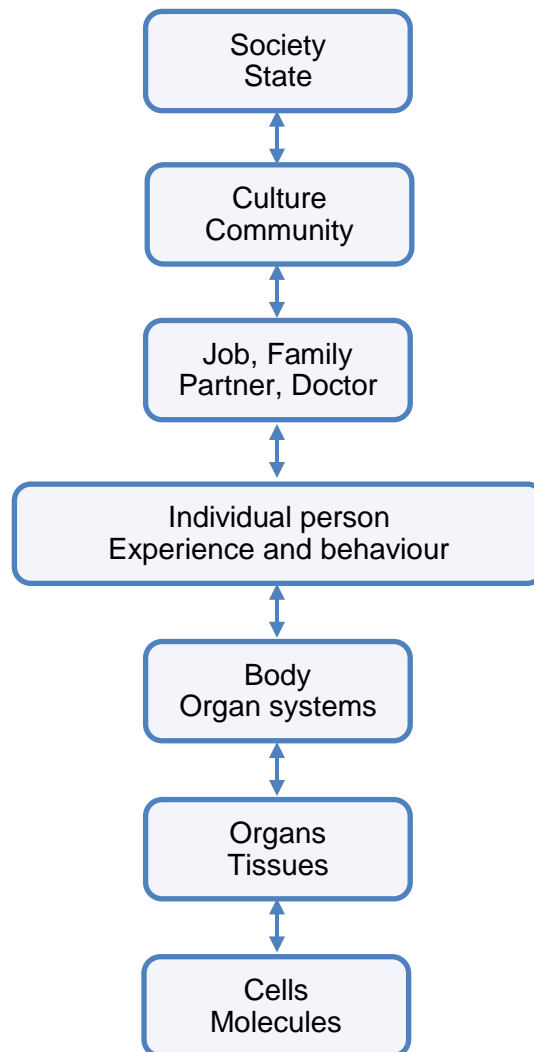


Fig. 4.3: Hierarchical system representation of the biopsychosocial model (simplified after Engel 1981, v. Uexküll, Wesiack 1991, Smith et al. 2013, Egle et al. 2020, Lugg 2022)

Here, the caveat already outlined with Popper above (§ 4.1.2), that research into the "how" of an interrelation between body and mind is still in its infancy, also applies to medicine as a single discipline, which is not by chance beginning to open up to interdisciplinary cooperation with other disciplines (biology, bio-psychology, neuroscience, etc.).

Box 4.6 "An exemplary case of illness"

The following case study has repeatedly been used by v. Uexküll and Wesiack as the starting point for their justification of biopsychosocial medicine, as "an everyday medical history" in their "Theory of Human Medicine" (1991) as well as in various variants of their science-theory oriented introductory chapter to the handbook of "Psychosomatic Medicine" (cf. v. Uexküll, Wesiack 2011) (v. Uexküll, Wesiack 1991). At the same time, the case report serves as an introduction to a learning unit on bio-psycho-social medicine, as it was developed and differentiated in several steps in the lessons given in our clinic.

Box 4.6 "An exemplary case of illness"

(Part 1) A woman of about 50 enters the consulting room for the first time and reports that she has had attacks of acute shortness of breath twice a night over the last three weeks. She had lost her breath and thought she was going to die. When the doctor asked her to describe the circumstances under which the attacks of breathlessness had occurred, she reported with a deep sigh that she was married to a foreigner in a bad marriage; he neglected her and often stayed out all night. The attacks of respiratory distress, which she perceived as so threatening, had begun when her eldest son (18 years old) had declared that he wanted to separate from the family and move away. After saying all this in a rather reproachful tone, she bursts into tears.

During the patient's report, the doctor's mood changes. On entering, he perceived a small, obese - as it turned out later, she weighed 108 kg at 161 cm tall - and short-tempered woman with somewhat cyanotic lips, who initially made a "scruffy" and unsympathetic impression on him, although, as he later noticed, she was by no means unkempt. This dismissive mood of the doctor, evoked by the first impression, changed into benevolent interest and helpfulness during the patient's report.

Further examination of the patient revealed signs of heart failure due to obesity and mild hypertension with left (ventricular) hypertrophy of the heart and a slight increase in blood lipids.

(Part 2) Later she reports that she had already felt unloved and rejected at home, had already been teased by her classmates at school because of her incipient obesity, and had already become pregnant at the age of 18 and fled into marriage, where she again experienced no love and warmth but only rejection.

v. Uexküll, Wesiack 1991: 13 (= part 2) and 2011: 4 (=part 1)  
(cf. v. Uexküll, Wesiack 1997 (in: Adler et al. (eds.) (English edition): 12)

Fig. 4.4 Schematic representation ("blackboard")

We can only briefly discuss this case here, which v. Uexküll and Wesiack discuss again and again in their introductory chapter on the theory of science (2011) as well as in their book on the "Theory of Human Medicine" (1991) (spread over more than 600 pages) to explain their theory of biopsychosocial medicine under diverse (semiotic, system-theoretical, constructivist, developmental psychological, psychoanalytical, etc.) aspects. Here we attempt a didactic reduction for teaching purposes, which is to be reversed if necessary - in case of doubt by recourse to the original sources mentioned.

We initially present the case the way it has often been discussed in a course unit in this or a similar way in the practice of teaching at our clinic. Ideally, the knowledge of the critique of dual medicine and the justification of the paradigm shift to biopsychosocial medicine - as explained above (§ 4.2) - can already be assumed. The case discussion can then be placed at the centre of the following *learning unit*, whereby the teaching-learning process can take approximately the following course with the following didactic-methodological steps.<sup>1</sup>

....

The "blackboard" or "slide image" (Fig. 4.4), which can thus be used deductively (if time is short) as well as developed inductively in class with the students during text work, is intended to help promote text comprehension and subsequently serve above all to elaborate the circular *upward and downward movements* in the biopsychosocial model.

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<sup>1</sup> In the following, we present a *learning unit* on *biopsychosocial* medicine based on this exemplary case, which has been repeatedly tested in our clinic in this or a similar way, whereby the realisation of the individual didactic-methodical steps is also a question of the time unit, which is why this learning unit offers corresponding possibilities for shortening or extending.



## Box 4.7 Upward and downward effects in the hierarchical system

At the organism level, hormones and nerve action currents mediate the exchange of information between organs; and at the next more complex level, psychological processes mediate the connection between organism and environment. The problem of how to conceive of the connections between these different levels can be formulated in systems theory terms as the question of how *upward and downward effects* come about in a hierarchical system (Popper 1977). It can be solved with the assumption that the sign systems of the different levels are connected through translations or transmutations.

Within the framework of such an approach, the so-called psychophysical problem is only one among others. For the problem posed by the patient's story described at the beginning, these backgrounds offer the practitioner clarification and orientation in his everyday work: The somatic sign systems of an endocrine and nervous nature, which regulate the patient's cardiac, circulatory and pulmonary functions, are coupled with psychic sign systems, which inform the patient about the - for her vital - aspects of her environment. Husband and son are meaning carriers, i.e. they convey messages that decide what aspect the environment has for the patient and what somatic provision of the organs is required in each case. Couplings of meaning, in which reference persons acquire such importance, have usually been established in early childhood.

v. Uexküll, Wesiack 2011: 34f

(cf. v. Uexküll, Wesiack 1997 (in: Adler et al. (eds.) (English edition): 28f)

With the couplings of meaning described in this way (Box 4.7, Fig.4.4), both the current conflicts and the patient's previous coping patterns can be identified, which are currently threatening to fail. If the patient sought to compensate for previous conflict situations of rejection and mortification by eating as a substitute, which is self-damaging enough in itself, this type of coping attempt fails in the face of the imminent separation from her son.

While the "moving out" of an adult child – despite all the problems of detachment on both sides – should usually be able to be integrated into everyday family life as an expected "normal case" without major problems, in this case the detachment process turns into an individual catastrophe in view of the patient's previous history, in which she develops attacks of breathlessness with fear of death: ...

## 5 Structural and Functional Change in Medicine

Box 5.11 Ambiguity of well-being

Kagan 2012: 78f

In his current critique of definitions of illness and health as well as research methods in medicine and psychology, Kagan (2012) laments the lack of context-sensitive studies on concepts such as *well-being* or *happiness*, whose ambiguities can only be investigated and understood in a culture-, history-, language-, class-, gender- and age-specific manner. Inasmuch as, according to Kagan (2012) (Box 5.11), one cannot in principle escape the *ambiguity* of supposedly similar self-disclosures by individuals, one must not rely on the first best verbalisations of interviewed persons but must systematically question them in the respective context and classify them appropriately in the respectively valid semantic network of the interviewees.

Box 5.11 Ambiguity of well-being

The meaning of life satisfaction, or well-being, does not escape this ambiguity. Most adults who have sufficient food and shelter and are free of serious chronic illness rely on a judgment of the ethical quality of their lives when they answer the few questions that define well-being: "How satisfied are you with your life?" "Have you gotten most of things that you wanted in life?" and "All things considered, how satisfied are you with your life these days?" The judgments of individuals from diverse societies would change only a little if the question were "All things considered, have you lived the life of a good person?" However, because the semantic networks for good vary across historical eras and cultural settings, the meaning of a low, moderate, or high level of well-being must also vary. Put simply, individuals who report the same level of well-being could have behaved in different ways, achieved different goals, held different values, and experienced different feelings over their lifetimes.

Kagan 2012: 78f

The methodical-systematic research of such concepts as well-being and happiness is one thing, the communication with individual patients about their treatment goals that are significant in their lifeworld is another. The problem of the ambiguity of what the patient formulates as his or her final interest in the medical treatment (§ 8.4) must be faced by the doctor in communication with his or her individual patient.

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 Box 5.17 Guidelines: "The gap between evidence and practice"
 

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Due to the complexity of the situation, guidelines can soon reach their limits, especially in the case of patients with multiple illnesses, for whom the individual competence of the doctor is still required to make use of guidelines as decision-making aids, which leave sufficient scope for decision-making in each case. However, the scope for decision-making and action is not only *granted*, but at the same time *imposed* on the individual doctors. Their competence will be challenged especially in complex treatment situations, in which they can only refer to a certain "guideline-compliant" recommendation to a limited extent. Smith (2013) (Box 5.17) describes what he calls the "gap between evidence and practice", which can certainly be generalised beyond the UK, with a drastic example that will be reproduced here in detail because of its illustrativeness.

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 Box 5.17 "The gap between evidence and practice"
 

---

Evidence-based guidelines also proliferated explosively. However, it is unclear whether and how much this information processing has ultimately advanced evidence-based action. Doctors also seem to make little use of these service programmes when treating patients. One reason may be that it is difficult to apply evidence to individual patients because the questions that come up in practice are usually not "What is the best treatment for a patient with atrial fibrillation?" but rather "What is the best course of action for a 75-year-old woman who has atrial fibrillation, chronic obstructive pulmonary disease, mild dementia, drinks large amounts of alcohol, smokes, lives alone and only sees the doctor when her son pressures her accordingly?" In reality, the questions in daily practice are much more often like the latter and not the former (...). Consequently, it is no wonder that evidence-based interventions are difficult to apply.

Smith 2013: 287

(...) In such complex cases, the doctor's *fitting competence* is particularly challenged, which also consists in the selective use of relevant guidelines that are to be applied flexibly.

## 6 Key Medical Competences

Fig. 6.1 Categories 1-9 (Analysis of interviews)

The analysis and interpretation based on the frequency of occurrence of the categories suggest a dominance structure, the tendencies of which would have to be examined in further, comparative studies (Herzig et al. 2006). First of all, according to the quantitative evaluations, the 4 categories of *professional competence*, *action competence*, *empathy* and *patient orientation* prove to be essential, accounting for about 2/3 of the entire spectrum, with *professional competence* and *empathy* dominating in each case (> 20%) (Fig. 6.1). The categories "cooperativeness", "willingness to learn", "reflexivity", "authenticity" and "role of the doctor as helper" are added to the image of the doctor with considerably lower frequencies.

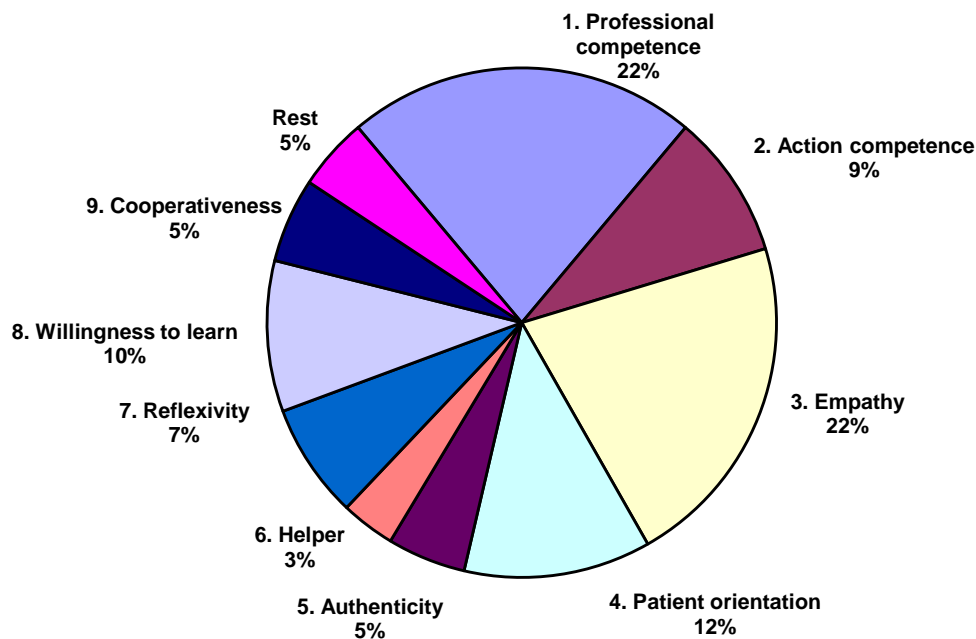


Fig. 6.1: Categories 1-9 (mod. on Herzig et al. 2006, Herzig, Koerfer 2018)

These first results of our study must be placed under a methodological reservation insofar as a specific bias is to be expected here: After all, we are dealing with professional judgements of professors of medicinal disciplines who, moreover, were to answer the question: "When is a doctor a good doctor?" for a scientific journal (*Deutsche Medizinische Woch-*

#### 44. Teaching Materials on Medical Communication

*enschrift*). Here, therefore, a rather *academic* image of a doctor could be expected from the outset, which, although drawn by a very relevant professional group (professors) who, because of their dual research and teaching function, perform a high multiplier function (*role model*) for prospective and practising doctors, cannot represent the entire spectrum of what is supposed to be considered a "good doctor" in the medical professions as a whole. ...

In order to broaden the spectrum of the medical profession, we asked the same question ("When is a doctor a good doctor?") to practising physicians (general practitioners, or GPs, n=51) in the direction of a comparative study (Herzig, Koerfer 2005), with partly congruent, partly divergent results (Fig. 6.2).

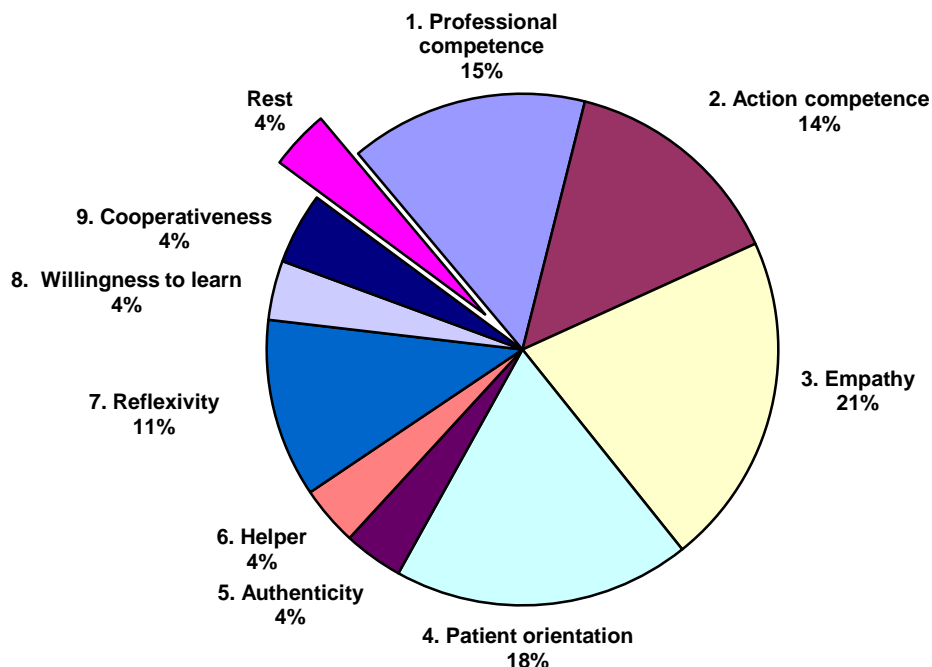


Fig. 6.2: Categories 1-9 (GPs) (mod. on Herzig, Koerfer 2005, Herzig, Koerfer 2018)

These differences can be interpreted as different weightings in the "theory-practice" relationship, in which the GPs would like to see *action competence* and *patient orientation* strengthened on the one hand, and emphasise *reflexivity* more on the other. In order to systematically pursue such (preliminary) tendencies further, above all the data basis would have to be expanded and differentiated, also to enable *comparative* studies between different groups. Here, possible differences between general practitioners and specialists as well as specialists (internists, surgeons, etc.) among themselves (e.g. Simon (ed.) 2005), doctors and

other health care professions as well as doctors and medical students and finally, in general, between professional representatives and laypersons (patients) would have to be determined in order to obtain a differentiated overall picture of the "good doctor".

Fig. 6.3 Profession model (Harden et al. 1999a,b, Simpson et al. 2002)

In analogy and modification to this Scottish profession model (Fig. 6.3), the nine categories found in our study can be divided into three centripetally structured areas, which are then occupied in total (per circle) with approximately equal frequencies of mention (Fig. 6.4).

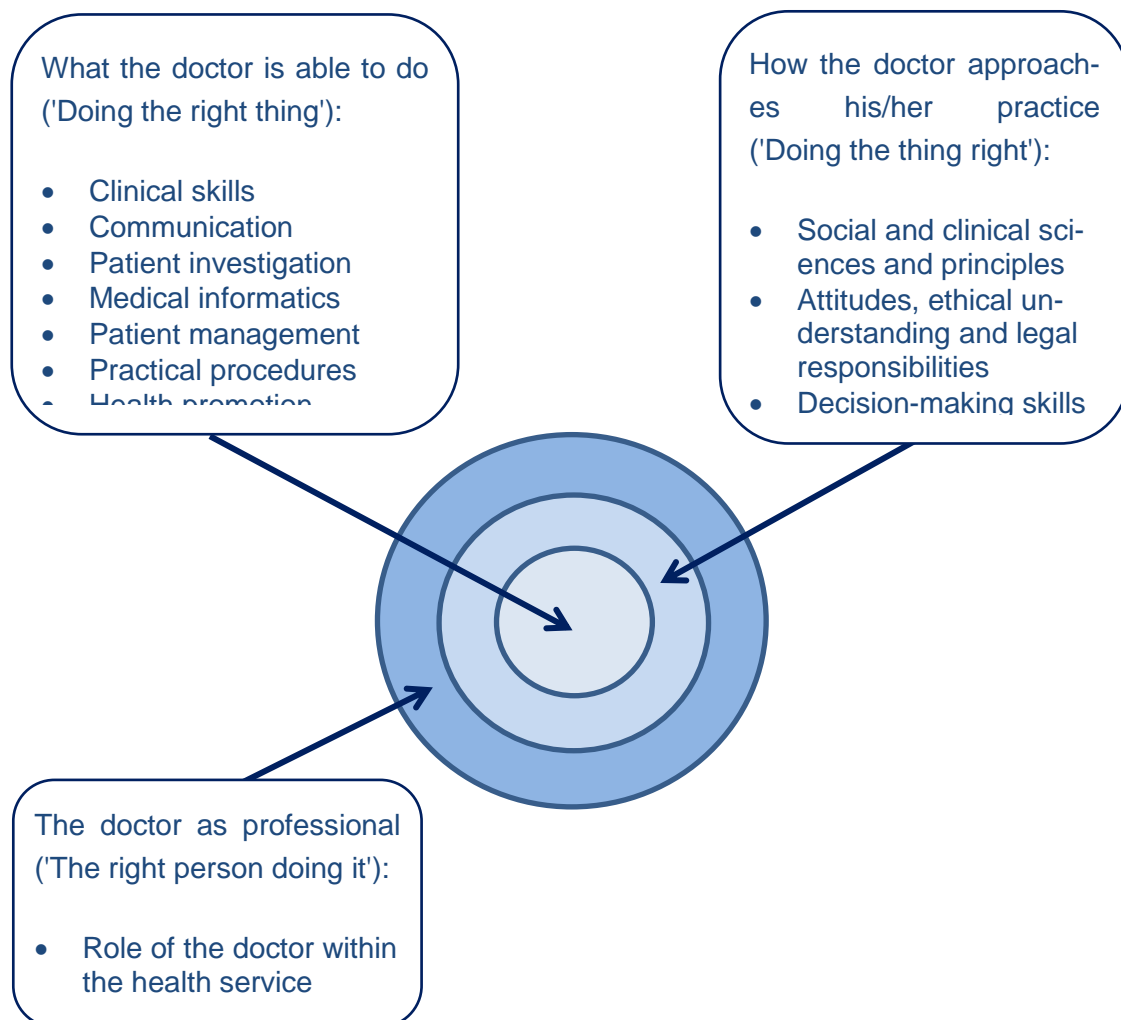


Fig. 6.3: Profession model (Harden et al. 1999a, b, Simpson et al. 2002)

#### 44. Teaching Materials on Medical Communication

Both professional models are analytical distinctions of (areas of) medical competences that can only be effective by interaction in practice. The commonalities between the two professional models consist in the threefold division of the areas of competence, which are, however, specified with different classifications: While in the "Scottish" professional model only the professional roles and personal developments of the doctor are "external" prerequisites for the "right" person to act ("outer circle"), the "Cologne" model differentiates a series of further qualifications that the "good" doctor must combine as a person in order to be able to bring the core competences of medical action to bear in direct interaction with the patient:

Fig. 6.4 Medical profession model (Herzig et al. 2006, Herzig, Koerfer 2018)

In order to be able to appropriately perceive his or her *professional* and *action competences* ("inner circle") towards the patient with the necessary *patient orientation* and *empathy* ("middle circle"), the acting person must have acquired a series of individual qualifications ("outer circle"), which he or she must continuously prove in the interaction with his or her action partners. These include a constant *willingness to learn*, *reflexivity*, *cooperativeness*, *authenticity* and, last but not least, the *willingness to help*, which remains a primary virtue even in a post-Hippocratic medical ethic.

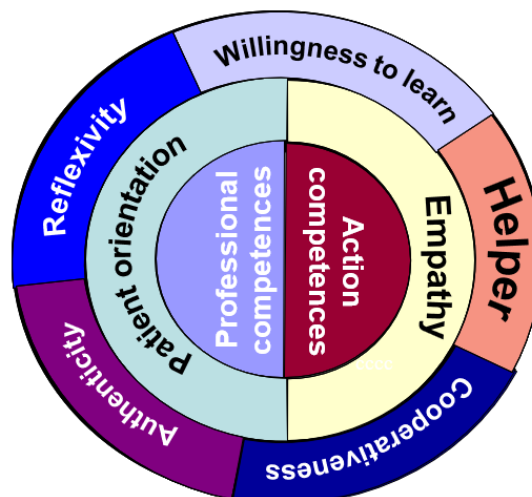


Fig. 6.4: Medical profession model (on Herzig et al. 2006, Herzig, Koerfer 2018)

Fig. 6.5 Observation and development stages 1st-3rd order

In the tradition of Balint group work, which v. Uexküll, Wesiack (1991) follow with their construct of the (self-)critical *meta-doctor*, the critical case discussion, in which a doctor presents an example from his or her practice to the critical judgement of the group, is a core element of continuing medical education. In the meantime, modern recording media (audio, video) have provided possibilities to escape the "data distortions" of merely remembered and narrated patient cases (§ 2.3). Enriched by the authentic audio and visual material created by recordings from ongoing medical practices, Balint's old demand for *training cum research* could gain a new dimension from which both the group and individual participants benefited. Individual learning progress as well as group effects could be demonstrated in an intersubjective test procedure (Köhle et al. 2001, 2010, Koerfer et al. 2004, Cataldo et al. 2005), which will be explained in detail later (§ 40).

In anticipation of the later presentation of the design and results of evaluation studies, the learning and professional situations of the self-reflective meta-doctor, who has to prove him- or herself as a "communicator" in many fields of action, of which direct patient care remains the core area, will first be outlined here as an example. What the doctor practices there as a key communicative competence can be transferred to other areas of medical action, such as communication with relatives, colleagues, media (see above), who can benefit from the self-reflexive meta-competence just as much as the patients themselves. As already briefly outlined above (§ 3.3), the (self-)reflexive role of the meta-doctor can be differentiated, for example, from the training perspective of a Balint group in a constellation of three observation and development stages (Fig. 6.5), which will be further described below:

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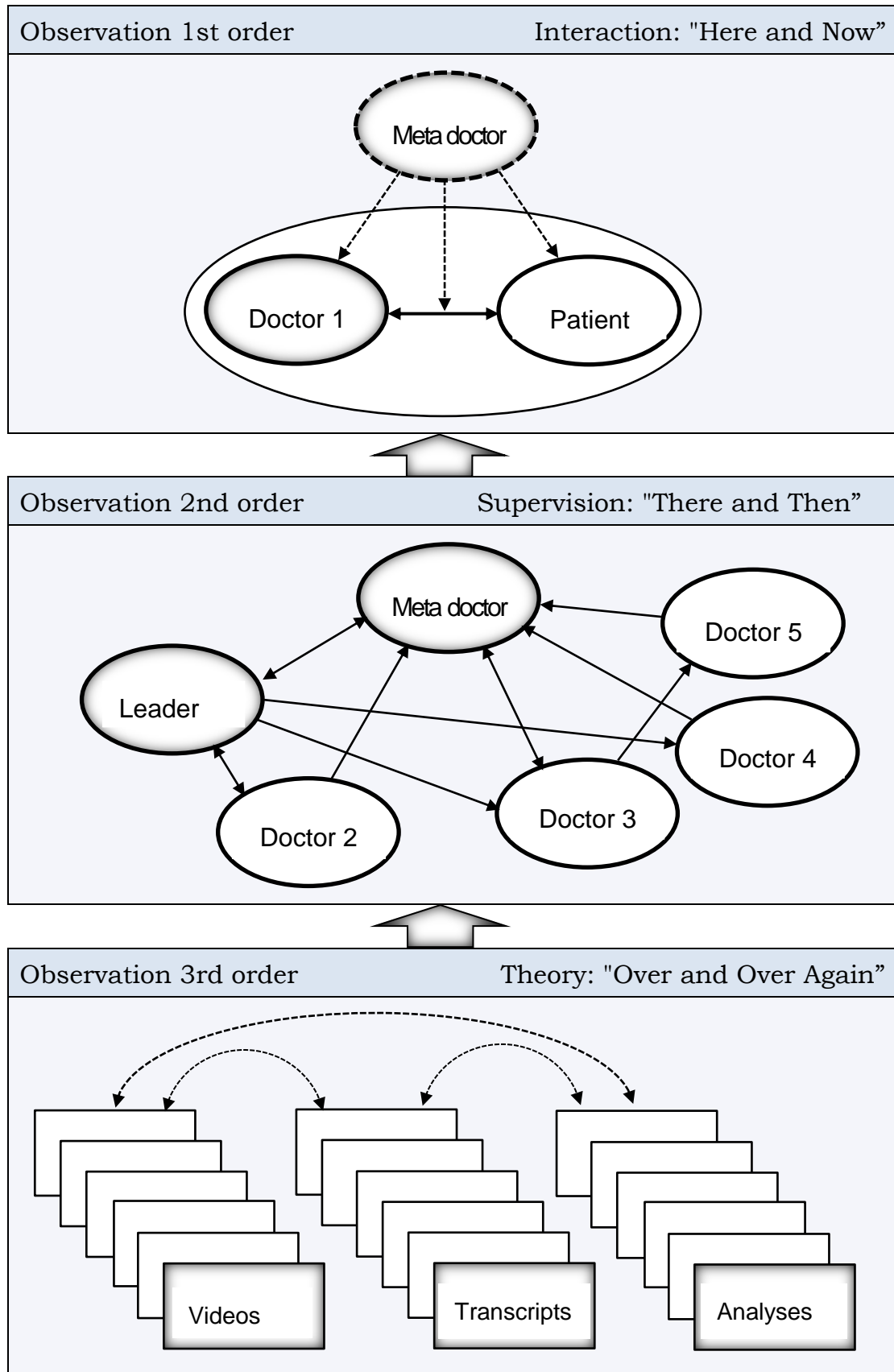


Fig. 6.5: Observation and development stages 1st-3rd order

Under the ideal objective of a "limited but essential conversion of the personality" of the doctor, Balint (1964) (Box 6.4) describes how the learning group method he founded can contribute to the doctor's personality formation if the (self-)criticism takes place in a good friendly atmosphere in which all group members can profit from each other by learning not only from their own but also from the "mistakes" of others in order to compensate for their personal deficits.

Box 6.4 *Limited, but essential conversion of the personality*

Intellectual instruction, no matter how clever, has virtually no effect on this process of liberation and general relaxation. What we needed was an emotionally free and friendly atmosphere in which the realisation could be processed that our actual behaviour is often completely different from our good intentions and does not correspond much to the idea we had of it so far. Perceiving this discrepancy between our actual behaviour on the one hand and our intentions and beliefs on the other is not an easy task. But if the cohesion in the group is good, the faults, blind spots, and limitations of each member can be brought to light and at least partly accepted by them. The group, both collectively and individually, develops a better and better understanding of its own problems.

The individual can bear the perception of his mistakes more easily if he feels that the group understands these mistakes and can identify with him in them, and if he sees that he is not the only one who makes mistakes. Furthermore, it does not take long for the group to discover that the technique of each member, including the psychiatric group leader, is an expression of his personality, which of course also applies to his habitual mistakes (...) As long as the mutual identification of the members is strong enough, the individual can bear burdens because he feels accepted and supported by the group. He does not feel that his mistakes and failures, as shameful as they may be, make him worthless to the group; on the contrary, he feels that by having his mistakes used as a basis for discussion, he has contributed to the group's progress.

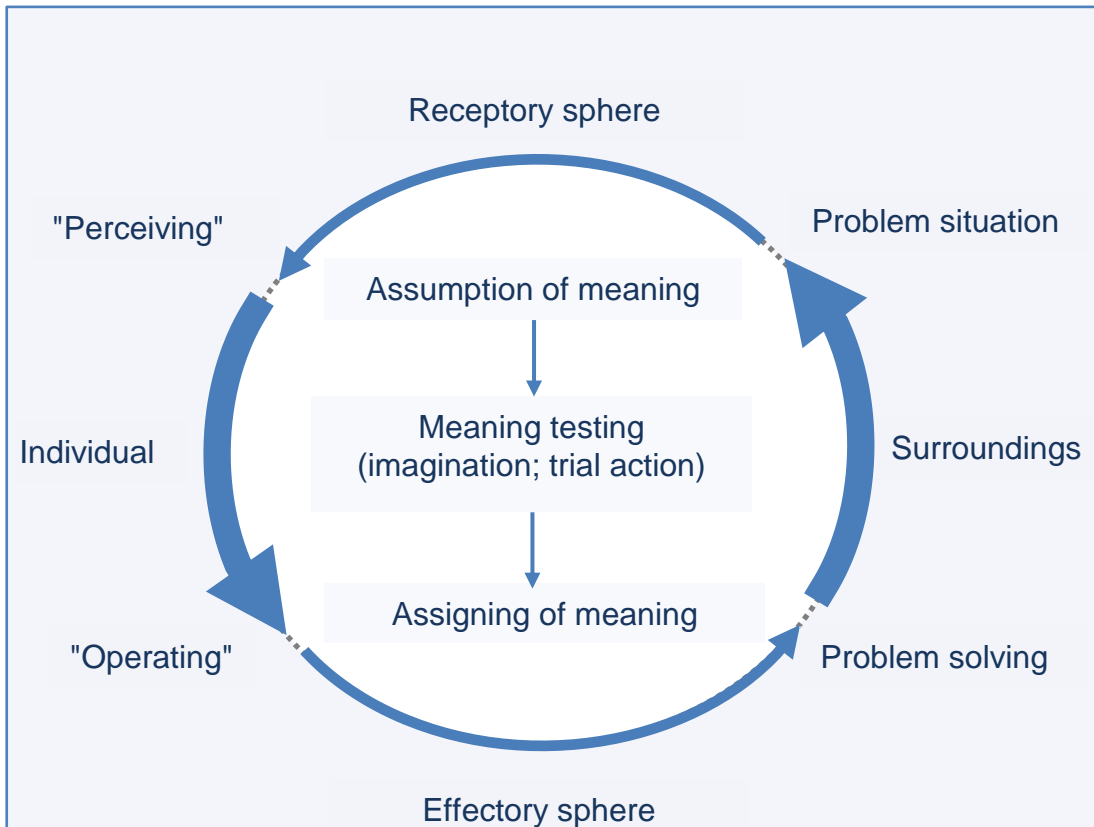
Balint 1964/1988: 405f

The recognition of one's own personal limitations is thus a first step in the personal development of the doctor, who has to overcome possible reservations and inhibitions towards self-critical reflection in group work. Only in the solidary criticism of the group can "mistakes, blind spots and limitations" be recognised and worked on, which threaten to remain hidden from individual self-observation, precisely because the "habitual" mistakes of the individual can already be an "expression of his personality", which can easily elude the self-observation of the individual.

## 7

## Dialogical Communication and Medicine

Fig. 7.1 Situation circle (on v. Uexküll, Wesiack 2011: 32)



The situation circle differs from the functional circle in that the imagination is an obligatory intermediary, in which programs for assigning of meaning (“perceiving”) and meaning utilization (“effecting”) are at first be tested as assumption of meaning and testing of meaning, before the ego releases them for the motor activity. In this process, the situation (which corresponds to the characteristic or problem situation in the functional circle) is quasi-experimentally pre-structured in the imagination: This means that assigning meaning is initially given as a hypothetical assumption of meaning, whose consequences can be probed in the imagination by means of “testing acts”.

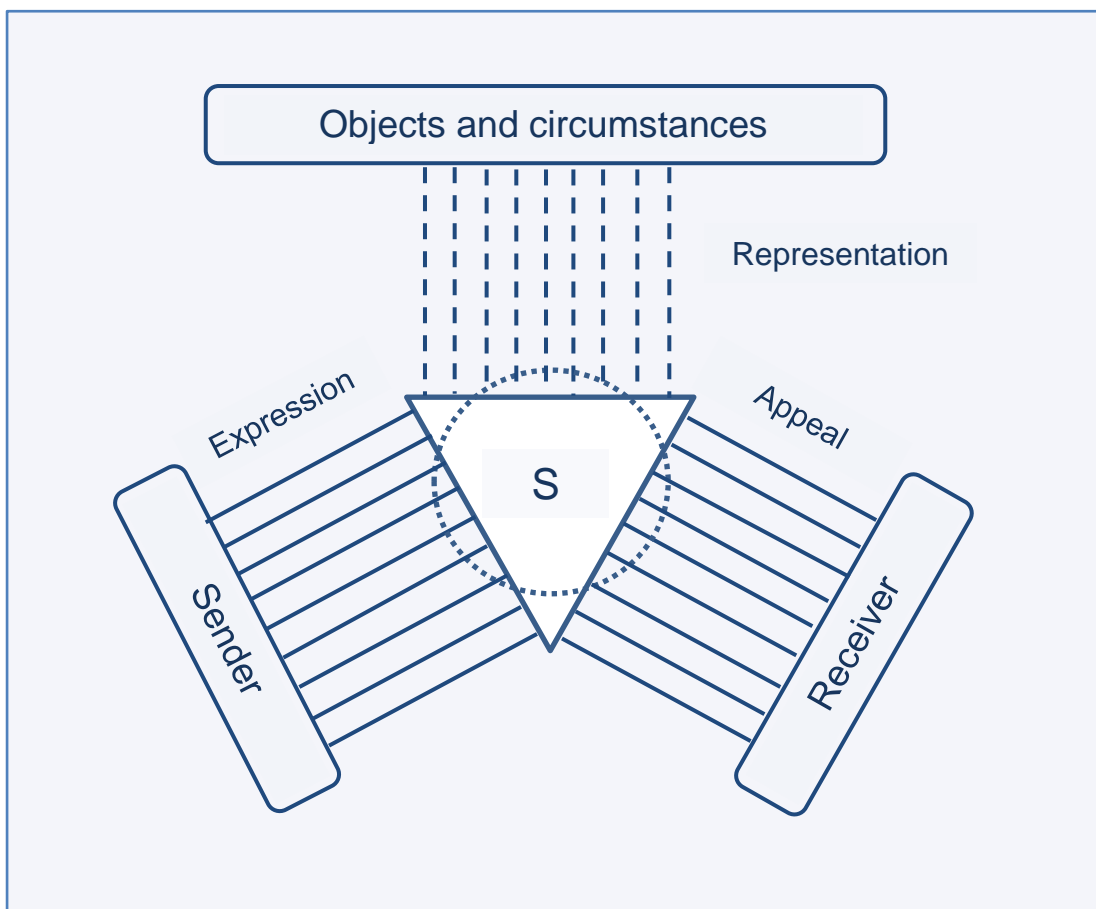
Fig. 7.1: Situation circle (on v. Uexküll, Wesiack 2011: 32)

(cf. in: Adler et al. (Eds.) (English edition) (1997)

(Psychosomatic Medicine): 31f; and v. Uexküll, Wesiack 1991: 274)

Fig. 7.2 Organon model (on Bühler 1934/82)

It is certainly a special merit of Bühler (1934/82) to have brought the *expressive* and *appealing function* of language and speech into the focus of attention in addition to the traditional *representational function*. Although Bühler does not want to fundamentally deny the commonly assumed *dominance* of the representational function, he would like to relativise it in the sense that the other two basic functions can also come to the fore, individually or together.



The circle in the middle symbolises the concrete sound phenomenon. Three variable moments in it are called upon to elevate it three times differently to the rank of a sign. The sides of the triangle symbolise these three moments (...) The groups of lines symbolise the semantic functions of the (complex) speech sign. It is a *symbol* by virtue of its association with objects and circumstances, a *symptom* (sign, indicium) by virtue of its dependence on the sender, whose inwardness it expresses, and a *signal by virtue* of its appeal to the listener, whose external or internal behaviour it controls like other traffic signs.

Fig. 7.2: Organon model (on Bühler 1934/82: 28)

## Box 7.6 The "philosophical revolution"

With his *theory of speech acts* ("How to do things with words"), John Austin (1962/72) certainly initiated a *paradigm shift* (Kuhn 1973), which has had an impact up to the present. Of course, as with (almost) all paradigm shifts, there are precursors and harbingers of development, for which one could name Karl Bühler (§ 7.1.2) or Ludwig Wittgenstein in the case of speech action theory. But Austin brought an emerging development to the conceptual and theoretical point for which he himself (in all modesty) saw the starting point of a "philosophical revolution" (Box 7.6).

## Box 7.6 The "philosophical revolution"

Philosophers have now long enough assumed that the business of "statements" is solely to "describe" a state of affairs or "assert a fact", either accurately or inaccurately (...). [It] has now been shown in detail, or at least made very plausible, that many traditional philosophical difficulties have arisen from a mistake: statements which are *either* meaningless (for interesting non-grammatical reasons) *or* which are supposed to represent something quite different from statements or ascertainties have simply been taken to be statements of fact (...) and we can deplore however much the confusion into which the content and method of philosophy have once fallen: we cannot doubt that a philosophical revolution is now dawning with it.

Austin 1962/72: 23-25

Austin illustrates his "revolutionary" view right in the first of his twelve lectures with a series of utterance examples where anyone would say "that I am doing something specific with these utterances (only under appropriate circumstances, of course)" (27). (...) Austin then develops his "speech act theory" on further examples also under other "circumstances" which must "fit" the respective utterances. A specific method of investigation comes into play here, namely to conclude from the possible "failures" of communication (i.e. from *misfortunes* such as *abuses*, *misappointments*, *misexecutions*, etc.) that it is rule-like.

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Box 7.7 The speech act as the "basic unit of communication"

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In this context, it is less a question of the well-formedness of sentences, as has traditionally interested linguistic research on grammar, but rather of the expansion of the subject area, which later gradually extended to the study of the *context* in which action is taken under certain conditions and for certain purposes. Initially, however, the speech act as the *basic unit* of linguistic communication was the focus of consideration, as formulated following Austin by John Searle (1969/1971) (Box 7.7).

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Box 7.7 The speech act as the "basic unit of communication"

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The reason for concentrating on the study of speech acts is simply that linguistic acts belong to every linguistic communication. The basic unit of linguistic communication is not, as has been generally assumed, the symbol, the word or the sentence (...), but the production or bringing forth of the symbol or word or sentence in the performance of the speech act. (...) Speech acts (...) are the basic or smallest units of linguistic communication.

Searle 1969/1971: 30

This "concentration on the study of speech acts" then laid the foundation for entire research programmes. These deal, for example, with the (systematic) spectrum of *performative* ("speech act-designating") verbs (*assert, promise, command, etc.*), a possible *classification* of speech acts, their *direct* or *indirect* forms of realisation, as well as the "appropriate circumstances" of speech acts, up to and including the social *contexts* that can be extended by specific actions in specific *institutions*. Before we go into some aspects in more detail, let us roughly mark two research directions.

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E 7.2 P02: "what are your tips for this?" – P30: "more or less advice"

---

In addition, there are further differences in certain exemplars/types of action that also fell undifferentiated into the class of *directive*, even if the institutional binding is obvious. For example, the doctor's *recommendation* in the medical consultation has a different quality of action

#### 44. Teaching Materials on Medical Communication

than the well-intentioned *advice* of a neighbour, which is also often given when it is not asked for at all, etc. In contrast, competent medical advice is not only expected, but also more or less directly requested by patients, as this becomes clear in the following example (B 7.2) (shortened here with relatively large omissions "(...) (...)").

| E 7.2 |   | P02: "what are your tips for this?" – P30: "more or less advice"   |
|-------|---|--|
| 01    | D | (...) these complaints have been around for a while (...) .  |
| 02    | P | so, all in all, I have to say, it hasn't gotten worse (...) (...) (...) sometimes it takes hours for it to get better. umm what are your experiences or what are your tips for this? . |
| 03    | D | yes . we have to look first , these . the pain is just still there . and you are thinking .  |
| 04    | P | not always .   |
| 05    | D | not always, that means, there are differences? .   |
| 06    | P | huge . yesss .   |
| 07    | D | huge differences . um . we have to look at how ... when ... how does that come about? . what are .   |
| 08    | P | so for example (...) (...) (...) . [longer description]  |
|       | D | (...)  |
|       | P | (...)  |
| 29    | D | well . Mr. [X] we have to see . um . the . what did you expect from me . that we .   |
| 30    | P | hm . so more or less eh advice . or whether I should try something eh with some medicine . Medicine something uh try ... (...) (...) (...)   |
| 31    | D | so I would definitely suggest . that you take a medication to support . that the pain is somewhat alleviated . yes . and that physiotherapy also continues, yes (...)                  |

This example, in which other treatments are also considered and the doctor advises against cortisone treatment, for example, and similar examples will be discussed in detail under the aspect of *dialogical negotiation* (§ 22).

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Box 7.12 The *cooperative principle* (CP)

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Now, in order to be able to explain why communication processes that rely so heavily on *hints* can function at all as well as they generally do, Grice makes a strong assumption regarding the *rationality* that guides all of us in everyday conversational practice: "I would like to be able to think of standard type of conversational practice not merely as something that all or most do *in fact* follow but as something that is *reasonable* for us to follow, that we *should not* abandon" (1975: 252: 48). Under this assumption of rationality, Grice now formulates the principle that sustains us all as a general *cooperative principle* (CP) (Box 7.12), the validity of which is constitutive for all possible, subordinate conversational maxims (see below).

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Box 7.12 The *cooperative principle* (CP)

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Our talk exchanges do not normally consist of a succession of disconnected remarks, and would not be rational if they did. They are characteristically, to some degree at least, cooperative efforts (...) We might then formulate a rough general principle which participants will be expected (*ceteris paribus*) to observe, namely: Make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged. One might label this the *cooperative principle*.

Grice (1975: 45; cf. 1979: 248)

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Box 7.13 Conversation maxims

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Under this basic assumption of a universally valid principle of cooperation, Grice now differentiates a series of subordinate conversational maxims (Box 7.13), which he classifies according to Kant's table of categories under the categories of *quantity*, *quality*, *relation* and *manner/modality*.

Box 7.13 Conversation maxims

Maxim of *quantity*

The category of quantity relates to the quantity of information to be provided, and under it fall the following maxims:

1. Make your contribution as informative as required (for the current purposes of the exchange).
2. Do not make your contribution more informative than is required.

Maxim of *quality*

Under the category of quality falls a supermaxim – ‘Try to make your contribution one that is true’ – and two more specific maxims:

1. Do not say what you believe to be false.
2. Do not say that for which you lack adequate evidence.

Maxime of the *relation*

Under the category of relation I place a single maxim, namely: ‘Be relevant’.

Maxime of *modality*

Finally, under the category of manner (...) I include the supermaxim: "Be perspicuous" – and various maxims such as:

1. Avoid obscurity of expression.
2. Avoid ambiguity.
3. Be brief (avoid unnecessary prolixity).
4. Be orderly.

Grice 1975: 45f

For all these maxims, Grice now discusses individual groups of examples that help to prove the validity of the maxims in our everyday conversations, even or especially when they seem to be violated at first glance.

[Cf. above Table 2.2 + 2.4 and conversation maxims on medical communication below Box 13.22]

Box 7.14 The ideal speaking situation

Habermas 1971: 139

The essential theoretical and methodological guiding ideas as well as basic concepts were already pre-formulated by Habermas in his *Preparatory Remarks on a Theory of Communicative Competence* (1971). There he develops his specific concept of an *ideal speech situation* within the framework of his universal pragmatic outline for a classification of speech acts, which ties in with speech act theory and linguistic pragmatics (Austin, Searle, Wunderlich etc.) (§ 7.3.1-2). This is characterised – however counterfactually – by a *symmetrical* distribution of opportunities of dialogue roles, which allows the free use of all possible speech acts (assertions, questions, proposals, objections, etc.) without the speakers having to reckon with social, institutional, etc. restrictions (sanctions) in advance. Restrictions (sanctions) would have to be reckoned with in advance. As Habermas sums up (Box 7.14), these ideal conditions are to be understood as structural features of a speech situation that come into play independently of personality traits of, say, "ideal" speakers.

Box 7.14 The ideal speaking situation

The counterfactual conditions of the ideal speech situation turn out to be the conditions of an ideal form of life. It now turns out that not only the model of pure communicative action, as shown, requires the possibility of discourse, but that, conversely, the conditions of discourse cannot be thought of independently of the conditions of pure communicative action (...) I have tried to characterise the ideal speech situation not by the personality traits of ideal speakers, but by structural features of a situation of possible speech, namely by the symmetrical distribution of chances to perceive dialogue roles and to perform speech acts.

Habermas 1971: 139

The "counterfactual conditions of the ideal speech situation" must be assumed to be effective in action practice even or especially when they should be ignored or even counteracted in extreme cases in real conversations. Such extreme types of conversations are conspicuous, simply because they generally cannot withstand even a spontaneous *test of acceptability*, because they obviously seem to violate elementary rules of understanding that we are more or less prepared to follow as commonly accepted standards ... (cf. Habermas 1985 English Edition).

Fig. 7.3 Action typology

Habermas 1981 (English 1985, Vol.1)

While forms and functions of *systematically distorted* communication are to be expected in any case in psychoanalytic therapy, which, moreover, from a professional point of view is specifically raised to the subject and topic of the conversation, this is not necessarily self-evident for everyday medical care practice. Here, systematically distorted communication may have a latent effect without being recognised in medical practice and "answered" appropriately in the interaction with patients.

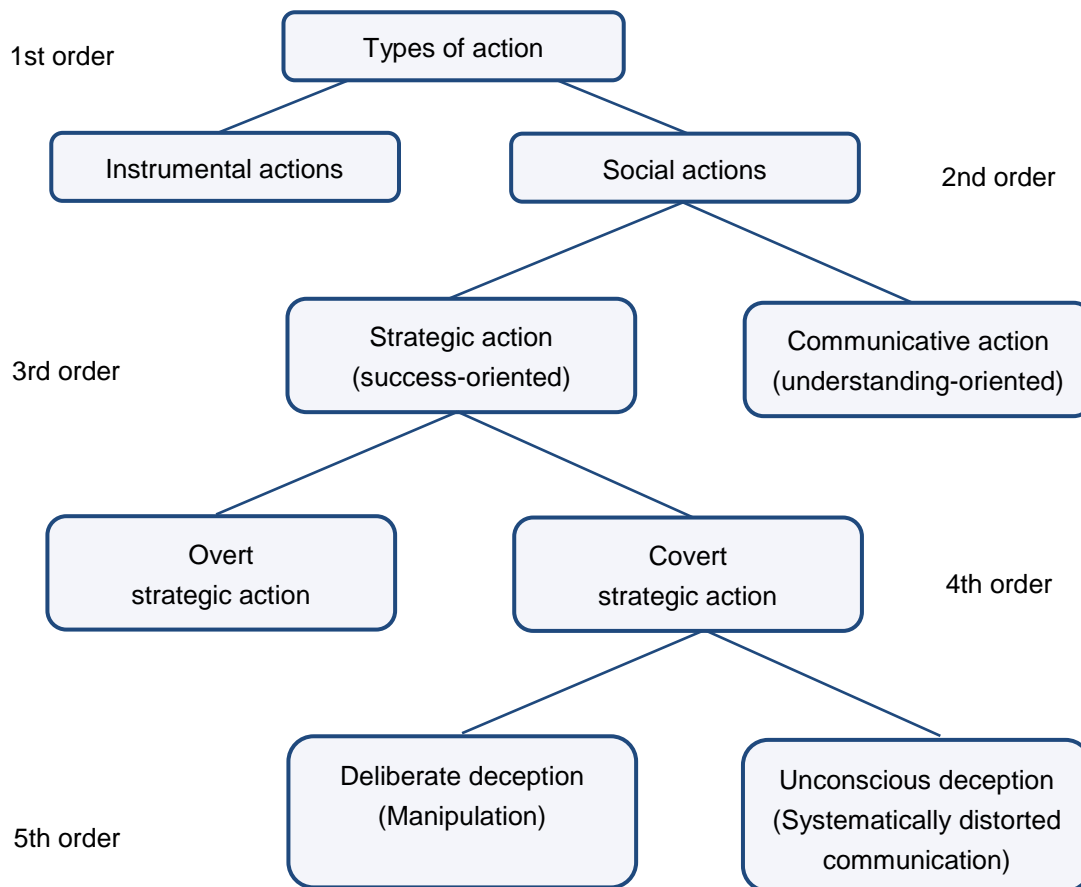


Fig. 7.3: Action typology (mod. and extended from Habermas 1981, vol.1: 446)

It is therefore no coincidence that basic psychosomatic care and interviewing have become the subject of continuing medical education (§ 15-16, 42-43). This is particularly about the promotion of general *relationship competences* and especially of *understanding* and *empathic competences* in dealing with *forms of defence*, for example, as this has already been described in advance (§ 3.3) and will be further elaborated in the practical part (§ 17-23) using the *Cologne Manual of Medical Communication* (C-MMC) and empirical examples.

---

Box 7.17 All behaviour is communication (Watzlawick et al. 1967/2011)

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As justified in their remarks on the "conceptual foundations", Watzlawick, Beavin, Jackson (1967/2011) see themselves entirely in the tradition of *semiotics* ("theory of signs") (§ 7.2). With explicit reference to Charles Morris and Rudolf Carnap, they follow the traditional division into *syntax*, *semantics* and *pragmatics*. In doing so, they use a very broad concept of *communication* (Box 7.17), which corresponds to a broad concept of *pragmatics* as already claimed in the (English) title ("Pragmatics of Human Communication").

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Box 7.17 All behaviour is communication

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In this context, it should be pointed out from the outset that we use the two terms communication and behaviour here as practically synonymous. For the material of pragmatics is not only words, their configurations and their meanings - i.e. the data of syntactics and semantics - but also all non-verbal concomitants, including so-called body language. And finally, the role of the context, i.e. the "environment" of every communication, which co-determines the communicative processes, must be taken into consideration. In this pragmatic view, therefore, not only language but all behaviour is communication, and all communication - even the communicative aspects of each context - influences behaviour.

Watzlawick et al. 1967/2011: 25f.

This very broad concept of communication, which has been criticised many times (see below), already anticipates the first of the *pragmatic axioms* of communication, which are then gradually developed by the authors, illustrated with examples and finally summarised. Since these axioms form the core of their "Pragmatics of Human Communication", they will be reproduced here in excerpts (Box 7.18) and then commented on very briefly.

Box 7.18 Pragmatic axioms of communication

1. *You cannot not communicate. (60)*
2. *Every communication has a content and relationship aspect, such that the latter determines the former and is therefore a metacommunication. (64)*
3. *The nature of a relationship is conditioned by the punctuation of the communication processes on the part of the partners. (69f.)*
4. *Human communication makes use of digital and analogue modalities (...). (78)*
5. *Interpersonal communication processes are either symmetrical or complementary, depending on whether the relationship between the partners is based on equality or difference. (81)*

Watzlawick et al. 1967/2011: 60-82 (there italic).

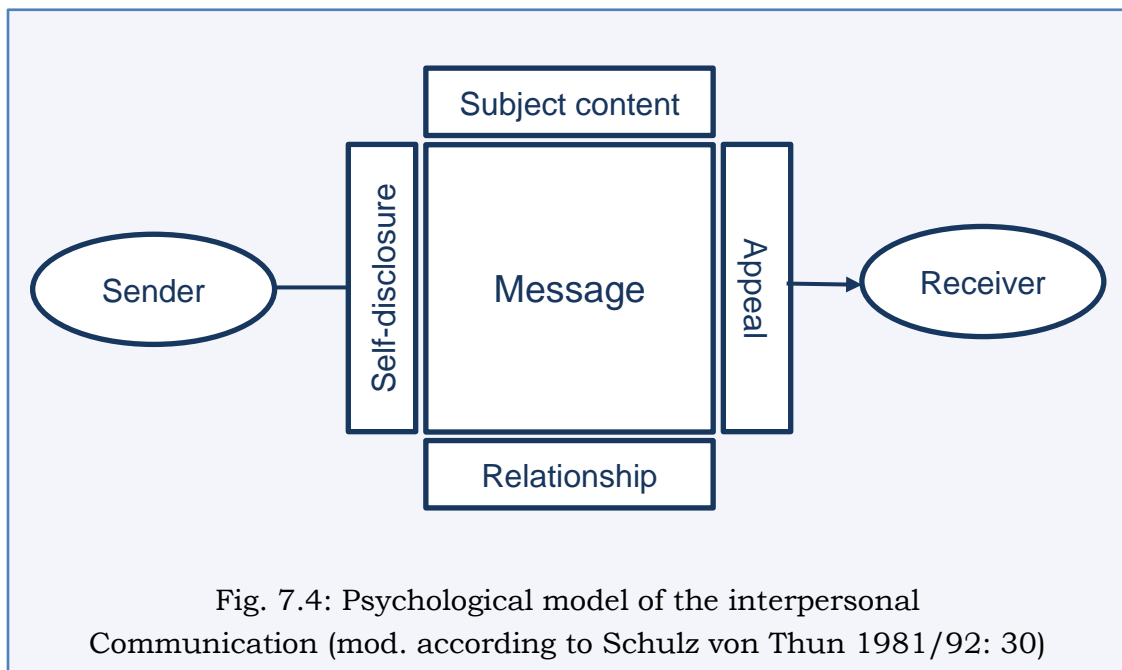
Criticism is mostly already directed at the very broad concept of communication, as already expressed in the conceptual foundation (Box 7.17) and then reduced to a short denominator in the first axiom. According to this, all behaviour is communication (see above), i.e. *action* as well as *non-action*, *words* and *silence* all have a "communicative character" (59) (...) Such a broad concept of communication, under which even the man who has merely fallen asleep would consequently "communicate" something, is usually problematised as being too "vague" and therefore of little use for research, as the (linguistic) psychologist Hans Hörmann (1978: 316) still formulates this relatively moderately in rhetorical question form:

The danger, of course, lies in the vagueness of the concept of communication thus taken up: if all behaviour that takes place in the presence of another person is communicative - what scientific use can still be made of labelling behaviour as 'communicative'?

Likewise, the linguist Rudi Keller, while starting from a broad concept of signs, would like to maintain a narrower concept of communication (cf. his "Theory of Signs" 1995) ....

Fig. 7.4 Psychological model of the interpersonal Communication

Schulz von Thun's approach, which claims to be a *General Psychology of Communication* in the subtitle of his book in Volume 1, is essentially based on the work of Bühler and Watzlawick, to whom he also explicitly refers in developing his model: "This model is inspired by Bühler (1934) and Watzlawick et al. (1969)" (Schulz von Thun 1981/1999: 30). Since we have described their communication models in detail in advance, we can limit ourselves here to the essential aspects of his integrative approach, which extends Bühler's *triadic* Organon model by Watzlawick's *relationship aspect* to a *four-sided* communication model (Fig. 7.4).



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Box 7.22 "Getting into the conversation"

Gadamer 1993

When we use the term "conversation leadership" as a matter of course in medical conversation, this already seems to contain a *paradox*, because *conversation* and *leadership* seem incompatible. This paradox seems resolvable if we revise our traditional notions of conversation. Thus, Gadamer has emphasised as a possibility also between doctor and patient the "involvement" in a conversation (Box 7.22), as we know it "also otherwise in living together".

Box 7.22 "Getting into the conversation"

The word "conversation" already implies that one speaks to someone who answers one (...) All forms of the use of language are modifications of conversation or slight shifts of weight in the game of question and answer. There is the invitation to talk and the getting into the conversation, so that it almost seems as if the conversation is the active one, the perpetrator, which involves both sides (...).

So it is the conversation that can be helpful in the tense situation between patient and doctor. But this conversation is actually only successful when it is almost exactly like what we know in other ways of living together, namely that one gets into a conversation that no one actually has, but that leads us all. In the end, this also remains true for this kind of conversation between the doctor and the patient.

Gadamer 1993: 161f and 172

If, in this "involvement" in a conversation, the authorship can no longer be clearly attributed to one or the other partner, the question of the *art of conducting a medical conversation* arises in a way according to which the traditional role of conducting a conversation by the doctor is to be abolished or at least strongly modified. The initial withdrawal of the doctor's role in leading the conversation, as it has applied specifically to the psychotherapeutic conversation since Freud's writings on treatment techniques (1912/1913) (Thomä, Kächele 1989, Koerfer, Neumann 1982, Lang 2000, Kächele et al. 2006) (§ 9), can be generalised in a moderate form for the doctor-patient conversation in general, especially at the beginning of the conversation ...

[Cf. Chin-Yee et al. 1919]

Box 7.23 "A real conversation cannot be predisposed" Buber 1954

In order to overcome *asymmetries* (of whatever kind) (see below) in the long term, a "dialogical principle" should be applied, as is the case in certain traditions of the "philosophy of dialogue" (Martin Buber, Viktor von Weizsäcker, Gabriel Marcel, Emmanuel Levinas, Peter Kampits et al. or a *hermeneutic philosophy of conversation* (Hans-Georg Gadamer, Hermann Lang) or the *discourse ethics of the philosophy of communication* (Karl-Otto Apel, Jürgen Habermas, Matthias Kettner) (§ 7.3, 10). According to this, (certain types of "genuine") conversations are to be conducted as "unbiased" as possible and "open-ended" for as long as possible, as Martin Buber so pointedly described it in his own language (Box 7.23).

Box 7.23 "A real conversation cannot be predisposed" .

But everyone must be determined not to withdraw if, according to the course of the conversation, it is up to him to say what he has to say. Of course, no one can know in advance what that will be: a real conversation cannot be predisposed. It has its basic order from the beginning, but nothing can be ordered (...) But this too is self-evident, that all participants, without exception, must be of such a nature that they are able and willing to meet the requirements of genuine conversation. Authenticity is already called into question if even a small part of those present are perceived by themselves and by the others as those to whom no active participation is intended.

Buber 1954/1986: 296

What is already generalised here for the multi-person conversation is, according to Buber, initially essential in the "*two-person*" conversation, as it is also conducted between doctor and patient. Not being able to "predispose" a "real" conversation between doctor and patient means that the "good" doctor may have prepared himself "well" for the conversation, in which he brings - as far as possible - his "good" knowledge of the file and his "good" professional competence in general with his nosological knowledge of the clinical picture as well as his structured professional experience of typical patient reactions (§ 3, 6).

Fig. 7.7 On the scales: (A)Symmetry of (non-)knowledge

In recurring *dialogue threads* (in the above sense of Bühler) (§ 7.2), the information of one partner must necessarily build on that of the other in a way in which both partners use each other as experts: the doctor the patient as an expert in his history of suffering and the patient the doctor as an expert in his art of healing (cf. e.g. Tuckett et al. 1985, Smith, Hoppe 1991, Koerfer et al. 1994, 2010, Koerfer, Albus 2015). The patient is initially a "blank slate" for the doctor and only gradually does his knowledge of the patient fill in, to whom he can likewise successively impart his professional knowledge with reference to his individual illness. At first, there is a *symmetry of non-knowledge* on both sides of the scales, before they gradually fill up and a sufficiently shared knowledge has emerged for both interlocutors, which then needs to be deepened in order to throw new knowledge into the respective scales (Fig. 7.7) for the purpose of medical decision-making, etc.

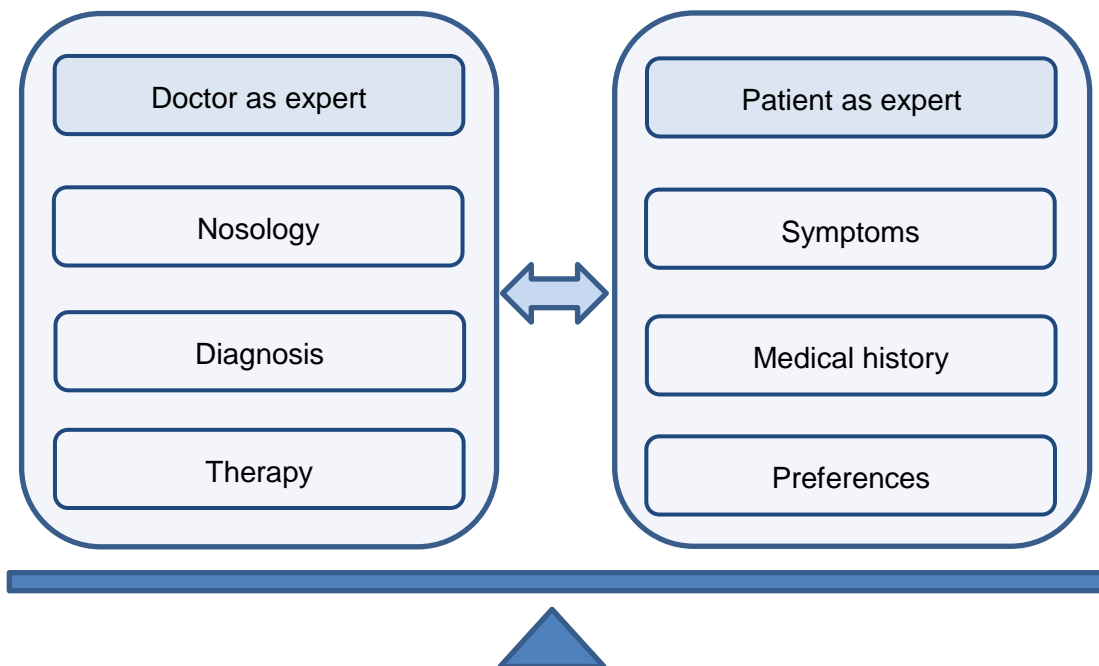


Fig. 7.7: On the scales: (A)Symmetry of (non-)knowledge

The specific expert roles refer to specific symmetry and asymmetry relationships, insofar as both interaction partners are equally *knowers* and at the same time *non-knowers*, and this in turn in relation to different individual or professional bodies of knowledge, for which they must first make themselves mutually competent to a certain extent ....

Box 7.28 Both physician and patient 'teach' one another in dialogue

In order to pre-structure the further discussion on the (a)symmetry of doctor-patient communication, the aspect that the doctor and the patient act with different responsibilities should first be emphasised, namely the one is essentially (co-)responsible for the other, the other in self-responsibility. In order to overcome the mutual lack of knowledge described above, a conversational attitude is necessary according to which both interlocutors encounter each other as *teachers* and *learners*, as Pellegrino and Thomasma (1981) described early on (Box 7.28), not without emphasising who has to shoulder the greater responsibility in the conversation.

Box 7.28 Both physician and patient 'teach' one another in dialogue

The clinical interaction is the locus of mutual responsibility of a patient and physician. In the clinical interaction there must be an interpenetration of minds as well as physical contact, because, as Kant showed, the human mind deals with experience in concepts. Both physician and patient 'teach' one another in dialogue. However, in the clinical interaction there is an imbalance of scientific knowledge which places the heavier burden of responsibility on the physician.

Pellegrino, Thomasma 1981: 65

Despite all the reciprocity of responsibility, doctors bear a greater responsibility, which is based not least on their professional *knowledge*, which guides their *communicative* competences (§ 3.3). As will be explained (§ 10, 22), they cannot and must not follow arbitrary *patient preferences due to the* professional commitment of their actions, but must take these into account within the framework of *evidence-based* medicine, which can contradict the individual concerns, wishes and hopes of their interlocutors, which in turn must be justified and justified *transparently* and *rationally in* the conversation, possibly also against patient objections that initially seem irrational, etc. This also includes "false" subjective theories of illness, which can stand in the way of a successful therapy. If the patient's "errors" are to be "invalidated" in the long run, the doctor must do the corresponding *work of persuasion* and *motivation* (§ 10, 26, 29), with which he appeals to the patient's rationality, which can be assumed in principle.

Fig. 7.8 Sub-principles as sides of the dialogue cube

Irrespective of the fact that failures of all kinds can occur in the practice of dialogue, which may be caused not least by individual inadequacies of the individuals up to the point of self-deception, the counterfactual validity of the *dialogical principle* had been concretised by the interactive recognition of a number of *sub-principles*, among which the *principle of transparency* is to be counted above all. What must be effective overall in a dialogue worthy of the name is to be represented in a dialogue cube (Fig. 7.8), the sides of which correspond to the following dimensions:

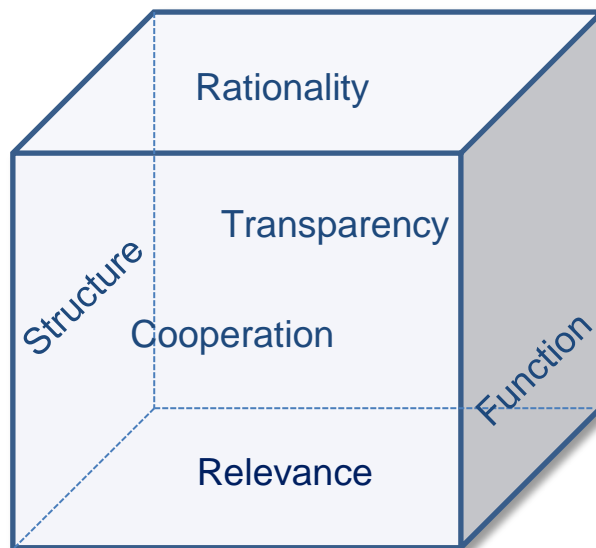


Fig. 7.8: Sub-principles as sides of the dialogue cube

The dialogue cube is to be specified here for doctor-patient communication, but it can also be transferred to teaching-learning conversations in schools or universities, as long as these are not understood as mere monological knowledge transfer ("teacher lecture"), but as dialogue in the *Socratic* sense. In this context, the specific *midwifery* handed down with Socrates should also interest us in the *art* of medical conversation (§ 9, 17-23). The concrete applications of the dialogue cube in medical conversation will first be outlined here in a rudimentary and thesis-like overview, before we elaborate on individual dialogue sub-principles (such as cooperation, transparency, relevance) both theoretically (§ 9, 10) and in the empirical practical part (§ 17-23) ...

## 8 Intervention Types and Therapy Goals

Fig. 8.1 Direct (solid) and indirect (dashed) pathways

In an interim review, we first follow a schematic representation here (Fig. 8.1), which we will use for further orientation across chapters, following Street et al. (2009), Street (2013), and Laidsaar-Powell et al. (2014), Koerfer, Albus 2018).

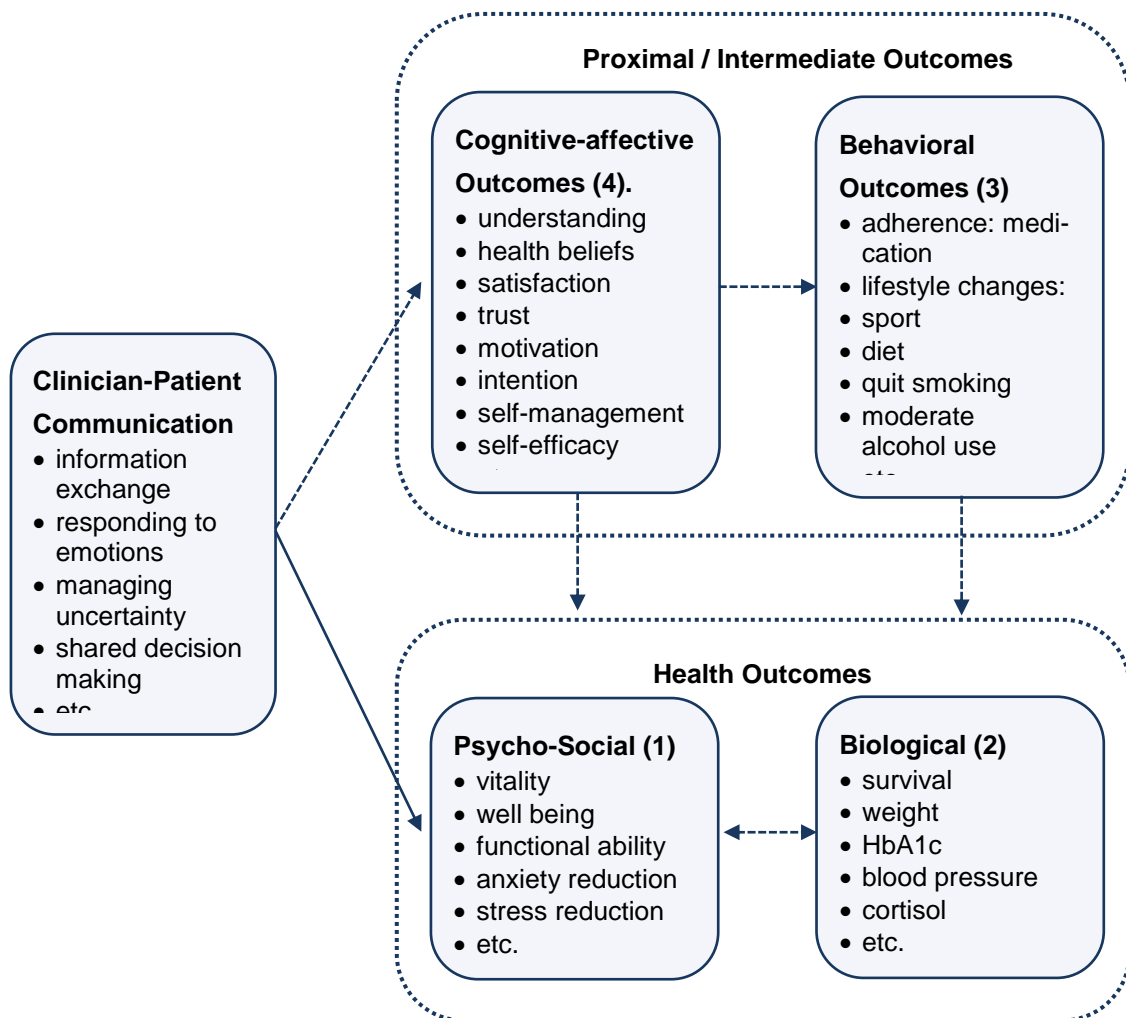


Figure 8.1: Direct (solid) and indirect (dashed) pathways between physician-patient communication and health outcomes (adapted from Street et al. 2009, Street 2013, Laidsaar-Powell et al. 2014; Koerfer, Albus (eds.) 2018).

The initial thesis of Street et al. (2009) is that communication between physician and patient can also lead to a *health outcome in a direct way*, but that it usually requires *indirect, mediated ways (...)*

Fig. 8.2 Ideal-typical model of medical practice

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

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

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

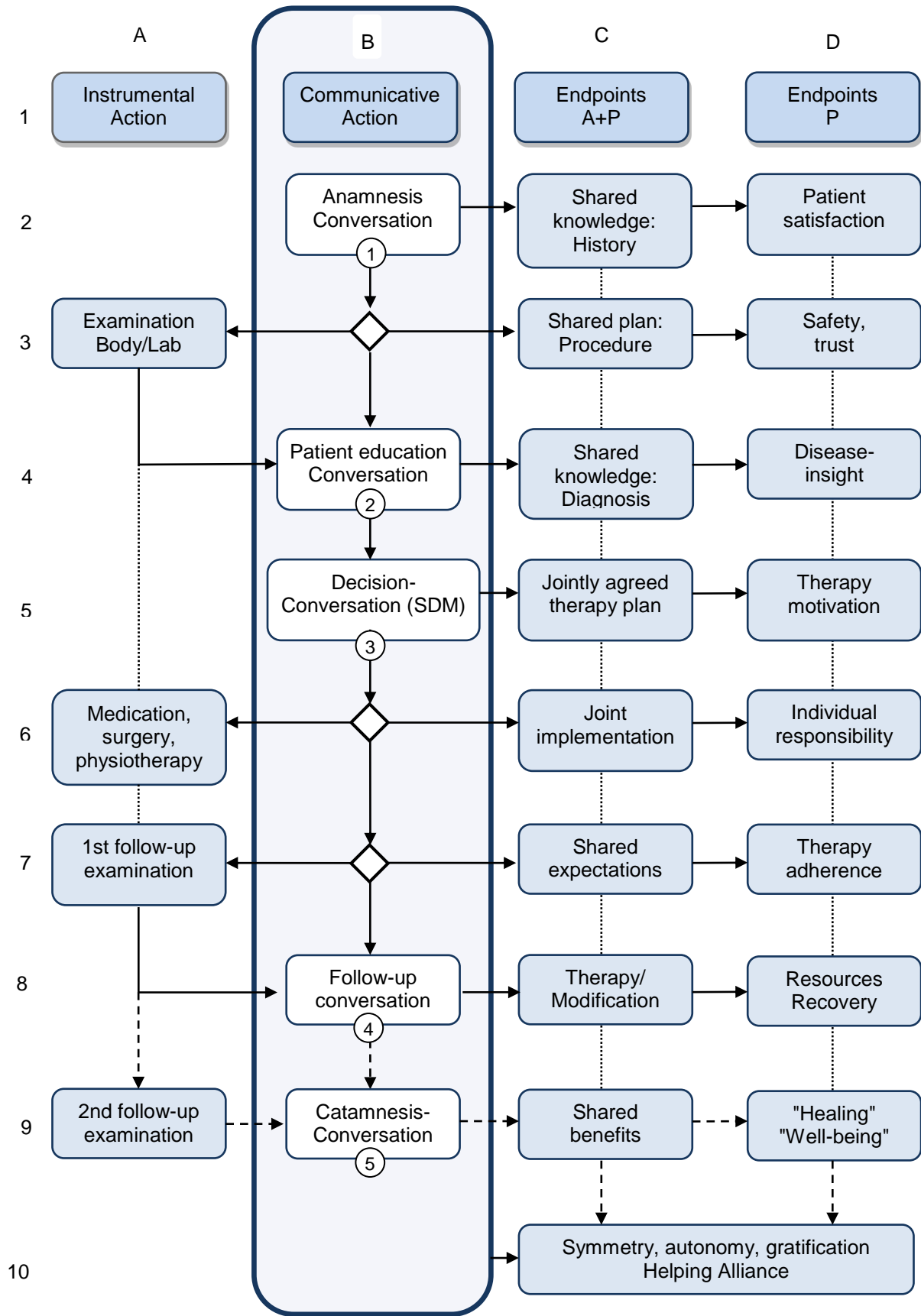


Fig. 8.2: Ideal-typical model of medical practice

## 9 Narrative Medicine

### Box 9.1 On the concept of anamnesis: remembering and searching

With the orientation towards a *biopsychosocial* medicine and a corresponding conduct of the conversation, the thematic scope of what should be the subject of the anamnesis has expanded considerably. Beyond the patient's *body*, his or her *body* and *life* also become the subject of the medical consultation, in which not only *physical symptoms* but also the *personal experience* are moved into the focus of conversation (Langenbach, Koerfer 2006). In this way, a broad concept of anamnesis is also pursued in the more recent research on doctor-patient communication, which ties in with traditional understandings as they have been handed down through the meaning of the term and the history of concepts, to which, for example, attention is drawn by Gadamer (1993) (Box 9.1):

### Box 9.1 On the concept of anamnesis: remembering and searching

At least the Pythagoreans already linked 'anamnesis', i.e. the realm of memory and recollection, with the concept of the psyche. The Greeks made a whole series of efforts to master this by thinking (...) We probably say 'mneme', 'memoria', both of which are firmly programmed into the life traits of living beings and their instincts. But anamnesis, remembering, is obviously something else. While it is related to mneme, it seems to be reserved for humans in a specific way. Memory, anamnesis, is a form of thinking, of logos, that is, of seeking. We all know that when one has a word on the lips and yet has to search for it and usually does not find the right one. But the fact that one can search and in the end know when he has found what he is looking for is the distinction of man.

Gadamer 1993: 179f

If this interpretation of the traditional meaning of *anamnesis* is taken as a basis, the question arises as to what the patient should remember in a searching manner and in what communicative form this can best be done. For the medical interview, this also means in concrete terms how the doctor in his specific *midwifery function* can *help* communicatively in remembering and searching (§ 9.5) ...

Box 9.2 Biopsychosocial patient history

Smith, Hoppe 1991

The promotion of patient narratives results above all from the necessity of reconstructing patient histories that are as comprehensive as possible, which, in the sense of a biopsychosocial medicine, concern the individual medical history of the patient as a person with a lived biography. Biopsychosocial medicine must be associated with the claim to reconstruct the patient's story as a history of illness and life in the interaction of all three components of the model, as already highlighted by Smith, Hoppe (1991) (Box 9.2), among others, with reference to the early work of Engel (1977).

Box 9.2 Biopsychosocial patient history

According to the biopsychosocial model, every patient has a story that demonstrates the interaction among the biologic, psychologic, and social components of his or her life (...) The patient's story emerges in a meaningful, integrated, and complete way. The physician's task is to elicit and understand this story, for it provides an introduction to who the person is and why he or she is seeing the physician. The story also provides clues to diagnostic and therapeutic issues relevant to the patient's problem.

Smith, Hoppe 1991: 470

If the medical task is seriously pursued to *elicit and understand the patient's story* under the interaction of all three *biopsychosocial* components, this conversational attitude must manifest itself in the practice of conversation at least under the following two aspects of *content* or *dialogue*, which should also guide our later empirical conversation analyses:

1. On the one hand, from a *content* point of view, the conversational practice must be characterised by a *thematic progression* in which biotic, psychological and social thematic complexes can be alternately initiated, ratified and integrated by both partners into their shared understanding of the reality they jointly produce (Uexküll, Wesiack 1991, 2011).
2. On the other hand, under a dialogical aspect, specific forms of conversation are to be expected, which come close to *storytelling* by one interlocutor and listening by the other interlocutor, as is also common in everyday communication.

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 Narrative Medizin
 

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The *asymmetry* that one partner essentially *tells* and the other essentially *listens* before asking further questions is by no means to be understood as a disturbing factor of an overall *symmetrical* communication (§ 7, 10). Rather, the patient's narration and the doctor's attentive listening can be used productively to bring to light the relevant biopsychosocial issues in the common interest of action in the first place. Before the advantages of *narrative* over *interrogative* conversation can be illustrated with examples of conversations, the theoretical aspects that should guide the empirical narrative analyses must be worked out.

The communication form of narrative is receiving increasing attention both in research and in many practical fields of action. The "narrative turn" has currently reached not only the social sciences in general (Mishler 1995, Straub (eds.) 1998, Baroni 2014) and *psychotherapy* in particular (Labov, Fanshel 1977, Schafer 1995, Boothe 2011, Scheidt et al. (eds.) 2015, Lätsch 2017, Deppermann et al. 2020, Habermas, Fesel 2022), but also medicine in the narrower sense: In the meantime, in analogy to *evidence-based medicine* (Lauterbach, Schrappe (eds.) 2001) (§ 5, 10), there is a corresponding plea for *Narrative-based Medicine*, for which the abbreviation *Narrative Medicine* has also become established (Greenhalgh, Hurwitz (eds.) 1998/2005, Launer 2002, Mehl-Madrona 2007, Lucius-Hoene 2008, Koerfer et al. 2000, Koerfer, Köhle 2009, Arntfield et al. 2013, Charon 2012, 2013, Goyal 2013, Gülich 2017, Birkner 2017, Köhle, Koerfer 2017, Galvagni 2022, Kirmayer et al. 2023).

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Narrative medicine is a recent innovation in clinical training, research, and practice that recognizes the human capacity to tell stories as central to health care. People are storytellers, and patient's stories are key to understanding their health care problems, predicaments and concerns and to negotiating effective treatment.

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Kirmayer et al. (2023: 235)

Box 9.5 Observation, introspection, dialogue

Engel 1997

In order to be able to achieve intimacy *qua* narratives, on the other hand, the change from an interrogative to a narrative interview style, according to Engel, must at the same time be accompanied by a fundamental change in the *understanding of the roles* of doctor and patient: In a narrative approach to medicine, the role of the patient is no longer that of a mere object of the doctor's action, but rather that of an *initiator* and *collaborator*, while the role of the doctor as a *participating observer* is determined with recourse to the following terminological distinctions (Box 9.5), which can be used to describe the interactive mediation of doctor-patient knowledge resources and competences.

Box 9.5 Observation, introspection, dialogue

The physician in turn is a participant observer who in the process of attending to the patient's reporting of inner world data taps into his own personal inner viewing system for comparison and clarification. The medium is dialogue, which at various levels includes *communing* (sharing experiences) as well as *communicating* (exchanging information). Hence, *observation* (outer viewing), *introspection* (inner viewing), and *dialogue* (interviewing) are the basic methodologic triad for clinical study and for rendering patient data scientific.

G. Engel 1997: 525

In this "methodological triad", it is precisely the interactions between *observation*, *introspection* and *dialogue* that are important. As Engel further explains with the help of recalled or reported examples, the doctor cannot limit himself to a purely external observation (*outer viewing*), especially with a *biopsychosocial* approach to the patient, but must look at his own personal inner world (*inner viewing*) in the dialogue with the patient (*interviewing*). According to this, the doctor can only muster the necessary *empathy for the patient* by allowing himself to be sufficiently stimulated by his own life experience through the patient's stories.

Table 9.1 Report/chronicle versus Narrative

In his dialogue role as an active listener, the doctor will pay attention to the distinctions the patient can make with words (Tab. 9.1), namely, for example, between *event* and *experience*, *outer* and *inner* world, *objective* and *subjective* meaning, *historical* and *narrative* truth, *calendrical* and *biographical* time, *anonymity* and *intimacy*, *rationality* and *emotionality*, etc.

|    |                      | Chronicle/Report                                   | Narrative  |
|----|----------------------|--|--|
| 1  | Subject              | Events   | Experiences  |
| 2  | Area                 | Outer world  | Inner World  |
| 3  | Validity             | Historical truth                                   | Narrative truth  |
| 4  | Time                 | Calendar   | Biographical   |
| 5  | Perspective          | Past   | Visualisation  |
| 6  | Room                 | Everyday reality                                   | Scenic performance                                       |
| 7  | Form of presentation | Logical-linear                                     | Sequential   |
| 8  | Dialogue form        | Question-Answer                                    | "Free" narrative   |
| 9  | Language             | Impersonal ("man")<br>Abstracts<br>Indirect speech | Personal ("I")<br>Richness of metaphors<br>Direct speech |
| 10 | Evaluation           | Rational   | Emotional  |
| 11 | Orientation          | Listener-neutral                                   | Listener-specific  |
| 12 | Relationship         | Anonymity  | Intimacy   |
| 13 | Medical focus        | Disease history                                    | Illness history  |
| 14 | Topics               | Biomedical   | Biopsychosocial  |
| 15 | Relationship model   | Paternalism /Service                               | Cooperation (SDM)  |

Tab. 9.1: Report/chronicle versus Narrative (on Koerfer, Albus 2018)

We will take up and concretise these differences between report and narrative in empirical narrative analyses. In advance, we will only point out the relevance of the simple distinction between "objective" and "subjective" time data of patients (cf. § 19.7).

Box 9.6 Narratives of the Self

Schafer 1992/1995

Just as in everyday life, general functions of narration are also perceived in the medical consultation, which have to do with the *meaning- and identity-forming function* of (biographical) narratives in general (Schafer 1995, Stern 1998, Bruner 1998, Gergen 1998, 2002, Lucius-Hoene, Deppermann 2002, 2004, Habermas 2006, Goyal 2013, Römer 2017, Habermas 2019, Deppermann et al. 2020). Who we are can hardly be *summed up* in a word, but it can be in a *narrative* in which we can illustrate our course of life with all its designs, realisations and dislocations for ourselves and an interested listener.

The role of narrative has been used in psychotherapy in particular, where various self-presentations of patients are to be promoted via the patient's *associations* (§ 9.4). Before we go into the interactive framework of narrative in more detail, the general function of patients' *self-narratives*, as formulated by Schafer (1995) (Box 9.6), for example, from a specifically psychoanalytic perspective, should be prefaced here.

Box 9.6 Narratives of the Self

My theoretical argument is that the so-called self-concepts, self-images, self-presentations or, more generally, the so-called self, can be seen as a set of narrative strategies or storylines that each person follows in an attempt to develop an emotionally coherent representation of his or her life among other people. We organise our past and present experiences in narrative ways.

Schafer 1992/1995: 62

Although a narrator strives to develop "an emotionally coherent account", this "attempt" often remains provisional. In patient narration, it is by no means possible to assume constant stories that would be told in the same way in all situations and to different people. Rather, according to Schafer (Box 9.7), depending on the occasion and conditions of the telling, different versions of self-narratives can be expected, in which the narrator can position himself in several roles from different perspectives.

Fig. 9.1-4 Types of narratives

In addition, *mixed types* of narratives can also be differentiated, which are not characterised by an "either-or", but linguistically-communicatively by a "one-sided-other-sided" or "both-as-well" or "yes-but", i.e. are determined by a complex type of evaluation, which will be further differentiated in the exemplary narrative analysis. In doing so, we first follow Gergen's (1998 and 1999/2002) typology on the evaluation function of narratives, according to which general types of *progressive* and *regressive*, *tragic* and *comedic* narratives can be distinguished, which we reproduce here as *prototypical* representations (Fig. 9.1-4).

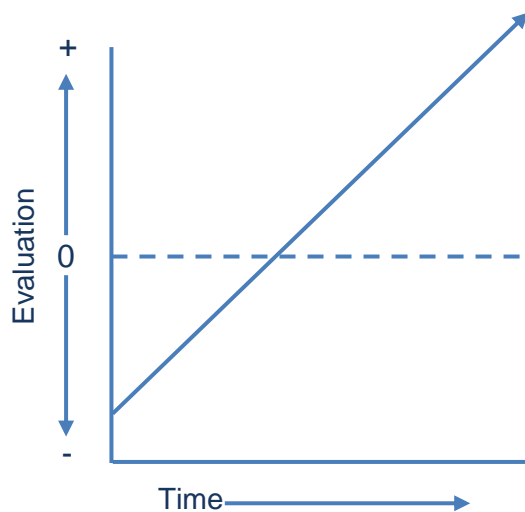


Fig. 9.1: Progressive narrative

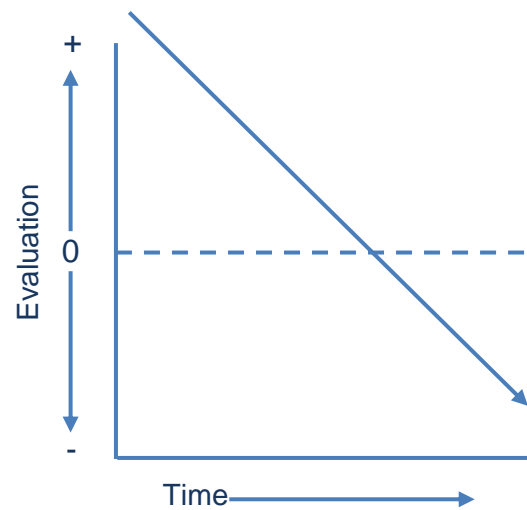


Fig. 9.2: Regressive narrative

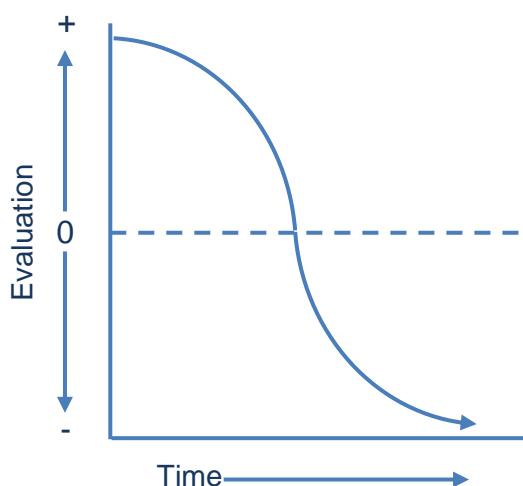


Fig. 9.3: Tragic narrative

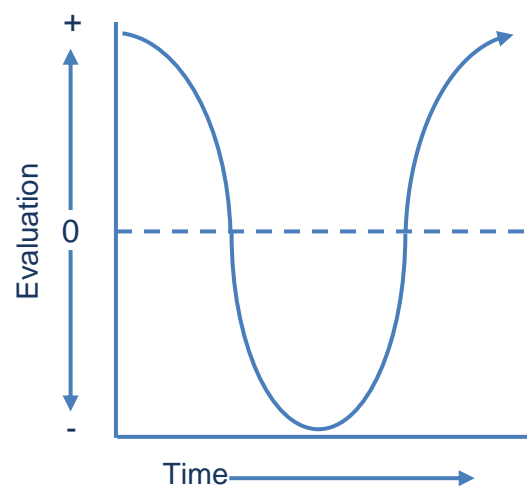


Fig. 9.4: Comedic narrative

(mod. after Gergen 1998: 179ff and 1999/2002: 94ff)

Fig. 9.5 Normal form of narration

The normal form of storytelling can be represented by the following diagram:

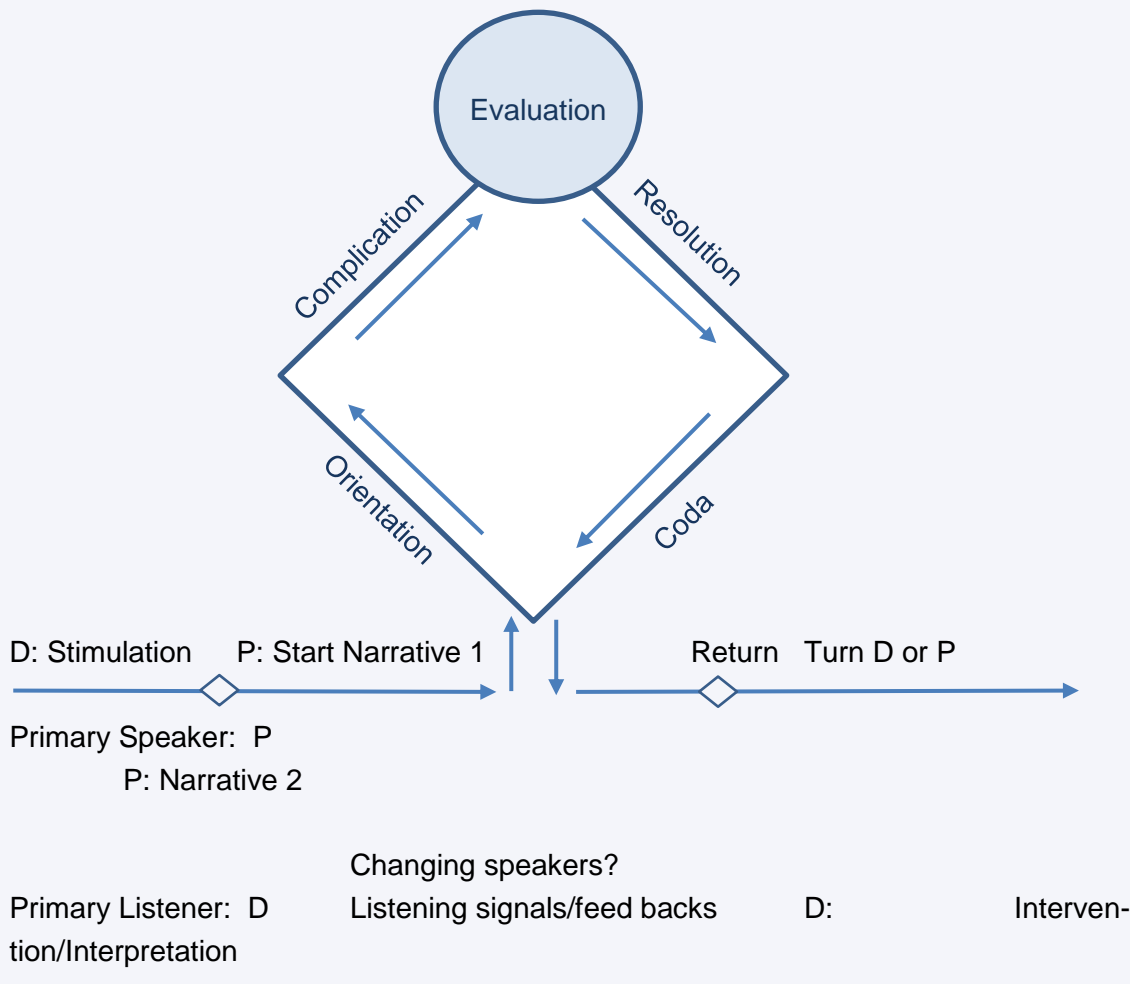


Fig. 9.5: Mod. on Labov, Waletzky 1967/73: 124 and on Koerfer, Albus 2018: 425

Box 9.8 Explanations of the narrative model (cf. Fig. 9.5)

The development function of the narrative starts at the base of the square, followed by the orientation part at the top left, then the complication part towards the top. Often, though not always, the evaluation stops the plot at this apex, which is expressed by the circle. The resolution takes place downwards to the right, and the coda appears as the line that returns to the situation (the point in time) in which the narrative was originally stimulated.

Labov, Waletzky 1967/73: 124

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|     | Primary speaker                                | Primary listener   |   |
|-----|--|--|---|
|     | Patient  | Doctor   |   |
|     | Actional                                       | Mental   | Actional  |
| 1   | Communication 1                                | New focusing 1<br>Speech transition                          | Narrative stimulus<br>"How did that happen?"  |
| 2   | Framing<br>Thematisation                       | Logical<br>Understanding                                     | Issues:<br>"Where was that?"<br>"Who else was there?"<br>"When was that?"   |
| 3   | Orientation<br>Place, time, people             |  |   |
| 4   | Personal<br>Perspectivation                    | Psychological<br>Understanding                               | Settings:<br>"This was what you<br>wanted (hoped for,<br>feared)?"  |
| 5   | Complication,<br>Scandalon                     | Scenic-empathic<br>Understanding                             | Listener feedback:<br><br>"hm", "yes", "ah", "oops",<br>"terrible", "great", "gosh",<br>"Oh my goodness",<br>"jeez", etc. |
| 6   | Problem solution,<br>-Clarification            |  |   |
| 7   | Evaluation:<br>Morals, maxims                  |  |   |
| 8   | Coda<br>Speech transition                      | Willingness to<br>taking the floor and<br>making a statement | Empathic Response,<br>Interpretation:<br>"This must have been a<br>shock for you"   |
| 9   | Feedback<br>"hm", "yes", "right",<br>"exactly" | Securing understanding                                       | Reconfirmation:<br>"even", "that's how it is"   |
| 10A | Communication 2A                               | Focusing 2A  | Narrative stimulus 2  |
| 10B | Communication 2B                               | Focusing 2B  | Interpretative Intervention   |

Tab. 9.2: Dialogic narrative model (DNM) of doctor-patient communication  
Modified on Koerfer et al. (2000: 96), Koerfer, Albus (2018: 228)

Box 9.10 Basic psychoanalytical rule

Freud 1913/1970

The problems of cooperation between doctor and patient were already anticipated by Freud early on, at least for the psychoanalytical conversation, and they can be generalised to a certain extent for the medical consultation. In his "Advice to the Physician", Freud (1913) at the same time makes recommendations for the communicative behaviour of patients who might obviously find it difficult - as Freud literally puts it (Box 9.10) - to deviate from an "ordinary conversation".

Box 9.10 Basic psychoanalytical rule

One more thing before you begin. Your narrative should differ from an ordinary conversation in one respect. Whereas otherwise you rightly try to hold on to the thread of the context in your presentation and reject all disturbing ideas and secondary thoughts so as not to get, as they say, out of the hundredth into the thousandth, here you should proceed differently (...) You will be tempted to say to yourself: This or that does not belong here, or it is quite unimportant, or it is nonsensical, therefore it need not be said: Never give in to this criticism and say it anyway (...) So say everything that crosses your mind.

Freud 1913/1970: 194

What is more or less action-guiding in everyday communication is apparently to be negated in psychoanalytic conversation. The Freudian distinctions "from an ordinary conversation" read six decades before Grice (1975/1979) like an early *anti-maxims catalogue*, with which the validity of the everyday rules of communication is precisely to be invalidated: Although the maxims, even after Grice, are not always separable in detail (§ 7.3.3), in retrospect they can easily be assigned to Freud's formulations of psychoanalytic basic rule communication, as this can be contrasted in a tabular overview (see above Table 2.2).

It is no coincidence that Freud addresses the patient directly with his specially formulated basic rule message, which is condensed into a general maxim ("So say everything that crosses your mind") and passes on this "ideal" model formulation of the message as a recommendation to the attending physician. Obviously Freud has assumed here a correspondingly strong validity of everyday rules of communication when he makes these everyday rules so explicitly the subject and appeals to the

patient's willingness to negate in such an insistent way: "Never give in to this criticism and say it anyway" (Box 9.10).

...

The patients' problem of accepting and then practising the basic psychoanalytical rule, which is initially "unfamiliar" from their participant perspective, in the practice of conversation can only be illustrated here in rudimentary form. In order to clarify the context of the following examples, Menninger and Holzman's (1977) expert perspective (Box 9.11) professional assessment of the double effect that the "privilege" provided in the psychoanalytic setting can have on patients should be prefaced:

Box 9.11 Effects of the privilege granted: satisfaction and frustration

If a person seeking therapeutic help is allowed the privilege of telling a listener, who refrains from excessive or discouraging insinuations, everything he thinks, he will feel two things at the same time, a certain satisfaction and also a growing frustration.

Menninger, Holzman 1977: 57

Thus, at the beginning of therapy, patients already enjoy this "privilege" by narrating in a more or less *monologue-like manner*, thus following the basic psychoanalytic rule. In the following example (E 9.1) (from Koerfer, Neuman 1982: 110) the specific listening role of the analyst in the whole setting - as here by a patient in the 4th therapy hour - is then judged *expressis verbis* as "positive".

E 9.1 "positive that there is one person to whom I can tell everything"

01 P2 (...) what I feel . is positive, that there really is a person to whom I can tell everything . or who willy-nilly has to listen and who must not scold me if I say something stupid .

However, the "growing frustrations" expected according to Menninger, Holzman (1977) do not remain absent, especially because the patients begin to miss the corresponding reactions of their interlocutors after their initial narratives. Thus the same patient, who had just in the 4th hour of therapy still positively assessed the listening role exercised by the analyst, already in the 11th hour complains about the *quasi-monological* structure of a *one-way communication* (E 9.2) (from: Koerfer,

Neumann 1982: 111), which she aptly characterises from her experiential perspective with a metaphorical expression ("pneumatic post").

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E 9.2 "I can't even get a reply to my pneumatic post"

---

01 P2 (...) and if I say something . then maybe it goes to you by pneumatic post . in writing maybe . but then I'm not there, and I can never know, and I can never find out what you're thinking at that moment when I say something to you, I don't even get an answer to my pneumatic post.

---

Of the numerous examples of reflexive acceptance testing and "resistant" application of the psychoanalytical basic rule, a few examples (E 9.3-7) (from: Koerfer, Neumann 1982: 112ff) will be cited here as exemplary excerpts from various therapies. The examples all come from the first 12 therapy sessions, because special problems of *socialisation* were to be expected in the early stages. As expected, the learning process then manifested itself in many *meta-comments* on the "unfamiliar" type of conversation experienced in this way.

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E 9.3 "I could try to draw you into the conversation"

---

01 P4 (...) I could try to draw you into the conversation, but you wouldn't get involved at all ... probably.

---

---

E 9.4 "I don't ask a question where I can't get an answer to"

---

01 P3 (...) yes, precisely because this question that you have raised,/ it is actually,/ because it is not the answer that matters, but because I am interested in the background of the question.  
02 P3 It depends on the answer, otherwise I wouldn't have asked . I don't ask a question where I can't get an answer . and it really is a terse question . I don't understand why you have to talk about it so much.

---

---

E 9.5 "that everything I tell is basically irrelevant"

---

01 P4 (...) I have the feeling that everything I tell is basically irrelevant, nech . [=right?]

---

#### 44. Teaching Materials on Medical Communication

E 9.6 "other thoughts started, which were completely unimportant"

- 01 D3 you are silent (...) perhaps you yourself also know something of the background . if you then take a break ... for example now ....
- 02 P3 yes, I couldn't think of anything more to say about the topic in question, and then there was silence about this . silence of thought/and then some other thoughts started, which were completely unimportant and actually have nothing to do with the whole thing.

E 9.7 "my thoughts are actually quite disorganised"

- 01 P1 yeah, I don't know, so my thoughts are actually quite disorganised .
- 02 D1 It doesn't matter, you can share them in an unorganised way.

Without being able to further differentiate the various metacommunicative aspects here (Koerfer, Neumann 1982), the acceptance problems of the patients in the psychoanalytical conversation can be recognised from the few examples, which deviates considerably from an "ordinary conversation" precisely in the above sense of Freud (Box 9.10).

While the patient in example (E 9.4) still insists on his right to ask questions and more or less indignantly demands the answer of his interlocutor in the sense of a normal expectation, the patient in example (E 9.3) already seems to be able to come to terms with the non-responsiveness of the analyst, even if he clearly expresses his preference and resignation. In examples (E 9.5) and (E 9.6), the patients each in their own way doubt the relevance (*Be relevant*) of their contributions, which they have to decide on themselves without communicative agreement with their therapist. (...)

B 9.8 "that I can almost do what I want with the hour"

- 01 P (...) that is for me/and above all it was very astonishing for me eh . to see that the whole hour is just put at my disposal, that I can do what I want with it . hm . that I am just ... proactive and/ or tell something or whether I tell nothing or whether I tell hm/what I tell . that it is pretty much up to me how and what and how long . and that I can do with the hour . almost what I want .

Box 9.14 Let the patient tell the story

Freud 1913

The need to promote *free patient speech*, which can be used for *free narration*, has already been justified several times in advance with reference to the "classics". Here we should again recall one of Freud's "Advices to the Physician" (1913/77) (Box 9.14), which should apply not only to the psychoanalytic therapy session but to every medical consultation, even if the time frame is certainly more limited.

Box 9.14 Let the patient tell the story

Overall, it does not matter with which material one begins the treatment, whether with the patient's life story, the history of his illness or his childhood memories. In any case, let the patient tell the story and let him choose the starting point.

Freud (1913/1977: 197)

As discussed above, such a conversational maxim of *letting the patient tell the story*, especially at the beginning, can be generalised not only for therapeutic but in a moderate form for medical communication as a whole (§ 9.3). With all the differences between a more "psychotherapeutic" and a more "medical" communication, which should more or less converge anyway in *basic psychosomatic care* (§ 15, 25), the principle of *association should be followed* to a greater or lesser extent in medical conversation. The spontaneous *flow of thoughts* of patients should be expressed as a *narrative flow* as unhindered as possible in appropriate forms of communication before it can be "steered into certain channels" in the joint conversation work of doctor and patient, for which not least the professional competence of the doctor is required.

The *principle of association*, which is essentially linked to free patient narratives, owes its origins to the psychoanalytic tradition (Thomä, Kächele 1989, Heenen-Wolff 2014), which goes back to Freud's *basic rule formulation* (§ 9.3). In the meantime, however, the principle has become established in medical communication (in the broad sense), albeit certainly in the weaker variant of a *biographical narrative* anamnesis, with which a biopsychosocial care approach (§ 4) is pursued.

Box 9.17 *interrogation vs. narration - defensiveness vs. intimacy*

The quintessence ("*Interrogation* generates defensiveness; *narration* encourages intimacy") is to be placed here in the developed context (Box 9.17), in which Engel begins by reminding his readers of their own experiences with the specific type of medical history taking ("taking ..."):

Box 9.17 *interrogation vs. narration - defensiveness vs. intimacy*

Readers need only review their own experiences with doctors "taking" [sic] their histories to appreciate the difference between *encouraging narration* and *requiring reporting*. The latter approach is deliberately interrogative, the doctor assuming the initiative and agenda, the patient an object of study rather than an active participant in his/her own study. Eighteen seconds has been reported to be the mean length of time to elapse before doctors interrupt the patient's first response (...) Small wonder patients complain that doctors don't listen. *Interrogation* generates defensiveness; *narration* encourages intimacy.

Engel 1997: 526 (emphasis and "[sic]" so in the original).

In this conception of *conditioning*, which is described here by related terms (*generates, encourages*), the conversationalists, by choosing between a (primarily) *interrogative* and (primarily) *narrative conversational* style, bear the main responsibility for negative as well as positive conversational developments, which can amount to two alternatives (*defensiveness vs. intimacy*). For the empirical conversation analyses, it should ideally be demonstrated in each case how these alternative conversational developments came about from case to case, i.e. under which conditions and for which topics and purposes with which participation roles (*object vs. active participant*) of the respective conversation partners. The alternative participation roles of the patient as *subject* and *object* had already been described in advance (§ 1, 9.2) with Engel's justification of a *dialogical* communication between doctor and patient, which is derived not least from the functions of a *biopsychosocial* medicine (§ 4), which directs its topic and treatment focus not only to the body, but also to the illness of the patient as subject.

Box 9.18 The "dilemma" of "balance"

Platt, Gordan 2004

The criticism of the interrogative style of conversation should not be exaggerated to the point that questions are frowned upon at all. Rather, the relationship between *interrogation* and *narration* should be seen as *complementary* overall, which remains a challenge in practice. As Platt and Gordon (2004) point out (Box 9.18), doctors will not be able to avoid the dilemma of choice ("doctor's inquiry" vs. "patient's narrative") in practice, but only to "work through" it.

Box 9.18 The "dilemma" of "balance" in conversation practice

Throughout the conversation there must be a balance between the doctor's inquiry and the patient's narrative. You can decide in the first few minutes of the interview how much guidance your patient needs to tell his story so it will be useful to you. But even if it gives you little biomedical information, telling his story is therapeutic to the patient. *The dialectic between our need to understand, sort, and recombine data and the patient's need to tell his story always creates tension in the interview. We cannot avoid the dilemma; we can only work with it.*

Platt, Gordan 2004: 39 (emphasis there)

These "tensions" between the two ways of conducting a conversation are not only to be endured in principle, but also to be decided on a case-by-case basis in one direction or the other in the practice of conversation. A *super-maximum* could apply here: In case of doubt, the patient's word should be given preference over the doctor's word. The specific functions of *targeted* questions, which are indispensable for *detailed exploration*, will have to be further differentiated later (§ 21). However, as long as patients can muster a sufficient willingness to talk as a willingness to tell, a certain priority should be given to medical *listening*, as will be further elaborated with Balint's critique of traditional anamnesis (§ 9.5) and further illustrated in empirical conversation analyses. This is in no way to advocate a dichotomy of *questioning* and *listening*, but rather to emphasise their unity in a *dialogical* communication (§ 7).

E 9.9 "You can tell a doctor anything".

Freud 1895/1952

Once the necessary trust between doctor and patient has been sufficiently established, the medical consultation often becomes an original setting for narratives that have never been told before in this or a similar way, which is occasionally also specifically emphasised by patients. The doctor thus becomes a *privileged* listener who is authorised as a witness to "unheard-of" events whose meaningfulness is called into question with a specific need for clarification. As the first "crown witness" for the medical listener privilege, we will call here the patient "Katharina", who told about her story of suffering after a chance encounter with the holiday guest Freud, from whom she learned that he was a "doctor". From this conversation, which we will reproduce in more detail later and recommend as a lesson in conversation management (§ 21.8), we will cite the reaction of Katharina (K 16) to Freud's invitation to tell her story (F 15) (E 9.9), who, as a patient, convincingly announces the medical listener's privilege before, after another invitation to tell her story from Freud (F 17), she continues to tell the story she has already begun in detail (K 18).

E 9.9 "You can tell a doctor anything".

- 13 F If you don't know, I will tell you what I think gave you your fits. Once, two years ago, you saw or heard something that embarrassed you, something you would rather not have seen.
- 14 K Oh yes, I caught the uncle with the girl, with Franziska, my cousin!
- 15 F What's the story with the girl? Don't you want to tell me?
- 16 K You can tell a doctor anything. So you know, my uncle, he was my aunt's husband, the one you saw there, used to have the inn on the **\*\*kogel** with my aunt, now they're divorced, and it's my fault that they're divorced, because it came up through me that he's keeping it up with Franziska.
- 17 F Yes, how did you come to the discovery??
- 18 K It was like this. Two years ago, once ... [longer narrative]

Freud 1895/1952: 185ff

Although the conversation at that time (1895) was of course not yet "documented" with modern technology, but reconstructed from Freud's memory ("The conversation that now occurred between us, I give it as it

impressed itself on my memory"), the authenticity of this statement by Katharina cannot be doubted. Her statement ("you can tell a doctor anything") is a self-disclosure of her experience of the meaningful function of a doctor's consultation and at the same time an *appeal* to the doctor's willingness to listen, to whom one is not only allowed to "tell everything" but also to *expect him to do so*. In empirical conversations from "our time", patients also emphasise the *listening privilege*, which they sometimes grant only to their doctor, in marked contrast to other potential trusted interlocutors (e.g. relatives, friends). For example, a patient apparently tells her "unheard" story for the first time in a doctor's consultation. In this example (E 9.10), some of the previously differentiated categories for the narrative analysis are already included in the comment column.

| E 9.10 | Dramatic narrative: "deadly bad"<br>Exclusive story: "I never told my husband"  | Comment  |
|--------|---|--|
| 37     | D this dizziness, did it start when you found out about this diagnosis [= daughter has MS]? .   | Detail exploration (time, condition) + narrative invitation  |
| 38     | P yes, I think so ... once I had something in my head at night, uh ... I never told my husband that, once I had something in my head at night, deadly bad ... I woke up ... I thought: "Oh dear, oh dear, what's wrong now?" ... once I got really sick in bed at night ... I fought it, always did everything at her house, took care of the household a bit . until it was no longer possible, no ... | Framing, theme<br>Orientation<br>Listener privilege<br>Complication<br>"unheard of Event"<br>Direct speech<br>Evaluation:<br>Mastery <i>versus</i> failure, coda |

Since we will come back to the pre- and post-history of the narrative itself and its functions and structures in a detailed analysis of the conversation (§ 19.7), we will only note here under the aspect of *listener privilege*: Following her (partly reworked) local and temporal *orientation* ("there was me once at night...", "once at night ...", "at night in bed"), the patient lets the doctor in on an "unheard-of event", the relevance of which she marks by the very fact that she specifically emphasises her previous secrecy towards her husband ("uh . I never told my husband that") (...)

## Box 9.19 The art of listening

Balint 1964

Instead of constantly interrupting the patient with other questions and thus distracting him from his initiated topic, the patient's current *narrative flow* should first be *encouraged*. In this way, patients can "freely provide" information that is difficult or impossible to ask for, as Michael Balint (Box 9.19) so pointedly summarised in his well-known dictum criticising traditional anamnesis taking:

## Box 9.19 The art of listening

According to our experience, if the doctor asks questions in the style of the usual anamnesis, he receives answers to his questions - but nothing more. If he wants to arrive at a deeper diagnosis, he must first learn to *listen* (...) The ability to listen is absolutely an art and requires an essential, albeit limited, *inner conversion of the doctor*. While the doctor discovers in himself the ability to listen to things in his patients that are hardly expressible because the patient is only vaguely aware of them, he begins to listen to this barely audible language in himself as well. During this process, he will soon realise that there are no direct, unapologetic questions that can bring to light what he wants to know.

Balint (1964/1988: 171), emphasis in original

This "art" of *listening*, as Balint called it, will be illustrated in detail with examples, against which counter-examples of the conversational practices of "listening away" and "overhearing" are to be contrasted, to which we will also return with Balint (§ 10.2, 17.4).

To begin with, despite all the theoretical and practical differences, the common ground between a psychotherapeutic therapy hour and a GP consultation hour, in which *basic psychosomatic care* is provided (§ 15, 25), must be emphasised once again: In both cases, the doctor must have the *competence* to "listen to things that are hardly expressible because the patients are only nebulously aware of them". These "hardly pronounceable things" are a challenge for the professional listener both in the psychotherapy hour and in the medical consultation hour, which can only be mastered in the interplay of active listening and questioning. It is in this interplay that the *art of medical communication* must prove itself (§ 17, 21), which will be further concretised below as the *art of medical midwifery*.

## 10 Dialogical Decision Making

### Box 10.1 Democracy and the Third Health Revolution

With the concept of the "responsible patient", which is derived from the basic idea of the "responsible citizen" in a democratic society, particular emphasis is placed on the right to *information* and *self-determination*, especially in the case of illness. The patient's *information* and *participation* in medical decision-making are no longer seen as optional but as obligatory components of the doctor-patient relationship, whose traditional, paternalistic character has become obsolete in view of social developments and advances in medicine ...

### Box 10.1 Democracy and the Third Health Revolution

The 20th century became the age of the doctor, the clinics and the industry. Well-informed patients were not the primary goal of the second revolution (...) Now we need a third health care revolution. While the first brought clear water, the third should bring clear information. It should transform the 21st century into a *century of the patient* - a truly democratic ideal. Citizens have the right to know the basic facts, and they have a responsibility to make decisions about their health based on the best available evidence. We envision a healthy health system as a democracy in which knowledge is distributed to all levels of society.

Gigerenzer, Gray 2013: 27, emphasis in original

The strengthening of patients' rights in the sense of information and participation in decision-making is a basic democratic idea that essentially aims at the *autonomy of the patient*. As will be explained (§ 10.4, 10.6), this autonomy is by no means to be confused with *self-sufficiency* of a patient who could enforce his or her decision without or even against the doctor without jeopardising the relationship.

Patients can only exercise their autonomy with the appropriate *health literacy*, which is to be conveyed by medical action in an ongoing information process (§ 10.5). Thus, by providing basic information, the patient must first be enabled to ask further questions that are relevant to him or her. By answering these questions, physicians contribute to further promoting the patient's competence in the sense of "qualified" participation (*empowerment*), which ultimately allows a "joint decision at eye level" ...

#### 44. Teaching Materials on Medical Communication

The term and concept of *concordance* (Box 10.4) assumes a *dialogical*, but by no means a merely *harmonious* process of understanding; rather, it is intended to concede conflicts that may be rooted in the different attitudes and interests of the participants, which make compromise difficult.

##### Box 10.4 *Concordance* as a potentially controversial negotiation process

Concordance is based on the idea that health care practitioners and patients should work towards a mutual understanding about medicine taking and the development of a therapeutic alliance. Fundamental to the concept of concordance is that there is an open exchange of beliefs about medicines upon which both prescribing and medicine-taking decisions may then be based. Thus concordance seeks to make patient participation explicit.

The exchange of beliefs and views by both health care professionals and patients may result in an agreement to differ over treatment choices but the key issue is that all the participants in the consultation are aware of differences where they exist. This awareness may then be used as the basis for joint negotiation or compromise over the final outcome. Thus concordance seeks to make apparent potential areas of disagreement and conflict.

Stevenson, Scambler 2005: 13

In the *joint negotiation* process, conflicts between doctor and patient can thus be both overcome and exacerbated, which may put the "therapeutic alliance" to a serious test. If a conflict cannot be resolved satisfactorily, the relationship can also be dissolved by mutual agreement, provided it is not an emergency care situation. A rationally justified separation then exhausts itself in a consensus on a dissent that can no longer be resolved recognisably for the participants (principled non-concordance). Sometimes conflicts also end in an abrupt termination of the relationship, which is *de facto* carried out by the patient with a change of doctor (§ 19.6), without this having been announced beforehand.

As experience teaches and will be shown by examples, controversies between doctor and patient are not exactly rare, even if they do not always come to light openly. The controversies are carried out in different participant roles, which are not least based on the difference between the professional, medical perspective of the doctor and the lay, lifeworld perspective of the patient ...

Box 10.8 Voice of medicine versus voice of the lifeworld

Here, Mishler's (1984) critique (Box 10.8) of the *dominance* and *control* of the medical "voice" over the lifeworld "voice" of patients who are continuously "interrupted" by their doctors - a factual relationship that needs to be programmatically reversed in the sense of *humane* care in analysis and practice - should be cited first:

Box 10.8 Voice of medicine versus voice of the lifeworld Mishler 1984

Physicians' control of structure is matched by their control of content. The relevance and appropriateness of information is defined through what physicians choose to attend to ask about. This bounded domain of relevance is summarized as the voice of medicine. Occasionally, the flow of the interview is "interrupted" by the "voice of the lifeworld" when patients refer to the personal and social contexts of their problems. Physicians rapidly repair such disruptions and reassert the voice of medicine (...)

If we wish to break free of the voice of medicine, to open up new perspectives that would help us understand how to change a pattern of coercive medical care to more humane practice, then we have to begin again in a different way. In order to do this, the analysis must be inverted; the relations between the voices of medicine and the lifeworld must be reversed. In this way, the voice of medicine may be understood as an interruption of the voice of the lifeworld.

Mishler 1984: 95, 98

This methodological reversal perspective has already been demonstrated by Mishler (1984) in many empirical examples, in which he also shows how doctors should allow themselves to be "interrupted" by their patients in order to integrate their lifeworld concerns productively. Before adopting this perspective for our empirical conversation analyses, the essential theoretical provisions for an analytical consideration of the conflict between the "voices" of medicine and the lifeworld are to be compiled in a diagram (Fig. 10.1) in a didactic overview by way of *contrast*.

44. Teaching Materials on Medical Communication

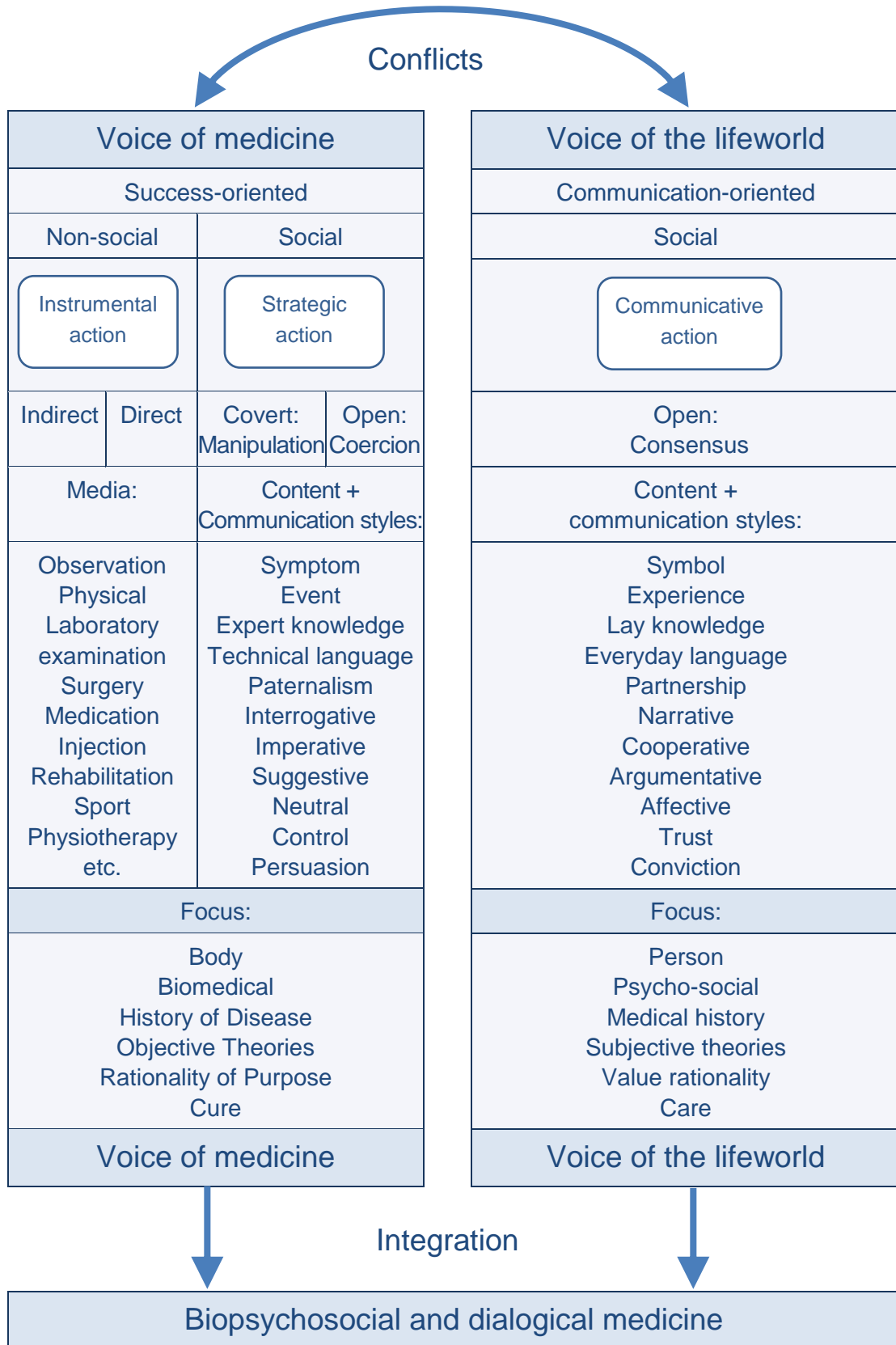


Fig. 10.1: Conflicts and integration of lifeworld and medicine

Fig. 10.2 Preference and evidence-based decision dialogue

A major problem in medical decision-making is first of all to clarify between the parties involved, by *means of discussion*, which treatment options can or should be chosen at all for a certain disease, or which options are not (or no longer) available for a certain course of disease, etc. (Fig. 10.2) ...

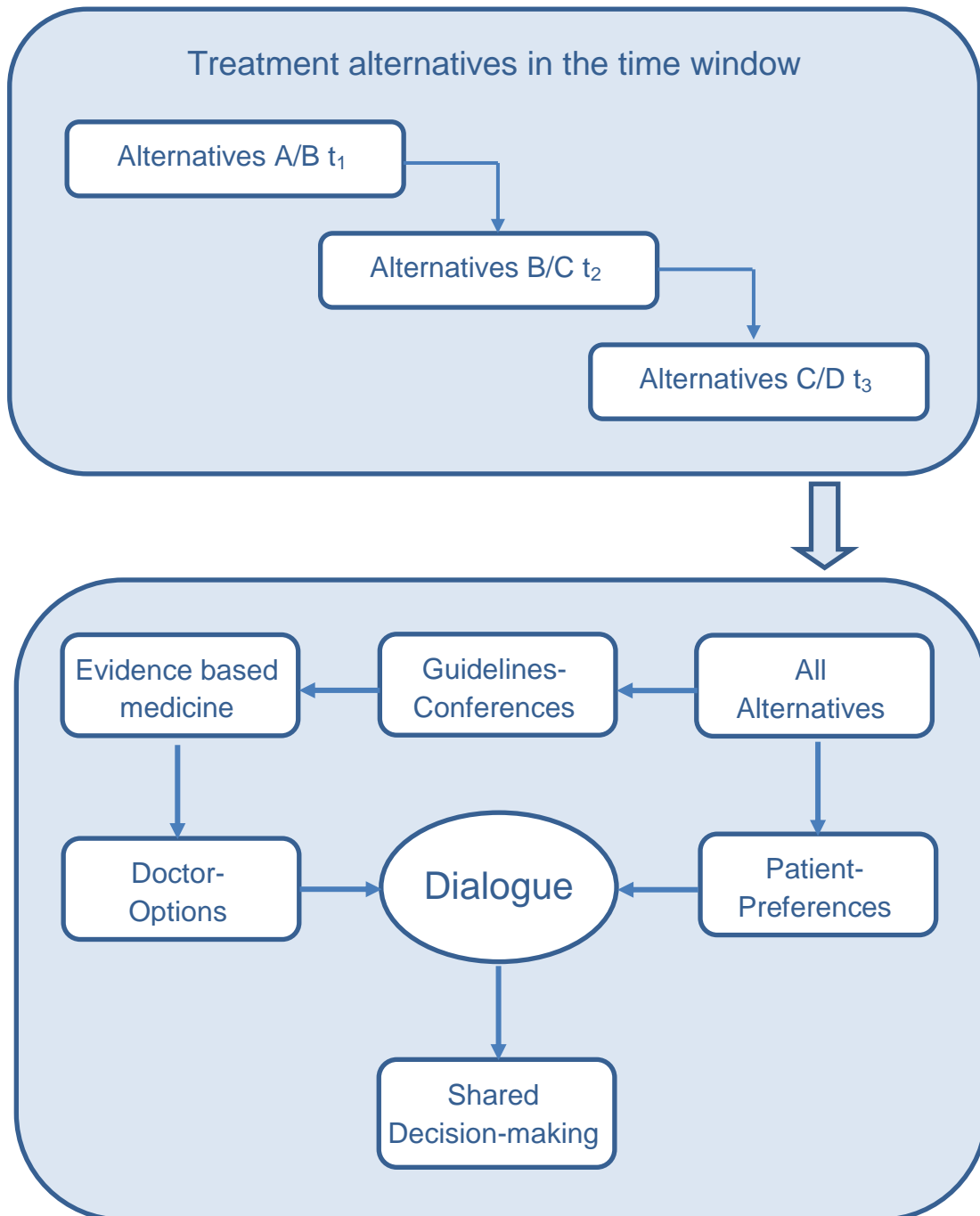


Fig. 10.2: Preference and evidence-based decision dialogue

44. Teaching Materials on Medical Communication

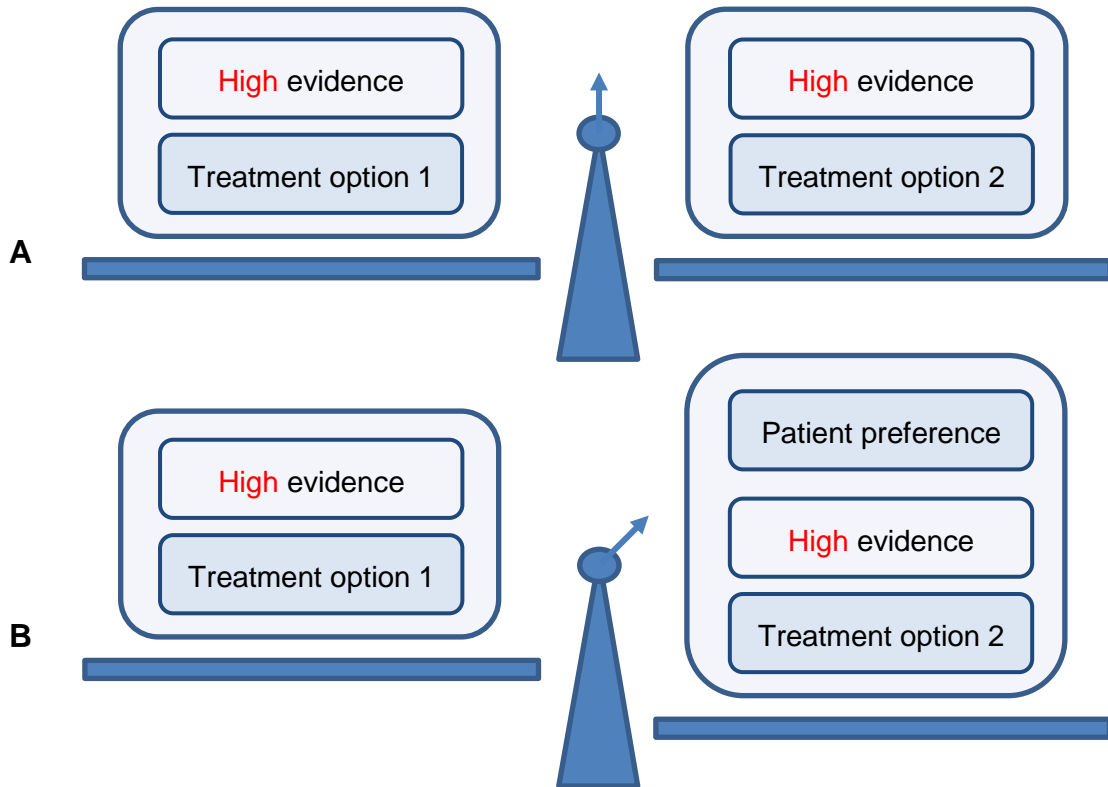


Fig. 10.3: Weighting of preferences and (equal) evidence

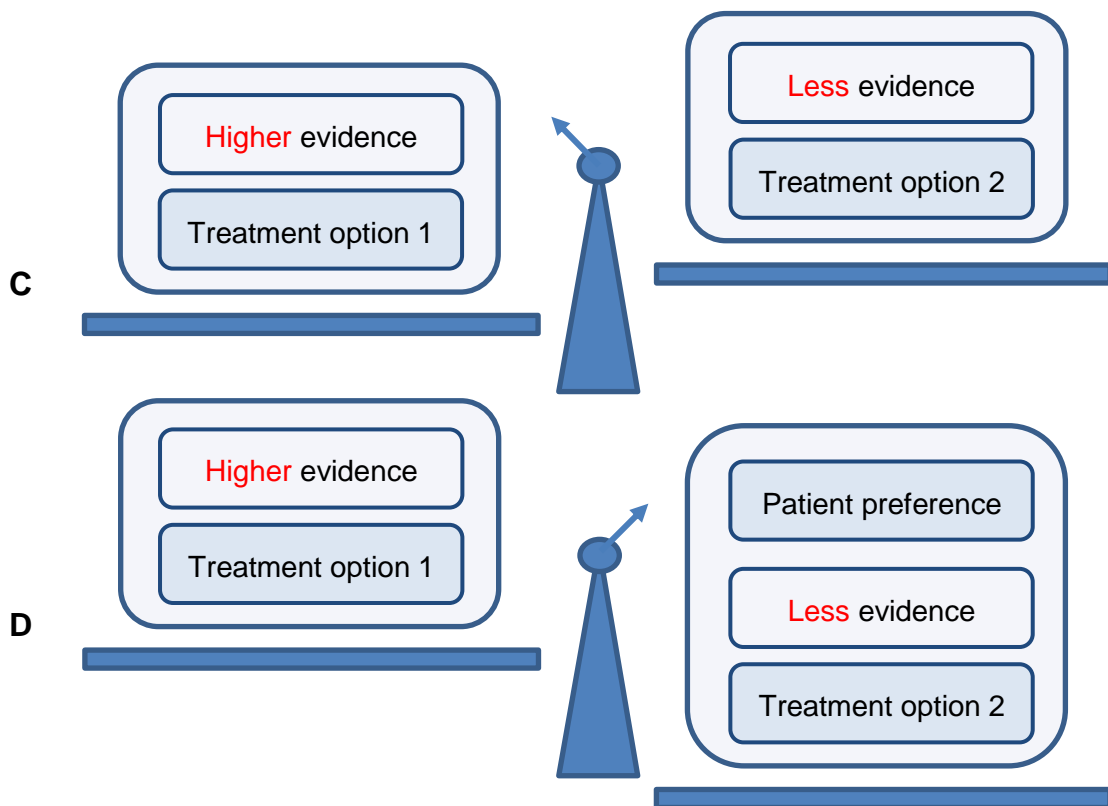


Fig. 10.4: Weighting of preferences and (unequal) evidence

According to the characteristics (*high - low*) in the two dimensions (*relevance - safety*), there are different "zones" for decision-making (Fig. 10.5), in which either the joint decision of both partners has priority, or the priority lies with the doctor if safety is high and relevance is low, or in the opposite case the priority lies with the patient. In addition, there is a "conflict zone" where both relevance and safety are high.

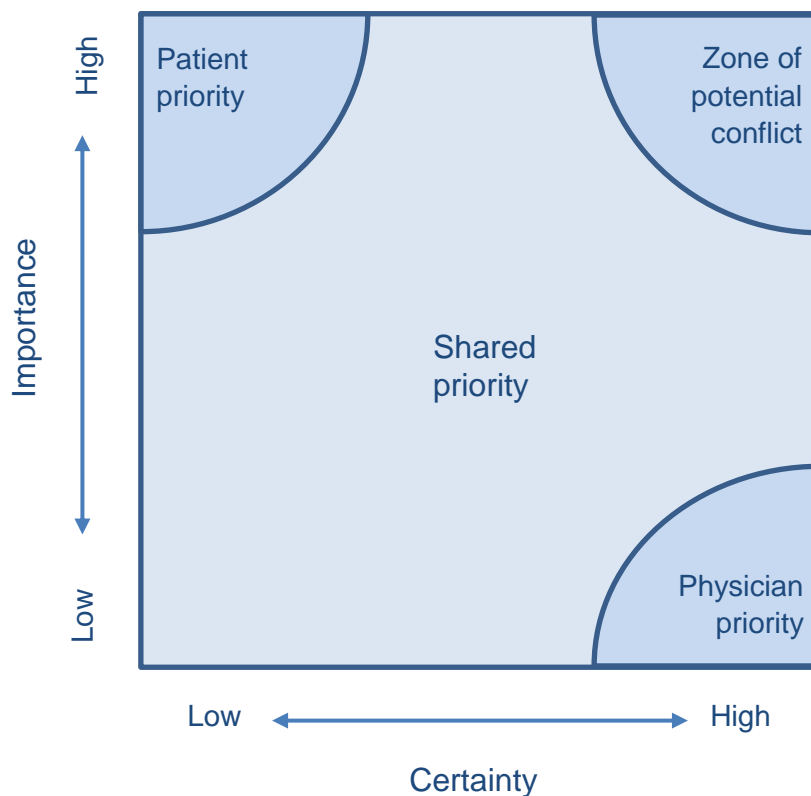


Fig. 10.5: Decision plane for medical decisions (on Whitney 2003: 278)

Due to the high relevance, the patient would have "every right" to assert himself against the doctor's strong recommendations in case of conflict, even though this is "fortunately" rather unusual: "Fortunately, the usual dynamic in this situation is for physicians to make strong recommendations and for patients to accept them" (2003: 27). However, the experience of the "usual dynamic" will not yet be able to exclude any deviation in the *individual* case, which always has to be renegotiated. In this negotiation process, the problem of balance arises again, for example, when a decision has to be made about the relevance of a given certainty, in which the patient finally has a "weighty say" from his or her lifeworld perspective.

#### 44. Teaching Materials on Medical Communication

Table 10.1 Three basic models of medical decision making

|                       | Paternalism  | Cooperation<br>(shared decision)                                  | Service (informed<br>choice)  |
|-----------------------|--|---|---|
| Ethics                | Authoritative ethics   | Ethics of discourse   | Libertarian ethics  |
| Relationship          | doctor-centered  | relationship-centered   | patient-centered  |
| Physician role        | Guardian, Samaritan,<br>Father   | Partner, Consultant   | Service provider,<br>Seller   |
| Patient role          | Needy person; child  | Partner, client   | Consumer, customer  |
| Topic focus           | biomedical   | biopsychosocial   | biomedical  |
| Strategy/<br>Attitude | Coercion → Obedience   | Dialogue → Conviction   | Manipulation<br>→ Persuasion  |
| Direction             | ("one way") D → P  | ("two way") D ↔ P   | ("one way") P → D   |
| Evidence (DC)         | yes  | yes   | no  |
| Preference<br>(PZ)    | no   | yes   | yes   |
| Transparency          | no   | yes   | no  |
| Information           | Monologue  | Dialogue  | Interrogation   |
|                       | Selective mediation and<br>reception of information                      | Sufficient knowledge<br>exchange and mutual<br>understanding      | Selective knowledge<br>acquisition through<br>question-answer pat-<br>terns |
| Decision              | Instruction  | Deliberation  | Suggestion  |
|                       | Order or prescription<br>according to medical<br>prefix                  | Negotiation of evi-<br>dence- and preference-<br>based options    | Advertising and con-<br>tracting, supply and<br>demand of options           |
| Responsibility        | External control by D  | Joint control   | Self-control of P   |
|                       | Tendency towards self-<br>sufficiency of D with<br>loss of autonomy of P | Tendency towards mu-<br>tual trust with autonomy<br>on both sides | Tendency towards self-<br>sufficiency of P with<br>loss of autonomy of D    |

Tab. 10.1: Comparative representation of three basic models of medical decision making (mod. according to Koerfer, Albus 2015: 121)

Fig. 10.7 Communication pattern for paternalism model

| Phase          | Paternalism   |        | Authoritative ethics   |
|----------------|---|--------|--|
|                | Patient   | doctor | Constitutive features  |
| Information    | <pre> graph TD     D1[1. communicate information] --&gt; P2[2. receive information]             </pre>  |        | Reception ("informed")<br>Unidirectional: D → P<br>Information - Acknowledgement; Information needs:<br>Selection by D:<br>Only the "bare essentials"<br>Knowledge type:<br>Objective information:<br>Diagnosis, therapy, prognosis, risks, etc. |
|                | <pre> graph TD     D3[3. make arrangement] --&gt; P4[4. accept arrangement]             </pre>  |        | Instruction:<br>Solitary Decision D:<br>Order → Compliance (D → P)<br><br>Evidence versus preference<br>Options imposed<br>Intransparency (D → P)<br>Coercion → Obedience  |
| Responsibility | <pre> graph TD     D5[5. realise examination and therapy plan] --&gt; D6[6. control behaviour]     D6 --&gt; P7[7. tolerate control]             </pre> |        | Responsibility D<br><br>External control-control for (non-)adherence:<br>D → P<br><br>Autonomy D<br>Heteronomy P   |
|                | (Non-)adherence   |        | (Non-)obedience  |

Fig. 10.7: Communication pattern for paternalism model

Fig. 10.8 Communication pattern for service model

| Phase          | Service (informed choice)   | Libertarian ethics  |
|----------------|---|---|
|                | Patient doctor  | Constitutive features   |
| Information    | <pre> graph TD     P1[1. search for information] --&gt; D2[2. give information]     D2 --&gt; D3{3.}     D3 --&gt; P4[4. obtain offers]                     </pre>          | Reception ("informed")<br>Unidirectional: P → D<br>Question and answer pattern<br>Information needs:<br>Selection by P<br>Knowledge type:<br>Objective information:<br>Diagnosis, therapy, prognosis, risks, etc. |
| Decision       | <pre> graph TD     P4[4. obtain offers] --&gt; D5[5. make offers]     D5 --&gt; P6[6. communicate decision]     P6 --&gt; D7[7. accept decision]                     </pre> | Advertising Contract:<br>Demand → Supply →<br>Solitary Decision P<br>("informed choice")<br><br>Preference vs. evidence<br>Intransparency<br>(P → D; D → P)<br>Manipulation → Persuasion                          |
| Responsibility | <pre> graph TD     P8[8. realise examination and therapy plan] --&gt; P9[9. self-control]     P9 --&gt; D10[10. tolerate behaviour]                     </pre>              | Responsibility for the decision primarily P,<br>secondary D for medical measure (surgery, medication);<br>Self-control P<br>Laissez-faire D<br>Self-sufficiency P<br>Loss of autonomy D                           |
|                | (Non-)adherence   | (Non-)persuasion  |

Fig. 10.8: Communication pattern for service model

Fig. 10.9 Communication pattern for cooperation model

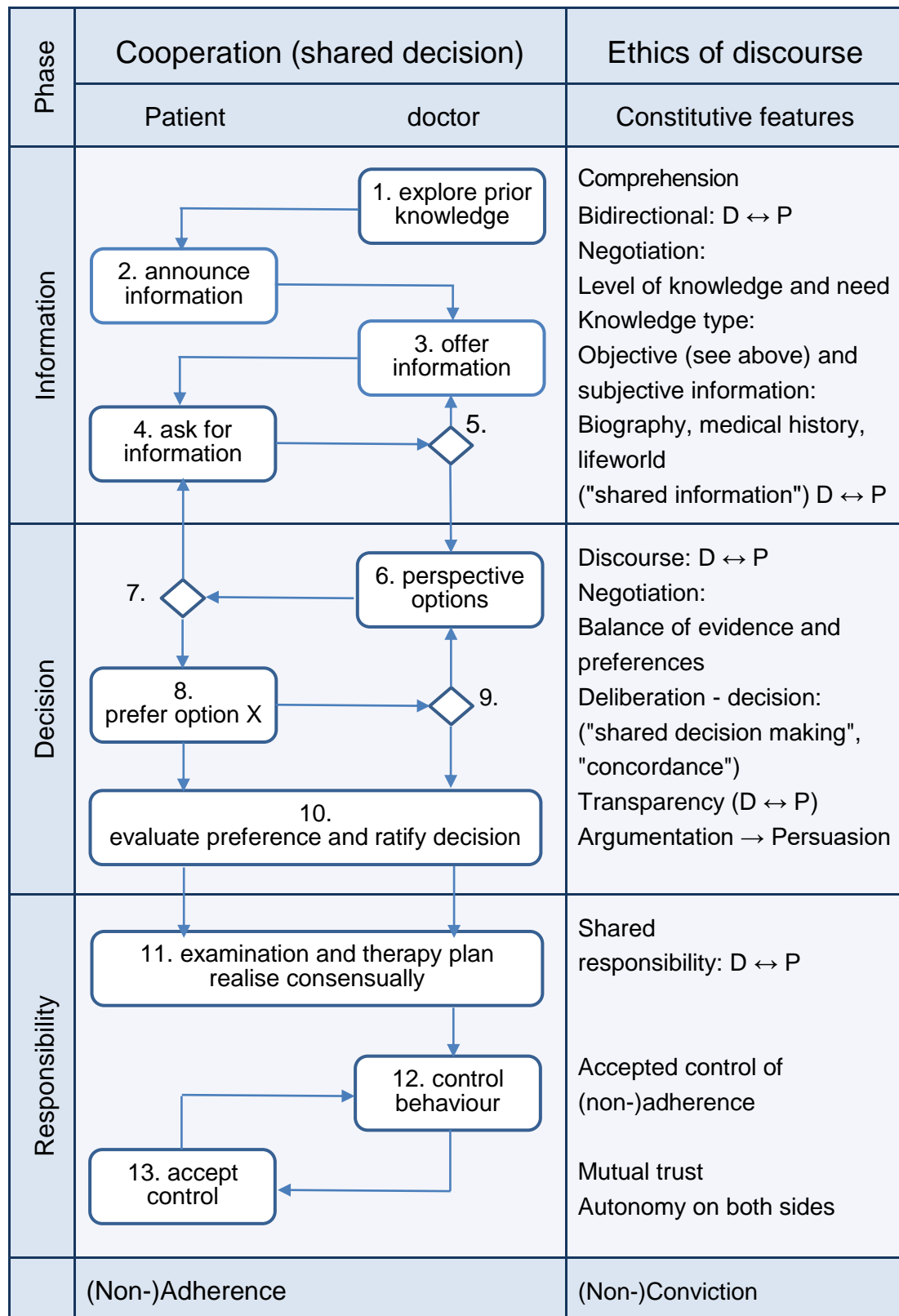
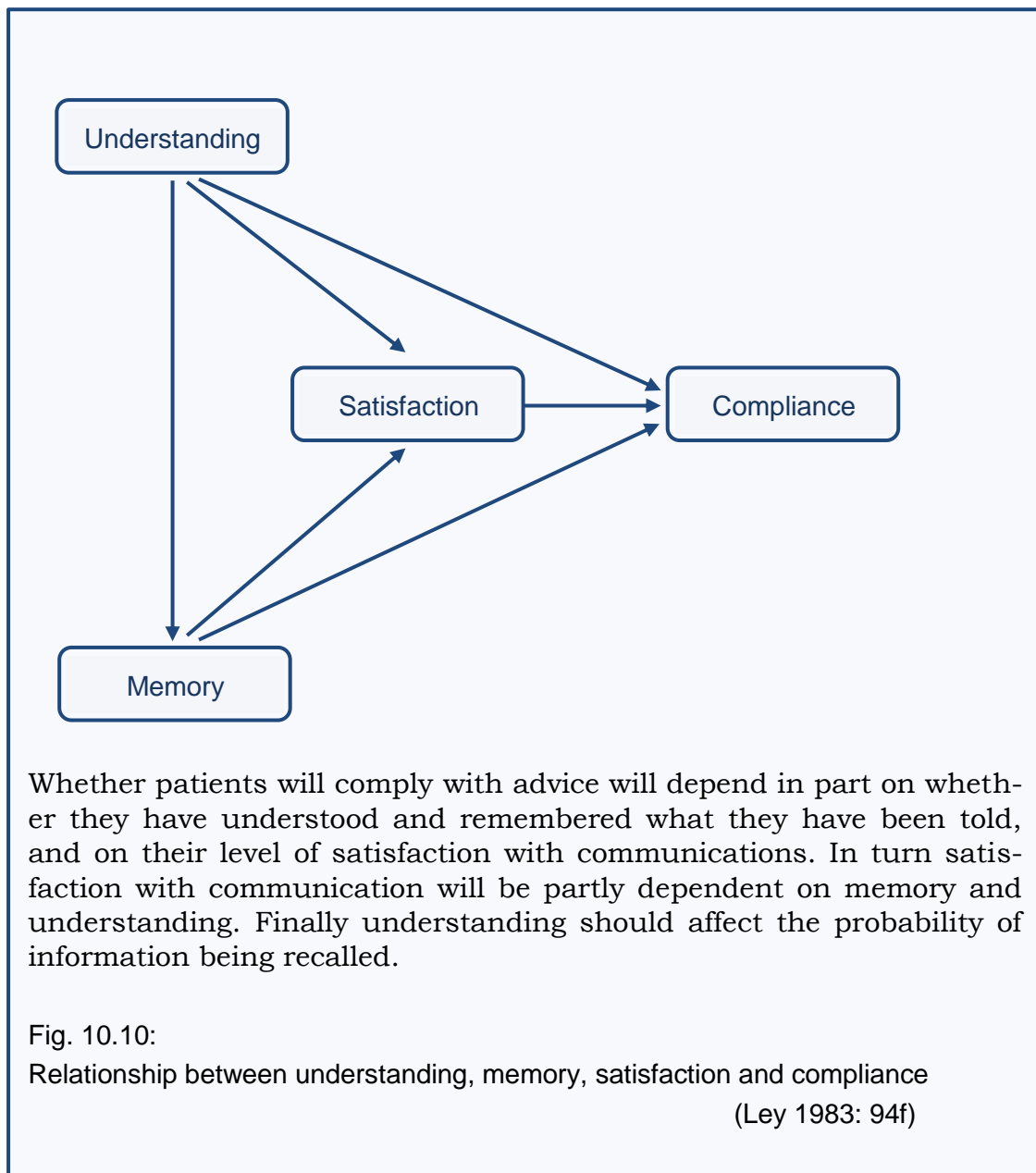


Fig. 10.9: Communication pattern for cooperation model

Fig. 10.10 Understanding, memory, satisfaction and compliance

Ley 1983

To begin with, in order to demonstrate the immediate consequences of a lack of communication between doctor and patient, the explanatory model that one of the pioneers of doctor-patient communication, Philip Ley, presented and explained in a simple diagram (Fig.10.11) (1980, 1983, 1988) should be introduced.



Box 10.16 Participation preference as a development process

The fact that increased participation is also increasingly desired and, in addition, that adherence to therapy (*adherence*) and therapy success (medical *outcomes*) are favoured is now increasingly confirmed by research (Härter, Simon 2013, Martin, DiMatteo (eds.) 2014, Hauser et al. 2015). Nevertheless, one can neither take a uniform object of research as a basis, which is characterised by very different terms and conceptions of participation (SDM) (Makoul, Clayman 2006), nor assume a homogeneity of patients' participation preferences that would allow a uniform, standardised conversation practice in decision-making. Thus, Härter, Simon (2013) (Box 10.16) also emphasise in their review that preferences in participation vary depending on many factors (age, gender, education, type of illness, etc.) and may themselves be subject to change and development.

Box 10.16 Participation preference as a development process

Patient preferences in participation are not immutable and may vary depending on factors such as age, gender, education, experience of illness, medical care, health status, type of decision, attitude to decision-making, relationship with the doctor and information preference (...) Furthermore, qualitative studies have shown that participation in decision-making is a developmental process that is reinforced by access to information, the development of personal expertise and a good relationship with the doctor. Barriers that inhibit participation preference are a lack of understanding on the part of patients about their potential role in decision-making, as well as a lack of knowledge and understanding that there is not always one right decision (...) Therefore, patients fear that they lack the expertise, knowledge and clinical experience necessary to make decisions, as well as the support to identify their own preferences.

Härter, Simon 2013: 57

Of course, it makes sense and is useful to be able to start from a *typological* knowledge that enables doctors to orient their conversation practice in decision-making according to the age, gender, education or type and severity of the illness of their patients and to be able to take possible obstacles into account (Braun, Marstedt 2014) ... A review of the effects of SDM on outcomes, quality, cost and consultation time is provided by Bruch et al. 2024.

## 13 Medical Communication Training

Table 13.1 Curriculum of the Department of Psychosomatics and Psychotherapy (University of Cologne)

The Cologne study reform covers all preclinical and clinical semesters. (§ 14). Our teaching offer as a whole (Table 13.1) ranges from the first-semester tutorial to lectures in both the preclinical and clinical training phases, in which courses are central to communicative interaction with real and simulated patients (SP), to the PY (practical year) starting block, which is designed to prepare students for the practical year under the guidance of the Dean of Studies (§ 14). In addition, we offer continuing education events aimed at practising doctors within the framework of the Continuing Education (§ 16, 43).

Within this framework, we also offer specific further training for tutors and lecturers ("teach the teachers"), who in turn work on learning concepts for teaching communicative competences in their specific medical areas of activity. In preclinical and clinical training, the courses at our clinic are closely linked thematically with neighbouring disciplines in which the teaching of *psychosocial* competences is central.

### Legend (Table 13.1)

|     |                           |      |   |
|-----|---------------------------|------|---|
| POL | Problem-oriented learning | MMC  | Manual Medical Communication (C-MMC)      |
| RP  | Real patients             | BBN  | Breaking Bad News                         |
| RS  | Role play                 | SDM  | Shared Decision Making                    |
| SP  | Simulation patients       | OSCE | Objective Structured Clinical Examination |
| MC  | Multiple Choice           | MTP  | Multimedia Training Programme             |
| DPV | Doctor-Patient-Videos     | EMC  | Evaluation of Medical Communication       |
| MM  | Multimedia                | VC   | Video-Conference (D-P plus students)      |

| Semester             | Type of teaching | Contents - Learning goals   | Didactics - Methodics  | Exam                                 |
|----------------------|------------------|---|--|--------------------------------------|
| 1 preclinic          | Tutorial         | Biopsychosocial Medicine and D-P Communication  | Theory, Reflection, DPV, RS, SP, POL                                     | Text exam                            |
| 1-4 preclinic        | Lecture          | Interdisciplinary fields of competence: diabetes, back pain, myocardial infarction, death and grief, etc. | Lecture, Multimedia, DPV, Manual   | Text, MC exam                        |
| 1 clinic             | Course           | Biopsychosocial anamnesis, medical interviews   | Theory, Reflection, Training; POL, RP, SP, RS, DPV, VC                   | OSCE, C-EMC                          |
|                      | Video conference |   |  |                                      |
|                      | Multimedia (MTP) |   |  |                                      |
| 1 clinic             | Elective seminar | Interviewing, taking medical history, BBN, SDM, palliative care   | Theory, Reflection, POL, D-P-V, Video Conference, Multimedia MTP         |                                      |
| 4 clinic             | Lecture          | Psychosomatics and psychotherapy  | Lecture; Multimedia MTP, DPV, Interactive                                | MC exam                              |
| 4 clinic             | Block course     | Psychodiagnostic interviewing for specific clinical pictures; self-awareness                              | Theory, reflection, training, POL, RP, SP, DPV, MMC, Junior Balint work, | MC-, Text-Written Examination        |
| 4 clinic             | Elective seminar | Theory and practice of Psychodynamic Psychotherapy, BBN, SDM  | Theory, Reflection, POL, VC  |                                      |
| 4 clinic             | Elective seminar | Oncology, BBN, SDM  | Theory, Reflection, POL, MMC   |                                      |
| Continuing education | Course           | Psychosomatic Primary care  | Balint work, POL, case reports, DPV, RP, RS, SP                          | MC-, Text-Written Examination, C-EMC |

Table 13.1: Curriculum of the Department of Psychosomatics and Psychotherapy (University of Cologne) (see legend below)

## Box 13.1 Clinical reasoning and communication

Cary, Kurtz 2013

The *development of communication competences* in teaching and their later further specialisation does not take place "in the air", but is linked to clinical education and experiential practice in clinical reasoning. Following the results of a workshop (conducted at EACH 2012), Cary, Kurtz (2013) explicitly highlighted the need to integrate clinical reasoning and communication (Box. 13.1).

## Box 13.1 Clinical reasoning and communication

Integrating clinical reasoning and clinical communication into the broader medical curriculum helps to drive skill development and learning of content material deeper and provides an efficient means of educating a well-rounded clinician.

Cary, Kurtz 2013: 362

The interaction and interplay between medical knowledge and action competences and specific communicative competences has been explained in detail in advance in the *formulation of learning goals* (§ 3). There it was differentiated that doctors must have a *double medical competence*, in which the communication competence is not merely a "rhetorical" competence, which would have to be acquired additionally, but it is to be taught already in teaching with clinical competences in a problem- and practice-based way (§ 3, 13.4-5).

....

These *professionelle double competences* are to be realised with a *fitting competence* (§ 3) in specific problem situations, which are to be permanently controlled from a *self-reflexive* observation perspective of a so-called "meta-doctor" (v. Uexküll) (§ 2, 3.6). Here, degrees of professional competence are to be differentiated, which constitute relevant differences, for example, between *novice* status and *mastery*, as discussed in the introduction (§ 1.3, 3.6) for *didactics* and finally for the *evaluation* of medical communication (§ 13.6, 40).

Fig. 13.1 Learning goal taxonomy for medical communication training (Focus: Active Listening) (AL)

The interaction and interplay of hierarchically organised learning goals of different orders had already been described in didactic and theoretical foundation chapters (§ 1-12). Here, the focus should once again be on the fact that *learning goals* should not be formulated more or less ad hoc, but within the framework of *theory-based* didactics and evaluation (§ 2, 3, 17, 40). A here merely *3-level taxonomy* of *macro*, *meso* and *micro* learning goals can be captured in a *hierarchical structure* as it can be reproduced in a reduced and selected representation (Fig. 13.1).

The exemplarily marked *main path* runs on three levels of order from the branching node of *biopsychosocial medicine* via the preferred *relationship model* of *cooperation* or *partnership* and via the central *dialogue function* ("listen to concern") and then the associated basal *dialogue type* of *narration* to the specific communication forms of *active listening*, which *manifests* itself linguistically in conversational practice on a *behavioural* level and can therefore be well identified and finally well rated or coded (§ 40).

With all the need of a didactic reduction, to which we will return shortly, should be taken into account for teaching: The structure of the schematic flow chart (Fig. 13.1) contains only selected *placeholders* for *relationship models*, *dialogue types* and *communication actions and forms* (interrogation, narration, repetition, listener signals, etc.), which are to be derived from medical and communication theories and models, as summarised above with reference to our didactic and theoretical chapters.

The interaction, dependency, combination and differentiation of the learning goals should be explained as far as possible using examples which are referred to below (13.4-6) and which will be analysed later using transcripts from real D-P communication in the practical part of the handbook (Part IV), which is based on our *Cologne Manual on Medical Communication* (C-MMC) (see below Fig. 13.11). The learning goal taxonomy can also be presented in a verbally differentiated way, which is illustrated by an excerpt from the manual (cf. 13.4. In the next example, Fig. 13.x, the focus in teaching is placed on Exploring Details (ED) (cf. Cologne Manual Fig. 13.11).

44. Teaching Materials on Medical Communication

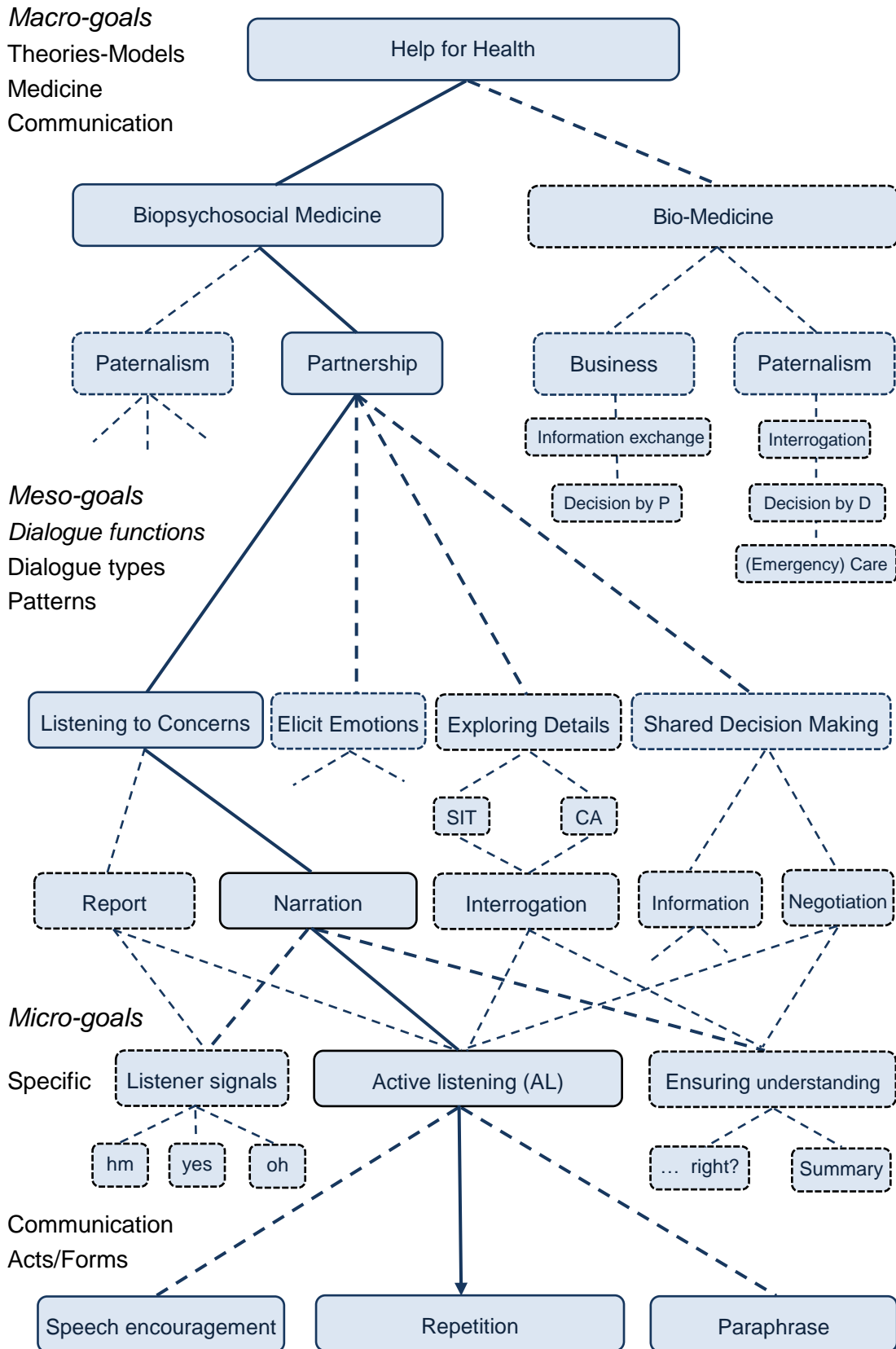


Fig. 13.1a: Learning goal taxonomy for medical communication training (Focus: AL)  
(Flow chart modified on Koerfer et al. 2008, Koerfer, Albus 2018) (cf. § 2, 3)

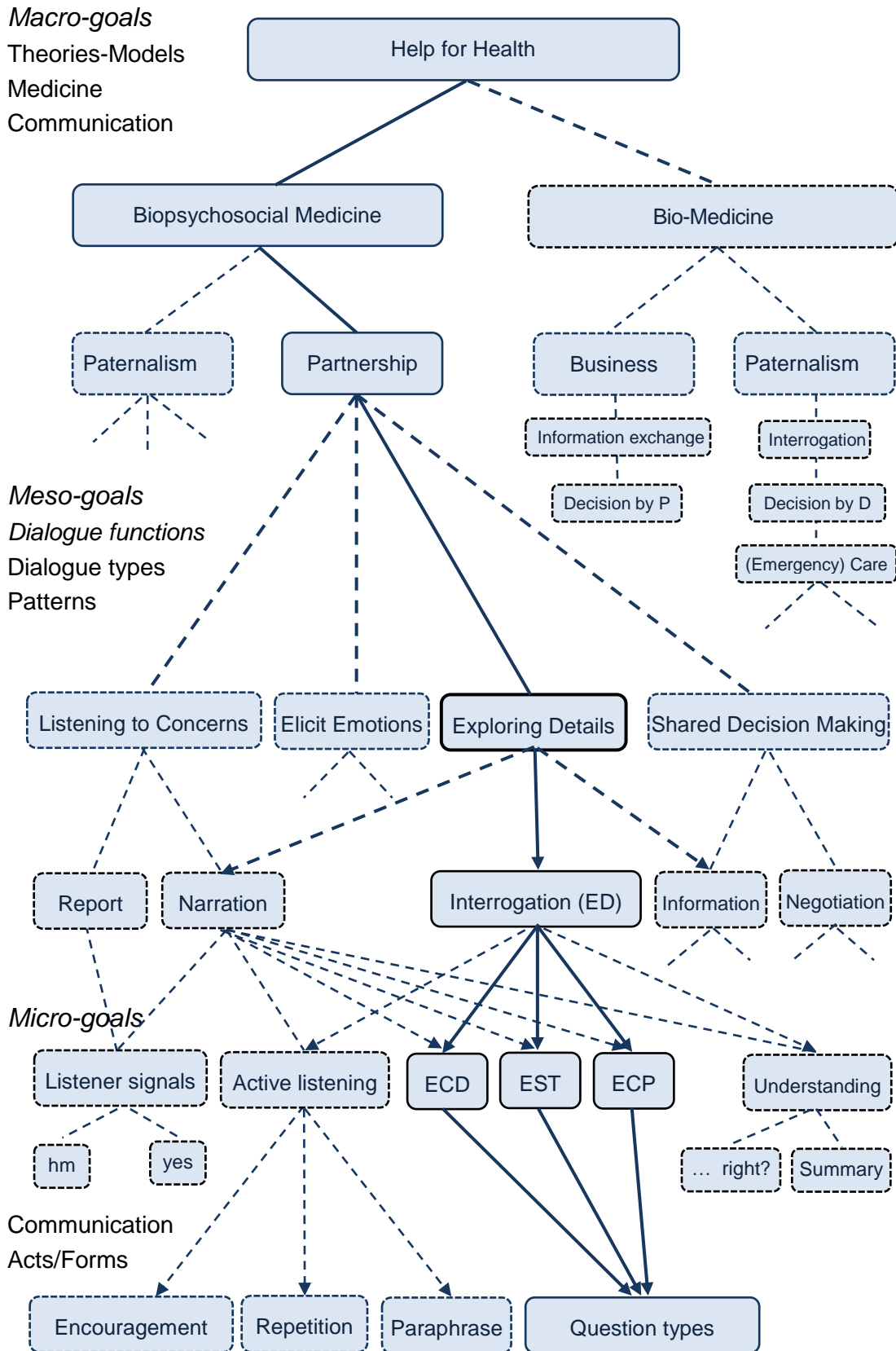


Fig. 13.1b: Learning goal taxonomy for medical communication training (Focus: ED)  
(Flow chart modified on Koerfer et al. 2008, Koerfer, Albus 2018)

Box 13.4 Learning goal taxonomy for "Listening to concerns" (excerpt)

For further concretisation and illustration of verbal representations of the *learning goal taxonomy* (with *by-relations*) (*top down*), the example from our basic didactics chapter (§ 3) should be used again here (Box 13.4), in which a summary selection is given for the conversational function "Listening to Concerns", which is oriented on our Cologne Manual (C-MMC) (§ 13.4).

These are examples that are located on the order level of the meso- and micro-learning goals (Fig. 13.1) and are to be taught with the higher learning goals on the relationship model (partnership or cooperation) within the framework of biopsychosocial medicine.

Box 13.4 Learning goal taxonomy for "Listening to concerns" (excerpt)

The doctor practices a *biopsychosocial* approach to care

- by taking a *biographical-narrative anamnesis*
  - by *listening to the patient's concerns*
    - by starting the conversation openly
      - by asking about the motive for consultation  
"What leads you to me?"
      - or by asking about the patient's well-being  
"How are you doing (today)?"
      - or by offering herself as a helper  
"What can I do for you?"
  - and by *promoting the patient narrative*,
    - by giving listening signals (*nodding, hm, yes, etc.*)
    - by avoiding interruptions
    - by tolerating speaking pauses
    - by allowing a free development of themes
    - etc.

Excerpt from *Cologne Manual on Medical Communication* (C-MMC)

(cf. § 2, § 3 and Appendix of this chapter)

A targeted *change* in doctors' *conversational behaviour* only makes sense if it is also in line with the higher-ranking goals of a biopsychosocial medicine ...

Table 13.2 Concepts of medical communication didactics

Before we go into further detail in the practical part on the intended changes in doctors' conversational *behaviour* within the framework of the higher-ranking goal of *biopsychosocial* patient care, our *didactic-methodological* concepts should be presented, which are first summarised here in a tabular overview of *medical communication didactics* (Table 13.2).

As is already clear from the overview, we also use the general concepts of medical didactics in our courses, as they have become established in medical education and training. What has proven itself for *medical didactics* as a whole will be concretised and specified below for a specifically *medical didactics of communication*.

For example, the proven *problem-oriented* learning should also be used for medical communication didactics by *contrasting* unsuccessful with successful cases of conversation ("best practice") (§ 13.4), without this difference having been explicitly marked beforehand in the lessons. Only in this way can the active and independent problem-solving of the students also be promoted in medical interviewing, which should by no means follow a certain *pattern* (Scheme X). In this respect, our *Manual on Medical Communication (C-MMC)* (§ 13.4) should be used as a *structuring aid* both in the classroom and in self-learning, which should be used flexibly and case-specifically in the sense of problem-oriented learning.

The methodological approach of empirical conversation research already described in the introduction (§ 1, 2) is to be linked with our didactic approach in such a way that in the case- and practice-related teaching and in the self-learning we use real doctor-patient conversations as a basis, which the learners either conduct themselves with real patients in live situations, which are modelled on a workplace situation, or which have already been recorded directly at the doctor's workplace in the ward round or GP practice.

These recorded conversations were processed in a multimedia way so that they can be used as learning occasions for conversation reflections or own intervention exercises (in a multimedia programme), which we will come back to in a moment (§ 13.4.5).

How the didactic-methodical concepts work together in an integrative curriculum will be described below in a progressive *Teaching-Learning Spiral* (TLS) (§ 13.3) (see next pages)

#### 44. Teaching Materials on Medical Communication

| Didactics and methodics            | Features - Examples   |
|------------------------------------|---|
| Theory-based                       | Biopsychosocial medicine, relationship theory, communication theory, models of decision making, etc. (§ 4, 9, 10, 13.4.3)   |
| Competency-based                   | Competences and attitudes in instrumental action (surgery, medication) and communicative action (cf. § 1, 2, 3, 14)   |
| Manual-based                       | Manual for Medical Communication (and BBN) (C-MMC) (cf. § 17-23)  |
| Problem-oriented                   | Transparency vs. manipulation, interrogation vs. narration, confrontational vs. tangential interviewing (cf. § 2, 3, 7, 9)  |
| Research-oriented                  | Controversial issues of "good" medical communication: interruptions; open vs. suggestive questions, confrontational vs. tangential interview stiles etc. (cf. § 13.4.3) |
| Case- and practice-related         | Practical relevance in the clinic (ward rounds) and GP practice or specialist practice (cf. § 18-25)  |
| Transcript-based                   | "Transcription" of recorded D-P-communication, specific "best practice" examples (cf. § 17-23)  |
| Multimedia-based                   | D-P-Video conversations (with specific clinical pictures), information texts, transcriptions, graphics, video conferences with real patients, etc. (cf. § 18-25)        |
| Training-oriented                  | Practice talks with real and simulated patients, trial acting, multimedia training programme (C-MTP) (cf. § 13.4.5)   |
| Group and self-learning oriented   | Lecture ("frontal teaching"), practical course ("group teaching"), tutorial, "homework" (reading, exercises)(cf. § 14)  |
| Self-reflexive and self-evaluative | Role play, simulation, multimedia training programme (C-MTP), evaluation (§4, 13.4)   |
| Exam-oriented                      | Simulation patients, evaluation: OSCE, feedback, Cologne Evaluation of Medical Communication (C-EMC) (cf. § 13.5-6)   |

Table 13.2: Concepts of medical communication didactics

Fig. 13.3 Teaching-Learning Spiral (TLS)

The *spiral curriculum* at our clinic already begins in the first semester (§ 14.2), in which basic communication competences (such as *active listening*) are taught on the model of *biopsychosocial* medicine (§ 4, 13.2), which are then gradually expanded. The courses are interlinked in terms of content and each follows the concept of *problem-oriented* learning (POL) (§ 13.4.2), which moves at each learning level in a multi-phase teaching-learning spiral of *theory, reflection, training* and *evaluation*.

Depending on individual and institutional learning conditions (group size, prior knowledge, learning level, learning time, learning pace, etc.), the entry into this teaching-learning spiral can be chosen to be more theory-based or more practice-based. As marked in the illustration (Fig. 13.3), the starting points of the learning loops can be set differently:

- Depending on the course of the learning process, in which different problems can occur, the learning loops do not have to be stepped through continuously (theory, reflection, training, evaluation).
- If problems arise during training, it is possible to go directly to a theory-based learning phase, for example to discuss possible solutions to conflicts of maxims, as described above (§ 13.2.3) and taken up again as an example (§ 13.4.3).
- Likewise, transitions from training to comparative reflection can be chosen, in which problems can be illustrated with multimedia processed D-P communication (§ 13.4.4-5).

At any time, the *Cologne Manual of Medical Communication* (C-MMC) can be consulted (§ 13.4.1), which every learner always has at hand, who can consult it or critically question it and thus initiate a theory-based learning phase, etc., in which the manual is supplemented, modified or even revised.

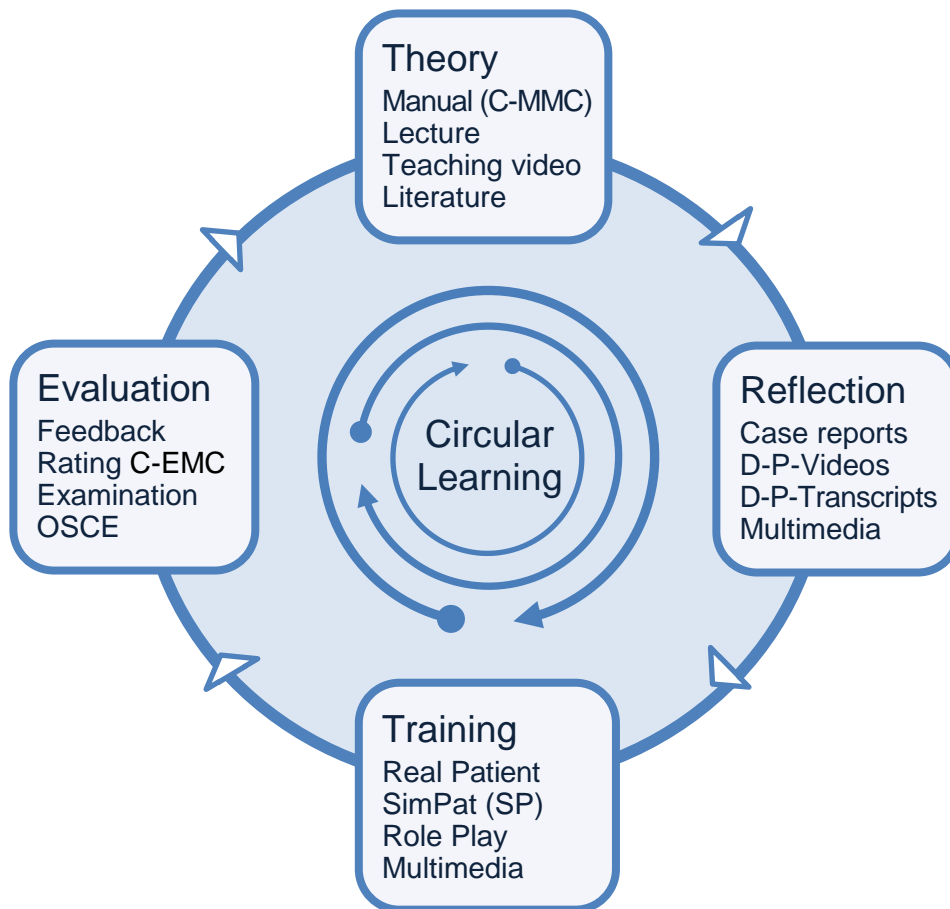


Fig. 13.3: Teaching-Learning Spiral (TLS)  
(modified on Koerfer et al. 2004, 2008, Koerfer, Albus 2018)

As a rule, at our clinic, after a short *theoretical* introduction based on selected research literature, our *Cologne Manual (C-MMC)* (§ 13.4.1) is taken as the starting point for further learning processes. The first *reflection* phases are often initiated by case reports or video conversations from our *Multimedia Training Programme (MTP)* (§ 3.4.5), which offers both *positive* ("best practice") examples and *negative* ("poor practice") examples that can be used for *comparative* learning (§ 13.4.4).

The learning progress achieved in the *reflective learning* phase can then be deepened in specific *training* phases in conversations with real patients (RP) or simulated patients (SP) (§ 13.5) as well as in self-reflective *role play* (RS) (Koerfer et al. 1996, 2008, Koerfer, Albus 2018). The practice conversations are then each subjected to an *evaluation* (§ 13.6) ...

Fig. 13.11 Cologne Manual & Evaluation of Medical Communication (C-M+EMC)

The didactic-methodical basis for teaching at our clinic is the Cologne *Manual of Medical Communication* (C-MMC) (Overview: Fig. 13.4), which we developed for training, continuing education purposes and whose first edition (1998) has since been revised several times (Koerfer et al. 1999, 2004, 2008, Köhle, Obliers, Koerfer 2010, Koerfer, Albus 2018).

The *manual* is designed in the form of a *Leporello* and is intended to be used as a "study companion in pocket format", which can be applied in a differentiated way from first semester tutorials to continuing medical education in basic psychosomatic care (cf. § 15,16, 42, 43).

It is evident that such a *pocket-sized* manual cannot reflect what needs to be taught in teaching with a complex *learning goal taxonomy* (§ 13.2) and an extensive catalogue of learning goals (§ 2, 3). In teaching practice, therefore, if possible, the entire multimedia teaching material should always be available (§ 13.4.5), which can be called up on the basis of current learning occasions and problems and which contains the corresponding empirical anchor examples (§ 17-25).

Furthermore, the *Cologne Manual of Medical Communication* (C-MMC) serves as a structuring template for the *Multimedia Training Programme* (MTP) (Koerfer et al. 1999, 2008, Koerfer, Albus 2018), which is available for individual applications and in group teaching (§ 13.4.5, 13.5.2).

All 6 or 12 main functions of the manual are subdivided into further sub-functions which are to be understood as *conversational maxims* (§ 13.2; cf. § 3.4, 7.3, 9.3, 17.2; nonverbal: cf. § 12, 18) and which have been operationalised as far as possible down to the *behavioural* level of medical communication and provided with exemplary anchor examples for individual conversation steps and functions.

As explained above, all the basic conversational functions of our manual and the sub-functions can be transformed into specific learning goals and conversational maxims, which we have exemplified in extracts from the hierarchy of learning goals (§ 2.3, 13.2).

The functions (for supervision) of a teacher or leader of a learning group were previously differentiated, which consist of promoting the self-reflective *meta-competences* of the learners on several levels of (*self-*) *observation* of the conversation practice (§ 3.3). In the initial phase, it is important that the teacher communicates the challenges of using the manual, i.e. explains the opportunities and limitations.

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| Cologne Manual & Evaluation of Medical Communication  |        |             |  |  |       | C-M+EMC  |
|---|--------|-------------|--|--|-------|--|
| OSCE Checklist for Medical Interviewing   |        |             |  |  |       | <sup>1</sup> 1998                                    |
| © Department of Psychosomatics and Psychotherapy at the University of Cologne   |        |             |  |  |       | <sup>6</sup> 2022                                    |
| No.   | Course | Interviewer | Date   | Patient (SP)   | Rater | Sum:   |
|   |        |             |  |  |       | <input type="checkbox"/> <input type="checkbox"/> 50 |
| 1 Building a relationship   |        |             | <input type="checkbox"/> 4                           | 4 Exploring details  |       | <input type="checkbox"/> <input type="checkbox"/> 12 |
| 1 Framing <ul style="list-style-type: none"> <li>• Enable confidentiality</li> <li>• Avoid disturbances</li> </ul> 2 Greeting <ul style="list-style-type: none"> <li>• Make eye contact</li> <li>• Verbal greetings, shaking hands</li> <li>• Address by name</li> </ul> 3 Introducing yourself <ul style="list-style-type: none"> <li>• Introduce yourself by name</li> <li>• Communicate function ("ward doctor")</li> </ul> 4 Situating <ul style="list-style-type: none"> <li>• Speak sitting down (chair to bed)</li> <li>• Ensure convenience</li> <li>• Coordinate proximity/distance</li> </ul> 5 Orientation <ul style="list-style-type: none"> <li>• Structure conversation</li> <li>• Goals, time frame</li> </ul>   |        |             | 0 1<br>0 1<br>0 1<br>0 1<br>0 1                      | 1 Inquire about complaint dimensions <ul style="list-style-type: none"> <li>• Localisation and radiation</li> <li>• Quality, intensity (scale 0-10)</li> <li>• Dysfunction/disability</li> <li>• Accompanying symptoms</li> <li>• Time (beginning, course, duration)</li> <li>• Condition "In what situation ...?"</li> </ul> 2 Exploring subjective ideas <ul style="list-style-type: none"> <li>• Concepts "What do you imagine?"</li> <li>• Explanations "Do you see causes?"</li> </ul> 3 Complete anamnesis <ul style="list-style-type: none"> <li>• Systems ("From head to toe")</li> <li>• General health, sleep, etc.</li> <li>• Previous illness, pre-treatment</li> <li>• Family risk factors</li> <li>• Family, friends, job, finances, etc.</li> <li>• Addressing gaps (sensitive issues)</li> </ul> |       | 0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4     |
| 2 Listening to concerns   |        |             | <input type="checkbox"/> <input type="checkbox"/> 10 | 5 Negotiating procedures   |       | <input type="checkbox"/> <input type="checkbox"/> 12 |
| 1 Start the conversation openly <ul style="list-style-type: none"> <li>• Offer "What can I do for you?"</li> <li>• Occasion "What brings you to me?"</li> </ul> 2 Encouraging storytelling - feedback <ul style="list-style-type: none"> <li>• Listener signals <i>hm</i>, yes, nod, etc.</li> <li>• Avoid interruptions</li> <li>• Allow pauses, free choice of topics</li> </ul> 3 Active listening - verbal support <ul style="list-style-type: none"> <li>• Encourage speaking up</li> <li>• Repeating statements verbatim</li> <li>• Paraphrase statements</li> <li>• Openly ask further: "How did that come about?"</li> </ul> 4 Ensure understanding <ul style="list-style-type: none"> <li>• Ask "Do I understand correctly ...?"</li> <li>• Summarise</li> </ul> |        |             | 0 1<br>0 1 2 3 4<br>0 1 2 3 4<br>0 1                 | 1 Plan an evidence-based approach <ul style="list-style-type: none"> <li>• What is secured?</li> <li>• Do diagnostics have consequences?</li> </ul> 2 Clarify expectations <ul style="list-style-type: none"> <li>• Ideas, wishes, hopes</li> <li>• "What did you have in mind?"</li> <li>• Control beliefs</li> <li>• "What could you change yourself?"</li> </ul> 3 Explaining previous findings <ul style="list-style-type: none"> <li>• Communicate diagnosis</li> <li>• Communicate problems</li> </ul> 4 Examination or therapy plan <ul style="list-style-type: none"> <li>• Explore decision model (SDM)</li> <li>• Discuss proposals and risks</li> <li>• Consider reactions</li> <li>• Strive for consensus</li> </ul>   |       | 0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4                  |
| 3 Eliciting emotions  |        |             | <input type="checkbox"/> 8                           | 6 Drawing conclusions  |       | <input type="checkbox"/> 4                           |
| 1 Pay attention to emotions <ul style="list-style-type: none"> <li>• Verbal (e.g. metaphors)</li> <li>• Non-verbal (e.g. gestures, facial expressions, gaze behaviour, etc.)</li> </ul> 2 Empathise with patient's situation           3 Respond empathically <ul style="list-style-type: none"> <li>• Offer appropriate help and comfort</li> <li>• Acknowledge burdens, coping</li> </ul> 4 Promote emotional openness <ul style="list-style-type: none"> <li>• Addressing "I perceive that ...?"</li> <li>• Naming "You are sad then?"</li> <li>• Clarify "What do you feel then?"</li> <li>• Interpret "Your fear may come from..."</li> </ul>  |        |             | 0 1 2 3 4<br>0 1 2 3 4                               | 1 Summarise the conversation <ul style="list-style-type: none"> <li>• Reason for consultation, complaints,</li> <li>• Diagnosis, therapy agreement</li> </ul> 2 Offer clarification of outstanding issues <ul style="list-style-type: none"> <li>• Information "Do you still have questions?"</li> <li>• Satisfaction "Can you handle it? "</li> </ul> 3 Arrange follow-up appointments <ul style="list-style-type: none"> <li>• Examination appointments</li> <li>• Set a meeting date</li> </ul> 4 Say goodbye to the patient           5 Complete documentation <ul style="list-style-type: none"> <li>• Coding &amp; conversation impressions</li> <li>• Topics for follow-up talks</li> </ul>   |       | 0 1<br>0 1<br>0 1<br>0 1                             |
| 0 1 [0 = not met; 1 = met] 0 1 2 3 4 [0 = not met ... 4 = fully met]  |        |             |  |  |       |  |

Fig. 13.11: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)

Fig. 13.6 Specific hexagram of medical communication

In the hexagram (Fig. 2.8), *individual* communication structures and dynamics of real conversations can be localised that deviate considerably from an ideal type of conversation. For example, a patient can confront the doctor with their *emotions* (function/position 3) right at the beginning or demand a certain *treatment* (position 5) right at the start of the conversation, for which many examples (§ 19-25) are given in the practical section (IV) of the handbook, such as when a patient begins the conversation with the request for a "gastroscopy" (§ 19.8).

In order to take account of the *dynamics* of conversations, we have cancelled the *linear* form of presentation in the manual in the *circular* illustration of a *hexagram* (Fig. 2.8), which can be used in class to subsequently mark and explain the diverse, dominant structures of conversations (traditional blackboard picture, PowerPoint, multimedia) (§ 13.4.5). The course of the conversation in an empirical example, which will be analysed in detail with its *dramatic narrative* (§ 19), can be represented as in the *specific* hexagram (Fig. 13.6).

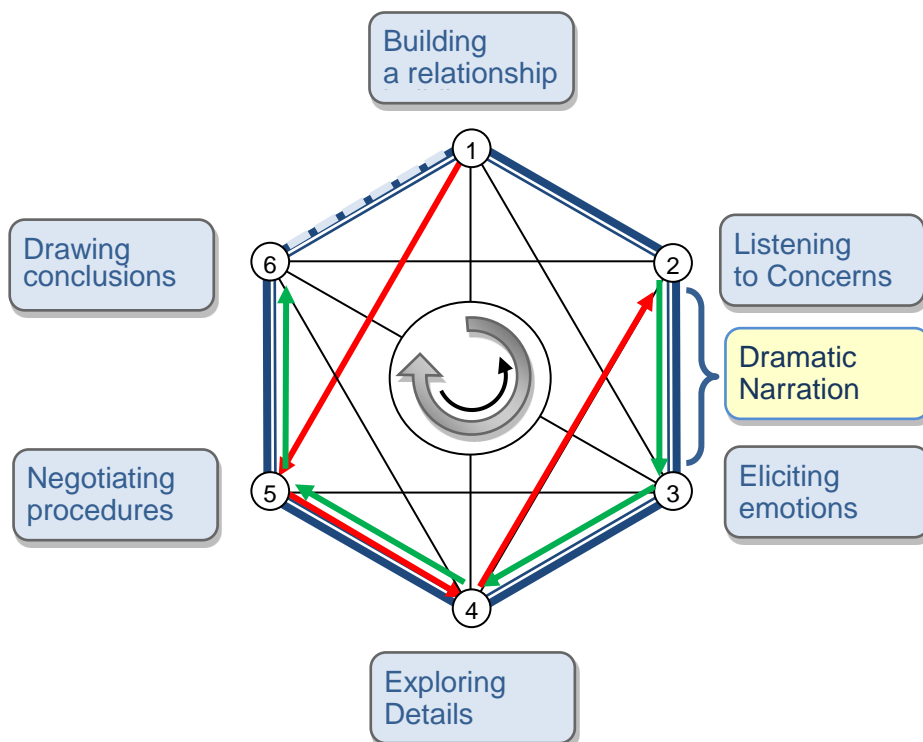


Fig. 13.6: Hexagram of medical communication:  
 Individual conversation structure (main steps) 1-5-4-2 (red) 2-3-4-5-6 (green)  
 (Cf. detailed conversation analysis in § 19)

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 Box 13.8 Manual Maxims and Supportive Super Maxims (Examples)
 

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If specific conversational maxims conflict (e.g. *allowing talking* versus *interrupting*), higher-ranking *meta maxims* (or super maxims) must be applied, which must be formulated independently of the concrete manual, because (in the long run) they are to be derived from and justified by a *theory of good D-P communication* (Koerfer 1994, 2008, and Handbook § 1-3). We have provisionally compiled some of the super maxims here (Box 13.8), which will later be differentiated and expanded for the "Dialogic Medicine" (DiaMED learning module).

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 Box 13.8 Manual Maxims and Supportive Super Maxims (Examples)
 

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*Manual Maxims*

- 1 Avoid interruptions
- 2 Allow a free choice of topic
- 3 Ensure understanding, etc.

 -----  
*Super Maxims*

- A In D-P communication, the doctor should grant the patient speaking privileges.
  - B The patient should be able to use this speaking privilege to freely choose topics according to their interests.
  - C In the event of conflicts about the right to speak, the doctor should allow the patient to have the floor in case of doubt.
  - D Questions to ensure understanding have priority.
  - E Interruptions are permissible if the understanding of the patient descriptions, reports, narratives, etc. is in danger of being lost, etc.
- 

Depending on their status and function, these *super maxims* can be labelled differently from the manual (e.g. with letters or Roman numerals), collected in class according to problem-based learning occasions (§ 13.4.2) and added to the manual as a *supportive mind set* with higher-ranking maxims. In group lessons, such *supportive super maxims* should be worked out independently in group work where possible. If there is a lack of learning time, the learning process can be accelerated by the teacher's preliminary work.

For teaching objectives that also involve supermaxims in medical communication, we have condensed the third chapter of Morgan and Engel's pioneering work from 1969 (*The Clinical Approach to the Patient*) into a collection of maxims. Where possible, the maxims should be read by learners in context (approx. 30 pages).

| <b>Conversation maxims</b>  |
|---|
| <ol style="list-style-type: none"> <li>1. The doctor must <i>encourage</i> the patient to <i>speak freely</i>, because only the patient can <i>tell</i> him what he has experienced.</li> <li>2. The <i>degree of guidance</i> needed is different for each patient.</li> <li>3. The doctor must remain <i>flexible</i> when taking the medical history and adapt to the nature of the patient.</li> <li>4. Neither should he allow himself to be passively swamped by numerous insignificant details, nor should he guide the anamnesis in the manner of a cross-examination.</li> <li>5. The doctor must always start a topic with <i>open questions</i>. He uses <i>specific questions</i> only to fill in gaps, to remove ambiguities or to substantiate certain facts.</li> <li>6. If possible, <i>avoid questions</i> that the patient can answer with a simple "yes" or "no".</li> <li>7. A question must be easy to <i>understand</i>. It must <i>not influence</i> the patient's answer.</li> <li>8. (The doctor) takes over the <i>patient's expressions</i>, at least until he understands what the patient means by them.</li> <li>9. (He tries to) <i>link each question</i> to what the patient has mentioned.</li> <li>10. So the doctor <i>picks up the thread</i> where the patient left off.</li> <li>11. At the <i>end</i> of the conversation, the doctor asks, 'Is there <i>anything else</i> you would like to talk about?'</li> <li>12. Once the doctor has taken the patient's medical history, he <i>informs</i> the patient about the next <i>planned step</i> (usually the next examination).</li> </ol> |
| <p>Box 13.22: from: Morgan, Engel: Chapter 3<br/>(English 1969; German 1977: 31-75) (selection and emphasis ours).</p>  |

#### 44. Teaching Materials on Medical Communication

|           |                         |                |
|-----------|-------------------------|----------------|
| Box 13.11 | Problem-based questions | DiaMed: UE 1+4 |
|-----------|-------------------------|----------------|

In each learning loop (of the Teaching-Learning Spiral) (TLS) (§ 13.3) (Fig. 13.3), specific problem-based questions can either arise spontaneously in the classroom or can also be used in a differentiated way by lecturers as teaching questions in the function of learning impulses. We have compiled an *overview* of the *typical questions* (Box 13.11 and Box 13.11), which can also be assigned to specific learning units (of the DiaMed learning module) (Box 13.6) in combination.

| Box 13.11 | Problem-based questions (A)   | DiaMed: UE 1+4 |
|-----------|---|----------------|
| 1.        | What <i>consequences</i> can be drawn from the <i>paradigm shift</i> from <i>biomedicine</i> to <i>biopsychosocial</i> medicine for an adequate <i>relationship and communication model</i> ? | 1 MR           |
| 2.        | What are the similarities and differences between <i>everyday talk</i> and <i>medical communication</i> ?   | 1 MR           |
| 3.        | What are the similarities and differences between <i>everyday narratives</i> and <i>patient narratives</i> ?  | 1 MR+4 NM      |

From the DiaMed learning module (learning goals) (§ 13.3.3)

| Box 13.12 | Problem-based questions (B)   | DiaMed: UE 4-6+10       |
|-----------|---|-------------------------|
| 1.        | What is the difference between a <i>traditional anamnesis</i> (of biomedicine) and a <i>dialogue-based anamnesis</i> , which is to be specified as a <i>narrative-based anamnesis</i> ? | 4 NM+3 AL               |
| 2.        | What is the difference between <i>interrogation</i> and <i>narration</i> ?  | 4 NM+3 AL+<br>5 EC+6 ED |
| 3.        | Why doesn't a doctor complete the necessary anamnesis <i>more effectively and efficiently by asking</i> typical medical questions?  | 4 NM+3 AL               |
| 4.        | Why should a doctor <i>utilise</i> the patient's everyday narrative competence during a consultation or ward round and <i>encourage</i> them to <i>tell their story</i> ?               | 4 NM+3 AL+<br>5 EC      |
| 5.        | To what extent should a doctor give the patient room for manoeuvre for their narrative <i>associations</i> ?  | 4 NM+3 AL               |
| 6.        | What <i>forms of communication</i> should a doctor use to <i>encourage</i> patients to tell their stories?  | 4 NM+3 AL+<br>5 EC      |
| 7.        | Why should the doctor pay particular attention to the patient's <i>gaze behaviour</i> in patient narratives? (keyword: turn taking)   | 3 AL+10 NV              |

From DiaMed learning module (§ 13.3.3)

Table 13.5 Overview of the Multimedia Training Programme (C-MTP)

In terms of content, the *Cologne Multimedia Training Programme* (C-MTP) is structured like a handbook according to chapters, but it can also be used with the help of search terms, so that an *individual* usage profile according to topics, conversation techniques, clinical pictures, etc. is possible. As can be seen from the exemplary overview (Table 13.5), information can be obtained on major topics (biopsychosocial medicine, epistemology) as well as communication patterns (greeting, questioning, clarifying) or individual phenomena (eye greeting, eye contact, listener feedback, etc.). The core of the C-MTP is a rich collection of videos from *real D-P-Communication* that can be used in teaching and self-learning under many aspects (conversation techniques, clinical pictures, etc.).

| Theme-Techniques-Phenomena                                   | Examples   |
|--|--|
| Biopsychosocial medicine and epistemology ("constructivism") | Educational film "How safe is reality?" (duration: 13 min)   |
| Talks on specific disease patterns                           | Depression, anorexia, diabetes, somatoform disorders, etc.   |
| Talks about problems (further treatment)                     | Adherence, Coping, Defence, etc.   |
| Fields of competence and phases of the medical interview     | Medical history, decision making (SDM), communication of serious diagnoses (BBN), dealing with the dying, etc. |
| Verbal intervention techniques                               | Opening questions, active listening, naming emotions, detail questions   |
| Dialogue role structure                                      | Turn taking, listener feedback, speech proportions of doctor/patient, etc.                                     |
| Nonverbal communication                                      | Eye greeting, eye contact, gestures, facial expressions, posture, etc.   |
| Communicative action patterns                                | Greeting, questions, clarification, decision making, etc.  |
| Theme developments   | Biopsychosocial theme progression, emotions, "sensitive" issues, etc.  |

Table 13.5: Exemplary overview of the Multimedia Training Programme (C-MTP)

## E 13.2-6 Simulated conversation (C-MTP)

Another component of the Cologne *Multimedia Training Programme* (C-MTP) presented above (§ 13.4.5), which has undergone various developments since the end of the 1990s, is a simulated learning situation in which learners are stimulated to engage in comparative reflection and verbal intervention exercises (Koerfer et al. 1999, 2008). This type of learning can be organised both as *self-learning* on the individual computer and in *group learning*.

In both cases, a particularly successful, real doctor-patient conversation (in the sense of "best practice") is played to the learners, without, however, communicating this information beforehand. The learners should follow the presented conversation, which is usually an initial conversation, as impartially as possible without prior information. The general instruction to the learning users is only that they should intervene on behalf of the real doctor at certain pre-programmed points in the conversation (E 13.2: contribution 05), where the video presentation stops for a certain period of time.

## E 13.2 Last patient statement:

- |    |   |   |
|----|---|---|
| 01 | P | (...) and I have pain ... and so far I have been taking [name of drug] for the last 20 years ...                    |
| 02 | D | hm [nods] .   |
| 03 | P | then taken, if it was then . then after half an hour not gone . still uh [drug name] .                              |
| 04 | D | yes .   |
| 05 | P | for the pain ... and I think ... I think I'll have a look and see if it's something my previous doctor didn't find. |

In this period, the simulated intervention of the learner must follow the last patient statement, so that in each case for the learner as simulated doctor it is currently: "It's your turn!" (E 13.3). Afterwards, the learner's own interventions can be systematically and critically compared with the interventions of the other learners or with the real intervention of the real doctor guiding the conversation (E 13.3-5). The respective advantages and disadvantages of the intervention alternatives can be assessed and also formally evaluated in class or in an examination (differentiated according to "school grades").

The fact that *problem-based learning* always emphasises the *autonomy of learning* is due to the *sustainability* of this type of learning (Box 13.9), which was recognised long before empirical learning psychology:

Box 13.9 Self-learning by doing

The powers of the mind are best cultivated by doing everything oneself that one wants to do (...) The greatest aid to understanding is production. One learns most thoroughly and retains best that which one learns, as it were, from oneself.

Kant 1803/1964: 736

E 13.2-6 Simulated conversation (C-MTP)

E 13.3 "It's your turn!"

Evaluation

L1 D [My intervention is:]

-----  
-----

1 2 3 4 5

E 13.4 Simulated Conversation:  
Alternative Interventions

Evaluation

L2 D how long have you had this pain?

1 2 3 4 5

L3 D can you describe the pain in more detail?

1 2 3 4 5

L4 D what are you thinking about?

1 2 3 4 5

L5 D what other medicines are you taking?

1 2 3 4 5

L6 D where and how is the pain? Is it sharp, pulling or pressing?

1 2 3 4 5

L7 D what did your previous doctor find?

1 2 3 4 5

E 13.5 Real continuation of the conversation:  
Intervention of the real treating doctor

Evaluation

06 D what do you think might have been overlooked? .

1 2 3 4 5

Fig. 13.10 The general learning setting with patients

The two variants of the learning procedure, which we have been practising with both *real* patients (RP) and *simulated* patients (SP) at our clinic for almost two decades, are based on a common *learning setting*, the basic structure of which will be illustrated here first with Baile (2011) (Fig. 13.10). Although Baile has tailored the learning setting specifically to conversation training with SP in oncology, it can be generalised for other learning situations on medical conversation.

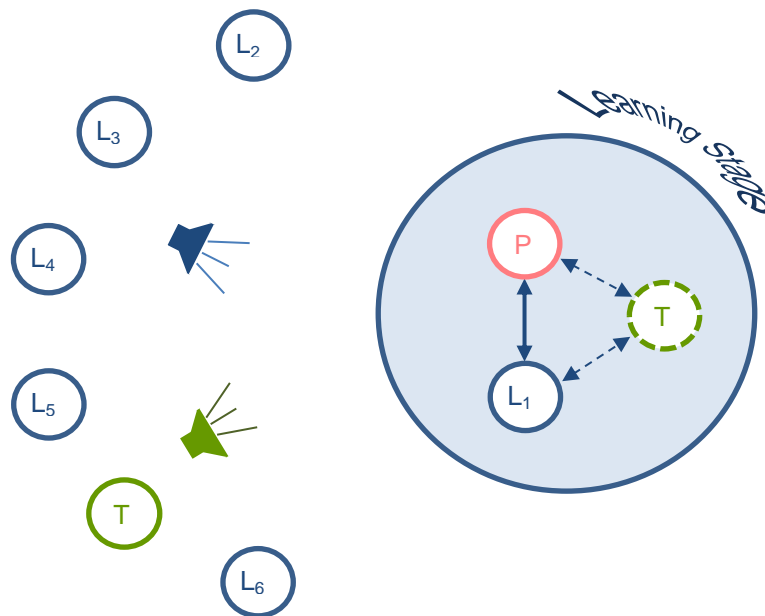


Fig. 13.10: The general learning setting with patients, modified based on Baile (2011)  
(L = learner, P = patient, T = teacher; or D = docent)

In the typical learning constellation, the two main actors  $L_1$  and P act in their respective doctor and patient roles more or less separated from the rest of the learning group, as it were on a "stage" (*learning stage*), on which the dyadic doctor-patient conversation takes place under the observation of an attentive "audience", which follows the "performance" on stage in critical observation.

Although the external influence during the conversation between  $L_1$  and P should be kept as low as possible (see below), "stage directions" are certainly given in advance by the teacher (T) (marked here with a dashed line), who then withdraws into the rest of the learning group before the doctor-patient conversation begins, until a critical "review" from the entire "audience" can be expected afterwards.

E 13.6-7 Feedback (Simulation patients = SP)

For the examinees themselves, the experiential feedback of the simulation patients is valuable because they can already anticipate the possible "(dis)satisfaction" of the real patients with their (way of) conducting the conversation, analogous to their later professional practice. Feedback can also be enriching in critical cases, for example when "uncertainty" in the formulation or "lack of eye contact" or "too much guidance through questions" are reported back.

For example, the same SP in the same sick role gave rather negative feedback in the case of a strongly *interrogative* interview (SP: "that's why I told less than I would have liked to") (E 13.6), while after the other examination interview (E 13.7) she expressed an overall "very positive" opinion towards the student (S):

E 13.6 OSCE No. 43 - SP feedback:  
"I told less of myself than I would have liked to".

01 SP and um . maybe you could hear that there was a bit of insecurity (...) that's why I told less than I would have liked to . that was my impression . and I would agree with the examination [suggested by S] ... yes .

E 13.7 OSCE No. 44 - SP Feedback:  
"I had to really tell the story"

01 SP . yes . my impression was (...) that someone was serious and didn't mix things up and just wanted to make sure that he had understood it correctly . the same thing . there were a lot of open questions . so I had to tell the story properly . that was real work .

02 S . yes .

03 SP I found that pleasant . and then this story . "Am I right in assuming that you are busy or have a lot on your plate" . that I could say: "yes, that's how it is" . that also gave me the feeling . someone recognises my performance (...) and I found that very positive .

04 S hm .

## E 13.8 OSCE questionnaire/free texts (selection):

The spectrum of the students' (S) statements which are only listed here as a selection of examples, can be arranged under content-analytical categories (*authenticity, learning success, trial action, feedback, etc.*). First of all, there are isolated cases (S5) in which the examinees, with general prior knowledge that their interlocutors are not "real" patients, apparently find it difficult to engage in the conversation simulation in a way that *conforms to the role* ("difficult ... because you know that they are not real patients"). However, these are rather rare exceptions, which may also be due to an "examination blockade" that could no longer be overcome during the examination interview. A *relative* weighting is given by S2, according to which positive entry functions with SP are not disputed, but in the long term practice conversations with *real* patients are preferred, which of course is not possible in exams ...

## E 13.8 OSCE questionnaire/free texts (selection):

- |    |   |  |
|----|---|--|
| 01 | S | I found the patient very authentic, so it was not so difficult for me to get into the situation.   |
| 02 | S | Conversations are a good way to get over the first inhibitions. But the best way to get real "practice" is with "real" patients.               |
| 03 | S | Personally, the conversation showed me very clearly on which points I could have asked more.   |
| 04 | S | I also think it's good that you get direct feedback on what you did well and where you can still improve.                                      |
| 05 | S | OK, just difficult to take the situation really seriously, knowing that they are not real patients.  |
| 06 | S | Imitating a realistic situation is very good.  |
| 07 | S | I think it's good that you can try out how such a conversation is conducted.   |
| 08 | S | The patient described his complaints (physical and mental) very credibly.  |
| 09 | S | Simply super! effective  |
| 10 | S | Personally, the conversation [= debriefing] after my medical history interview showed me very clearly in which points I could have asked more. |
| 11 | S | I think it [=OSCE method with SP] is good and it should be done more often.  |
| 12 | S | It was fun   |
| 13 | S | Maybe a course [with SP] could be offered on a voluntary basis.  |

## 14 Cologne Curriculum Communication

Table 14.1 Cologne Curriculum Communication - Preclinical and Clinical

Table 14.1 provides a chronological overview of the courses in the various disciplines that contribute to the communication education of students at Cologne University Hospital based on their specific responsibilities and expertise. We follow the traditional division into preclinical and clinical courses, which also applies to communication training.

| Se-<br>mester        | TE        | Subject/type of<br>course  | Contents - Learning<br>objectives   | Didactics<br>Methodolo-<br>gy | Examinati-<br>on                      |
|----------------------|-----------|--|---|-------------------------------|---------------------------------------|
| Preclinical training |           |  |   |                               |                                       |
| 1                    | 12        | Psychosomatics first<br>semester tutorial  | Biopsychosocial<br>Medicine, DPC DPR  | TH RE TR<br>VC RPL SP<br>POL  | Text exam                             |
| 1                    | 24+18     | Medical<br>sociology   | e.g. DPC DPR  | TH RE POL                     | MC exam                               |
| 2                    | 3         | General medicine   | DPC DPR SDM   | VC RE MM                      | MC exam                               |
| 3                    | 4         | General medicine   | DPC, SDM, motivatio-<br>nal interviewing                                      | RE RPL<br>MM                  | EV, MC<br>exam                        |
| 1 - 4                | 1<br>each | Interdisciplinary<br>areas of expertise,<br>e.g. diabetes, death<br>and bereavement,<br>etc. | Clinical picture, thera-<br>py, coping, behaviour<br>modification, DPC<br>DPR | Lecture<br>MM VC              | e.g. text ex-<br>am, MC ex-<br>am, TP |
| 4                    | 3         | General medicine   | DPC, diversity-<br>sensitive communica-<br>tion                               | TH RE MM                      | MC exam                               |
| 4                    | 6         | Core examination<br>course   | physical examination,<br>DPC  | TH RP RPL                     | EV, OSCE                              |

Tab. 14.1a: Cologne Curriculum Communication - Preclinical (overview; see legend below)

#### 44. Teaching Materials on Medical Communication

| Se-<br>mester            | TU        | Subject/type of<br>course   | Contents - Learning<br>objectives  | Didactics<br>Methodology        | Exami-<br>nation                       |
|--------------------------|-----------|---|--|---------------------------------|--|
| <b>Clinical training</b> |           |   |  |                                 |  |
| 5                        | 12        | Psychosomatics<br>internship medical<br>communication                               | DPC, DPR, BPS<br>Taking medical history,<br>interview techniques                             | TH TR EV<br>SP POL RP<br>MG1 VC | OSCE,<br>C-EMC<br>PDT                  |
| 5-10                     | 1<br>each | Interdisciplinary<br>areas of expertise, e.g.<br>CHD, heart failure, ad-<br>herence | Clinical picture, thera-<br>py, DPC, DPR   | Lecture<br>MM VC                | e.g. text<br>exam,<br>MC ex-<br>am, TP |
| 5                        | 2         | Core examination<br>course, psychiatry  | Clinical diagnostics<br>DPC, DPR   | TH SP                           | EV                                     |
| 5+9                      | 9         | Internal medicine<br>BI   | Physical examination,<br>DPC   | TH RE POL<br>RP                 | OSCE                                   |
| 6                        | 2         | Medical ethics course   | DPR  | TH                              | SC exam                                |
| 6                        | 6         | Pharmacology ES   | Prescription discus-<br>sion, SDM, DPC, DPR  | TH POL SP<br>VC                 | EV                                     |
| 7                        | 3         | General medicine  | DPC, climate-sensitive<br>consulting   | TH RE MM                        | MC exam                                |
| 7                        | 5         | Palliative medicine<br>Field of expertise   | Change of therapy<br>goal, DPR DPC BBN<br>SDM  | TH RP SP<br>RE POL              | EV                                     |
| 8                        | 12        | Psychosomatics<br>lecture   | Clinical images, thera-<br>py, DPC DPR   | Lecture MM<br>VC                | MC exam                                |
| 8                        | 24        | Psychosomatics BI   | Psychodiagnostics,<br>BBN DPC DPR  | TH RE VC<br>TR EV POL<br>RP SP  | -                                      |
| 8                        | 8         | Psychosomatics WS   | BBN, DPC in oncology   | TH RE POL<br>MG2 VC             | -                                      |
| 8                        | 2         | Human genetics<br>Seminar   | DPC, lay language  | TH RPL                          | SC exam                                |
| 8                        | 18        | Psychiatry BI   | psychopathological<br>findings, DPC DPR  | TH RE POL<br>TR RP SP           | SC exam                                |
| 8 - 9                    | 100       | General medicine<br>BI  | DPC DPR BBN SDM,<br>anamnesis survey   | TH RE TR<br>RP                  | EV                                     |
| 9/10                     | 10        | Gynaecology BI  | DPC, medical history   | TH SP EV                        | OSCE                                   |
| 10                       | 2         | Medicine of ageing BI   | DPC, age-related self-<br>awareness  | RPL                             | Exam                                   |
| 10                       | 24        | Interdisciplinary<br>PY-STArT block   | ward round communi-<br>cation, DPC for diabe-<br>tes, depression, BBN,<br>SPIKES, NURSE etc. | TH RE POL<br>TR SP EV           | EV                                     |

Tab. 14.1b: Cologne Curriculum Communication - Clinic (overview; see legend below)

Legend (Tab. 14.1)

|     |                              |       |  |
|-----|------------------------------|-------|--|
| TU  | Teaching units               | BPS   | Biopsychosocial  |
| ES  | Elective seminar             | DPC   | Doctor-patient communication                                 |
| POL | Problem-oriented learning    | DPR   | Doctor-patient relationship                                  |
| TH  | Theory (research)            |       |  |
| RE  | Reflection (of cases/videos) | MG1   | Manual for general conversation management                   |
| TR  | Training for APK             | MG2   | Manual for diagnostic reporting                              |
| EV  | Evaluation/feedback          | BBN   | Breaking Bad News  |
| RP  | Real patients                | SDM   | Shared decision making                                       |
| RPL | Role play                    | OSCE  | Objective Structured Clinical Examination                    |
| SP  | Simulation patients          | PDT   | PatDocTalk (multimedia program)                              |
| VC  | Video conference             | C-EMC | Cologne Evaluation Manual Communication, see Appendix § 44.2 |
| MM  | Multimedia                   | SC    | Single Choice  |
| MC  | Multiple Choice              | BI    | Block internship   |
| TP  | Term paper                   | PY    | Practical Year   |

Even a brief comparison between the different courses reveals a certain overlap of topics and learning objectives. However, the *reintroduction* of certain topics (*empathy, coping, adherence, defence, etc.*) is by no means to be seen as mere redundancy, but rather considers the didactic requirements of biopsychosocial medicine and interviewing (§ 4), for which the foundations are already laid in the first semester tutorial (§ 14.2.1).

As explained above (§ 13.3), the reintroduction of exemplary topics and tasks in a spiral *curriculum* serves the needs and possibilities of expanding and deepening specific *clinical* and *communicative* competencies of learners at their respective learning level (Murrhardter Kreis 1995, Kurtz et al. 1998, Harden, Stamper 1999, Koerfer et al. 2008, Fragstein et al. 2008, Silverman 2009, Venktaramana et al. 2022). In such an integrative spiral curriculum (Fig. 14.1), the knowledge, action and communication skills already acquired are alternately developed and tested in ever new learning situations with new clinical and communicative challenges.

Fig. 14.1 Cologne Curriculum Communication - Preclinical and Clinical

For example, this increase in learning at increasingly higher learning levels can be achieved with a constant topic (e.g. *defence: denial*) on the same clinical picture (*diabetes*) or with a transfer performance on other clinical pictures (*myocardial infarction*), first theoretically and then practically in discussions with real patients or SP who *deny* a serious illness and behave *non-adherently* as a result.

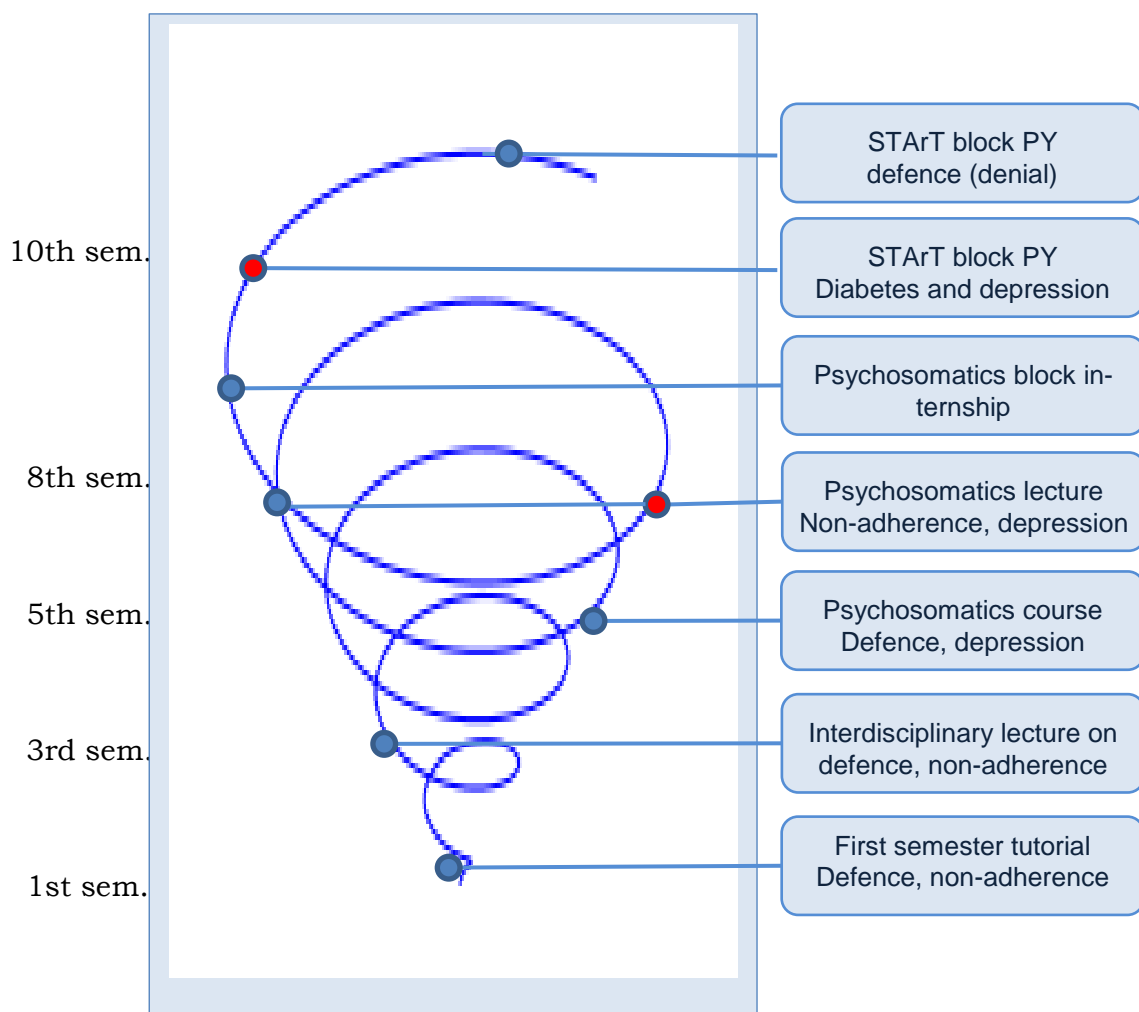


Fig. 14.1: Exemplary spiral curriculum communication (selection) in cases of *defensive behaviour* (denial) and *non-adherence* in a serious disease (e.g. *diabetes mellitus*) as well as additional *psychological comorbidity* (e.g. depression) (blue-red dots).

The learning process can take place in an integrative spiral curriculum over several pre-clinical and clinical semesters with the interdisciplinary involvement of various subjects, which can only be considered here as examples (Fig. 14.1) can be further differentiated and illustrated in clin-

ical training using specific medical conditions (e.g., diabetes mellitus, myocardial infarction) What has already been addressed as a topic of research and teaching in medical *psychology* or *sociology* as *maladaptive* patient behaviour, can be further differentiated and illustrated in clinical training using specific medical conditions (e.g. diabetes mellitus, myocardial infarction). *diabetes mellitus, myocardial infarction*) (§ 29) (Kruse et al. 2006, Kruse 2017, Albus, Herrmann-Lingen 2017, Albus, Köhle 2017, Albus et al. 2019, Albus, Petrak 2021, Kulzer et al. 2023, Herrmann-Lingen et al. (eds.) 2022). The communicative handling of *denial* (of an illness), which can be self-damaging, represents a further deepening of the topic. Addressing this issue can simultaneously be a challenge in conversations, e.g. with a suitably trained simulation patient.

At the same time, the connection with psychological co-morbidity (*depression*) can be repeatedly addressed in teaching, for example using the same illness (*diabetes*), which results in a further *psychodiagnostic* task in conducting the interview (§ 30). It is precisely this conversational task that arises in the preparatory course for the practical year (STArT block) (§ 14.3.11), in which the students are asked to conduct a conversation with a depressed patient (SP) with diabetes (Fig. 14.1, 10th semester: blue-red dot), who lacks appropriate self-care, as can be seen from the patient's "poorly controlled diabetes".

Here, knowledge and communication skills can interact synergistically: the understanding of (reasons for) possible non-adherence, which has already been acquired in pre-clinical subjects (medical *psychology*, medical *sociology*) and expanded and deepened in clinical lectures and practical courses with patient contact, sharpens the observation of *non-verbal* and *verbal* communication with the patient. In turn, perceiving the person during the conversation forms the basis for continuing the medical conversation in a certain direction, in which the possible co-morbidity (*depression*) (§ 30), e.g. in this patient (SP) with diabetes, is adequately clarified with a corresponding medical *adaptability* (§ 3, 17) through *active listening* (§ 19) and *detailed questions* (§ 21) (Kulzer et al. 2023, Kruse et al. 2006, 2017, Albus, Petrak 2021). Even if psychotherapy for depression (Niecke, Albus 2011) often exceeds the possibilities of clinical or GP primary care, the *psychodiagnostic* skills should be developed to such an extent that depressive co-morbidity is not "overlooked" e.g. in the case of diabetes treatment, but is recognised in conversation and adequately explored through further detailed questions about symptoms (§ 30).

## 17 The Art of Medical Communicating

Box 17.5 "This is the crux of the matter ..."

Here, we first follow the theme of Skelton (2011: "Clinical communication as a creative art"), whose positive replication of the initial article by Salmon and Young (2011) contains a historical-systematic justification. Skelton (2011) rightly recalls the decades-long, not only linguistic, discussions around the concept of competence. Skelton cites the banal example from foreign language teaching, according to which it is not enough for the learner to be able to form grammatically well-formed sentences such as "Sit down, you fool", but which can be "inappropriate" to say to the boss. With reference to Salmon and Young (2011), Skelton formulates the "crux" of the matter as a question of the *appropriateness* (Box 17.5) with which *skills* are used.

Box 17.5 "This is the crux of the matter ..."

Skelton 2011

What we teach instils and confirms our values. If we teach merely a set of skills, our values will appear to be as shallow as the skills themselves. Instead, therefore, we should 'encourage practitioners to be imaginative in using their skills'. This is the crux of the matter. The question is not whether people *have* the skills, but whether they *deploy* them appropriately.

Skelton 2011: 213 (emphasis there)

This problem that *skills* must also be used *appropriately* in specific, concrete communication situations points to a broad concept of *communicative competence*, as Skelton calls for with reference to the early work of Dell Hymes (1967/73, 1971/73) and as we have already used in advance with reference to further traditions (John Austin, Paul Grice, John Searle, Jürgen Habermas) in the formulation of learning objectives (§ 2, 3, 13) and justification of a dialogical medicine (§ 7).<sup>2</sup>

<sup>2</sup> The history of terms and concepts of *communicative competence* cannot be further elaborated here. We refer to the relevant chapters 3, 7, 13 and the literature cited there, from which the following selection will only be made once again as an example: Hymes 1967/73, 1971/73, Wunderlich 1969, Habermas 1971, 1981, Lenzen 1973, Dickson et al. 1991, Deppermann 2004, Hartung 2004, Duffy et al. 2004, Koerfer et al. 2008, Albanese et al. 2010, Laughlin et al. 2012, Grimmer 2014, Hannawa, Spitzberg (Eds.) 2015, Jünger et al. 2016, Thistlethwaite 2016, Kiessling, Fabry 2021, Kowalczyk, Rypel 2023, Horila 2025.

Box 17.6 *Skills teaching versus creativity?*

A broad notion of communicative competence is apparently also assumed by Silverman (2016) when he subsequently seeks to mediate the potential conflict between *skills teaching* and *creativity*.

Box 17.6 *Skills teaching versus creativity?*

Going beyond specific skills into individuality is the real challenge of experimental learning (...) Indeed a potential conflict between skills teaching and creativity has been highlighted by Salmon and Young (2011). However, also we must recognize that there are considerable variables that influence what is best for any individual in any given situation, we can also advocate certain behaviourally specific skills that are proven to be more effective than others (Silverman et al. 2011). The specific skills of effective communication provide a toolkit of evidence-based approaches to enable clinicians to put intentions into practice.

Silverman 2016: 70

In communication teaching, the teaching of *behavioural skills* and *creativity* obviously do not have to be mutually exclusive. If one assumes a sufficiently broad concept of *communicative competence*, with which the context-sensitive *appropriateness* or *fit* of verbal and non-verbal expressions in concrete conversational situations between doctor and patient can be taken into account (§ 3.2), *skills* and *creativity* are not to be understood as opposites but as a unity.

Of course, there can also be failures in the fit of medical conversation. Just as the above statement by the foreign language learner ("Sit down, you fool") to the boss was "inappropriate", medical questions can also prove to be inappropriate because they are too confrontational (§ 17.3.4).

However, switching to a *tangential* way of conducting a conversation does not have to be "creative" any more than offering the boss a place in "appropriate" words (or at all). It may be exhausting to listen patiently to a patient who talks "like a waterfall" and is obviously talking "non-sense", but not all active listening or all listener feedback has to be considered "creative". The word "creative" should not be used inflationary, but reserved for special cases ...

Fig. 17.3 Fitting – Communication Manual (overview)

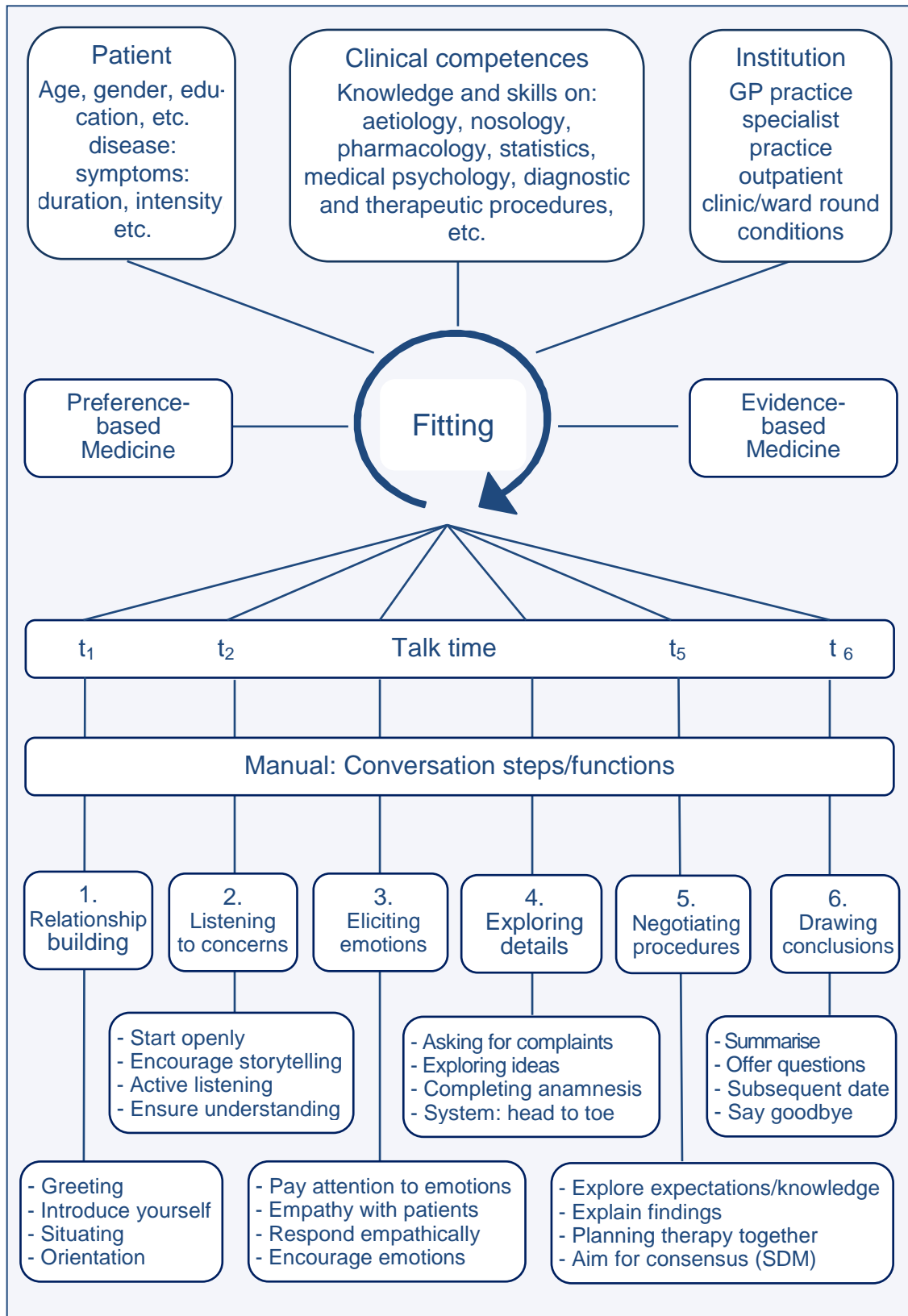


Fig. 17.3: Fitting – Communication Manual (overview) (cf. Fig. 17.8 and § 18-23)

Box 17.15 "Now Moment" - "Moment of Meeting "

In psychotherapy research (§ 2), dramatic climaxes in psychotherapy conversations have been studied in detail (e.g. Stern et al. 2001, 2012, Stern 2004/2010, Ribeiro et al. 2011, 2014, Gonçalves, Stiles 2011, Gonçalves et al. 2014). Here, attention has been drawn to particular, innovative conversational moments of change (*now moments, innovative moments, narrative change, meaning transformation, etc.*), with which a new conversational and relational quality can emerge between the two interlocutors (Box 17.15), provided they both respond accordingly.

Box 17.15 "Now Moment" - "Moment of Meeting "

In the course of a "moving along" process, a qualitatively different and unpredictable moment suddenly appears. It is a "hot" present moment, a kind of "moment of truth" that is affectively highly charged. It also has a possible meaning for the immediate or indirect future. In ancient Greece, the term "kairos" was coined for it. It is a moment that wants to be seized if one wants to change one's destiny. If it is not seized, one's destiny changes as well, namely for not having been recognised. It is a moment that brings both participants in an interaction fully into the present (...) A "present moment" that is used therapeutically in time and is mutually recognised can become a "moment of encounter". This requires that each of the two partners contributes something unique and authentic in response to a present moment.

Stern et al. 2001: 149f

The opportunity for change can therefore also be missed if one of the two partners fails to recognise the decisive moment or - for whatever reason - does not want to recognise it and closes itself off to the new development opportunities. The conversation then falls back to the level of a stable equilibrium, on which it moves along without any noteworthy occurrences, before a new critical development point arises where the two conversation partners decide anew on the further qualitative progress of the conversation.

Fig. 17.6 Dialogue role structure: Narrative interview style

The starting point of the *comparative* conversation analyses is the formal comparative aspect of the *right to speak* that is granted or used, which can initially be depicted for each conversation in a specific, quasi-analogue representation form of the dialogue role structure (Fig. 17.6). All speech contributions of a conversation are arranged continuously between doctor and patient alternating on the x-axis, the patient's contributions are shown on the y-axis positively ("as columns upwards") and the doctor's contributions correspondingly negatively ("as columns downwards"), whereby the respective contribution length (column size) is measured in words. The exemplary progression diagram (Fig. 17.6) reproduces a prototypical conversation, which is formally characterised by a series of longer contributions (> 100 words) by the patient, which may prove to be candidates for narratives in the further qualitative conversation analysis (§ 19, 40).

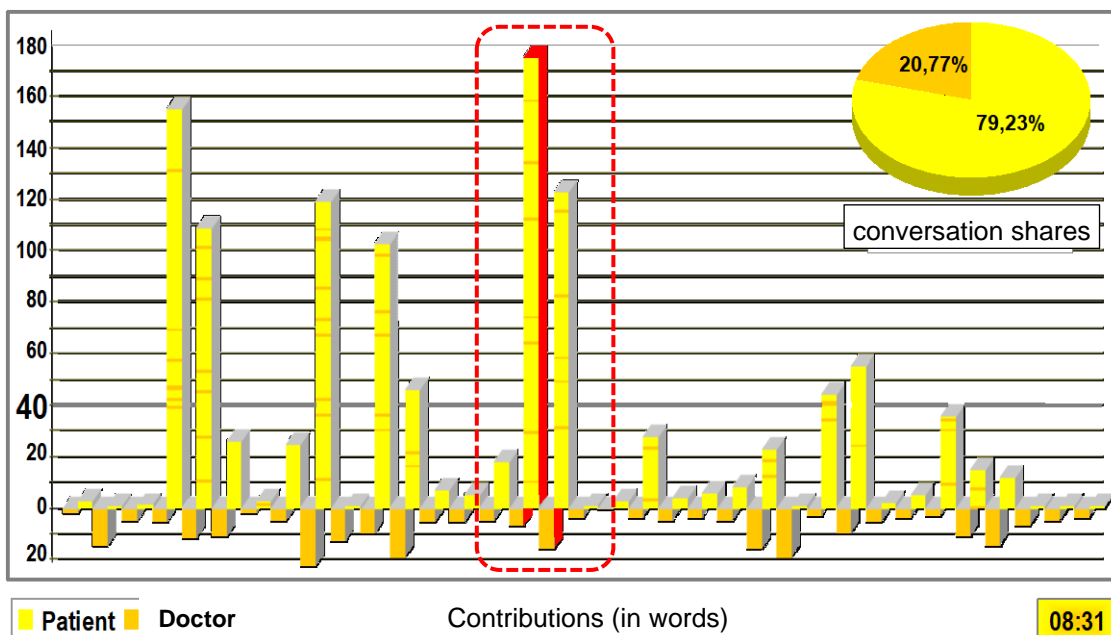
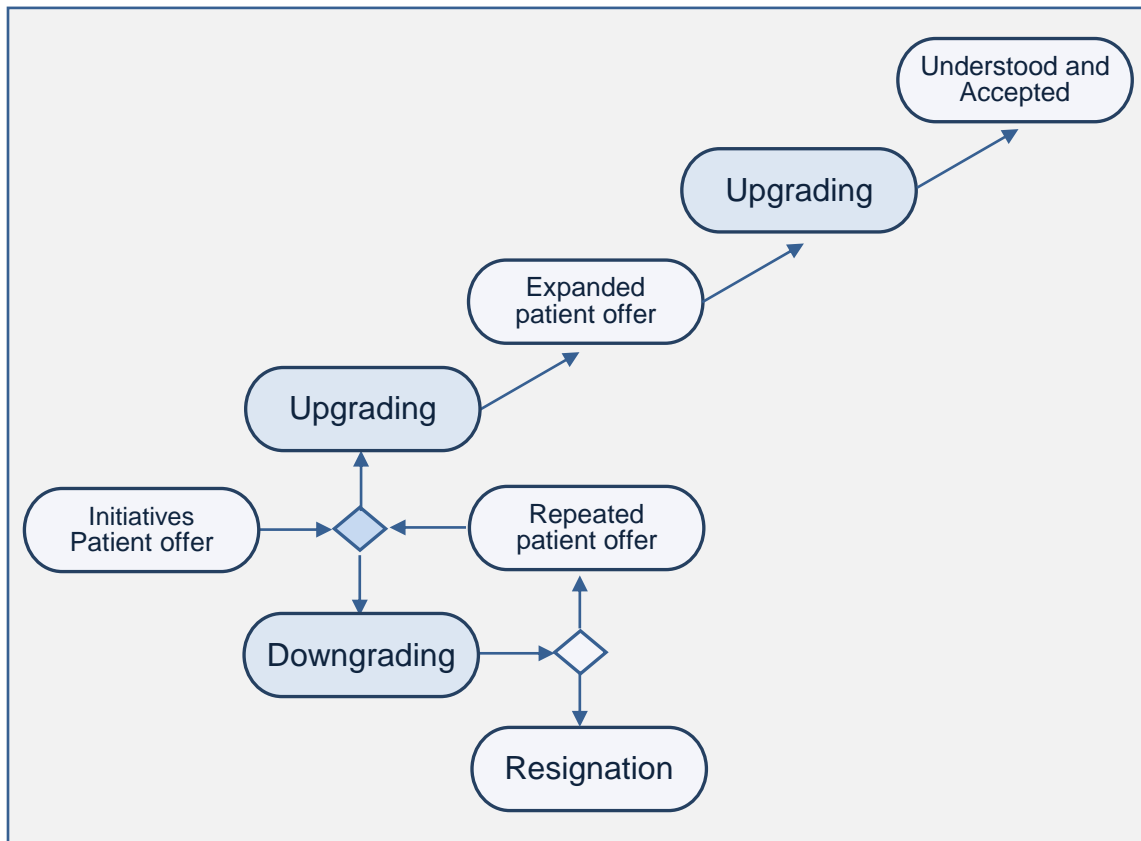


Fig. 17.6: Dialogue role structure: Narrative interview style

A methodological point of this formal representation is that mere listener feedback in the function of "auditor-back channel signals" are not counted as independent speech contributions (Flader, Koerfer 1983). According to Duncan (1974), this type of listener feedback (*hm, yes, okay, etc.*) allows a "speaker-auditor interaction during speaking turns", so that the speaker can continue in his or her speech "as if uninterrupted".

Fig. 17.7 Dialogue feedback model of doctor-patient communication

In a flow chart of a *dialogue feedback model* (Fig. 17.7), essentially four basic types of conversational developments can be differentiated under the aspect of *relevance action* with two decision nodes (= rhombs), at which the interlocutors must each perform their specific decision functions.





Legend: Speaker/Decision Node (=Rhombuses)      Patient       Doctor 

Fig. 17.7: Dialogue feedback model of doctor-patient communication

The ideal case, in which the doctor achieves empathic understanding and sufficient recognition of the patient's individual reality with a great accuracy of fit of interventions, i.e. with maximum efficiency through corresponding relevance upgrading of diverse patient offers in a direct way, is certainly not the rule in routine clinical practice, but empirical cases of doctor-patient communication are ultimately to be measured against such a *normative* feedback model of relevance action ....

**18 Building a Relationship**

Fig. 18.1 Excerpt: Step/Function 1. "Building a relationship"

In the following overview of the first step of the consultation (Fig. 18.1), the "normal form" of an initial consultation is assumed, as is usual in general practice (§ 19-23, 25) and should also be aimed for in clinical ward rounds (§ 24).

|  |   |  |
|--|---|--|
| Cologne Manual & Evaluation of Medical Communication | <p><b>1 Building a relationship</b></p>   | <p><sup>6</sup> 2022</p>                                   |
|  | <p>1 Framing</p> <ul style="list-style-type: none"> <li>• Enable confidentiality</li> <li>• Avoid disturbances</li> </ul>   | <p>0 1</p>   |
|  | <p>2 Greeting</p> <ul style="list-style-type: none"> <li>• Make eye contact</li> <li>• Verbal greetings, shake hands</li> <li>• Address by name</li> </ul>                                  | <p>0 1</p>   |
|  | <p>3 Introduce yourself</p> <ul style="list-style-type: none"> <li>• Introduce yourself by name</li> <li>• Communicate function (e.g. ward doctor, surgeon, etc.)</li> </ul>                | <p>0 1</p>   |
|  | <p>4 Situating</p> <ul style="list-style-type: none"> <li>• Speaking in a sitting position (chair to bed)</li> <li>• Ensure convenience</li> <li>• Coordinate proximity/distance</li> </ul> | <p>0 1</p>   |
|  | <p>5 Orientation</p> <ul style="list-style-type: none"> <li>• Structure the conversation</li> <li>• Clarify the goals of the conversation</li> <li>• Communicate time, frame</li> </ul>     | <p>0 1</p>   |
| <p><sup>1</sup>1998</p>                              | <p><b>EVALUATION</b></p>  | <p><input type="checkbox"/> <input type="checkbox"/> 4</p> |

Fig. 18.1: Excerpt: Step/Function 1. "Building a relationship"  
(The complete manual can be found at the end of the chapter, Fig. 18.5, cf. Fig. 13.11)

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Box 18.3 The four-eyes conversation

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

---

Box 18.3 The four-eyes conversation

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

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

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

44. Teaching Materials on Medical Communication

| E 18.2 | "I'm still talking to the patient" | Comment |
|--------|------------------------------------|---------|
|--------|------------------------------------|---------|

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

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

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

Fig. 18.3 Verbal and non-verbal communication modes

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

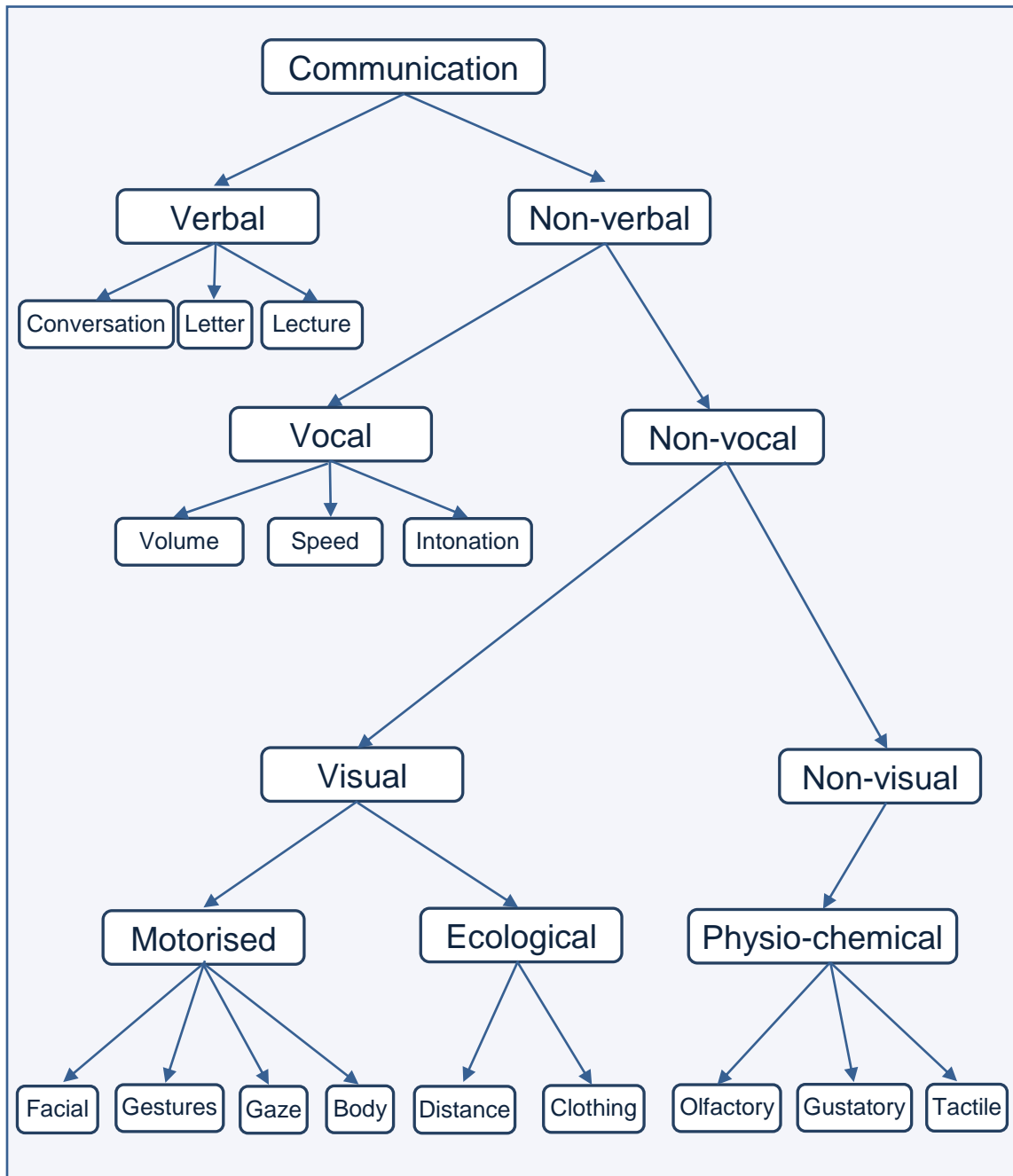


Fig. 18.3: Verbal and non-verbal communication modes

Table 18.1 Voice and emotion

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

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

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

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

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

Box 18.8 Clinical cues right from the greeting

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

Box 18.8 Clinical cues right from the greeting

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

Morgan, Engel 1969/77: 34

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

Both partners will interpret their behaviour as a *sign of the relationship* and continue to act according to their interpretations (Goffman 1974: 255ff) ...

Fig. 18.4 Sub-actions of the complex greeting action

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

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

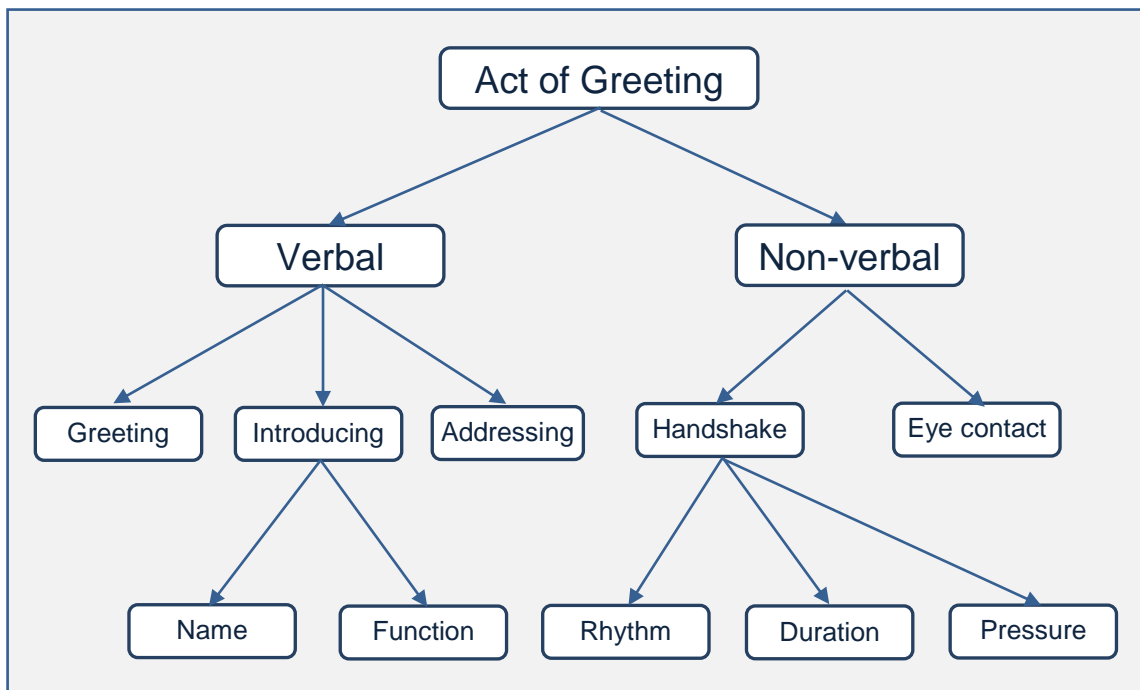


Fig. 18.4: Sub-actions of the complex greeting action

As part of the greeting ritual, the handshake is generally expected by the patient and also realised by the doctor. According to Morgan, Engel (1969/1977) (see Box 18.8), doctors should use the handshake with the patient to make an initial diagnosis, and patients also interpret the way the doctor greets them with a handshake as the first *sign of a relationship*.

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

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

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

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

Georg Simmel 1908/1992: 723ff

It is only through eye contact that the presence of the participants is mutually confirmed before the exchange of souls can begin on the line between the two pairs of eyes, along which personality, moods and impulses are transmitted. While from a sociological point of view, considerations on the non-verbal *transfer relationship without words* are still being stimulated here, the observations on empirical research into eye and gaze behaviour relate to a range of aspects in different social and cultural contexts.

Box 18.12 Speaker change and gaze behavior

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

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

Box 18.12 Speaker change and gaze behavior


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

Kendon 1973/1979: 229

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

E 25.17b "I have no more hope" (without eye contact) Start of narration

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).

|   |  |
|---|--|
| <p>Nonverbal response</p>  <p>Fig. 25.13</p> | <p>Beginning of the narrative</p> <p>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 .</p> <p>The patient seems isolated, no longer has eye contact</p> <p>33 D: why do you have no more hope? .</p> <p>34 P: yes, because she can no longer walk.</p> |
|---|--|

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.

For a further analysis of the conversation, see § 25.5

## E 19.33 "Where are your main complaints?" (Part 1+2) Comment

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

## E 19.33 "Where are your main complaints?" (Part 1+2) Comment

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

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

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

Box 18.13 Spatial proximity

Depending on our familiarity with the person we are talking to and the situational, social or cultural conditions of the conversation, we regulate *proximity* differently (Box 18.13). Depending on the conditions, we prefer a distance of between 50 cm and 150 cm in a face-to-face conversation, which we do not perceive as too far or close enough.

Box 18.13 Spatial proximity

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

Argyle 1969/1972: 93ff

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

## E 18.10 "Make yourself comfortable while telling the story"

If sensitive doctors notice that their patients are becoming more restless, they can also extend this invitation later, as happens in the following example (E 18.10) after more than a minute.

## E 18.10 "Make yourself comfortable while telling the story" Comment

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

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

The doctor's behaviour can help to create a relaxed *atmosphere during* the initial *consultation*. They can often observe the success of their efforts themselves. The video shows that patients who initially sit on the edge of the chair and clutch their belongings ("just in case") become increasingly relaxed as the consultation progresses: They place their glasses, handbag, file etc. on the table or empty neighbouring chair, lean back and cross their legs – in other words, they no longer behave "as if on the run", but have finally "arrived" at the consultation.

Box 18.14 "Flexibility of agenda"

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

Box 18.14 "Flexibility of agenda"

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

Cole, Bird 2014: 289

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

**19 Listening to Concerns**

Fig. 19.1 Manual: Step/function 2: "Listening to concerns".

The Cologne Manual (C-MMC) and the Evaluation of Medical Communication (C-EMC) are also integrated in this representation (Fig. 19.1). In the evaluation, a total of 10 points can be reached in this second step for a doctor's conversation behaviour that is accessible to direct observation (by third parties).

|  |  |   |
|--|--|---|
| Cologne Manual & Evaluation of Medical Communication | <p><b>2 Listening to concerns</b></p>  | <p><sup>6</sup> 2022</p>                                    |
|  | <p>1 Start conversation openly</p> <ul style="list-style-type: none"> <li>• Offer "What can I do for you?"</li> <li>• Motive question "What brings you to me?"</li> <li>• Condition "How are you today?"</li> </ul>  | <p>0 1</p>  |
|  | <p>2 Promoting storytelling</p> <ul style="list-style-type: none"> <li>• Listener signals <i>hm, yes, right</i>, nod, eye contact</li> <li>• Avoid interruptions</li> <li>• Tolerate pauses</li> <li>• Allow free development of themes</li> </ul>   | <p>0 1 2 3 4</p>  |
|  | <p>3 Active listening – verbal support</p> <ul style="list-style-type: none"> <li>• Encourage speaking up</li> <li>• Repeating statements verbatim</li> <li>• Paraphrase statements</li> <li>• Openly ask further: "How did that come about?"</li> </ul>   | <p>0 1 2 3 4</p>  |
|  | <p>4 Ensure understanding</p> <ul style="list-style-type: none"> <li>• Questions "Do I understand correctly that ...?"</li> <li>• Summarise</li> </ul> <p>5 Reflect on relationship behaviour</p> <ul style="list-style-type: none"> <li>• How does P deal with offers of help?</li> <li>• Which relationship model is P looking for? (SDM?) (see step 5)</li> </ul> | <p>0 1</p>  |
| <p><sup>1</sup>1998</p>                              | <p><b>EVALUATION</b></p>   | <p><input type="checkbox"/> <input type="checkbox"/> 10</p> |

Fig. 19.1: Excerpt: Step/function 2: "Listening to concerns".  
(The complete manual, cf. Fig. 13.11)

| Situation         | Focus          | Openings |                                     |   |
|-------------------|----------------|----------|-------------------------------------|---|
|                   |                | No.      | Type                                | Copy  |
| Initial interview | Patient        | 1        | Reason for consultation             | "What brings you to me?"<br>"Why are you coming?"                             |
|                   |                | 2        | Concern                             | "What is your concern?"<br>"What's up?"                                       |
|                   |                | 3        | Problem                             | "What are your problems?"<br>"What is your main problem?"                     |
|                   | Relationship   | 4        | Offer                               | "What can I do for you?"<br>"How can I help you?"<br>"What can I serve with?" |
|                   | Body           | 5        | Complaint question                  | "What are your complaints?"<br>"Where does it hurt?"                          |
|                   |                | 6        | Deficit question                    | "Where is something missing?"   |
|                   | Right to speak | 7        | Storytelling invitation             | "Tell me!"  |
|                   |                | 8        | Non-verbal speaking invitation      | Gesture<br>nod  |
|                   |                | 9        | Verbal speaking invitation          | "Mr Miller!"<br>"Please", "So"  |
| Consil            | Med. referral  | 10       | Medical referral question           | "You come from Dr Smith?"<br>"You were referred to me for ...?"               |
| Visit/Follow-up   | Health         | 11       | Question on state of mind (general) | "How are you?"<br>"What does it look like today?"                             |
|                   |                | 12       | Sensitivity question (specific)     | "How is your leg today?"<br>"How did you sleep today?"                        |

Table 19.1: Types of conversation openings

#### 44. Teaching Materials on Medical Communication

|        |   |  |
|--------|---|--|
| E 19.1 | "Where are your ... main complaints?"   | Comment  |
| 01     | D [both sit down]<br>so Mrs A, what brings you here? .  | 2.2: Opening question: reason for consultation |
| 02     | P so, in general now um ... [Looking up to the left, pondering].  | Beginning of the answer                        |
| 03     | D what are your main problems, what/or main complaints, what do you come for? .   | Early Interruption/Funneling                   |
| 04     | P I have often had heartaches, i.e. sharp pains in the region of the heart.   | Focus: "chief complaints"                      |
| 05     | D since when have you had this pain? ... [3] ...  | 4.1: Detailed exploration: Time                |
| E 19.2 | "What's up?"  | Comment  |
| 01     | D Mrs X, what's up? .   | 2.2: Opening question: concern                 |
| 02     | P with the heart . (difficult to understand) . the last time . I also don't know if it's excitement or w . if it's from what it comes . | Beginning of the answer                        |
| E 19.3 | "Mr W, what's up? (wat jiddet?)"  | Comment  |
| 01     | D come in . please take a seat  | 1.4: Situating                                 |
| 02     | P [Patient sits down]   |  |
| 03     | D Mr W, what's up? .  | 2.1: Opening Q: Concerns                       |
| 04     | P yes ... well, I feel empty somehow ..... .  | Beginning of the answer                        |
| E 19.5 | "how are things this morning?"  | Comment  |
| 01     | D how are things this morning? .  | 2.1: Opening Q: Condition                      |
| 02     | P breathing is better, but I'm still coughing [clears throat].  | Start Patient Offer<br>1                       |

Box 19.1 Function of listener feedback

(...) auditor back-channels as opposed to auditor turn claims, provide the auditor with means by which to participate in the interaction. Through the back-channel he may acknowledge his receipt and understanding - or lack thereof - of the speaker's message.

Duncan 1974: 177

Even minimal listener activity can "irritate" the (primary) speaker in his flow of thought and speech, for example, when a "yes" or "hm" is not used to express "understanding" or "agreement" (*convergence*), but rather "surprise" (*deliberation*) or "doubt" (*divergence*) with the corresponding form (intonation) (Ehlich 1979, Koerfer 1979, Flader, Koerfer 1983, Kliche 2015). Here, a *polyfunctionality* of forms of listener feedback is to be assumed, whose modes of use are to be examined in different contexts. Without claiming a "final" system, a typology for specific listener feedback (such as "hm", "yes") is given here (Tab. 19.2), which can also serve as a guide for teaching.

|   | Dimension     | Function  | Paraphrase  |
|---|---------------|---|---|
| 1 | Speech option | turn yielding<br>claim of the turn              | keep talking / I'm listening listen<br>/ I want to talk now                               |
| 2 | Reception     | convergent<br>divergent<br>tending to divergent | I understand what you say / mean<br>I don't understand<br>do I understand correctly?      |
| 3 | Acceptance    | affirmative<br>adversative<br>dubitative        | I agree / agree / yes<br>I disagree / I deny that / no<br>I doubt / really? / is that so? |
| 4 | Anticipation  | deliberative                                    | ahja / ahso / aha<br>I wonder / amazing   |
| 5 | Relevance     | affirmative                                     | this is good / important  |

Tab. 19.2: Dimensions, functions and paraphrases of listener signals ("hm", "yes") (abbreviated and mod. according to Flader, Koerfer 1983: 76)

Box 19.2 Functions of the doctor's handset signal "OK"

Using the example of "OK", Platt and Gordon (2004) (Box 19.2) differentiate a whole range of functions also for doctor-patient communication. The detailed, rich and trenchant description that Platt and Gordon give from their specific perspective of observation and experience as physicians should serve us here as a prototype that can be transferred to other phenomena of listener feedback.

Box 19.2 Functions of the doctor's handset signal "OK"

"OK" can mean "good," as opposed to "Not OK," meaning "bad," but we also use "OK" to indicate that we have been listening, that we agree with the speaker's ideas, or that we are pleased with the information we are receiving (...) However, "OK" as a response can be confusing to listeners when the content of the patient's story or the feelings he expresses are not OK in the sense of "not good". At such times our patients may suspect that we are not listening to, let alone understanding, their problems (...) So what's the trouble?

- First, "OK" is an imprecise response. When used to indicate that we are present and listening, it falls to differentiate between good news and bad, between trivial abnormalities and serious ones. We might hope that our responses to our patient's story would be more varied and more appropriate.
- Second, "OK" tends to close communication rather than continue it. We've all experienced a person who uses "OK" to mean "Stop!" "OK" cuts the speaker short. It is a signal that further conversation is unwelcome (...).
- Third, "OK" lacks authenticity. It is a pat ejaculation rather than a measured human response.

However, there are plenty of times when "OK" is appropriate, such as: Pt.: I need a note saying I can go back to work. Dr.: OK. (...) But when "OK" is not appropriate, when the information the patient shares is far from good, the word creates a dissonance that may destroy any therapeutic relationship and confuse our patients about our level of concern and awareness.

Platt, Gordan 2004: 122f

An "inappropriate" use of "OK", which could even endanger the *therapeutic relationship* between doctor and patient, should perhaps also be reflected upon in one's own conversational practice and corrected if necessary ...

Box 19.5 "Story telling and ticket of entry"

Patients often do not know what they should or may present to their doctor and in what detail. As medical laypersons, their uncertainty results from the lack of a reciprocal perspective assumption with which they could place themselves on the professional standpoint of their medical counterpart. Often, patient stories remain untold because patients cannot assess their relevance. In such cases, doctors have to expect that their patients open the consultation with an "admission ticket" (Box 19.5) that does not necessarily correspond to their primary concern.

Box 19.5 "Story telling and ticket of entry"

But the telling is not so easy. Stories may not be told because patients fear that the stories do not meet the standards of life-and-death intensity the patients assume their doctors demand (...) If the doctor does not facilitate the story telling - if the patient is not encouraged to go on - the patient very often will not.

Facilitating the story-telling process is best accomplished when there are no strict parameters limiting or defining the patient's response. The patient's story is not limited to the first-presenting problem. Patients often state a medical complaint as a 'ticket entry' to medical care, even though the primary and most pressing concern may be unrelated to this complaint.

Roter, Hall 2006: 7

Patients' attempts to initially "buy" less relevant "tickets" reveal their insecurity and helplessness in the face of the relevance problem as it arises from their lay perspective. In concrete individual cases, patients are repeatedly faced with the decision at key points in the conversation as to what can be classified with "good reasons" as sufficiently "relevant" (*doctorability, reasonability*) and therefore as correspondingly "worth telling" (*tellability, narrativity*) or not and should therefore remain "unmentioned" if possible (Heritage, Robinson 2006, Halkowski 2006, Koerfer et al. 2000, Koerfer, Köhle 2007, Baroni 2014, Köhle, Koerfer 2017). In this process of deliberation, it is to be expected that patients will hold back in case of doubt, so that relevant information is often lost, although it would fulfil the relevant criteria (*doctorability, tellability*) if it had been "brought up" by the patients.

## E 19.33 "Where are your main complaints?" (Part 1+2)

In the present case (E 19.33), the patient is deprived from the outset of such a speaking privilege for an initial presentation of the problem, in that the doctor withdraws her right to speak as soon as it has been granted. With his early interruption, the doctor intervenes in her obvious act of deliberation ("generally now um ...") with a twofold *specification*, with which he thematically narrows his opening question (01D), which was initially kept relatively open, to a *biomedical* focus ("main complaints") (03D).

## E 19.33 "Where are your main complaints?" (Part 1+2) Comment

|    |   |   |  |
|----|---|---|--|
| 01 | D | [both sit down]<br>so Mrs A, what brings you here? . [+]  | 2.1: Opening:<br>Reason for consultation                                 |
| 02 | P | [-] so [+] [-], in general now um ... [Looking up to the left, thinking]                            | Start of the answer with thinking  |
| 03 | D | where are [+] your main problems, what/ or main complaints, what you come for? .                    | 2.2: Early Interruption/<br>Funneling                                    |
| 04 | P | I have often had heartaches, i.e. sharp pains in the heart area. [+]                                | Focus: "chief complaints"  |
| 05 | D | since when have [-] you had these pains? ... [3] ... [-] [ P scratches shoulder]                    | 4.1 Exploring details (time, start);<br>Patient: Contemplative gaze of P |
| 06 | P | for a little [+] longer, so in 2001 it was really bad, and then I also had my tonsils removed . [+] | Last sustained eye contact from P to D                                   |
| 07 | D | yes . [+]   | Listener signal  |
| 08 | P | that was still the case with Dr. Miller. [+]  | Pre-treatment  |

In this context, the self-correction in the intervention should be noted, after which the doctor replaces his first formulation ("main problems") with the focus "main complaints", from which a certain topic preference structure of the doctor can or should also be concluded from the patient's perspective of understanding, which consists in a double *relevance setting*:

Fig. 19.2 Funnel technique

| Example (E 19.33)  | Funnel technique  |
|--|---|
| <p data-bbox="411 1397 767 1429">Fig. 19.2: Funnel technique</p> | <p data-bbox="967 434 1361 568">The funnel technique can be used very effectively to conduct a doctor-centered conversation:</p> <p data-bbox="967 577 1361 1469">Formally through interruptions and functionally through targeted questions, the doctor very soon gains dominance of the topic in the conversation. The patient quickly learns to answer only the doctor's questions and then to wait for the next question in the sense of "verbal conditioning" (§ 9.4). In this way, he soon puts aside his own need for questions and information in favour of the doctor's need for information. While the funnel technique is quite useful in later phases of the conversation to further complete the anamnesis (§ 21), its early use can lead to a permanent inhibition of the patient's willingness to talk and self-exploration.</p> |

Thus, at the end it remains open how the questions and answers about "stress" or "rest" (E 19.34: Sequence 11-16) were meant and understood in each case, namely as statements either about *physical* or *mental* stress/rest. Because the doctor does not ascertain these alternatives of understanding, he cannot even register a secure gain of information here, so that this sequence of the conversation must also be assessed as negative under the aspect of *detailed exploration* (§ 21).

[cf. transcripts and conversation analyses in § 19]

#### 44. Teaching Materials on Medical Communication

| E 19.34 | "Did it get better afterwards?"   | Comment                           |
|---------|---|-----------------------------------|
| 09      | D did it get better afterwards? .   | 4.1:<br>Time, Course              |
| 10      | P yes, then it was better again, and then it occurred again, so now, recently.  | Improvement;<br>relapse           |
| 11      | D in which situations does this occur? . does this occur during stress or- .  | 4.1:<br>Condition                 |
| 12      | P no . [shakes head].   |                                   |
| 13      | D no .  |                                   |
| 14      | P at rest more, at rest . .   |                                   |
| 15      | D mainly at rest .  |                                   |
| 16      | P [nods] hm .... [2 sec.] ...   |                                   |
| 17      | D and does it radiate this pain somewhere? ...  | 4.1 Explore details: Localisation |
| 18      | P no [shakes head] ..... [3 sec] .....  |                                   |
| 19      | D do you have ... situations where you think it comes on particularly strongly? When you are in trouble? ..... [6 sec.] ..... | 4.1 Explore details: Condition    |
| 20      | P that could be, maybe with upset . I don't know exactly now .  |                                   |
| 21      | D do you have a lot of upset? ...   | 4.3: Complete medical history     |
| 22      | P [laughs friendly] yes, stress .   |                                   |
| 23      | D yes, how, how does the stress look? .   | 4.3: Stress: Quality              |
| 24      | P yes ..... [6 sec.] ..... yes a lot of work and then- .  |                                   |

Despite his further efforts to develop the conversation beyond biomedical information gathering into a biopsychosocial anamnesis conversation (Sequence 19-25), the doctor then surprisingly falls back into detailed exploration, hardly seeming to succeed in his efforts. At this further problematic point in the conversation, the alternative continuations of the conversation can be discussed in conversation theory, as opposed to real continuations by the doctor. First of all, the doctor could have waited to see whether and how the patient, who pauses in her speech after a long period of reflection of no less than 6 seconds after the first short communication (24 P: "yes, a lot of work and then-"), would continue on her own initiative if necessary ...

|      |                               | Opening (open)                  |                      |        |  |
|------|-------------------------------|---------------------------------|----------------------|--------|--|
| 01 D |                               | What brings you to me?          |                      |        |  |
| 02 P |                               | So in general now, um...        |                      |        |  |
|      |                               | Biotic                          | Psychic              | Social |  |
| 03 D | Main complaints?              |                                 |                      |        |  |
| 04 P | Heart pain [=H].              |                                 |                      |        |  |
| 05 D | These sharp pains since when? |                                 |                      |        |  |
| 06 P | It was bad in 2001            |                                 |                      |        |  |
| 09 D | Was it better afterwards?     |                                 |                      |        |  |
| 10 D | Does the [=H] occur with ...? |                                 |                      |        |  |
| 11 D | Does that radiate?            |                                 |                      |        |  |
| 19 D |                               |                                 |                      |        | Does this occur when there is trouble? |
| 20 P |                               |                                 |                      |        | In case of excitement.                 |
| 21 D |                               |                                 |                      |        | Much excitement?                       |
| 22 P |                               |                                 |                      |        | Yes, stress.                           |
| 23 P |                               | What does the stress look like? |                      |        |  |
| 24 P |                               |                                 | A lot of work.       |        |  |
| 25 D |                               |                                 | Which profession?    |        |  |
| 26 P |                               |                                 | Physician assistant. |        |  |
| 27 P | Shortness of breath [=H]?     |                                 |                      |        |  |
| 28 P | No.                           |                                 |                      |        |  |
| 29 D | Sweats?                       |                                 |                      |        |  |
| 30 P | Yes, sweating.                |                                 |                      |        |  |
| 33 D | No sweat at [H]?              |                                 |                      |        |  |
| 34 P | No.                           |                                 |                      |        |  |
| 35 D |                               |                                 |                      |        | Are you scared?                        |
| 35 P |                               |                                 |                      |        | No.                                    |
| 37 D |                               | Are you worried?                |                      |        |  |
| 37 D |                               | No.                             |                      |        |  |
| 41 D | (Pre-)examinations?           |                                 |                      |        |  |
| 42 P | Yeah, EKG.                    |                                 |                      |        |  |

Fig. 19.3: Biopsychosocial theme development

Fig. 19.4 Dialogue role structure and conversation parts of P and D

With her maximum contribution length of 28 words, she cannot even cross the extremely low threshold of 30 words, which would be a prerequisite for minimal narrative approaches, as will become clear in comparative analyzes with other conversations. The chances of participation decrease, especially in the last third of the conversation, which becomes increasingly unproductive for both conversation partners.

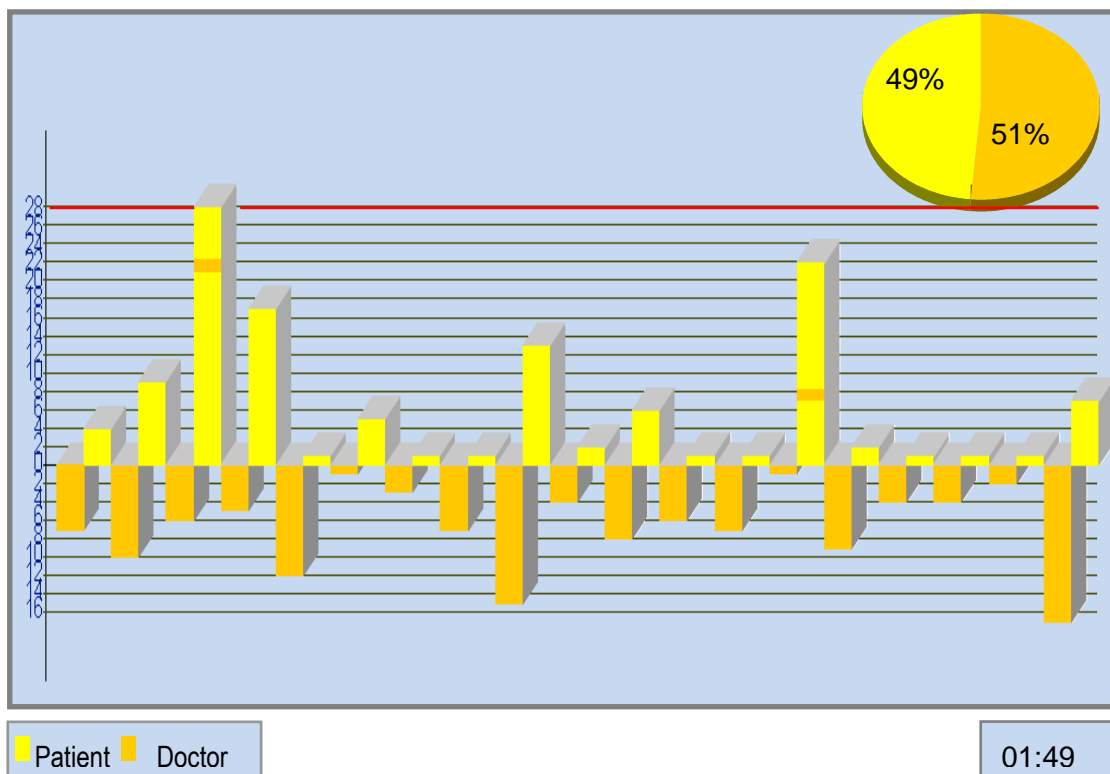


Fig. 19.4: Dialogue role structure and conversation parts of P and D

In the end, both interlocutors resort to *strategic* action, which obstructs points of connection for *communicative* action (§ 7.3, 7.5). The doctor's interrogative conduct of the conversation has led to an impasse from which both partners can no longer find a way out. It is possible that the patient does not "fall silent" completely because she believes she is still obliged to answer the doctor's questions out of politeness - in any case, the patient only does what is "absolutely necessary" to maintain the conversation by reacting more and more "monosyllabically" to the doctor's questions (27-42), which she finally only answers with one word ("no"). The patient chooses this *minimalist* form of answering ...

E 19.42 "deathly bad" - "Until it didn't work any more"

This theme of the failure of coping attempts is now brought into play again by the doctor when he brings the temporal connection of the daughter's MS disease with the patient's own vertigo symptoms, which the patient herself had already established (26 P), into the focus of attention, in which the patient herself now appears directly as a suffering subject in another narrative.

E 19.42 "deathly bad" - "Until it didn't work any more" Comment

|    |   |   |   |
|----|---|---|---|
| 36 | P | (...) the doctor did everything for her . but it's a very, very difficult case . she has to be in a wheelchair, she can't do anything anymore ... and I can't cope with that . I can't cope with that .   | Emotional patient offer<br>Resumption of "not being able to cope with it", see above P 26   |
| 37 | D | this dizziness, did it start when you found out about this diagnosis [=daughter has MS]? .  | 4.1 Exploring details (time, condition) + narrative invitation  |
| 38 | P | yes, I believe so ... once I had something in my head at night, uh ... I never told my husband, once at night in my head it was all weird in my head, deathly bad ... I woke up ... I think: "oh dear, oh dear, what's wrong now?" ... then I got really sick in bed at night ... I fought against it, always did everything at home, took care of the household, until/until it was no longer possible, no ... | Framing, theme<br>Orientation:<br>Listener privilege<br>Complication: "unheard of Event"<br>Direct speech<br>Evaluation:<br>Mastery <i>versus</i> failure, coda |

While the patient has so far told her story mainly from the family perspective, in which she was already involved as a suffering mother and failing grandmother, she now uses the doctor's exploratory question about a possible connection with her vertigo symptomatology for a self-narrative in which she tells a dramatic story about the beginning of her own illness. Despite its brief form, this narrative also contains essential functional and structural elements (see comment column), as they were differentiated earlier on the basis of the *normal form* of narratives (§ 9).

Fig. 19.5 Dialogue role structure and conversation parts of P and D

From the aspect of participation, it is already clear from the formal representation of the dialogue role structure of the patient and the doctor (Fig. 19.5) to what extent the patient gets to speak at all and how she can use the high proportion of speech (of 84%) for a series of longer speech contributions (> 160 words) especially in the middle of the conversation, namely as narratives concerning her past and present worries and needs.

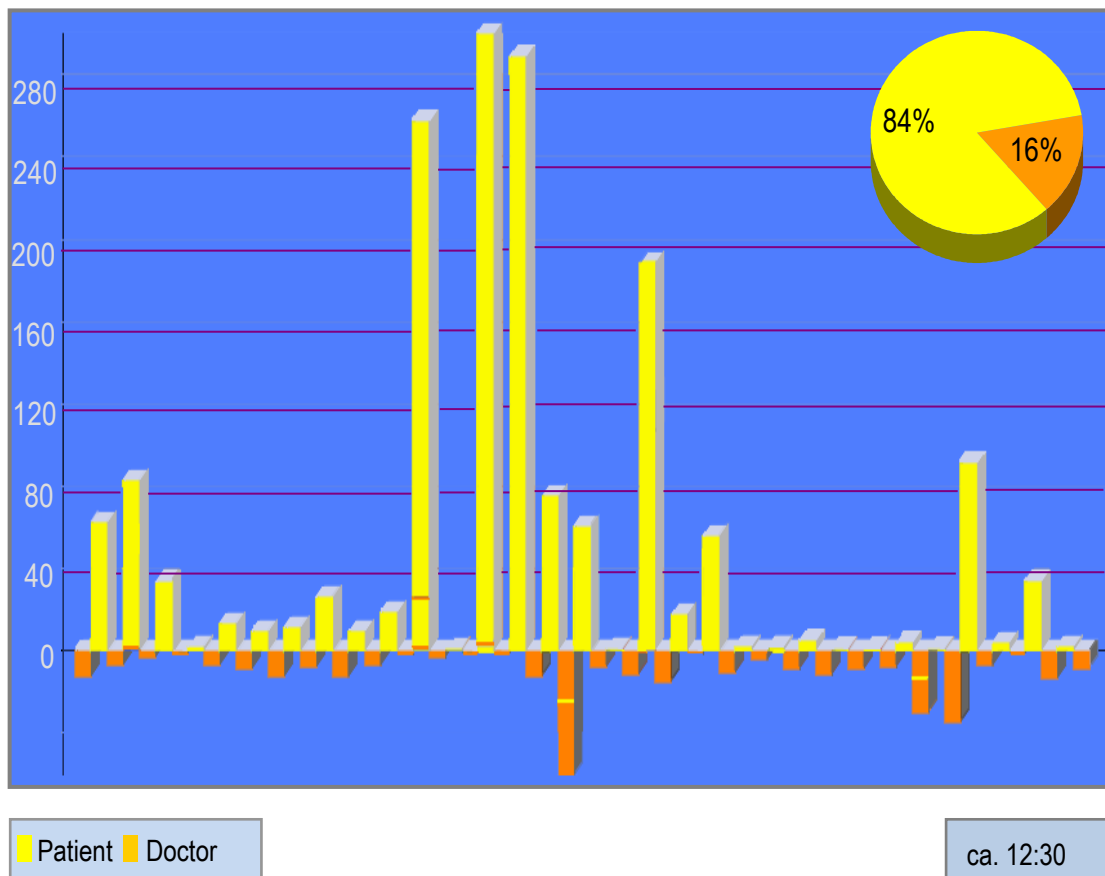


Fig. 19.5: Dialogue role structure and conversation parts of P and D

While in the previous "interrogation" conversation (§ 19.6, Fig, 19.4) it was already clear from the dialogue role structure that the patient, with a speech share of 49% and a maximum speech contribution of 28 words, can hardly get a word in edgewise, in this conversation the verbal restraint of the doctor is conspicuous, who restrains himself with relatively short contributions to a speech share of 16%.

Fig. 19.6 Life narrative: "Until it was no longer possible"

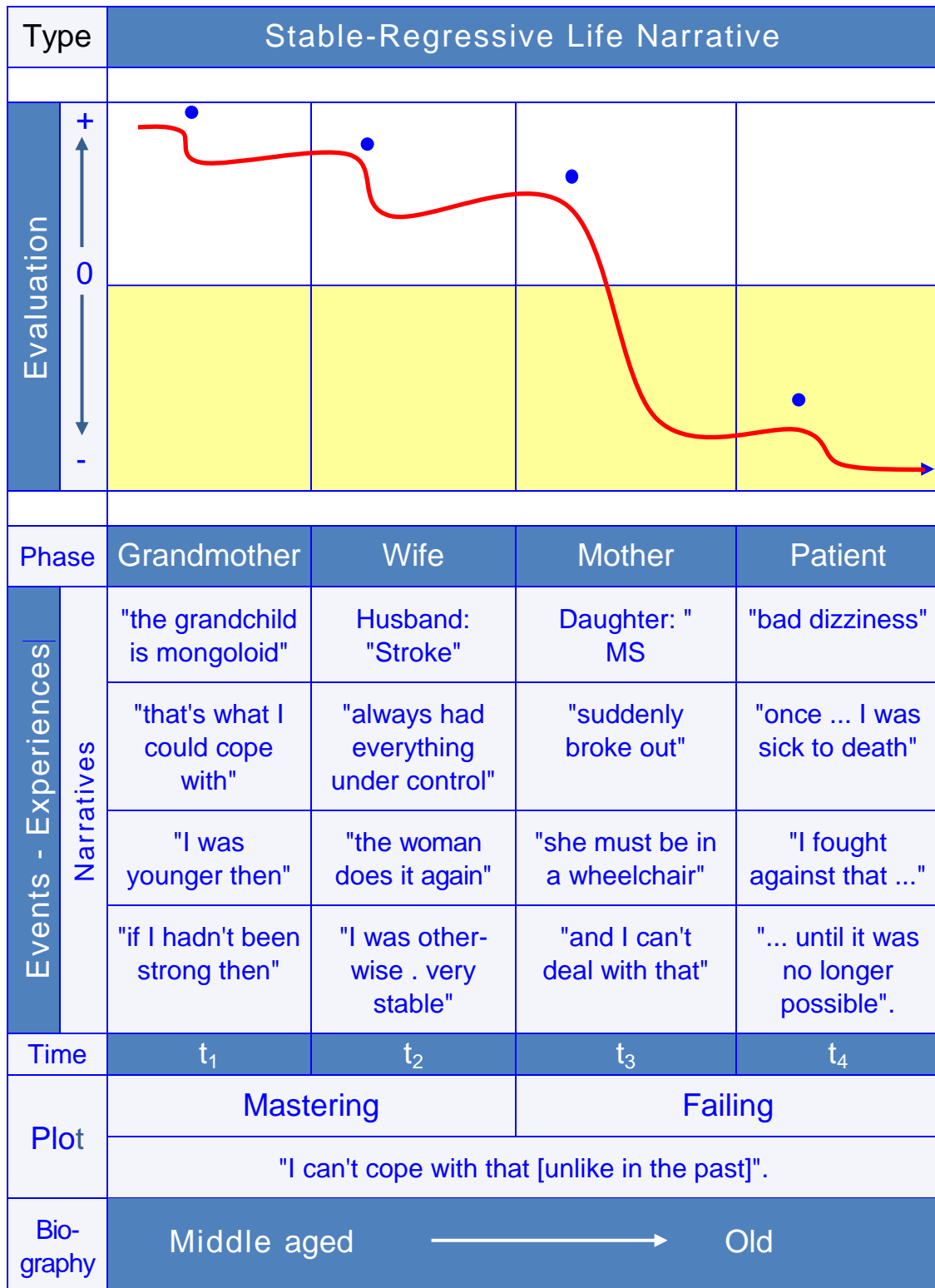


Fig. 19.6: Life narrative: "Until it was no longer possible".

## E 19.45 "that's no fun?"

In the present case, the doctor must counter the patient's *resistive*, because initially quite *vague, response* behaviour, which can be interpreted with Streeck (1995) as an interactive form of *resistance*, with an *insistent* intervention battery of (follow-up) questions for detailed professional exploration, through the cumulative effect of which he can successfully "elicit" the patient narrative that then follows (§ 9). Here, the "advance sequence" will first be reproduced as the interactive "prehistory" of the narrative.

## E 19.45 "that's no fun?"

- 01 D (hm) . what do you do for a living? .  
 02 P I am a civil servant in the city of A .  
 03 D and what field of activity? .  
 04 P I sit around in the office.  
 05 D (yes) . that's no fun? .  
 06 P well ... let's put it this way ... [smiles] uh ... I'm actually not the type of civil servant .  
 07 D hm . hm . but rather what/what (would you say what ) [quieter to silence] .

Through the doctor's repeated enquiries, with which he gradually tries to overcome the vagueness of the answers, the patient is also gradually put under more or less strong pressure to further specify his unspecific information. The cumulative effect of the doctor's interventions is increased in particular by the communicative function of the doctor's specific, emotion-related feedback (05 D: "that's no fun"?). This intervention proves to be a *key intervention* in the further course of the conversation, with which the *psychodynamically* relevant *narrative motivation* of the patient can apparently be sufficiently released, as this becomes clear with the type of biographical narrative subsequently chosen by the patient (see below). At any rate, at the end of the preceding sequence, the patient is given a special *licence* for a narrative in the sense of a narrative invitation by the doctor, which he can use largely at his own disposal in terms of form, content and function, which he then makes extensive use of (see below).

| E 19.46 "thrown off track" |   | Comment  |
|----------------------------|---|--|
| 01                         | P [leans back already, inhales audibly while A is still talking (see above), averts his gaze for a longer time] [-]<br>I had something completely different in mind, that ... used to be .... (4) .... it started somewhere, I thought about it, you see, you think about things like that, how do they come about, why (you ask me something like that) ... probably I ... (3) ... got the first crack somewhere .... (4) .... I wanted to study natural sciences, had/have also started, but then I dropped out in the pre-exam [-] ... | Nonverbal +<br>Verbal framing,<br>theme<br>Orientation<br>(beginning)<br>Meta-communication<br>Metaphor<br>(beginning of suffering)<br>Orientation<br>Complication,<br>scandal |
| 02                         | D hm .  | LS   |
| 03                         | P that threw me a little bit off the ... track ... [-]  | Life metaphor  |
| 04                         | D hm .  | HS   |
| 05                         | P I wanted to study physics, but something completely different ... and then somehow [shakes head] I completely failed the exam ... so I couldn't get anything out of myself [chokes and clears throat] ... how it is [+] [smiles, eye contact] ...   | Subjective<br>Perspective<br>Scandalon<br>Re-staging:<br>Symptom repetition  |
| 06                         | D hm .  | HS   |
| 07                         | P and then I didn't dare to start again . and then I hung around . didn't know what to do [+] .   | Subjective<br>Perspective<br>Problem,<br>Complication  |
| 08                         | D hm .  | LS   |
| 09                         | P and then I briefly did some administrative training on the side, I trained as a civil servant without making any particular effort at [-]....   | Problem "solution<br>Pseudo-sense<br>concept   |
| 10                         | D hm .  | LS   |
| 11                         | P and then do it [+] more or less like that now, because it's not fun for me either, unfortunately [continued eye contact] ...  | Evaluation:<br>Resignation, Coda<br>Turn-over  |

## Box 19.7 The importance of metaphors for self-understanding

Just as we seek out metaphors to illuminate and make coherent the commonalities we share with another person, so we seek out personal metaphors to illuminate and make coherent our biography, our activities, our dreams, hopes and goals. To a large extent, trying to understand one's self is a search for appropriate personal metaphors to make sense of our lives. Understanding one's self requires an endless process of negotiation in which we find the meaning that our experiences have for us. In psychotherapeutic treatment, for example, the step of understanding the self is for the client to become aware of how they unconsciously live according to certain metaphors and how these determine their lives.

Lakoff, Johnson 1980/98: 266

The importance of metaphor analysis for the study of medical and therapeutic communication has been elaborated in particular by Buchholz (1996/2003, 2014), who also elaborates his specific approach of therapeutic metaphor work in this Handbook (§ 11) theoretically and with examples in concrete terms. Narrative analysis, too, is essentially to be conducted as metaphor analysis. A possible misunderstanding must be prevented: when metaphors are used, their general ("objective") meaning remains; otherwise we would not be able to make ourselves understood either in self-interpretation or to other interlocutors (relatives, neighbours, doctors, etc.). But the use of metaphors also takes on a special form in the consultation hour, to which the *art* of medical *listening* and *understanding* should be sensitively directed.

This can already be shown in our case study if we look at the narrative of the patient under this aspect of metaphors, who (in the sense of Lakoff and Johnson) tries to *give meaning* to his whole adult life so far in a few *personal* metaphors that *suit* him (such as "thrown off track"), which can be arranged under certain concepts (CONTAINER, FIGHT, etc.) and a *positive* and *negative* polarity in each case ("intact" versus "hurt", etc.) (Tab. 19.3).

Table 19.3 General concepts and personal meaning of metaphors

| Concept   | Polarity        |                 | Example  |
|-----------|-----------------|-----------------|--|
|           | <i>Positive</i> | <i>Negative</i> |  |
| CONTAINER | Intact          | Injured         | "got the first crack somewhere"                                  |
| FIGHT     | Taking up       | Giving up       | "(Dropped out)"<br>"didn't dare to start again".                 |
| PATH      | Tracking        | Derailment      | "thrown off track"   |
| POWER     | Strength        | Weakness        | "did an administrative training on the side"<br>"without effort" |

Tab. 19.3: General concepts and personal meaning of metaphors

The choice, repetition and variation of metaphors is not arbitrary, but closely linked to personal experience, from which their "subjective" meaning is derived. The patient obviously sees himself as a "container" when he judges himself to have "got a crack". If one listens carefully, it is the "first crack" he got, which suggests further, later damage to the "container". As a consequence of the "failed pre-exam", the other metaphor comes into play here, with which the whole course of life is experienced as a "derailment" ("thrown off track"). Whoever talks about himself as a person in this way also sets fantasies free in the listener about how the patient's life would have turned out if he had not been "thrown off track", because he would have "dared" to "start again" etc. From the factual polarisation that the patient makes in his narrative ("hurt", "derailed", "giving up" etc.), the patient's secret *self-design*, which ultimately "had something completely different in mind", can already be anticipated via the counterfactual oppositional relation, to which we will return in the further course of the conversation with specific thematic contributions by doctor and patient.

Fig. 19.7 Effect/reach of medical interventions

Whatever the first medical intervention ("no fun"?) in combination with the second intervention ("but ...") may "trigger" in the patient from a psychodynamic aspect in detail, he finally reacts on the interaction level with a dramatic, strongly emotional *biographical narrative* of a long *history of suffering*, which after variant *metaphors* of failure, suffering, despair and giving up (Tab. 19.3) is marked in the *final evaluation*, i.e. after more than 1 minute of speaking time, by a resumption of the term in question ("because it's not *fun* for me either, unfortunately").

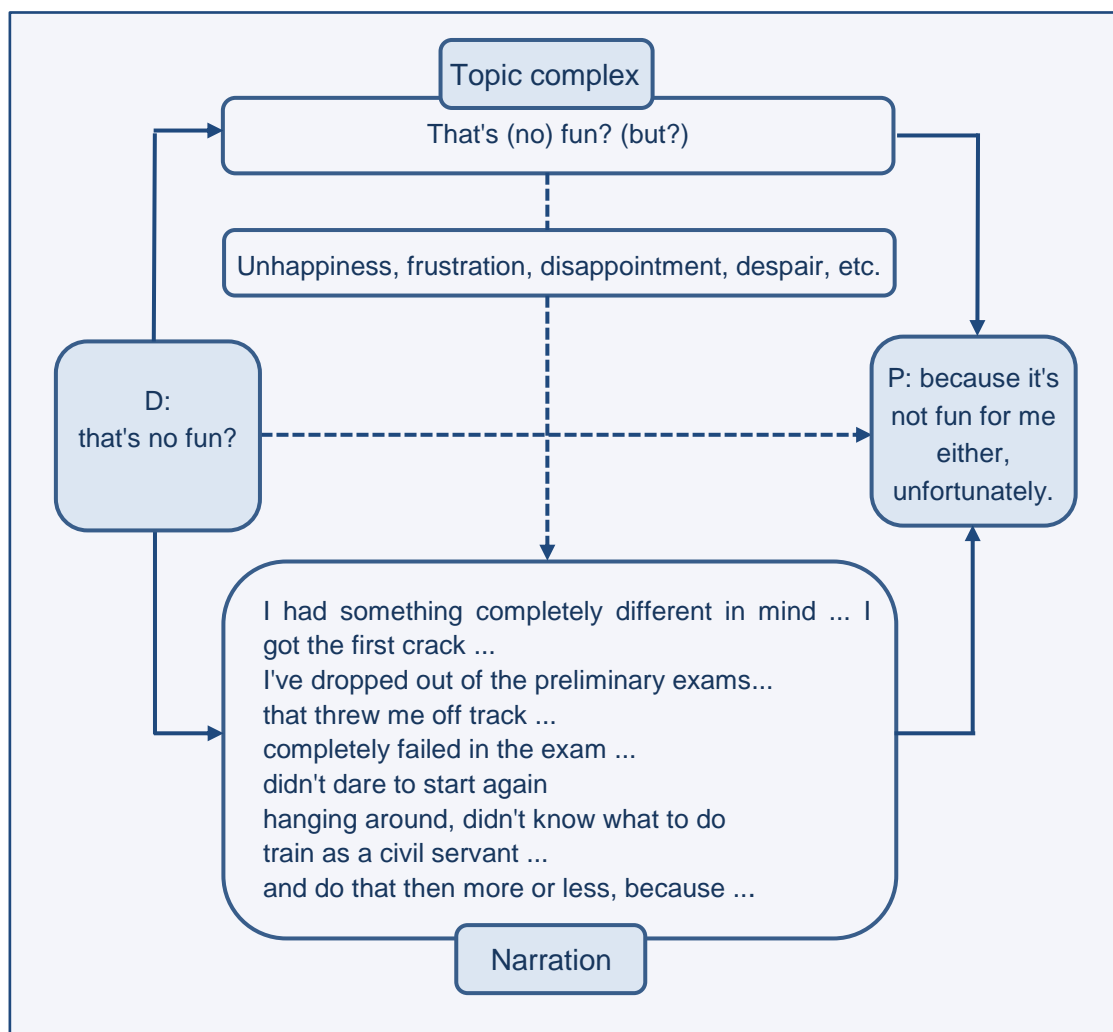


Fig. 19.7: Effect/reach of medical interventions

Fig. 19.8 Dialogue role structure of D and P: narrative interview style

As has already become clear from the few conversation excerpts so far, the doctor and the patient are each involved thematically and interactively in their own specific way in the *(re)construction* of the patient's story. Analogous to the previous conversation analyses, which focused on the differences between *interrogative* and *narrative* conversational styles (§ 19.6-7), the procedure described and applied there for depicting the *dialogue role structure* (Fig. 19.4-5) will also be used for this conversation (Fig. 19.8).

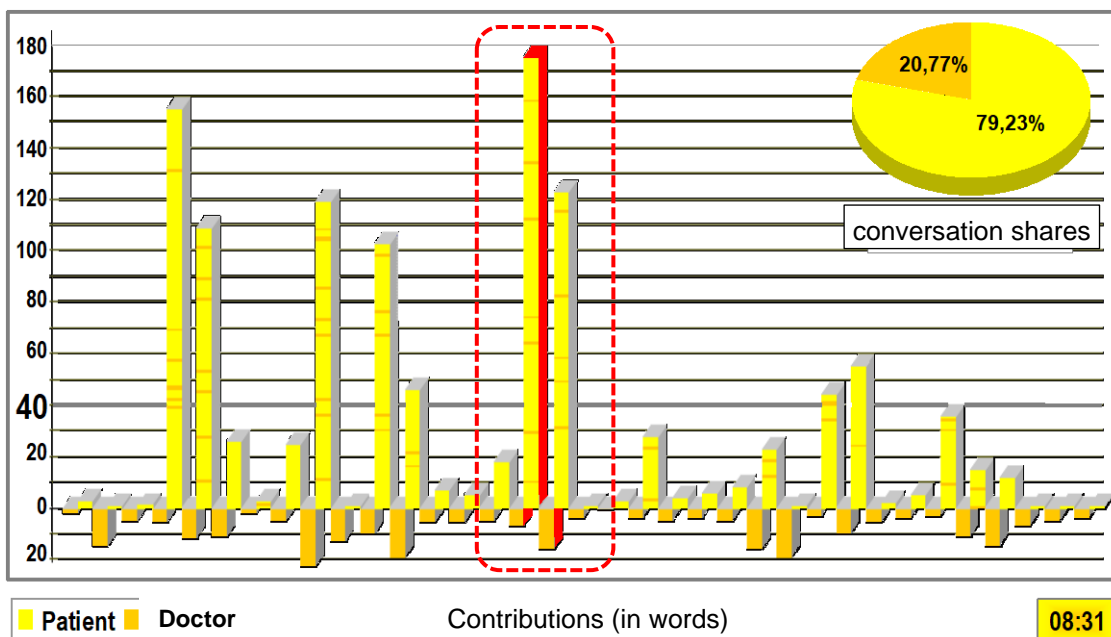


Fig. 19.8: Dialogue role structure of doctor and patient: narrative interview style

In this conversation, too, the doctor largely restrains himself with a share of speech of 21% and leaves the patient the right to speak for long stretches, which he uses for a series of narrations. After the welcoming scene (omitted in the transcript above) and the subsequent doctor's question about his concern ("yes Mr. B., what's up?"), the patient had presented his complex history of illness and treatment in longer, partly narrative conversational sequences, which were essentially limited to *biomedical* topics (outlined in blue), before the conversational turn with a *psychosocial* complex of topics (red), which leads into a *biopsychosocial* topic development of the conversation (green), is described in detail. Finally, we focussed on the longest speech of the conversation (> 160 words) (= red marked column), in which the patient tells the core of his life story with a speech time of more than one minute ...

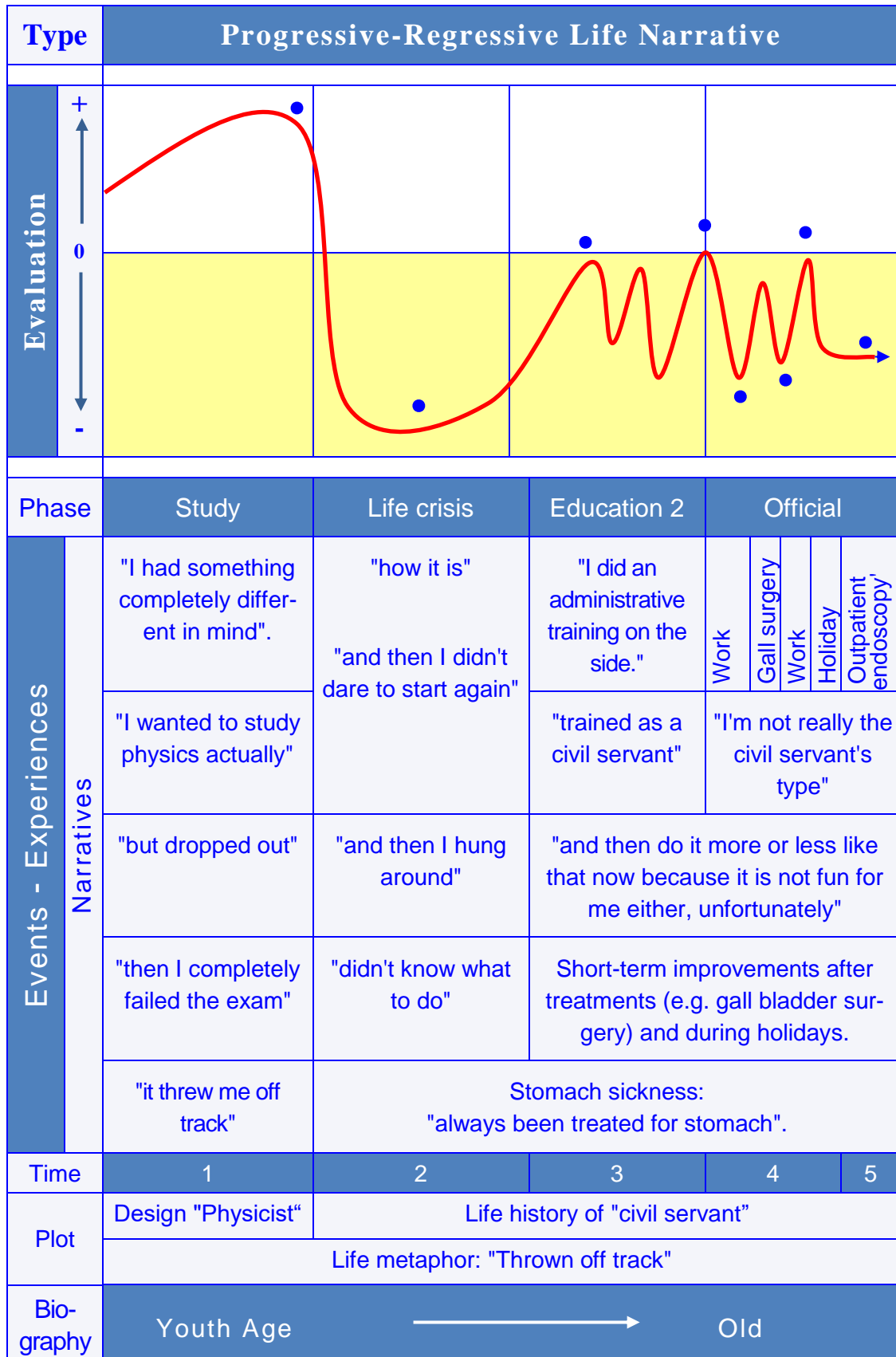


Fig. 19.9: Life narrative: "thrown off track"

**20 Eliciting Emotions**

Fig. 20.1 Manual: Step/Function 3: "Eliciting emotions"

|  |   |   |
|--|---|---|
| <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Cologne Manual &amp; Evaluation of Medical Communication</p>  | <p style="text-align: center;"><b>3 Eliciting emotions</b></p>  | <p style="text-align: right;"><sup>6</sup>2022</p>            |
|  | <p>1 Pay attention to emotions</p> <ul style="list-style-type: none"> <li>• Verbal (e.g. metaphors)</li> <li>• Non-verbal (e.g. gestures, facial expressions, gaze behavior, etc.)</li> </ul>   |   |
|  | <p>2 Empathise with P's situation</p> <ul style="list-style-type: none"> <li>• Recognising individual meanings</li> <li>• Registering clues to "delicate" things</li> </ul>   |   |
|  | <p>3 Respond empathically</p> <ul style="list-style-type: none"> <li>• Acknowledge burden / coping<br/>"You've been through a lot there"<br/>"You handled that well"</li> <li>• Offer appropriate help and comfort<br/>"I can reassure you because ..."</li> </ul>                              | <p style="text-align: right;">0 1 2 3 4</p>                   |
|  | <p>4 Promoting emotional openness</p> <ul style="list-style-type: none"> <li>• Addressing "Do I perceive correctly, that ..."</li> <li>• Naming "That makes you sad then"</li> <li>• Clarifying "How does that make you feel?"</li> <li>• Interpreting "Your fear may come from ..."</li> </ul> | <p style="text-align: right;">0 1 2 3 4</p>                   |
| <p>5 Use own emotions (indicator)</p> <ul style="list-style-type: none"> <li>• Interest, concern, fears etc.</li> <li>• Dislike, disappointment, anger etc.</li> </ul> |   |   |
| <p><sup>1</sup>1998</p>  | <p><b>EVALUATION</b></p>  | <p style="text-align: right;"><input type="checkbox"/> 08</p> |

Fig. 20.1: Excerpt (from: Manual & Evaluation): Step/Function 3: "Eliciting emotions" (The complete manual can be found at the end of the chapter, Fig. 20.6, cf. Fig. 13.11)

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 Box 20.4 Decline of empathy due to lack of role models
 

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While the barriers to empathic communication in professional practice can still be explained by the pressure to act and the time pressure under which doctors, in case of doubt, decide to reduce themselves to biomedically oriented conversation, the decline in empathy already during studies may at first seem surprising, especially since students generally begin their studies with great *enthusiasm* and *idealism*.

Nevertheless, a change in attitude soon occurs in the course of studies, in which the *decline in empathy* is also seen in connection with the *increase in cynicism* (Hojat et al. 2004, 2009, Neumann et al. 2011, Seitz et al. 2017, Andersen 2020). Many reasons are cited for this regrettable regression. In addition to the general reasons already given for later professional practice (stress, time pressure), Seitz et al. (2017) (Box 20.4) cite above all the lack of role models in training practice, in which teachers may teach empathy but hardly practice it themselves.

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 Box 20.4 Decline of empathy due to lack of role models
 

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It is interesting to note that students indicated that teachers are the strongest advocates of empathic behaviour towards patients, but rarely show it themselves from the students' perspective. According to students, doctors are the least likely to advocate empathic behaviour and rarely demonstrate it. In addition, most students are not oriented towards doctors when it comes to empathic behaviour, but towards psychosocial professional groups. According to the authors, this is a serious problem, since doctors and teachers have or should have a role model for the students (...) In order to improve the training of empathic conversation among students, psychosocial professions such as psychotherapists could be integrated.

The lack of integration of these and the negative or missing role modeling by doctors and teachers is a possible cause for the fact that there is a decline in the intention to show empathy in the course of studies.

Seitz et al. 2017: 29

From the students' point of view, the well-known dilemma that theory and practice can diverge widely is experienced here in the course of their studies. Apparently, the students orient themselves on the perceived conversational practice of their teachers, to which they still adapt during their studies ...

Box 20.7 Empathy (empathetic understanding)

The professional art of being able to "read thoughts and feelings" and "help to verbalise them" has a long tradition, in which a variety of theoretical and empirical studies on the forms and functions of empathic communication have emerged. The role of empathy was first recognised in psychotherapy before it became a topic in medical communication as well (Rogers 1942/1985, Miller 1989, Squier 1990, Zinn 1993, Finke 1994, Wellendorf 1999, Coulehan et al. 2001, Black 2004, Pedersen 2009, Lelorain et al. 2012, Neumann et al. 2009, 2012, Derksen et al. 2013, 2015, Sulzer et al. 2016, Childers et al. 2023, Zhang et al. 2023, Arshad et al. 2024). The therapeutic function of empathy has already been highlighted by Carl Rogers as one of three essential conditions for the development of a therapeutic relationship (Box 20.7). In addition to the therapist's congruence ("agreement with oneself") and *acceptance*, which requires unconditional *appreciation* and *positive attention* towards the patient, *empathy* ("empathetic understanding") is identified as the "second essential condition" for a "growth-promoting relationship".

Box 20.7 Empathy (empathetic understanding)

The second essential condition of the therapeutic relationship, in my view, is that the therapist develops a precise empathic understanding of the client's personal world and is therefore able to communicate some of the essentials of the fragments of what is thus understood. To feel the client's inner world with its very personal meanings as if it were one's own (but without losing the quality of 'as if'), that is empathy and that seems to me to be the essence of a growth-promoting relationship (...) When the world of the client has become clear to the therapist and he can move freely in it, then it is possible for him to convey his understanding to the client of what he is only vaguely aware of and he can also address meaning in the patient's experience of which he is hardly aware. This highly sensitive empathy is important to enable a person to come close to himself, to learn, to change and to develop.

Rogers 1962/1990: 216

Rogers' concept of empathy already includes *cognitive* ("understanding") as well as *affective* ("empathising", "feeling") and finally *actional* ("communicating") aspects ...

Fig. 20.2 Therapeutic empathic communication (TEC) process model

(...) These negotiations of meaning can only be captured in a suprasegmental conversation analysis, in which, for example, narrative conversation developments with specific emotion content are to be reconstructed (Koerfer et al. 2000, 2004, 2010) (§ 9, 19, 25). In order to be able to capture these developments in a model of empathic communication, we have added further stages (6-9), which initially serve formally as placeholders that are to be filled differently in terms of content depending on the individual case (Fig. 20.2).

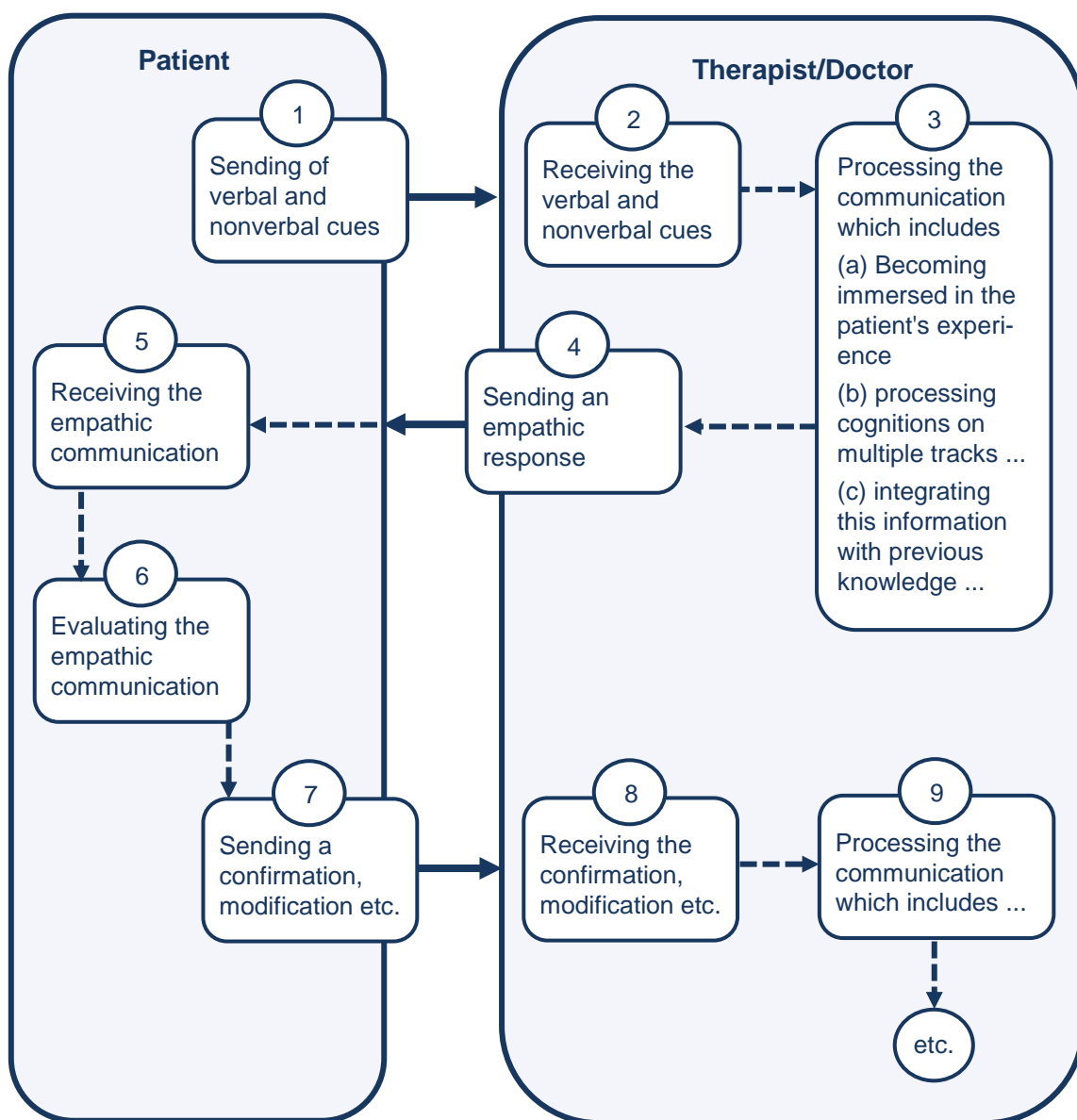


Fig. 20.2: Therapeutic empathic communication (TEC) process model  
(modified, shortened and extended on Miller 1989)

Box 20.12 Patient cues and medical (non-)responsiveness

"Emotions have priority!" If they are "suppressed" by other topics, they quickly disappear from the surface of the conversation, so that it is difficult to "bring them back out of obscurity". That is why the empathic doctor should react directly to the emotions of patients who have problems disclosing them anyway. That is why the empathic doctor should react directly to the emotions of patients who have problems disclosing them anyway. Thus, the doctor often has to be "all ears" in order to perceive the "discrete" patient *cues* at all. Pollak et al. (2007) (Box 20.12) describe that this is not always possible even for doctors who should have the necessary sensitivity in their specific field of action, even for oncologists who should be used to dealing with emotions professionally and yet often miss "empathic opportunities".

Box 20.12 Patient cues and medical (non-)responsiveness

Patients may not want to burden oncologists with their concerns and instead may provide indirect cues or clues about their concerns. For example, rather than ask about prognosis, patients may simply say, "I'm not sure what there is to look forward to." These indirect cues are often missed by oncologists (...) Such cues or clues often create empathic opportunities, or moments that beg empathic responses from clinicians. Empathic responses directly address patients' emotions, validate their feelings, and invite further disclosure. Such responses are considered empathic continuers. Unfortunately, clinicians often do not respond to cues with expressions of empathy. They may avoid the emotion or may change the topic with empathic terminators that can negatively affect the patient-physician relationship.

Pollak et al. 2007: 5748

Depending on the doctor's (non-)responsiveness, conversations can develop into very different topics, with corresponding effects on the relationship. As we will see in detail with examples, doctors miss not only *indirect* but also *direct* patient *cues*, which they obviously do not just overhear in the reception, but may well have heard, but nevertheless ignored, for example when they make a "*change of topic*".

Fig. 20.4 Typology of empathic (non-)responsiveness

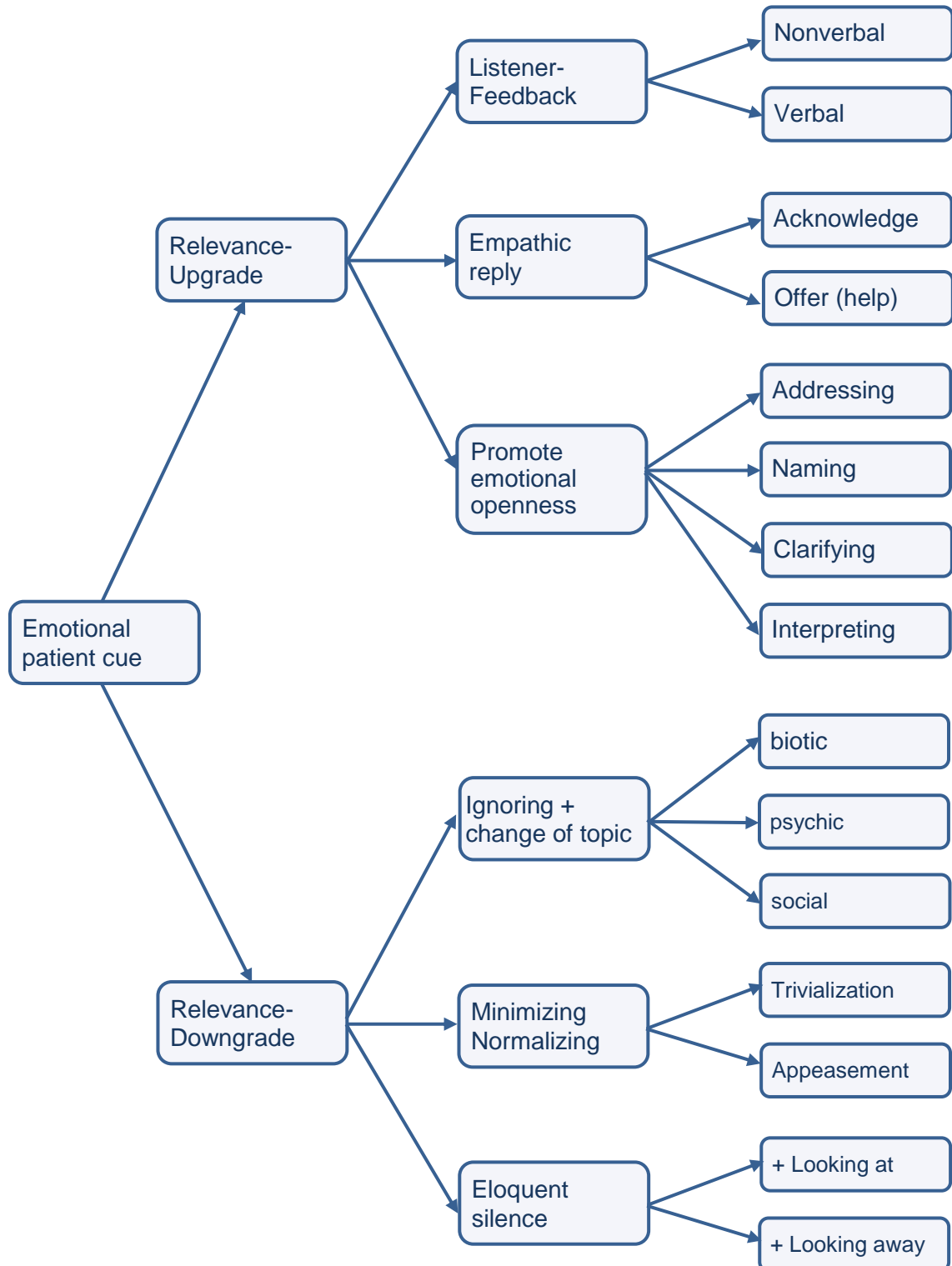


Fig. 20.4: Typology of empathic (non-)responsiveness

E 20.3 Minimise or normalise

In this context, what is said can remain "unheard" in various ways. Beyond the strict *ignoring* of emotional patient cues, which will be differentiated in a moment, different variants of *partial responsiveness* can be distinguished, which often appear no less "cynical".

These include forms of *minimisation* or *normalisation* with which the legitimacy of their emotions is more or less questioned vis-à-vis the patients (Salmon et al. 2004, Hsu et al. 2012). Because it is drastic and short enough, an (English-language) example (E 20.3) from the Salmon et al. (2004) corpus of conversations is given here.

E 20.3 Minimise or normalise

- 01 P oh dear. Have I got to have any more, any more? After me wife died I had both my knees, done. My second knee was done in February '97, in February '98 I had that appendix and December '99 I had this flu. I shouldn't have had it after I had the injection should I?
- 02 D It's bad luck, isn't it?

Salmon et al. 2004: 175

It remains to be seen whether this kind of "cynicism" can be surpassed by strict ignorance when doctors let their patients talk, perhaps even listen sufficiently, but "pass over" what is *said* and *meant* and also what is *understood* in the further interaction as if it had not been said or was not meant in this way, etc. In the preceding case, the emotional cues are not completely ignored, but they are answered with the "wrong" words. The downgrading of relevance consists in a degradation of the emotional experience of the patient, who has "gone through a lot" in the sense of critical life events.

Instead of adequately acknowledging these burdens (§ 20.5), the doctor takes refuge in an everyday phrase ("bad luck"), which can already be used in everyday life to "shut down" the emotions of our interlocutors if we (want to) lack empathy. Certain types of *trivialisation* and *appeasement* ("it's not that bad", "we'll get over it"), which are also borrowed from everyday communication, go in the same direction.

44. Teaching Materials on Medical Communication

| E 20.4 | "other trouble in the family" | Comment |
|--------|-------------------------------|---------|
|--------|-------------------------------|---------|

We start with a clear case of *ignoring* through a doctor's *change of topic*, where the patient had already explicitly introduced a specifically psychosocial topic ("trouble in the family") once, which she now seeks to renew because the doctor apparently gives her a good chance to do so.

| E 20.4 | "other trouble in the family"  | Comment   |
|--------|--|---|
| 01     | D (... ) so you say yourself that there is stress behind it ... or are there other things that cause you problems? I mean other difficult things.  | Opening of a psychosocial thematic opportunity (PS) |
| 02     | P well I had other/other trouble in the family within .  | Psychosocial patient offer                          |
| 03     | D hm .   |   |
| 04     | P which is actually still ongoing, which was only there recently, where a lot of things got mixed up ... but ... that's also the only thing then . | Psychosocial patient offer                          |
| 05     | D hm . yes Mrs S . I think I will examine you now .  | Downgrading ↓ through subject change PS→Bio         |
| 06     | P hm .   | Listener signal                                     |

As is already known from the history of the conversation shared by the doctor, the "other trouble within the family" coincided with a miscarriage and the patient's "anxiety" and heart-related complaints described at the beginning of the conversation (§ 21.5). The patient had already mentioned the "trouble in the family" beforehand, without coming directly to the point with it, because the topic of the miscarriage had first been given a relevance upgrade, and now tries it again at a point in the conversation where the doctor opens an opportunity for it (01D: "Stress (...) problems (...) other difficult things?"). The patient takes up this thematically broad offer of conversation and again places her offer of a topic explicitly and unmistakably (02P: "other trouble in the family (...) where a lot of things got mixed up"), so that the doctor is put under pressure to react to the patient's current offer.

Table 20.1 Codes for Empathic Opportunities and for NURSE

|                      | Definition  | Examples  |
|----------------------|---|---|
| Empathic Opportunity |   |   |
| Direct               | Explicit verbal expression of emotion             | "I have been really depressed lately."  |
| Indirect             | Implicit verbal expression of emotion             | "Does this mean I am going to die?"   |
| Continuers (NURSE)   |   |   |
| Name                 | State patient emotion                             | "I wonder if you're feeling sad about the test result."<br>"I can see this is making you angry."  |
| Understand           | Empathizing with and legitimizing patient emotion | "I can imagine how scary this must be for you."<br>"Many of my patients feel discouraged when they aren't seeing the response they want, so it makes sense that you feel this way". |
| Respect              | Praise patient for strength                       | "You've done a great job at keeping everything in perspective"<br>"I applaud you for your courage in all of this".  |
| Support              | Show support                                      | "I will be with you until the end."<br>"No matter what happens, I will always be your doctor."  |
| Explore              | Ask patient to elaborate on emotion               | "Tell me more about what is upsetting you."<br>"What do you mean when you say this is not going to happen to me?"   |

Tab. 20.1: Codes for Empathic Opportunities and for NURSE (mod. after Pollak et al. 2007) (cf. Smith, Hoppe 1992, Smith 2002, Back et al. 2005, 2007, Fortin et al. 2012, Childers et al. 2023).

#### 44. Teaching Materials on Medical Communication

| E 20.9 | "You've been through a lot too, yes."   | Comment  |
|--------|---|--|
| 01     | D (... ) and what happens to you .  |  |
| 02     | P yes - it all came down to me, I always had to go, I was always the stupid one who had to go, my mother called me at night, every time, whether the children were freshly born, whether they were old and grown up, I always had to come, he didn't want anyone from the neighbourhood to help, no (...) but then the mother, then the brother died of a heart attack at the age of 42, how long ago was that now? .... Yes ... ten, fifteen years ... and the mother a few years before that... | Abridged narrative about helper role as daughter<br><br>Early care and death in the family |
| 03     | D you've been through a lot too, yes.   | 3.3: Acknowledge burdens   |
| 04     | P yes, he came in the morning and said, come on, I can't wake up your mother, I said, you're crazy, I was still there last night, yes, we still had the doctor ... she never went to the doctor, she had more than 200 in both arms and the upper pressure must also have been ... over, completely over ... there ... she always had the pain ... up here ...  | Continuation of the narrative<br><br>Death of the mother                                   |
| 05     | D hm ... when you feel something like that in your body, you think, now I feel like the others?   | 4.2: Subjective ideas  |
| 06     | P now it's the same for me as for the others, that's that. and that's what makes my nerves all shot.  | Literal resumption and expansion   |
| 07     | D that's what it's like, it shots your nerves.  | 2.3: Literal repetition  |
| 08     | P yes, that that that . then you are - .  |  |
| 09     | D then you ca . that is also hard to bear ...   | 3.3: Acknowledge burdens   |
| 10     | P that's ... and that's what I've got now ... pfhh ... with the ... dizziness and everything (...)  | Continuation of symptoms   |

Doctor and patient cooperate in this narrative in a way that not only retrospectively stressful events and experiences of the patient are brought up, but also their current meanings for the patient in the "here and now" ...

|  |         |
|--|---------|
| E 20.10 "You can't stand it any more". | Comment |
|--|---------|

In the following example (E 20.10), the focus is first on the patient's current stresses, which include a visit from relatives abroad, before long-term stresses in the marriage are also discussed.

| E 20.10 "You can't stand it any more".  | Comment  |
|---|--|
| 01 D hm ...   |  |
| 02 P every excitement ... now the sister has grandchildren from America, and now we don't speak English and he doesn't understand us ... and he's so wild and ... and then the brother-in-law ... all the physical stuff around it ... I never had that before... | Subjective explanation of the (reasons for the) current agitations |
| 03 D You can't stand it any more ...  | Topicality<br>3.3: Acknowledge burdens                             |
| 04 P no ... I ... and now I have to say that my husband doesn't give me much support either, since the pension ... I would have imagined my pension life to be better ... like this ... (3) ...   | Permanent load since the start of the partner's pension            |
| 05 D you have to do everything on your own, you don't get any support, do you? .  | 3.3: Acknowledge burdens   |
| 06 P oh ... God, he does, but everything, everything with "must" then and before it was different how he worked hard . I said (...)   | Permanent load since the start of the partner's pension            |

In this case, it is about the empathic recognition of both current stresses (D03), which will also be temporary from the patient's point of view, and permanent stresses (D05), which can arise and persist as typical stresses due to social life changes such as one's own retirement or that of one's partner. Here, life development can be directed against expectations, which we will come back to with this example in a moment when *naming* emotions ...

#### 44. Teaching Materials on Medical Communication

| E 20.11 "good! . yes, you have found that out well" |   |  | Comment   |
|---|---|--|---|
| 01  | D | what was the sugar like now?   | 4.1+4.3:<br>Exploring details                             |
| 02  | P | my sugar is 170 this morning.  | Info  |
| 03  | D | that's good...   | 3.3: Acknowledge<br>Coping                                |
| 04  | P | yes, and yesterday too - I have to tell you, doctor. I injected 3 times a day and when I got up in the morning my sugar was always at 250, 260 ... and now I did that before I went to bed, and I go to bed quite late, about half past eleven every night, so I injected another 20 units . I injected 20 units and, lo and behold, in the morning I was under 200 again and again. | More info on the patient's individual treatment procedure |
| 05  | D | good! . yes, you have found that out well ...  | 3.3: Acknowledge<br>Coping                                |
| 06  | P | yes . and i believe that . i'll keep doing it ... i'll have 170, 160, 170 in the morning . and that's fine yes . for me anyway....   | Confirmation and<br>perspectivation                       |
| E 20.12 "gosh!, gosh!"                              |   |  | Comment   |
| 01  | D | (..)but then you kind of feel your way into it.  | 4.1+4.3:<br>Exploring details                             |
| 02  | P | yes, I have also done that so far . the last HbA1 value was ... which is perhaps quite good .  | Info  |
| 03  | D | yes .  | LH  |
| 04  | P | because it was still quite high before . with Dr. Z and also with my GP . it looked like . that at some point I was at 12.1 or something .   | Communication<br>current value                            |
| 05  | D | hm .   |   |
| 06  | P | I started in January ... and am now at 5.8 on 26.4 (=April) ...  | Comparative<br>values                                     |
| 07  | D | wow . Gosh! . gosh! that's a very very good value then . when were you diagnosed .   | 3.3: Acknowledge<br>+ 4.1: (time)                         |
| 08  | P | uh . [reaches for pocket] 7.10. last year (...)  |   |

| E 20.15 | " you make a very... worried impression" | Comment |
|---------|--|---------|
|---------|--|---------|

There are similarities and differences here in comparison with everyday communication. Although we are also guided by supersummed impressions in everyday life, we are usually careful not to "address" more or less strangers directly. *Addressing* perceived emotions is obviously a medical privilege that is used in the consultation for good reasons.

In the following example (E 20.15), the doctor first marks the change to "addressing" the perceived emotion with a caesura ("now something completely different") before he also brings up with the patient the "very worried impression" that he obviously "makes".

| E 20.15 | " you make a very... worried impression" | Comment   |  |
|---------|--|---|--|
| 01      | D  | (...) for a while now, too, ne?   |  |
| 02      | P  | yes that I ... I was working the night shift and ... Yes, I got up and ...  | Complaints                             |
| 03      | D  | hm .  |  |
| 04      | P  | poured a cup of coffee ...  |  |
| 05      | D  | hm .  |  |
| 06      | P  | I have this feeling. It's like someone is taking my breath away.  |  |
| 07      | D  | hm ... uh ... now something completely different ... you make a very... worried impression, huh? .. since you read [that the something- | 3.4: Addressing ("worried impression") |
| 08      | P  | [well, do I ... I don't know what it is...  | Confirmation of concern                |
| 09      | D  | because right . we want to see what it is .   | 3.3: Offer help                        |

After the caesura, the doctor formulates his impression and thus gives manifest verbal expression ("worried") to a patient emotion that had remained latent until then. What had previously been unspoken is now spoken and made an issue. The patient confirms the impression ("well I do") and justifies it with his *not-knowing* ("I don't know what it is"), which is in turn directly taken up by the doctor. In his reaction, the doctor performs a typical *supportive* function of medical action, namely the elimination of "not-knowing" that makes the patient "worried". Here the doctor holds out the prospect of a joint clarification (09D: "we want to see what it is"), which the patient then immediately takes up ...

#### 44. Teaching Materials on Medical Communication

##### E 20.17 / E 218: Naming emotions

The following examples (E 20.17) and (E 20.18) come from the same conversation (...) In both cases, when *naming* the emotions, the *term* "anger" or "disappointment" is used to describe what was already "in the air", as it were, because the patient had already "pre-formulated" it in other words.

| E 20.17 "then you get annoyed"  |   | Comment  |
|---------------------------------|---|--|
| 01                              | D you have to do everything on your own, you don't get any support, do you?   | 3.3: Acknowledge burdens                                 |
| 02                              | P oh ... God, he does, but everything, everything with "must" then and before it was different when he worked hard. (...) and then when he does, he goes to the garage, where he puzzles around ... he probably always has something to do ... but then the bottle of beer is already there and then, for me, the day is already over ... | Permanent load since the start of the partner's pension  |
| 03                              | D then you get annoyed? .   | 3.4: Naming emotions                                     |
| 04                              | P yes . and ... he doesn't admit anything . he counts the first and the last thing and not what was in the middle, and that's the (...)   | Confirmation + Expansion                                 |
| E 20.18 "a huge disappointment" |   | Comment  |
| 01                              | D (...)   |  |
| 02                              | P (...) because he, as I said, when I'm a pensioner, we do so many things... and it's just the opposite.  | Complaining about being "retired"                        |
| 03                              | D a huge disappointment.  | 3.4: Naming emotions                                     |
| 04                              | P yes . re:al . real disappointment! I have to say, he's doing his job, but . he's already doing everything, no . but then there's always the drinking and then (...)   | Strong confirmation through repetition + Theme expansion |

## E 20.20 "are you worried that something is wrong"

Whereas in the case of *naming*, the emotions in question seem to have been clarified for the time being because they have been brought to a concept, however provisional, in other cases *clarification* is still pending. Therefore, the possible emotions are also conceptualised, but are put up for conversation in questioning actions. The following example (E 20.20) is about clarifying the emotions of the patient who has already been treated for kidney stones and now wants another examination ("another ultrasound").

| E 20.20 "are you worried that something is wrong" |  | Comment                  |
|---|--|--------------------------|
| 01  | D (...)  |                          |
| 02  | P (...) and ultrasound again to see if there is anything from the kidney stone, uh ...         |                          |
| 03  | D whether there is anything left .   | 2.3: Sentence completion |
| 04  | P yes, whether again . yes, as a precaution ...  | Confirmation             |
| 05  | D do you have any complaints? .  | 4.1: Complaints?         |
| 06  | P no .... no, I noticed a bit here, but actually nothing, maybe (unintelligible) or something. |                          |
| 07  | D and eh . are you worried that something is wrong or something?...                            | 3.4: Clarifying emotions |
| 08  | P yes . just as a precaution .   | Confirmation             |
| 09  | D yes ... yes . you are a little anxious, yes? .   | 3.4: Clarifying emotions |
| 10  | P yes, I'd rather have it checked, no, because it's also my disposition (...)                  |                          |

Right at the beginning, the doctor shows his understanding of the patient's concerns by anticipating her further formulations through *joint sentence production*, which is a special form of *active listening* (§ 19). After the short speech delay and pause ("kidney stone uh ..."), the doctor rushes to the patient's aid by "standing in" for her. The verbal support here is not by paraphrase, but by completing the patient's speech, towards which an *anticipatory* understanding is indicated. After the patient's request has already been formulated cooperatively, the doctor tries to find out about her motivation in three steps: ...

Fig. 20.5 Sample application of the association rule

Within seconds, the doctor must decide whether to accept the patient's relevance downgrading or to insist with a further intervention on the topic in question ("death of the mother"). In order to "elicit" the patient's possible *associations* to this topic, the doctor must be prepared for patients to initially behave in the consultation as in psychotherapy in the same way as in "an ordinary conversation" (Freud 1913/1970: 194), i.e. to follow the *relevance maxim* as in everyday life (§ 7.3, 9.3). Freud anticipated the reservations of everyday knowledge and everyday action towards the psychoanalytical basic rule and therefore proposed a prototypical formulation for its mediation by the treating doctor (§ 9.3), the core of which is to be repeated here (Fig. 20.5, right-hand column) and placed in a cognitive and interactive context of conversational practice

| Relevance   | S | Interaction  | Association rule (Freud 1913)  |
|-------------|---|--|--|
| ↓           | P | Yes, my mother died, but that was ten years ago, yes   | <i>You will be tempted to say to yourself, this or that does not belong here, or it is quite unimportant, or it is nonsensical, therefore it need not be said:</i> |
| Downgrading | P | Action a   | b Diagnosis  |
| Upgrading   | D | Reaction d   | c Maxime   |
| ↑           | D | and what was that like for you? . I mean, it was a long time ago, but just because it comes to your mind . | <i>Never give in to this criticism and say it anyway (...) So say everything that crosses your mind.</i>   |

Fig. 20.5: Sample application of the association rule (mod. on Koerfer, Köhle 2007: 634; explanations in the text)

In the interaction with patients, who in conversational practice in the sense of Freud can demonstrably still remain completely attached to "ordinary conversation" (Koerfer, Neumann 1982), *reflexive* and *communicative* competences must work together (§ 3, 17) in order to draw the right conclusions from the current development of the conversation and to implement them in action.

| Development of thematic key symbols as basic vocabulary |  |                                      |
|---|--|--------------------------------------|
|   | Doctor                                   | Patient                              |
| 01  |  | my job has been cancelled            |
| 02  |  | I have done programming              |
| 03  |  | I am now the girl for everything     |
| 04  | is that still fun?                       |                                      |
| 05  |  | oh, not particularly                 |
| 06  | your feelings (about it)?                |                                      |
| 07  |  | that disappoints me                  |
| 08  | anger swallowed (...) anger in the belly |                                      |
| 09  |  | yes (...) possibly                   |
| 10  | hurt or offend in any way                |                                      |
| 11  |  | of course it does                    |
| 12  | What was the relationship like? [mother] |                                      |
| 13  |  | always tensions with my mother       |
| 14  | did you not feel well cared for?         |                                      |
| 15  |  | perhaps you could put it this way    |
| 16  |  | I am an illegitimate child           |
| 16  |  | not been wanted                      |
| 17  | were you always disadvantaged there?     |                                      |
| 18  |  | disadvantaged in my opinion          |
| 19  | that's hard for a kid                    |                                      |
| 20  |  | the hardest thing in my life         |
| 21  | oh, that's bad                           |                                      |
| 22  |  | yes, that was bad                    |
| 23  |  | in eh the soul it hurts then, no     |
| 24  | yes yes (...) soul pain                  |                                      |
| 25  | that remains like a scar in one          |                                      |
| 26  |  | that can be                          |
| 27  | when you had such a soul ache            |                                      |
| 28  | Injuries and insults remain              |                                      |
| 29  |  | I have never been so offended again  |
| 30  | could be that these old scars            |                                      |
| 31  | get into tension                         |                                      |
| 33  | so insults, injustices done              |                                      |
| 34  | this is something to think about         |                                      |
| 35  |  | sure (...) I have thought about it   |
| 36  | to do with your early programming        |                                      |
| 37  |  | maybe you feel it as an infant       |
| 38  |  | transfers to the child               |
| 38  | (For continuation see below E 20.39)     | (For continuation see below E 20.39) |

Tab. 20.2: Development and repertoire (excerpts)  
of the basic vocabulary shared by doctor and patient

## E 20.39 "it has something to do with your early programming ..."

In this conversation, too, doctor and patient repeatedly refer to each other without and with "quotation" in order to clarify their individual and shared perspectives. First, the conversation partners cooperate on a series of further narratives ranging from childhood to adolescence to adulthood, and then bridge back to the patient's very early childhood experiences (Koerfer, Köhle 2007, Köhle, Koerfer 2017). This bridge is built by the doctor by introducing the linguistic image of "early programming" with a lengthy, three-part interpretation, not by chance in allusion to the patient's professional language, before he then additionally chooses the established term of "imprinting" (D 09) .

## E 20.39 "it has something to do with your early programming ..."

- 01 D so, if you've done programming, then you actually have a good understanding of it . then you actually have a good understanding for it . because with you it has something to do with your early programming ... the way you grew up with not being wanted and so on . you didn't realize that until your mother mentioned it or somehow there eh . so from the (unintelligible) . of course you still feel that as a child, yes . and . ehm- .
- 02 P maybe you can even feel it as an infant, because my mother always claimed that she had never seen a child who cried as much as I did when I was a baby . maybe it was the mother's fault, who unconsciously, when she only gives the breast .
- 03 D yes .
- 04 P this is transferred to the child ... I don't know how to put it.
- 05 D you are absolutely right.
- 06 P that the child, that I felt that as a child eh . somehow . without her even saying anything, ne .
- 07 D yes .
- 08 P right? .
- 09 D yes . you express it wonderfully ... there's no better way to put it ... that's how it is ...(6)... it's only on the level of feeling, not talking or anything like that, yes ... and that's where it gets imprinted . (...) you would perhaps say: is then programmed .
- 10 P hm . hm .
- 11 D and when something like that comes up, we can still work on it with reason, but this old programme gets started again, so that it hurts (...)

**21 Exploring Details**

Fig. 21.1 Cologne Manual: Step/Function 4: "Exploring details"

|  |  |  |
|--|--|--|
| Cologne Manual & Evaluation of Medical Communication | <b>4 Exploring details</b>   | <sup>6</sup> 2022                                    |
|  | <p><b>1 Inquire about complaint dimensions</b></p> <ul style="list-style-type: none"> <li>• Localisation and radiation</li> <li>• Quality "What character ..."</li> <li>• Intensity "How strongly ..." (scale 0-10)</li> <li>• Dysfunction/disability<br/>"To what extent are you affected by this?"</li> <li>• Accompanying sign "Did you also ...?"</li> <li>• Time (beginning, course, duration)</li> <li>• Condition "In what situation does this occur?"</li> </ul> | 0 1 2 3 4  |
|  | <p><b>2 Exploring subjective ideas</b></p> <ul style="list-style-type: none"> <li>• Concepts<br/>"What do you imagine this to be?"</li> <li>• Explanations<br/>"What do you yourself see as the cause?"</li> </ul>   | 0 1 2 3 4  |
|  | <p><b>3 Complete anamnesis</b></p> <ul style="list-style-type: none"> <li>• Systems ("From head to toe")</li> <li>• General condition, sleep, noxae, pharmaceuticals</li> <li>• Previous diseases, pre-treatments</li> <li>• Familial diseases, risk factors</li> <li>• Social: family, friends, job etc.</li> <li>• "Difficult" topics: sexuality, losses, extreme experiences, violence, addiction etc.</li> <li>• Coming back to gaps (sensitive issues)</li> </ul>   | 0 1 2 3 4  |
| <sup>1</sup> 1998                                    | <b>E V A L U A T I O N</b>   | <input type="checkbox"/> <input type="checkbox"/> 12 |

Fig. 21.1: Excerpt (from: Manual and Evaluation): Step/Function 4: "Exploring details" (Cf. the complete Manual Fig. 13.11 and at the end of this chapter, Fig. 21.3)

Fig. 21.2 Didactic question-answer model

Without claiming here to have already found the "philosopher's stone" for the didactics of medical interviewing in the difficult question of the forms, contents and functions of medical questions, we strive in teaching for a mixture of both deductive and inductive methods that rely on the plausibility of anchor examples in the context. In this process, illustrations also prove helpful in marking and illustrating essential differences (Fig. 21.2). For example, the following circular figures and their relations in a didactic question-answer model have proven useful to illustrate the spectrum of more or less *open to closed* questions in teaching, which can be matched in combination with the following anchor examples.

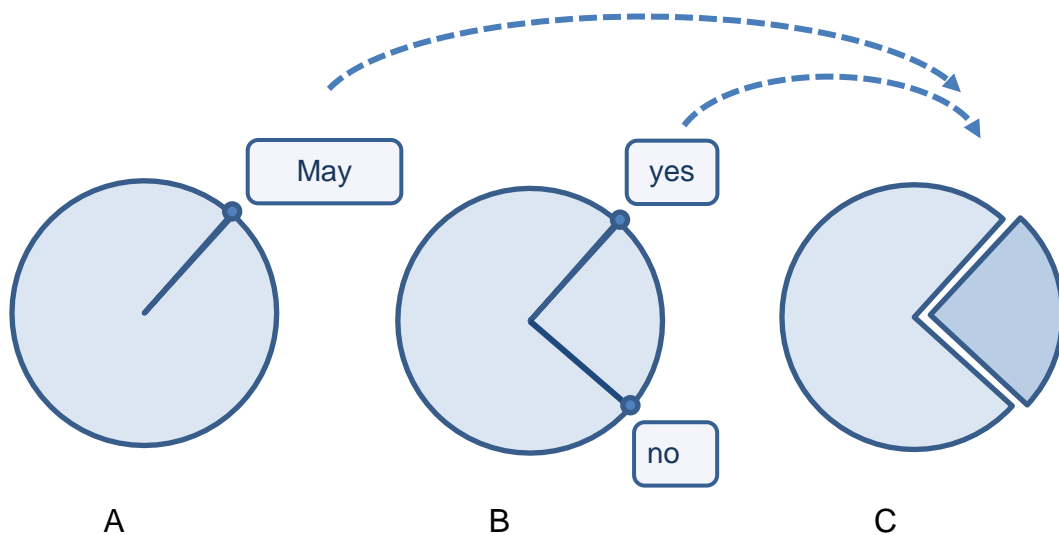


Fig. 21.2: Didactic question-answer model

Before we further explain the procedure for teaching purposes, a possible misunderstanding must be prevented: The didactic reduction is in no way intended as an attempt to depict the extremely complex world of action of questioning in a model with three (two-dimensional) circular representations and their relations. Rather, these simplistic representations are intended to serve as a rough comparison in teaching with anchor examples that are to be discussed, if possible, in the empirical context of real conversations in which the performance of questions can best be assessed. Thus, the anchor examples are compiled into a list of materials and work, referencing contexts in conversation sources where appropriate ...

E 21.7 "since when ..." - "is it after that..."

- 01 D how long have you had these stitches? ... [3] ... [scratches his shoulder] .
- 02 P it's been a little longer than that, so in 2001 it was really bad, and that's when I had my tonsils removed.
- 03 D yes .
- 04 P that was still the case with Dr. Müller. [+]
- 05 D did it get better afterwards? .
- 06 P yes, then it was better again, and then it occurred again, so now, recently.

Just as the *W-question* ("since when ...?") is not only answered with a temporal indication (Fig. 21.2: circle A), the doctor's *decision question* ("did it get better afterwards?") is not only answered with "yes" or "no" (circle B), but with an informative "surplus", which in turn triggers new doctor's questions on the expanded topic (in the direction of circle C) (§ 19.6). The fact that such a surplus, even if it is minimal, is not a matter of course is something doctors occasionally complain about in training when they report that they have to "pull everything out of some patients' noses" "because they don't say anything of their own accord", examples of which have already been given and more will be added. As has already been pointed out (§ 9, 17, 19), the "sparing" answering behaviour of patients can also (although not always) be the result of *conditioning* by the questioning behaviour of the doctor, which has solidified in an *interrogative* style of conversation that both partners can no longer "escape".

In contrast, in another conversation, which was already characterised by a narrative quality, a patient took the doctor's decision-making question about the coincidence in time between her symptoms of vertigo and her daughter's illness not only as an opportunity for an affirmation ("yes, I think so") (E 21.8), but for the placement of a dramatic narrative (§ 19.7), which culminated in the evaluation of exhaustion ("until it was no longer possible, no").

E 21.8 "This dizziness, did it start when ..."

- 01 D this dizziness, did it start when you found out about this diagnosis [= daughter has MS]? .
- 02 P yes, I think so ... once I had something in my head at night, uh ... I never told my husband, once I had something in my head at night, really bad ... I woke up ... I thought: "Oh dear, oh dear, what's wrong now?" ... once I got really sick in bed at night ... I fought it, always did everything at her house, took care of the household, until it was no longer possible, no ...

In these cases, where the questions already "favour" a specific "initiation" of topics due to their content, the patients take the initiative to expand from a narrow topic focus (circle type A or B) to a broad topic focus (circle type C), which with its informative or narrative "surplus" can go far beyond the corresponding doctor's questions. Relatively independently of the preferences expressed by the doctor, patients can "answer" as if the doctor had asked them a correspondingly broad question, i.e. they assume (whether rightly or not) that they are interested in this information. With this kind of "anticipatory" *cooperation*, which accommodates an anticipated overall interest of the questioner (Koerfer 2013: 97ff), patients hypothetically *upgrade relevance*, which can lead to a further *relevance negotiation* (§ 7.5, 17.4, 19.4, 20.4) between the interlocutors under a variety of aspects.

The *surplus* ranges from smaller to even larger communication units such as the narratives given by the patients with and without explicit narrative invitations, whereby the placement conditions can be more or less "opportune". Sometimes the patients' "additional information" can be very short, but equally significant, as in the following example (E 21.9), which we had already mentioned under the aspect of *empathic communication*.

E 21.9 "Children?" - "unfortunately no children"

- 01 D are you married? .
- 02 P yes .
- 03 D children? .
- 04 P unfortunately no children .
- 05 D hm . marriage good? .
- 06 P have been married for 20 years now (...)

Box 21.6 Function and communicative means of the leading question

The characteristic feature of the suggestive question is that, qua recognisable expectation conveyed by certain communicative means, it already provides a specifically pre-formulated answer, so that the interlocutor is apparently no longer granted a real choice between alternatives of answering (Box 21.6). In this way, the patient, as an exclusive "informant", is deprived of his classical role as "interviewee", whose knowledge and opinion should be important in the medical consultation, which is precisely about the exploration of *authentic* information.

Box 21.6 Function and communicative means of the leading question

The characteristic of *suggestive questions* is that the questioner does not keep the answer alternative open as in (real) decision questions, but more or less clearly indicates his expectation of an answer. Specific linguistic indicators are verb position, negation, intonation as well as speech action arguments such as "yes", "no", which are intended to elicit agreement.

Koerfer et al. 1996: 115

The following example (E 21.15) from the final phase of an initial consultation, in which the doctor is probably already "pushing the pace", seems "harmless" at first, because the necessary "repairs" can be made without problems and integrated into the conversation.

E 21.15 "Appetite is normal for you?" - "no medication?"

- 01 D hm ... appetite is normal for you? .  
02 P yo, it is normal .  
03 D nothing has changed there either? .  
04 P no, nothing has changed.  
05 D otherwise you do not take any medication? .  
06 P yes, I have to [name of drug X] uh have to/ [name of drug X] I already said, [name of drug Y) because of the too high cholesterol level .  
07 D yes ... (2) ... Well, then we'll just ... examine you now .

In this example, all three of the doctor's questions are asked as *suggestive questions* in a small conversation space, although only the first two questions are answered in the sense of the doctor's expectation ...

#### 44. Teaching Materials on Medical Communication

| E 21.31 "Since when have you had this pain?" |  | Comment   |
|--|--|---|
| 01   | D hm .   | Manual 2.2: LS                                    |
| 02   | P (...) and I have a [crosses his armpits with both hands] ... how should I put it ... (3) ... pain here/in the area [points to the right armpit]. |   |
| 03   | D in the armpits, in both? .   | Manual 4.1:<br>Question:<br>Localisation          |
| 04   | P yes .  | 4.1 Question:<br>Time (start)                     |
| 05   | D yes . since when have you had this pain? .   |   |
| 06   | P oh, they come and go . it's sometimes like I can't breathe .   | 4.1 Question:<br>Time (start)                     |
| 07   | D and yes, now the question again, this pain in the armpits, have you had it since you knew that something was wrong there (...).                  |   |
| 08   | P uh . that's why, no . there had been something before, so I thought (...)  | 4.1 Question:<br>Time (duration)                  |
| 09   | D yes, yes . how long has it been with these complaints? .   |   |
| 10   | P that was sometimes here and there . for short moments only . yes that was sometimes strong, sometimes less (...)                                 | 4.1 Question:<br>Time (duration)                  |
| 11   | D for weeks, for months? .   |   |
| 12   | P it's ... two, three days (...)   | 4.1 Question:<br>Time (start)                     |
| 13   | D yes when did it start . how many weeks or how many months ago? .   |   |
| 14   | P I've been back at work since ... March ... two years ago, when I was there, everything was ... still fine...                                     | 4.3 Complete<br>medical history:<br>Work of the P |
| 15   | D what kind of work do you do?   |   |

At the same time, the example stands for the difficulties with patients in clarifying simple facts such as the beginning of complaints, which finally succeeds because freedom from complaints can be traced back to a certain "subjectively" relevant date ...

Box 21.13 Quantity

Quantification ("How bad is this?" For pain, "On a scale of 1 to 10, with 1 being no pain and 10 being the worst pain you can imagine, like surgery without anaesthesia, what number would you rate your pain?")

- a. Frequency of occurrence?
- b. Intensity or severity?
- c. Impairment or disability?
- d. Numeric description
  - i. Number of events
  - ii. Size
  - iii. Volume

Fortin et al. 2012: 70

Since we cannot prove the complexity and diversity of the phenomena under the dimensions of intensity or quantity and quality with examples here, we will preface the teaching with tabular overviews, as they are given without direct reference to Morgan and Engel in the differentiated textbooks by Coulehan, Block (1992) (Tab 21.1) and Fortin et al. (2012) (Box 21.13). Fortin et al. (2012) also seem to equate the dimensions of intensity and quantity. Likewise, the dimension of *quantity* apparently also subsumes "impairments", which should be recorded separately, especially as they also affect patients' *quality of life*. Since no corresponding empirical examples are given in either textbook, selected examples from our interview corpus will be added for individual categories.

|   | <i>Complaints</i>                                       | <i>Quantitative questions</i>                        | <i>Qualitative questions</i>                            |
|---|---|--|---|
| 1 | I've been having chest pain.                            | How long have you had it?<br>How often does it come? | What does it feel like?<br>Where exactly is it located? |
| 2 | My side hurts   | How long have you had it?                            | Show me where.  |
| 3 | I have diarrhea.  | How many times a day?                                | What do they mean by diarrhea?                          |
| 4 | I vomited blood.  | How much?  | What did it look like?                                  |
| 5 | I can't walk as far as I used to without getting tired. | How far can you walk?                                | What do you mean by "tired"?                            |

Tab. 21.1: Patient complaints and possible quantitative or qualitative physician questions (Coulehan, Block 1992: 65)

## E 21.51 "can you tell me something about yourself?"

While a whole series of "typical" doctor's questions were announced *meta-communicatively* at an appropriate point in the preceding conversation sequence, specific *invitations* to talk about certain topics are issued at other points. Thus, invitations to talk are not only valid at the beginning of the conversation (§ 19.2), but can also be renewed again and again in the course of the conversation. A doctor who issues a further narrative invitation on a topic in the middle of the conversation explicitly indicates to his patient a relevance upgrade, which opens up a wider conversational space on the topic in question in the case of an everyday-world narrative concept. Four short examples of this *procedure* of a *topic-specific narrative invitation* with different broad topic focus will be given.

In the first example (E 21.51) from a conversation in which, after taking the history of a young patient's "abdominal complaints", a longer sexual history was also taken in detail, the doctor offers a broad topic focus ("telling about yourself") in the middle of the conversation, which the patient can then use at her own discretion. She seizes the opportunity to tell her story by first starting to talk about her parents and siblings (shortened here), before she comes to herself ("I am the youngest child").

## E 21.51 "can you tell me something about yourself?"

- 01 D (...) um, yes . can you tell me a little bit . I would like to get a picture of you, yes . because I first want to understand who you are and/ or can you tell me something about yourself? .
- 02 P pfh .... yes, my parents ... my father used to be a craftsman, but now he retired early because he (...) couldn't work any more ... it's probably also stress-related, because ... depending on when he gets upset, it's worse than usual ... I ... am the youngest child at home [Further explanations with medical enquiries].

E 21.55 "I had erectile dysfunction"

Sexuality is undoubtedly a *sensitive* topic that is often avoided, not only in everyday life but also in medical consultations (...) Thus, in an initial interview under the aspect of *relevance treatment* (§ 19.4), it turned out more or less incidentally that a patient had already discontinued a medication ("beta-blocker") (E 21.55) in accordance with his concern due to his experience ("erectile dysfunction") in consultation with the pre-treatment GP.

| E 21.55 "I had erectile dysfunction" |   |   | Comment   |
|--------------------------------------|---|---|---|
| 01                                   | D | what medicines are you taking? .  | Manual 4.3:<br>Medication   |
| 02                                   | P | Beta-blockers, ACE inhibitors and cardiac ASS and then stomach tablets.   | Information on taking medication  |
| 03                                   | D | hm ...  | 2.2 LS  |
| 04                                   | P | I don't know if this belongs here.  | Relevance test  |
| 05                                   | D | yes? .  | 2.2 LS<br>(question intonation)   |
| 06                                   | P | my GP wanted me to stop taking beta-blockers.   | Information   |
| 07                                   | D | why? .  | 4.3 Question:<br>Medication   |
| 08                                   | P | well, I told him that I had difficulties ... I had erectile dysfunction . and I wanted to stop taking the pills . so that it would get better again . I felt like half a person (...) | Narrative start:<br>Lifeworld relevance of the experienced sexual disorders |

Relevance to life is expressed here by the patient in a strong metaphor (08P: "felt like half a person"), which after discontinuation of the medication points to a serious conflict of goals: it is a potential conflict between patient *preferences* motivated by life and *evidence-based* requirements of medicine (§ 10, 22), which was apparently already taken into account in the pre-treatment by the GP, which now becomes an issue again. If the patient had not made a relevance test on his own initiative (04D: "I don't know if this belongs here now"), the conflict might have remained hidden ...

**22 Negotiating Procedures**

Fig. 22.1 Cologne Manual: Step/Function 5: "Negotiating procedures"

|  |  |  |                  |
|--|--|--|------------------|
| <small>Psychiatrie<br/>Klinische Psychologie<br/>Psychotherapie<br/>Sommatische Psychotherapie<br/>P.N.C.<br/>M.F. 2008/09</small> | <p><b>5 Negotiating procedures</b></p>   | <p><sup>6</sup>2022</p>  |                  |
|  | <p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Cologne Manual &amp; Evaluation of Medical Communication</b></p> | <p>1 Plan an evidence-based approach</p> <ul style="list-style-type: none"> <li>• What is secured?</li> <li>• Does diagnosis have consequences?</li> </ul>   |                  |
|  |  | <p>2 Clarify expectations</p> <ul style="list-style-type: none"> <li>• Ideas, wishes, hopes:<br/>"What did you imagine?"<br/>"What do you think could help?"</li> <li>• Explore control beliefs<br/>"What could you change yourself?"</li> </ul>   | <p>0 1 2 3 4</p> |
|  |  | <p>3 Explaining previous findings</p> <ul style="list-style-type: none"> <li>• Communicate diagnosis</li> <li>• Communicate problems (uncertainties)</li> </ul>  | <p>0 1 2 3 4</p> |
|  |  | <p>4 Plan diagnosis/therapy</p> <ul style="list-style-type: none"> <li>• Note preference for relationship model:<br/>Paternalism - Cooperation - Service</li> <li>• Discuss proposals and risks</li> <li>• Consider reactions</li> <li>• Aiming for consensus ("concordance")</li> </ul> | <p>0 1 2 3 4</p> |
| <p><sup>1</sup>1998</p>  | <p><b>E V A L U A T I O N</b></p>  | <p><input type="checkbox"/> <input type="checkbox"/> 12</p>  |                  |

Fig. 22.1: Excerpt (Manual/Evaluation): Step/Function 5: "Negotiating procedures" (Cf. the complete Manual, Fig. 13.11 and at the end of the chapter, Fig. 22.2)

E 22.2b "What did you expect me to say now?"

In addition to the complex cases in which the further procedure must be negotiated successively (§ 22.5-6), there are the numerous cases of a relatively speedy agreement between doctor and patient. Patients often accept the doctor's invitation to disclose their expectations immediately, as in the following example (E 22.2b), where doctor and patient quickly agree to continue a therapy they have started.

E 22.2b "What did you expect me to say now?"

- 01 D well, Mr S . we'll have to see ...  
02 P hm .  
03 D the ... what did you expect me to do now? . that we ...  
04 P hm . so more or less eh advice or whether I should try something  
eh . with some medicine / medication or (...) although I have  
made a lot of effort with the gymnastics I should do ...  
05 D so I would definitely suggest that you take a medication to sup-  
port you, that you alleviate the pain a bit, yes . and that physio-  
therapy continues, yes . that there is support, but the considera-  
tion was also that you take cortisone, which is, yes, that is also  
something stronger .  
06 P yes .  
07 D so it must be a bit stronger in terms of the complaints, I would  
say, first of all, we try again with medication.  
08 P hm . hm  
09 D yes, and about physiotherapy . although you have already done a  
lot of it .  
10 P yes . yes.

While the doctor and the patient decide "positively" on the further course of action in this short sequence of talks, they also decide "negatively" that they will wait with a specific treatment option ("cortisone") until the complaints become stronger. With this rather "casual" decision and justification, which the patient agrees to several times, the end of the conversation is gradually approached, where further agreements ("precautions") are made.

Box 22.1 Control and loss of control

The ambivalences manifest themselves, for example, in an interim denial of the illness or in a fear of loss of control, which can go hand in hand with a misjudgement of one's own resources. Fears of losing control can relate to the relationship with the professional helper himself, whose help is often difficult to accept, as Wöller, Kruse (2010) (Box 22.1) have described for the psychotherapeutic relationship.

Box 22.1 Control and loss of control

The need for orientation and control is one of the basic human needs. Quite a few patients have the shameful feeling of loss of control at the beginning of treatment. The feeling of having failed in actively coping with life and now being passively dependent on outside help can have a lasting negative impact on well-being. Here, it can be important in the sense of the effective factor of resource activation to give the patient back the feeling of active shaping and participation. Involving the patient in the formulation of the goal or focus as well as providing information before the start of treatment about how the disorder is to be understood, how it is to be treated and what they themselves can contribute can help to reduce the feeling of loss of control.

Wöller, Kruse 2010: 104

Patients' need for orientation and control can be pronounced in different ways, which can make it particularly challenging to shape the relationship. Here the doctor must also be prepared for so-called "difficult" patients, among whom different groups can be distinguished, such as "dependent" patients from "reproachful-aggressive" or "devaluing" patients. Since the problems of shaping relationships in dealing with "difficult" patients will be dealt with separately (§ 34), the spectrum of control beliefs of patients will be illustrated here by way of example, which essentially relate to themselves as ill persons with their own resources in the desired change of behaviour.

In the empirical examples, only a narrow thematic focus can be considered, which is representative of other thematic areas in which patients' control beliefs play a decisive role in health promotion (Kulzer et al. 2016, Harvey 2014, Heather, Hönekopp 2014, Albus, Köhle 2017, Albus 2022).

E 22.8 "I'm a bad patient, right"

The fact that one and the same patient cannot be assumed to have homogeneous control convictions with a correspondingly general health behaviour in all health matters becomes clear in the further course of the conversation with the preceding example of giving up smoking. Without any particular reason to talk about it, the same patient, who had just decisively explained her insights and intentions with regard to giving up smoking, makes a kind of "confession" to her doctor towards the end of the conversation, according to which she explicitly assesses herself overall as a "bad" patient (E 22.8).

E 22.8 "I'm a bad patient, right"

- 01 D hm .
- 02 P I'm, I'm a bad patient, right? It takes me a long time to get up the courage to go to the doctor when I have something.
- 03 D hm .
- 04 P for example, next week I'm going for my first check-up in ten years.
- 05 D (oh dear!) .
- 06 P but right now ... I ... I don't know ... I'm on the health kick right now ... and I want this ... I've got a really stubborn head now and I want this and want that .
- 07 D that is very nice .

What the patient has apparently found very difficult in general so far, seems to be particularly easy for her in the current case. All in all, her open statements are not without a certain self-contradiction, which should not have escaped the doctor's notice. On the one hand, the patient complains about her general lack of courage for visits to the doctor, of which she herself cites the long-standing avoidance of preventive care as an example, while on the other hand she *contrasts* her "current health kick" with an adversative transition ("but ..."), which she intends to pursue with a "stubborn head".

## Box 22.3 Ask - Tell - Ask

The essential aspects of a dialogical process of understanding and comprehension have been described with the *Ask-Tell-Ask scheme* of interviewing, which has since found wide application (e.g. Barrier et al. 2003, Back et al. 2005, 2008, Kemp et al. 2008, Goodlin et al. 2008, Schell, Arnold 2012, Hausteiner-Wiehle, Henningsen 2015, NKLM 2.0 2021). For further orientation, we reproduce here in excerpts the overview presentation by Back et al. (2005) (Box 22.3), which at the same time contains a series of concrete doctor's questions, the answers to which can in turn guide further patient-oriented information provision.

## Box 22.3 Ask - Tell - Ask

**Ask** the patient to describe his/her current understanding of the issue. This will help you craft your message to take into account the patient's level of knowledge, emotional state, and degree of education. Some sample questions to open your conversation include:

- What brings you here today?
- What is the most important issue for us to talk about today?
- To make sure we are on the same page, can you tell me what your understanding of your disease is?
- What have your other doctors been telling you about your illness since the last time we spoke?

**Tell** the patient in straightforward language what you need to communicate - the bad news, treatment options, or other information. Stop short of giving a long lecture or huge amounts of detail. Information should be provided in short, digestible chunks. A useful rule of thumb is not to give more than three pieces of information at a time. Avoid medical jargon.

**Ask** the patient if he/she understood what you just said. This gives you the opportunity to check his/her understanding. Did he/she get the facts straight? Is his/her understanding appropriate? Did he/she hear what was said? Consider asking the patient to restate what was said in his/her own words. This will give him a chance to ask questions, which will tell you where to go next - what details to elaborate, what implications to discuss, what things to repeat. For example, you could say, "Who are you going to tell about this visit when you get home?" or "To make sure I did a good job of explaining this to you, can you tell me what you are going to say?"

Back et al. 2005: 166

E 22.10 "And how did you understand that, if you had to explain it (...)?"

Instead, in a variant of the question types from the *Ask-Tell-Ask* scheme (Box 22.3), the doctor asks the patient about her subjective understanding, at the same time offering himself as a listener (07D: "and how did you understand that, if you had to explain it to me?") and later (E 22.10) still alternatively bringing the husband into play as a potential addressee of her explanation.

E 22.10 "And how did you understand that, if you had to explain it (...)?"

- 01 D [you have- .  
 02 P [ now I don't know, the EC/Long-term ECG result, I can't figure it out either ... (3) ...  
 03 D of the seventh of March? .  
 04 P hm .  
 05 D ah so, that's the same, yes ..... (6) ..... then maybe I have to look at it again ah yes ... (3) ... I have to look at it again uh . I have to look at it again in detail . did doctor X explain it to you uh .? .  
 06 P yes .  
 07 D and how did you understand that, if you had to explain it to me now? .  
 08 P he said it wasn't dangerous, and ... after a year I should come back, but now he sent me this long-term ECG, and I don't know, I couldn't figure it out, something else has come up.  
 09 D hm .  
 10 P or not? I wanted to have this explained anyway.

The patient first of all takes the initiative to express her need for clarification (02: "I can't figure it out either"). After she answers the doctor's question (05) in the affirmative as to whether "Doctor X explained it to her" (06), the current doctor asks her first question about her understanding, initially offering himself on the level of a professional listener (07: "If you had to explain it to me now"). Thus asked for her understanding, the patient, after quoting a general assessment by the cardiologist (08: "he said it's not dangerous"), again expresses her specific *lack of knowledge* ("I couldn't figure it out") with regard to an unclear additional piece of information from the subsequently sent report, which obviously makes her feel irritated to worried ("but [...] something else has come up") ...

E 22.16 "do you get the feeling that I'm just trying to comfort you?"

In the present case, the doctor's perception leads to a double strategy: he links his further "educational work" with the "question of trust". In the continuation of the previous conversation, he initiates a *meta-communication* in which he deals offensively with the problem of trust (E 22.16) by asking the patient directly about her "belief" in the matter and at the same time about her "feeling" towards him.

E 22.16 "do you get the feeling that I'm just trying to comfort you?"

- 01 D which eh, so I assume that you have such a form of cancer, yes . which only needs to be operated on, yes . and where the cancer is then also removed, yes . so something that can be cured very well today, yes . so that you have very good prospects . is that understandable to you? .
- 02 P yes .
- 03 D yes? . can you believe that, or do you have the feeling that I only want to comfort you? .
- 04 P oh no, I don't think so ... comforting... I mean, otherwise you'd say so too.
- 05 D yes, I would tell you that too, yes, but it looks like you have a form of cancer that is very well curable, yes (...)

If one takes only the "wording" of the first conversation sequence (01-02), the doctor could have justifiably continued "at first glance" in his explanation according to the extended *Ask-Tell-Ask-Tell scheme*: After a long chain of information and questions, he explicitly concludes his relatively short, well-dosed educational contribution with a question about her understanding, which the patient again explicitly affirms ("yes"). Apparently, however, the doctor interprets this kind of affirmation as too "weak" to simply continue. When interpreting *singular* utterances in context, it is always also a matter of the entire prehistory of the interaction, which enters into the perception of individual phenomena. The patient's *fear* and *skepticism* had become abundantly clear in advance, so that an "aftereffect" can be assumed here in the current conversational situation. In addition, the doctor can also be guided by his "scenic understanding" (§ 9.2), which also includes the perception of *non-verbal* phenomena (§ 12).

E 22.18 "an outpatient endoscopy"

In contrast, in the case also documented and analysed in detail (§ 19.8), the patient opened the conversation with the request for a specific examination ("outpatient endoscopy") (E 22.18), for which the doctor had been specifically recommended by a colleague.

E 22.18 "an outpatient endoscopy"

- 01 D yes, Mr B . what's up? .  
02 P yes, I . came here because my colleague . [name] . said that you have . uh . uh . such special examination methods . among other things you do an outpatient endoscopy and uh . determine that . what's the name . bacteria and .  
03 D hm .  
04 P stuff like that .  
05 D hm .  
06 P are in the stomach .  
07 D hm . hm ...

In this case, the *ticket* to the consultation is initially a biomedical examination request to the doctor as service provider. In the further course of the consultation, the doctor asks about the patient's complaints and his 30-year treatment history, which, from the patient's point of view, has not been satisfactory, despite short phases of improvement. Therefore he comes back to the examination, for which he had stayed "on an empty stomach" in order to fulfil the "formal" conditions for a "gastroscopy". Afterwards, the doctor accommodates the patient ("yes, okay, yes, we can do it"), but announces the continuation of the conversation with further questions.

E 22.19 "I just have a few more questions..."

- 01 D hm .  
02 P that's why I haven't eaten (...) drunk anything (...) so I'm (...) ready .  
03 D yes . okay . yes . we can do it . but I still have a few questions .  
04 P yes .  
05 D It's been going on for a few years now and then, right? .

E 22.27 "now we have x-rayed and everything is sorted out . yes ."

In contrast, the congruence between communicative and instrumental action is much greater in the following example (E 22.27). In the joint interaction history of this case, many diagnostic and therapeutic steps have already been taken, which the doctor sums up at the beginning of the conversation before the patient complains of a persistent cough.

E 22.27 "now we have x-rayed and everything is sorted out . yes ."

01 D now we have X-rayed and everything is sorted out. yes.  
 02 P yes, that's right, but the cough hasn't gone away yet and it's still a bit mucousy.  
 03 D what does it look like? .  
 04 P oh . what does it look like? uh ... the cough? .  
 05 D yes .  
 06 P if I spit this out? .... pff ... a bit greenish...  
 07 D greenish, yes . (...)

Although at first "everything seems to be sorted out", the patient insistently introduces the *persistent* complaints as a significant topic with a *but*-introduction to her contribution (02P: "yes, that's right, but the cough hasn't gone away yet ..."). In this way, the topic is upgraded in relevance, to which the doctor must react; in any case, he is prompted to ask about the "quality" of the cough, which the patient answers only after a query on her part ("greenish"). Since we had already dealt with this sequence in advance under the aspect of *detailed exploration* of the *quality* of complaints/symptoms (§ 21.4) and had focussed on the following sequence, omitted here, under the aspect of *empathic feedback* (§ 20.6), we can go directly to the decision-making phase here after introducing the central complaint topic, which concerns the (further) treatment of the persistent cough. After the doctor has "listened in", there is initially an ambiguity in the doctor's announcement (E 22.28) (03D: "we'll do the checks again (...)", which the patient immediately tries to resolve on *her own initiative* by asking a corresponding question of understanding ("what kind of checks?").

[cf. E 22.28]

E 22.34 "Desired change to pump"

The interview takes place in a polyclinic outpatient clinic where a specific consultation is offered for patients suffering from *diabetes mellitus*. In this case, we are dealing with a patient who comes to the doctor with an "organised" disease in the sense of Balint (1964/88), for whom the diagnosis has already been made and therapy has been successfully initiated. The patient, who is about 25 years old, has known the diagnosis ("diabetes mellitus type 1") for a long time and is being treated with insulin. The patient now comes to the consultation with a specific request (E 22.34) (06P: "desired changeover to pump"), with which he "opens the door", so to speak. With this specific "entrance ticket", the doctor is obviously given the role of a service provider right at the beginning of the conversation, who is supposed to provide the "desired" service without further consultation.

E 22.34 "Desired change to pump"

01 D Mr. Müller! . what brings you to us? .  
02 P Diabetes type 1 .  
03 D yes .  
04 P Bolus basis .  
05 D hm .  
06 P desired change to pump .

Already in the formulation of the request, the *business tone* is striking, with which the doctor's opening question is answered by the patient in an elliptically shortened "telegram style", in which the "desired" is directly expressed.

....

This development of the conversation in an approx. 30-minute polyclinic consultation can only be rudimentarily traced here in excerpts of the conversation, in which, as in the following transition, specific thematic switches are made ...

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E 22.35 "that means there are difficulties ..."

- 07 D yes, that means . uh . there are difficulties in the basal bolus concept with you? .
- 08 P let's put it this way ... I would like a simplification, more variability ...
- 09 D yes .
- 10 P and greater freedom ...
- 11 D yes ...
- 12 P because disappearing with the pen . and so . is also ... sometimes in my profession specifically not so favourable .
- 13 D yes . yes .
- 14 P so .
- 15 D so, disappearing means that you have to go away from time to time because you have to inject the insulin.
- 16 P right, for example .
- 17 D yes .
- 18 P and that is sometimes very bad . i am an industrial and advertising photographer ...
- 19 D yes .
- 20 P practically the customer is almost always there ...
- 21 D yes, yes .
- 22 P and so, so he probably notices that less [points to imaginary pump] or is rather not noticed as much as when you have to disappear and so . and then people don't understand that and then you have to lead big explanations or so .
- 23 D yes, yes .
- 24 P I think to myself . that could be a relief.
- 25 D yes .

Instead of reacting to the way the patient's request is formulated in the introductory sequence, the doctor, who is very familiar with the clinical picture, draws the corresponding conclusions ("that means ..."), which are already suggested by the patient with his "desired change to pump". The doctor anticipates the patient's personal "difficulties" with his current treatment as a "diabetic" and with his interventions already elicits the first information relevant to the patient's life, with which the patient seeks to plausibilise his motivation for a change in the therapy procedure vis-à-vis the doctor.

....

E 22.39 "rational pros and cons"

In the process, the doctor emphasises both the conversational quality of *rational communication*, which is about the exchange of *pros* and *cons* ("rational pros and cons"), and the active participatory role of the patient, who is once again encouraged to disclose his or her preferences for a change of therapy, especially since the previous form of therapy has led to an "optimal metabolic setting".

E 22.39 "rational pros and cons"

- 01 D (...) I think before we really get into these purely rational pros and cons ... I would be interested to know ... what are the aspects ... that make it difficult for you ... the basal bolus concept, which obviously in your case leads to an optimal ...
- 02 P hm .
- 03 D metabolic control, to continue that.

This conversation sequence is about an interim balance with a weighing of goods, in which "objective" and "subjective" weights have to be weighed in a "scale" of decision-making (§ 10.3). The "optimal metabolic adjustment" mentioned by the doctor had already been the subject of conversation before, in which the patient had described with a certain pride the success of the therapy so far in a pre-post comparison of the "HbA<sub>1</sub> values", to which the doctor had already expressly expressed his *appreciation* to the patient with an *empathetic* feedback.

E 22.40 "Gosh . that's a very, very good value then".

- 01 D (...) but that's how you get closer to it.
- 02 P Yes, I have also done that so far. The last HbA value was , which is perhaps quite good.
- 03 D yes .
- 04 P because it was still quite high before . with Dr. Z and also with my GP . it looked like . that at some point I was at 12.1 or something .
- 05 D hm .
- 06 P I started in January ... and am now at 5.8 on April 26th ...
- 07 D wow . gosh . that's a very, very good value then . when were you diagnosed .
- 08 P uh . [reaches for pocket] October last year (...)

E 22.41 "I think it's about trying"

- 01 D I think it's also about trying .  
 02 P hm .  
 03 D for example, at the moment I am not able to assess whether you  
 can tolerate a catheter with a steel needle under the skin.  
 04 P yes. I don't know that either.  
 05 D this is a very important aspect .

While here, despite the difficult-to-calculate *risk*, a consensus in the direction of a *trial treatment* is already emerging, the joint objective should be *expressis verbis* about an individual improvement of the "quality of life" in the patient's "everyday situation", in which a "relief" is to be created. Towards the end of the conversation, both partners agree (E 22.42) to obtain and exchange further information for a follow-up session (e.g. pump types, statement and cost coverage of the insurance provider), in order to finally be able to initiate a trial phase with a pump treatment of the patient (01D: "we can try it out").

E 22.42 "We can try this out"

- 01 D yes . Mr Müller . we can try it out (...) first of all I want to tell you  
 . I don't want to talk you out of the pump . I respect your wish .  
 completely .  
 02 P hm . hm .  
 03 D completely . but I also think that it is important . that we clarify  
 in conversation with each other . what your motivation is and  
 that you have the opportunity . to really say . what is on your  
 mind .  
 04 P hm . that's right .  
 05 D well . er. I have a few general questions to understand your situ-  
 ation . because I don't have any data to fall back on . how has  
 your body weight developed recently? .

E 22.43 "You become the specialist for yourself" - "Doctors are advisors"

After completing the anamnesis, which extends to a series of *detailed explorations* (§ 21) (weight, bowel movements, urination, allergies, stress, etc.), the doctor returns once more to the consensus reached in the meantime in this consultation and again describes in a meta-communication the distribution of roles entirely in the sense of *Participatory or Shared Decision Making* (SDM). Accordingly, the patient is assigned the self-referential *expert role* ("you become the specialist for yourself"), while the doctor's own participatory role is explicitly described as the patient's "advisor" and "companion".

E 22.43 "You become the specialist for yourself" - "Doctors are advisors"

- 01 D so that is again your very personal life experience (...) the self-observation, the self-experience in the area . what happens when you do something .
- 02 P yes . right .
- 03 D you become the specialist for yourself .
- 04 P yes , yes of course .
- 05 D doctors are the advisors . companions for a while .

As we know from the further catamnesis, the doctor continued to *advise* and *accompany* the patient for a while until finally a *mutually agreed decision* with a lasting result was reached between the two conversation partners. After several trial and adjustment phases, the patient was able to characterise himself as a "satisfied pump wearer" according to his own statement after more than a decade.

## E 22.44 "it was terrible" - "that's not a good record"

The approx. 65-year-old patient, who suffers from advanced ovarian carcinoma, comes regularly twice a week to the oncology practice, where she has developed a trusting, open relationship with her doctor. Chemotherapy was wisely discontinued, and the patient has opted for a "purely supportive" therapy, which is supposed to be about her "quality of life". Today, she visits the doctor because of her persistent "pain". Right at the beginning of the conversation, the doctor extends an open invitation to tell her about the "state of affairs". For a better understanding of the conversation, the two introductory sequences that were already mentioned in the *detailed exploration* (§ 21) under the aspects of *intensity*, *quantity* and *quality* of complaints (§ 21.4.3) should be mentioned again here. The first verbal descriptions of the patient's complaints ("bad", "it was terrible") already lead the doctor to draw a negative balance, which he provisionally sums up in the form of an understatement (*litotes*) ("that's not a good balance"), before he then switches from the verbal descriptions of complaints (E 22.44) to the use of an *analogue scale* (E 22.45), which he holds up to the patient.

## E 22.44 "it was terrible" - "that's not a good record"

- 01 D so, Mrs. Schmid . now you have to tell us . what is the state of affairs? .
- 02 P bad .
- 03 D is not good, no . hm .
- 04 P I was here on Monday.
- 05 D right .
- 06 P (...) at night (...) the drops had no effect at all.
- 07 D you already woke up with pain already .
- 08 P yes .
- 09 D and had hoped for help directly.
- 10 P yes . it was a bad night (...) it was terrible .
- 11 D that is not a good record .

Despite this overall assessment by the doctor, the patient again extends her description of her complaints (E 22.45) by describing the consequences of the "greater pain" which affects her facial expressions (02P: "my face also tenses up like this"). Following this, the type switches

from verbal descriptions of complaints to the use of a *visual analogue scale*, which he holds up to the patient with commentary. Previously (§ 21.4.3), attention had already been drawn to the fact that the doctor can not only assume knowledge of the scaling procedure, which he mentions again (03D: "You already know my scaling"), but that both interlocutors are already a "well-rehearsed team" in the use of the *analogue scale*; in any case, the patient already leans towards the table and points to the scale as soon as the doctor holds it out to her across the table. For both of them, the procedure seems to be routine and needs no further justification.

E 22.45 "You already know my scaling" - "that's not good"

- 01 D hm .  
02 P I notice that my face also gets so tense . when you're in constant pain . it's better in the afternoon .  
03 D hm . you already know my scale . would you perhaps for the moment again . the current . [holds up scale over desk]  
04 P as it is at the moment . [bends over beforehand]  
05 D yes .  
06 P like this [shows] .  
07 D that's not good, yes . do you dare to try a completely different way again . because that is not what we both wanted, that there is a bit of reassurance for you . I think we are at the point that we should try that with the pain patch . both in terms of tolerance and strength . [...]

Again, the doctor reacts with an "understatement" (*litotes*) ("that is not good"), which can be regarded as the "normal form" not only of doctors but also of patients, if they do not (want to) aggravate (more or less consciously) and therefore tend to "exaggerate" (*hyperboles*). The sense and purpose of different uses of *understatements* and *exaggerations* in doctor-patient communication has already been critically discussed in detail (§ 21.3) using examples in which the evaluation vocabulary reveals a difference between the professional attitude perspective and the subjective experience perspective of patients.

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The further course of the conversation is first to update the anamnesis. Specific complaints such as the patient's "dry mouth" and her "sleeping problems" and "bowel problems" are addressed before her "mobility" becomes a topic, for which the patient is dependent on the help of relatives and neighbours, but does not want to use taxis ("not necessary"). When a short pause creates a break, the doctor opens a new topic ad hoc, on which he once again puts the jointly made decision "not to do chemotherapy" up for discussion.

##### E 22.46 "I don't want chemotherapy"

- 01 D I would like to know one more thing, Mrs. Schmid, because I thought that in these difficult two weeks this could perhaps be a reason for you to reconsider the decision not to have chemotherapy .
- 02 P yes . no .
- 03 D it's a bit different now .
- 04 P I don't want chemotherapy .
- 05 D where the complaints also increase . so I .
- 06 P I realise that .
- 07 D I think I remember our agreement, but I still just wanted to mention it again, whether it somehow has a different weighting.
- 08 P no .
- 09 A for you now .
- 10 P no .

The short excerpt from the conversation refers to a shared history of interaction between doctor and patient that has already been developed and to which both interlocutors can now refer as shared knowledge in a *shared reality* (von Uexküll, Wesiack 1991, 2003, 2011) (§ 4.5). The doctor addresses the already *negotiated consensus* from the past (07D: "I remember our agreement") and at the same time puts it up for discussion again in the present of this consultation (07: "I still wanted to ... address whether ..."). In this way, the doctor initiates a new process of reflection, as is characteristic of the middle phase of "deliberation" in *participatory decision-making* (§ 10.4-6). The initiated interactive *review process* contains overall reciprocal reassurances as to the extent to which the decision taken can still retain its *validity* given known treatment options, but under a current course of disease.

In other words, a *completed* decision-making process is *resumed* with an *open-ended* perspective in which the conversation partners have to perceive their respective participation roles again in their own way. In this *resumption process*, *ambivalences* also come to light in several rounds of talks, which both conversation partners have to deal with *reciprocally* in a process of dialogue and negotiation.

The doctor introduces the fact that the decision already made could possibly turn out to *need revision* in the *deliberation process* (01: "perhaps to reconsider ...") with the changes that have already occurred in the meantime or that are to be feared in the future (01: "difficult two weeks", 05: "where the complaints are also increasing"). The patient reacts relatively spontaneously with early interruptions, so that the doctor has difficulty continuing in his speech to introduce his *thoughts in one piece*. Although the patient seems to have already made her position sufficiently clear with a dialogue pre-start (02: "yes . no") and then with an explicit verbal statement (04: "I don't want chemotherapy"), the doctor insists on a possible correction of the decision with further objections (07: "different weighting"), which increasingly puts the patient under pressure to make a further statement.

.....

When the doctor has now come to a relative conclusion of his contribution to the initiated "considerations" (D01), which he obviously nevertheless wants to continue (11D: "so that-), the patient finally begins to "cut him off" with a "rejoinder" (E 22.47: 12P), at the center of which is her clearly formulated and justified *objection to "chemotherapy"*.

---

E 22.47 "for me it's okay when it ends"

---

11 D so . that-

12 P for me it's okay . when it ends . but I don't want to be full of chemotherapy . just to live a few weeks longer . no . so that's out of the question for me .

13 D good . so we had talked about it .

14 P yes .

15 D I also think that's completely okay . and I also want to expressly support you in that, yes . I think that's the appropriate decision . and that's also where our agreement remains, yes .

---

**23 Drawing Conclusions**

Fig. 23.1 Cologne Manual: Step/Function 5: "Negotiating procedures"

|   |  |   |
|---|--|---|
| <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Cologne Manual &amp; Evaluation of Medical Communication</p> | <p><b>6 Drawing conclusions</b></p>  | <p><sup>6</sup> 2022</p>                                    |
|   | <p>1 Summarise the conversation</p> <ul style="list-style-type: none"> <li>• Reason for consultation, complaints</li> <li>• Diagnosis, therapy agreement</li> </ul>  | <p>0 1</p>  |
|   | <p>2 Offer clarification of open questions</p> <ul style="list-style-type: none"> <li>• Information "Do you still have questions?"</li> <li>• Satisfaction "Can you handle it?"</li> </ul>                       | <p>0 1</p>  |
|   | <p>3 Arrange follow-up appointments</p> <ul style="list-style-type: none"> <li>• Examination appointments allocated</li> <li>• Set a meeting date</li> <li>• Regulating contingencies in an emergency</li> </ul> | <p>0 1</p>  |
|   | <p>4 Say goodbye to patient</p>  | <p>0 1</p>  |
|   | <p>5 Complete documentation</p> <ul style="list-style-type: none"> <li>• Common coding</li> <li>• Personal conversation impressions</li> <li>• Topics for the follow-up meeting</li> </ul>                       |   |
| <p><sup>1</sup>1998</p>   | <p><b>E V A L U A T I O N</b></p>  | <p><input type="checkbox"/> <input type="checkbox"/> 04</p> |

Fig. 23.1: Excerpt (Manual/Evaluation): Step/Function 6: "Drawing conclusions" (Cf. the complete Manual, Fig. 13.11, and at the end of the chapter, Fig. 23.2)

E 23.1 "Let's call it a day. . you'll be in touch again"

Conversations are often concluded "briefly and succinctly", without any summarising transitions being given by the doctor. In contrast to initial conversations, in repeated follow-up conversations the two conversation partners can often already refer to longer histories of interaction and care, which apparently allow a more or less abrupt closing formulation by the doctor in routine treatment. In the following example (E 23.1), the doctor can conclude the conversation relatively abruptly with an explicit closing formulation without the patient being particularly irritated.

E 23.1 "Let's call it a day. . you'll be in touch again"

- 01 D (...)  
 02 P (...) because, as I said, when I'm a pensioner, we do so many things... and it's just the opposite.  
 03 D a huge disappointment .  
 04 P yes . a real . real disappointment! I have to say, he's doing his job, but he's already doing everything, no . but then there's always the drinking and then [...] like an old man of 70 .  
 05 D Mrs S . let's call it a day . yes? . you'll be in touch again .  
 06 P yes . i'll get back to you . right . it doesn't help . [I have to get through this.

The patient seems to be able to accept the abrupt conclusion well, because in the course of the conversation so far she had had her say about her complaints and concerns in detail. Most recently, she had complained about her retirement life with her husband, which the doctor had acknowledged in several *empathic* feedbacks (§ 20.6). The harmony between the interlocutors was last expressed again in the *empathic* communication when, after the doctor had named her emotion (03D: "a huge disappointment"), the patient indicated through the almost literal restatement (04P: "a real disappointment") that she obviously felt well understood by the doctor. In any case, the topic of the "disappointing" retirement life again experiences a relevance upgrade by the doctor, which stimulates the patient to prolong her tale of woe, which is reproduced here in abbreviated form (04P). The doctor can now intervene at this point in the conversation with a "final word" because this story of suffering is already sufficiently known to both partners from this and the preceding conversations.

E 23.4 " ... then I will examine you now"

For the subtype of an *abrupt* transition, the problematic example (E 23.4), which had already been described as deficient under the aspect of *empathic* communication (§ 20.4), should be mentioned again. For a better understanding, the information from the previous conversation history should be added, according to which the patient had already mentioned the "other trouble in the family" beforehand, without immediately getting to the point, which is why she now has to make another attempt on this topic.

E 23.4 " ... then I will examine you now"

- 01 A (...) so you say yourself that there is stress behind it ... or are there other things that cause you problems? I mean other difficult things.
- 02 P well I had other/other trouble in the family within .
- 03 A hm .
- 04 P which is actually still ongoing, which was only there recently, where a lot of things got mixed up... but ... that's also the only thing then .
- 05 A hm . yes Mrs S . I think I will examine you now .
- 06 P hm .

After the first unsuccessful attempt at the beginning of the conversation, the patient now tries again to introduce the topic that is obviously relevant to her ("trouble in the family") at a designated point in the conversation where the doctor had opened up a suitable topic opportunity (01D: "stress (...) problems (...) other difficult things?"). The patient readily takes up this conversation offer, which the doctor offers with a wide range of topics, and again places her specific topic offer explicitly and unmistakably (02P: "other trouble in the family (...) where a lot of things also got mixed up"). Although the doctor is here appropriately under pressure to react to the current patient offer under the aspect of *conditional relevance* (§ 9.4), he makes a radical change of topic with a relevance downgrade.

---

E 23.5 "yes . then I would like to examine you for a moment"

---

While in such cases the topic and at the same time the end of the conversation is abrupt because the doctor switches from *patient's events* (such as "trouble in the family") to doctor's *events* ("examination") (§ 19.7), the change of topic may appear less abrupt from the patient's perspective if the doctor is already moving within a thematic chain of doctor's *events*, for example in the case of the typical doctor's questions in the system anamnesis, which he goes through "from head to toe" (§ 21.6). A corresponding transition from the relatively saturated system anamnesis to the examination can then be perceived as less abrupt in many cases, because the patient has not been able to "get to the point" in an initiative way for some time anyway, but answers doctor's detailed questions much more reactively to complete the anamnesis. Following a series of doctor's *events*, the transition to the examination then appears to be *moderate* if the patient's interest in the topic is obviously not curtailed. In the following example (E 23.5), for example, the doctor moves directly from his last detailed explorations to the examination without first making an intermediate summary.

---

E 23.5 "yes . then I would like to examine you for a moment"

---

01 D great .  
 02 P hm .  
 03 D and appetite, digestion, bowel movements, is everything okay? .  
 04 P hm .  
 05 D great .  
 06 P hm .  
 07 D yes . then I would like to examine you for a moment .  
 08 P hm .

---

Such an abrupt transition from conversation to investigation could also be observed in many previous examples, which can only be referred to here by way of example (§ 19.6, 19.8). Since in these cases our empirical data collection also ended for the further analysis of the conversation, we can only speculate about the possible continuation of the conversation during and after the investigation.

## E 23.6 "that you can help yourself at the moment"

In the following example of an initial consultation (E 23.6), in which a number of complaints and suspected diagnoses have already been discussed, also by previous practitioners, the doctor sums up the knowledge and interim results gained so far with such a "picture" perspective, with the restriction that he would like to "study all the physical examinations again" (03D). After an interim solution of helping, the doctor then makes the proposal for another appointment, to which the patient has to adjust for the time being in a *wait-and-see perspective*.

## E 23.6 "that you can help yourself at the moment"

- 01 D hm . i would like to suggest the following . i have actually already been able to form a certain picture .
- 02 P yes .
- 03 D but I would like to say again that I would like to study all the physical examinations again.
- 04 P yes .
- 05 D and I now suggest that you first of all do this pain therapy immediately.
- 06 P yes .
- 07 D that you can help yourself at the moment .
- 08 P yes .
- 09 D but I would suggest that we make another appointment.
- 10 P yes of course .
- 11 D yes? .

As the many listener responses ("yes") show, the patient is quite reasonable about the reasons given ("studying the file") and is generally prepared to wait for the next visit to the doctor for further clarification before she can be helped further. The doctor can obviously anticipate that the vague summary ("I have actually already been able to form a certain picture") and the expected bridging perspective may be unsatisfactory for the patient. In any case, he simultaneously proposes a kind of interim solution ("pain therapy"), which is to be carried out "initially" and "immediately" in order to offer the patient some "help" "at the moment", which is then also realised immediately after the conversation in a treatment room.

E 23.13 "if complaints come, get back to me"

In the following example (E 23.13), the choice of the next appointment is also left up to the patient, who is allowed to use the consultation depending on his or her "complaints".

E 23.13 "if complaints come, get back to me"

- 01 D yes... shall we stay like this? .  
02 P yes .  
03 D or would you like some more ...  
04 P No... write that down and I'll get another pack.  
05 D good . let's do it .  
06 P and then I hope . as I said . there's nothing here at the moment .  
it's an hour or so in the morning . it's usually here around the  
knee, then it's gone, no . when I was here last week, I . it was  
here too . I was still standing outside with [name] . it was warm  
then too .  
07 D yes .  
08 P so it was so bad, I could hardly stand, my whole leg hurt so  
much and it's gone now.  
09 D is gone .  
10 P so it's already done some good . no . do it like this and then ...  
[patient rises already].  
11 D if any complaints come, get back to me.  
12 P yes . then I'll come .

The question about possible further patient concerns first leads to a short digression in which the patient presents his changing complaints, which the doctor then takes up again thematically in the final conclusion of the conversation. Here, the invitation to talk comes from the doctor, who leaves the perception of a follow-up appointment entirely to the patient's decision-making competence. This is different with fixed appointments, which primarily fall under the doctor's competence and responsibility.

## E 23.15 "if something is wrong"

In special cases, individual arrangements can be made if the doctor is willing and able to do so. There are certainly differences between general practitioners and specialists, for example, or between city and country doctors, who may be the next point of contact anyway. In the following example (E 23.15), the doctor offers the patient, who had presented herself as an emergency because of her "particularly high blood pressure" ("for all things call 110 . yes 112"), the possibility of calling her even at the weekend.

## E 23.15 "if something is wrong"

- 01 D um ... I'll be here at the weekend, yes ... if there's something wrong, yes ... come by .... I'm only not here on Saturday morning.
- 02 P you are not there .
- 03 D but back here on Saturday at noon.
- 04 P yes. okay . can I ring the bell if something is wrong? .
- 05 D yes, you must . you know, I'm in the back garden, yes .
- 06 P yes, yes . okay .

Such an offer for the "emergency" can rather be made by the family doctor in the countryside who is "on the spot" anyway and is also called for "house calls" not only on weekdays. Without wanting to derive a recommendation from this, only the willingness of doctors declared in training groups who had given their private telephone number for emergencies to certain patients should be mentioned. The experience was that very few patients had ever made use of this "emergency provision". However, many patients later explained that the possibility of being able to make use of this regulation "in principle" had given them a lot of security - an incentive not necessarily to copy it, but nevertheless to think about what could contribute to satisfying patients' need for security.

## 24 Ward Round Communication

Fig. 24.1.1 Ideal-typical process model of ward round communication

Although the sequence here suggests a certain ideal-typical sequence of functions (Fig. 24.1), these are to be performed repeatedly if necessary and in *circular communication processes* (§ 8), in which planning and discussion of examination and therapy measures as well as debriefing of their results etc. may alternate.<sup>3</sup>

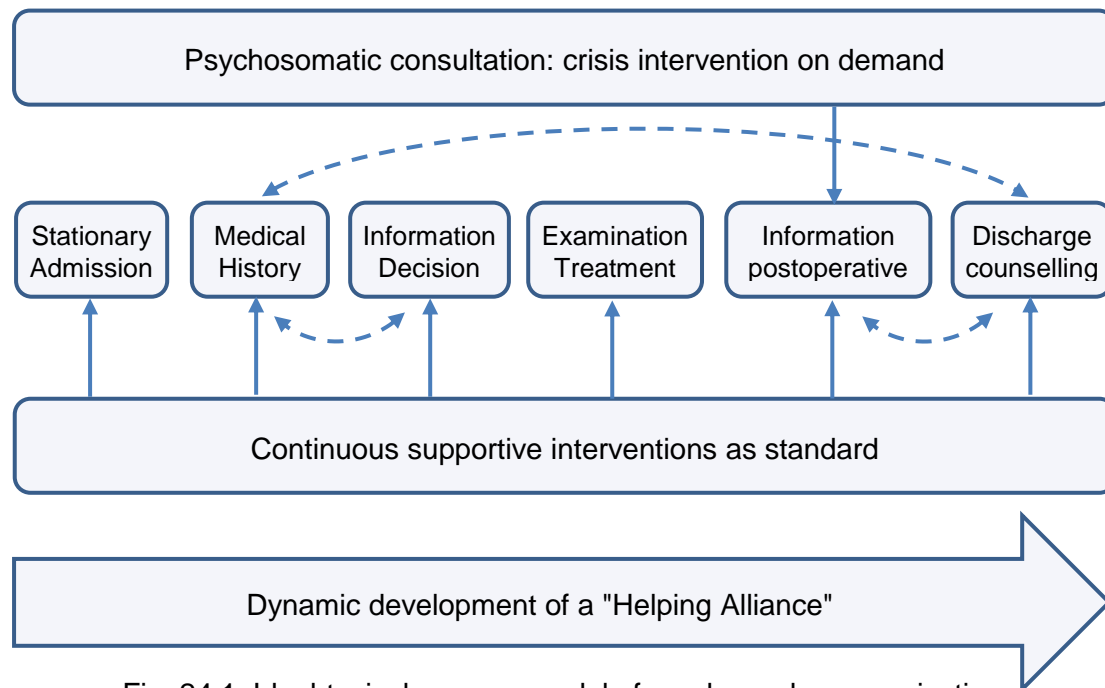


Fig. 24.1: Ideal-typical process model of ward round communication

The circular resumption of phase-specific functions becomes necessary when, for example, new situations with new findings and treatment alternatives arise and the patient's attitudes, fears and hopes change accordingly. The fact that a good biopsychosocial anamnesis can always be extended after a large number of ongoing ward rounds will be shown later by way of example using a specific consultation shortly before a patient is discharged, in which the focus is on a patient's illness behaviour and coping after discharge from hospital (§ 24.6-7).

<sup>3</sup> In a linear model, Merriman, Freeth (2022) distinguish four phases: „Phase 1, focusing attention; Phase 2, sufficient gathering of information, opinions and suggestions and formulating a management plan; Phase 3, articulating and checking the management plan; Phase 4, agreement, and closure“ (2022: 414ff.).

Fig. 24.1.2 Triadic communication constellation

In this context, the *asymmetry* of dialogue role assignment can become highly complex: The typical constellation of the ward round can be complicated by further *participation roles* (head physician, assistant physician, etc.), whereby a complex *hierarchy* of competences (knowledge, competences, responsibilities, etc.) can be assumed (Fig. 24.2). For example, in the usually weekly chief physician rounds, other physicians or the nursing staff can be asked to give a "report" instead of the patient, which is then given *coram publico*, as it were, in the sense of *trialogical* communication.

From the point of view of the intentionality of communication, different types of speakers and listeners must be distinguished: In trialogical communication, all those present can more or less be (made) listeners. For example, a de facto listener such as the patient should also be able to listen as a secondary listener, even if the head doctor (CA) has not primarily addressed him, but the ward doctor (SA) or the nurse (PF). Sometimes, however, the patient as a listening third party is systematically excluded from interprofessional communication, as we will see in empirical examples.

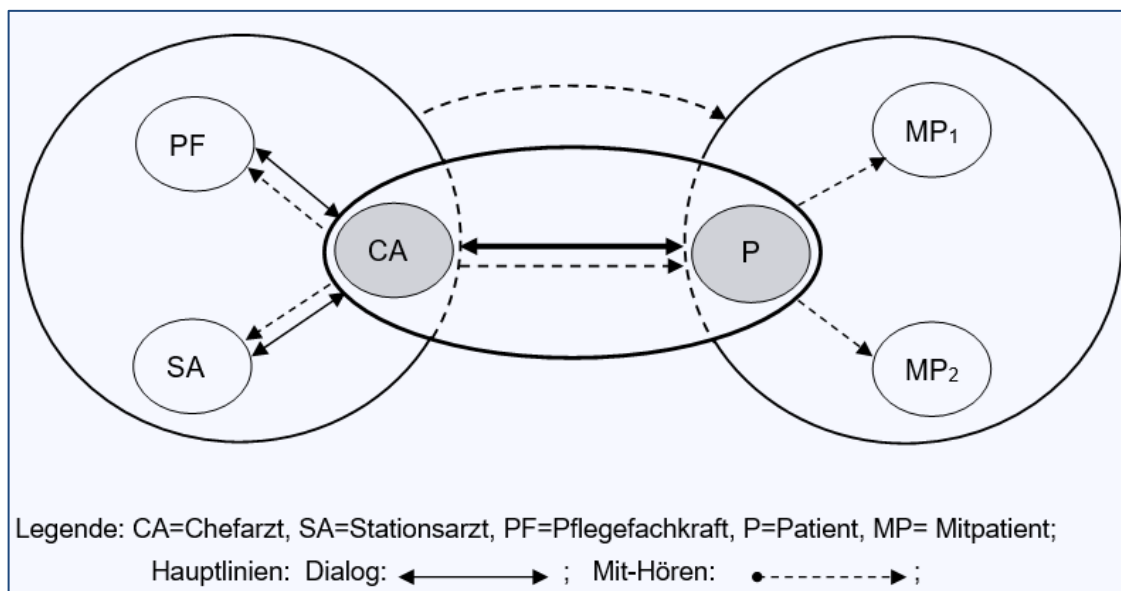


Fig. 24.2: Triadic communication constellation: Example of a ward round by the chief physician. English legend: (CA) chief physician, (SA) resident physician, (PF) nurse, (MP) fellow patient. Main lines: Dialog:  $\longleftrightarrow$  ; indirect listening:  $\bullet\text{-----}\blacktriangleright$

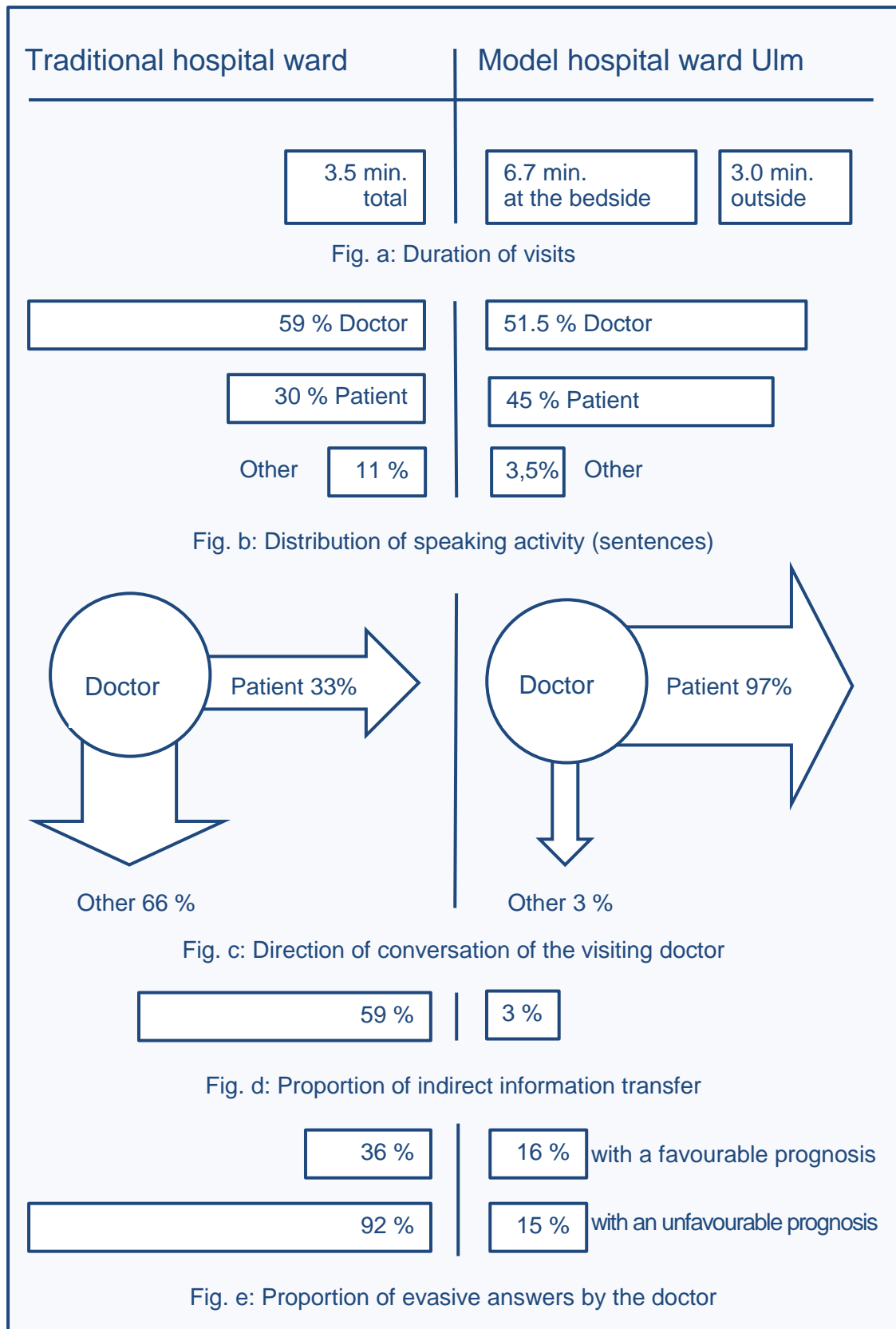


Fig. 24.3: (a-e): Dialogue structures of the ward round  
(after Westphale, Köhle 1982, Fehlenberg et al. 2003)

#### 44. Teaching Materials on Medical Communication

|        |                         |         |
|--------|-------------------------|---------|
| E 24.1 | "We cannot dismiss her" | Comment |
|--------|-------------------------|---------|

The following example (E 24.1) (from Nothdurft 1982) also demonstrates several aspects of the *impermeability* of ward round communication for a patient whose barriers to taking over the speech and active participation in a professional "side communication" between the doctor (D) and the MA (M) are unmistakably high.

| E 24.1 | "We cannot dismiss her"  | Comment       |
|--------|--|---------------|
| 01     | M She came in because of a suspected ischaemic myocardial reaction...  | Inscrutable   |
| 02     | D With absolute arrhythmia. If she moves and stands up a bit, yes then we don't need so much [unintelligible]. |               |
| 03     | M [talks in parallel to D] The last ECG was done on the 11th, when the welfare worker was positive.            | Unwatchable   |
| 04     | D What positive?   |               |
| 05     | M [quietly] assesses things, so that she finds accommodation somewhere, then                                   | Unpredictable |
| 06     | D No, we can't discharge her. She still has these huge wounds on her knee joint.                               |               |

Here, a "social case" that has to be "accommodated somewhere" is obviously compared with medical facts that ultimately speak against discharge ("giant wounds"). The potential discharge discussion is conducted as a purely interprofessional team communication without subject participation of the patient. Because of the technical hurdles (e.g. "ischaemic myocardial reaction", "absolute arrhythmia"), the sequence of the conversation remains not only *inscrutable* for the patient, but also *unobservable* in so far as the doctor and the MA make their secondary communication (also for the transcriber) incomprehensibly quiet at times, whereby they speak about the patient exclusively in the third person ("she"). The two professional interlocutors coordinate their speech organisation so closely (sometimes simultaneously) that the possibility of the patient taking over the conversation remains *unforeseeable*, if she even knew how to intervene in the dialogue in a meaningful way.

E 24.5 "What do you do for work?"

After the patient has markedly affirmed the doctor's reassurance (39D: "and when you work, too?") (40P: "when I work, too, yes"), the doctor initiates a change from the biomedical to the biopsychosocial anamnesis by making the patient's professional life the subject of a simple question for detailed exploration. Whereas up to now work was only marginally discussed under the biomedical aspect (wearing support stockings), the profession is now made the central topic of the ward round directly afterwards (41D: "what do you do for work?") and through further listening activities by the doctor according to content and individual significance.

E 24.5 "What do you do for work?"

- 33 D yes .  
 34 P and then they ordered me to wear rubber stockings during that time .  
 35 D hm .  
 36 P I wear this all the time .  
 37 D hm .  
 38 P so also on Sundays and always . innit. so during the day . not at night . at night I have it off .  
 39 D and when you work too? .  
 40 P when I work too . yes .  
 41 D what do you do for work? .  
 42 P I have a construction business .  
 43 D a construction business? .  
 44 P yes . with the children .

As in the preceding sequence, the patient must first be "lured out of his reserve" in this sequence and stimulated by appropriate interventions by the doctor to further elaborate on the topic in each case: First, the doctor uses a simple technique of *active listening* (§ 19), namely word repetition with question intonation (43D: "a construction business?"), through which the listener's interest is particularly marked in the sense of a *relevance upgrade* (§ 17.4, 20.4). The patient in turn reacts with an information supplement (44P: "yes . with the children") ("yes ..."), which would not have come about without the doctor's intervention (43D), or at least not in this way.

## E 24.6 "you don't do it alone anymore"

The doctor's further intervention (45D: "You don't do that alone any more ...") is more complex, in terms of form, content and function. Obviously, the doctor's intervention hits a "vital nerve" of the patient, who reacts vehemently and in one piece, without the need for further stimulation.

## E 24.6 "you don't do it alone anymore"

45 D you don't do that alone any more . your son does that already .  
or what-

46 P Yes . they do it . yes . that can certainly be the case . but up to  
now the father has always been the one in front, y'know. because  
the father is such a . how should I put it . so crazy, y'know . you  
can't do it without work, y'know.

Central to this second intervention is the thematic key symbol that the doctor introduces here (45D: "no longer do it alone"), with which the problem of *autonomy*, which is psychodynamically significant for the patient, is precisely retrieved, namely in the threatening context of a time perspective ("no longer") and real alternative ("your son is already doing that"). In this context, the patient is cognitively and emotionally confronted with a possible loss of autonomy, whereby he obviously feels audibly and visibly challenged to make a statement.

His *affirmative-adversative* reaction structure ("yes ... but", Koerfer 1979), which is characteristic for the further course of the conversation, refers to the ambivalence conflict of the patient, who verbally moves between agreement (46P: "yes, they are already doing that") and rejection of a possible presupposition ("but until now the father has always been the one in front").

Both with the specific time perspective ("until now") and with the specific metaphor ("the person in front"), the patient, who here presents himself in the third person of a social role ("the father"), apparently at the same time carries out image work that is experienced as necessary, with which he seeks to "save face" in self-presentation.

E 24.7 "then you shouldn't go crazy"

47 D how old are you now .

48 P 61 .

49 D 61 . well . then you're still working .

50 P well, it's clear that you're still working. You're supposed to work, innit [=isn't it?] . but if someone says a doctor said that if someone is working, then he should also take care of himself . then you shouldn't go crazy and still go to work . (I would) .

51 D how old are your sons, your children? .

52 P yes, one is 37/38 and the other 43 .

Again, the patient reacts with the ambivalence of a verbal double structure (50P). Its *affirmative* part is expressed in a marked agreement ("it's clear that you're still working"), while the *adversative* part ("but if someone says ... then you shouldn't go crazy") consists of the reproduction of a counter-argument of a citation authority (of a pre-treatment doctor). Before the consultant can take up this ambivalence conflict ("who shouldn't play crazy, is obviously playing crazy") and give it back to the patient for further processing, he in turn clarifies the necessary knowledge prerequisites for preparing further interventions, which firstly include age (51D: "how old are your sons?") and then the status and function of the patient's children, i.e. information about the real living conditions is obtained, which only allows realistic conclusions to be drawn (possibilities of detachment and relief through children - cf. below) for dealing with the conflict of ambivalence.

.....

The patient's ambivalence, already expressed in the preceding sequences of this current ward round, now becomes fully manifest in the following passage, after the doctor makes the possibility of the patient's professional relief through his children ("... already ... without you") during the current illness ("now, when you are ill") an explicit topic.

E 24.9 "I can already see that it works without me . "

55 D they already run the business without you now when you are sick .

56 P yes, I realise that it works without me .

57 D yes .

58 P I can already see that it works without me .

#### 44. Teaching Materials on Medical Communication

The marked, double reaction (56/58P: repetition with identical wording after the doctor's *signal to listen*: "I already realise that it works without me") already shows the relevance of the statement for the patient, who has to concede a loss of autonomy with this concession of a professional replacement by his sons. As an external observer, one can "hear" as well as "see" in "sound and image" that this concession can only be made by the patient "with a heavy heart". ...This serious concession is obviously also perceived or understood by the doctor, which is why he tries to clarify the patient's emotions at this point - also in the sense of a self-understanding of the patient, who must solve his current ambivalence conflict (autonomy vs. need for help = dependence) in the near future. Without building up a suggestive pressure of expectations at this "delicate" developmental point of the conversation, the doctor's intervention here provides a *real alternative to choose from* ("do you like it or not so much"), which the patient is free to decide.

---

E 24.10 "I am only healthy . if I can work"

---

59 D do you like it or not so much?

60 P me:?.

61 D yes .

62 P so frankly . I'm only healthy . if I can work . lots and lots and lots [clenches both fists vigorously, which he holds up in the air while lying down] .

63 D yes .

64 P then I am happy in the evening.

---

Although it is a genuine alternative in terms of form, content and function, the patient is put under a particular pressure to move, which he finds difficult to escape. The first thing that stands out is the patient's emphatically astonished question back (60P: emphatic: "me:" with question intonation). The patient is or acts surprised here, perhaps only to find time for his answer, which he begins after the doctor's listening signal ("yes"). After a special mark, with which the patient explicitly asserts his sincerity as a person and the truthfulness of his subsequent statement in advance (62P: "so frankly"), he then formulates his personal life motto ("I am only healthy . if I can work . lots and lots and lots"). In this life motto, the subjective concept of health is condensed in a few words to a "short denominator", which at the same time sums up the course of the conversation so far.

| D - P | Doctor  |   | Patient   |
|-------|---|---|---|
| 41-42 | what do you do for work?  | → | I have a construction business.   |
| 43-44 | a construction business?  | → | (yes) with the children .   |
| 45-46 | you don't do that alone any more . your son already does that or what-. | → | (yes) they do it on their own . that can certainly be the case . but until now the father has always been the forerunner, y'know . because the father is such a . how should I put it . crazy person, y'know . you can't do it without work, y'know . |
| 47-48 | how old are you now?  | → | so I'm 61 years old now.  |
| 49-50 | 61 . well . then you're still working .                                 | → | And it's clear that you're still working . you're supposed to work, no . but if someone says . a doctor said that if someone procures, then he should also take care of himself . then you shouldn't go crazy and still go to work .                  |
| 51-52 | how old are your sons/your children? .                                  | → | so one son is now 38 . and the other 43 .   |
| 53-54 | then they are already completely independent, aren't they?              | → | (yes) the children are already quite independent . so I was already . I was already independent at the age of 16 . when I came out of my apprenticeship, no . and they are already big today .  |
| 55-56 | do they already run the business without you now when you are sick? .   | → | so the children already run the business without me when I'm sick . so I already realise that it works without me .   |
| 59-62 | do you like it or not so much? .  | → | <i>and if you were to ask me if I like to see that or not so much, so frankly . I'm only healthy . if I can work . lots and lots and lots [clenches fists] .</i>  |
| 63-64 | yes   | → | then I am happy in the evening.   |

Fig. 24.5: Cooperative storytelling

Fig. 24.6 Life narrative (Patient, male, 61 years old, heart attack)

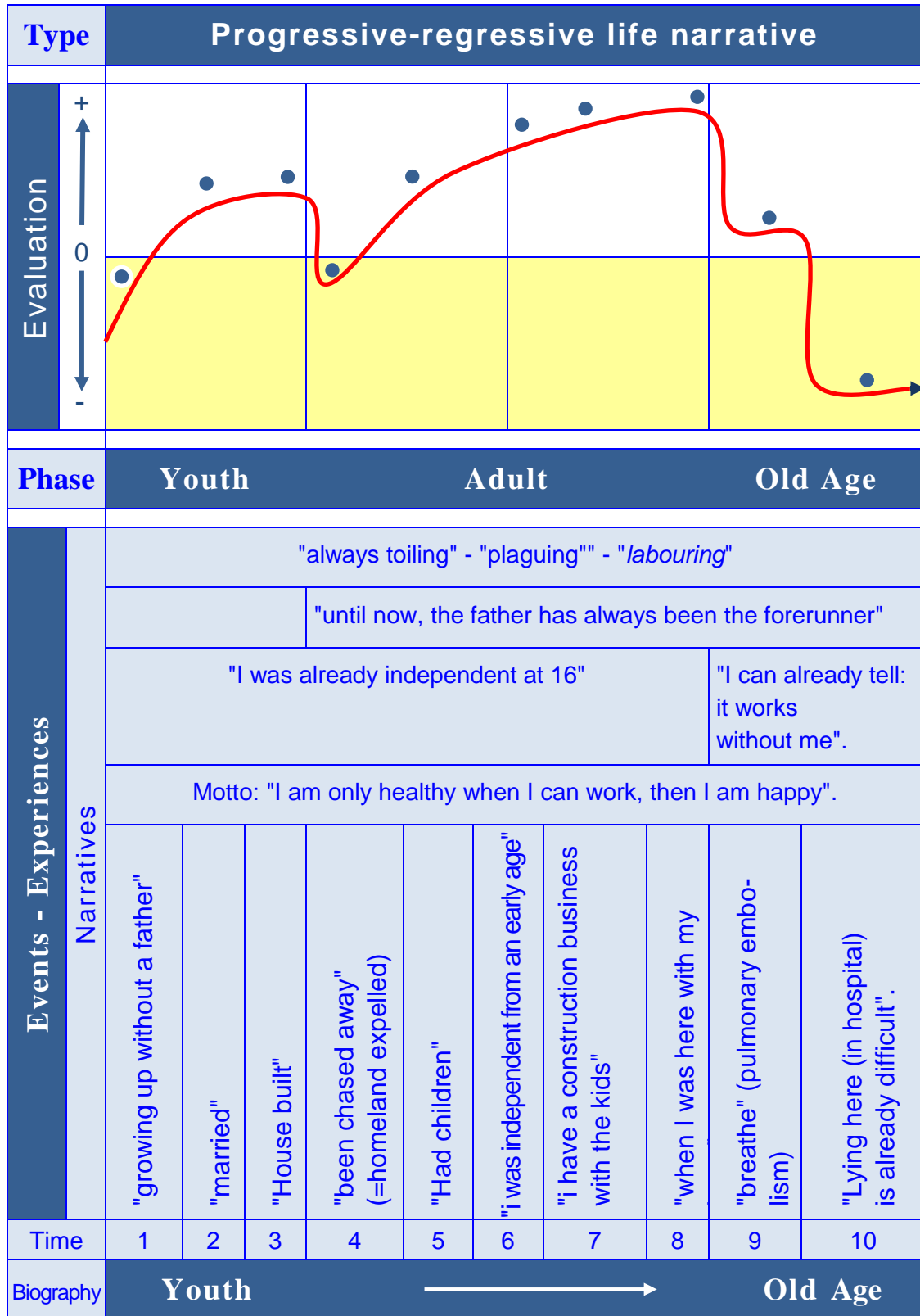


Fig. 24.6: Life narrative: 'I am only healthy/happy with work' (on Koerfer et al. 2005, Koerfer, Albus 2018)

Table 24.3 Subjective guiding concepts (Patient, male, 61, heart attack)

The patient's last *self-evaluation* (62P: "I am only healthy when I can work, then I am happy") reveals his *subjective concept of health* (§ 21, 29). Then, via the reverse conclusion suggested by the patient himself, the assumption of a subjective evaluation scale with the poles "healthy-happy" (*plus*) - "sick-unhappy" (*minus*) becomes clear, between which all snapshots of life (above all depending on work productivity) are evaluated by the patient.

In addition to this *salutogenic* evaluation concept, other evaluative guiding concepts of *autonomy*, *hierarchy*, *mobility*, *productivity* and *normality* come into play, with which the patient sets partly conflicting accents in the evaluation of the threatening life event of the current illness (Tab. 24.3). These ambivalence conflicts of the patient, who sees his health and happiness in life endangered by the loss of his fulfilled working life, will be summarised once again (Tab. 24.3) and commented on.

| Guiding concepts | Polarity  |  |
|------------------|---|--|
|                  | Positive  | Negative   |
| Autonomy         | "I was already independent at the age of 16"        | "I already realise that it works without me".                  |
| Hierarchy        | "Until now I was the forerunner"                    | <i>I will be the one left behind</i>                           |
| Mobility         | "Strive and move forward make"                      | "Lying there all of a sudden, that's hard"                     |
| Productivity     | "lots and lots of work"                             | "Do nothing"   |
| Normality        | "You shouldn't go crazy and still go to work"       | "The father (=me) is so crazy - you can't do it without work". |
| Salutogenesis    | "I am only healthy, if I can work, then I am happy" | <i>Without work I get sick and unhappy</i>                     |

Tab. 24.3: Subjective guiding concepts: Verbatim quotations are in quotation marks, conclusions in italics (on Koerfer et al. 2005; Koerfer Albus 2018).

## 25 Communication in Primary Care

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

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.

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.

E 25.2 "then mum should go out"

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,



Fig. 25.1

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.

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.

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.

## E 25.3 "My nerves get the better of me and I'm scared sometimes"

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*.

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 . |

For a further analysis of the conversation, see § 25.3

E 25.11 "I feel sick sometimes ... and I also have a headache"

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 .
- 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* (O4P: "I feel a bit sick sometimes (...) and I also have a



Fig. 25.8

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. 25.9

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*.

For a further analysis of the conversation, see § 25.4

Fig. 25.10 Dialogue role structure (phases, domains)

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),<sup>4</sup> it is 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.

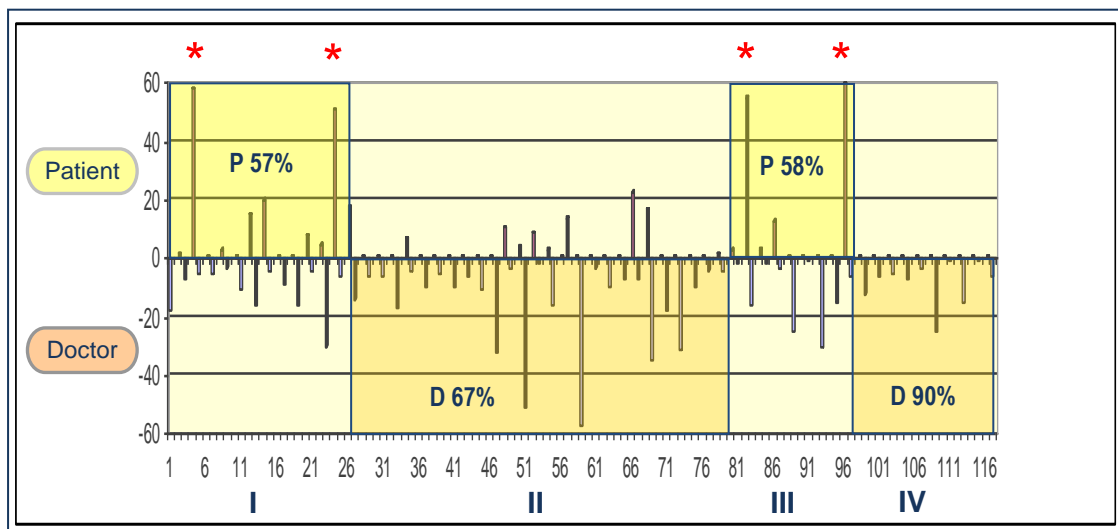


Fig. 25.10: Dialogue role structure (phases, domains) (on Koerfer et al. 2010)

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.

4 At this point, for methodological reasons, it should be noted again that mere feedback from the listener ("yes", "huh"), which allows the speaker to continue "as if uninterrupted", is not counted as "independent" speech contributions in this specific procedure (cf. § 17.3, 40.2).

Table 25.1 Cooperative storytelling

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)".

E 25.15 "Should we do the 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. Only excerpts from the full conversation analysis (§ 25) will be drawn upon here.

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 .

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



Fig. 25.11

opening form of encouraging address (§ 19.2), leaving the opportunity to speak to his interlocutor at his own disposal by mentioning his name.

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 explanations, 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.

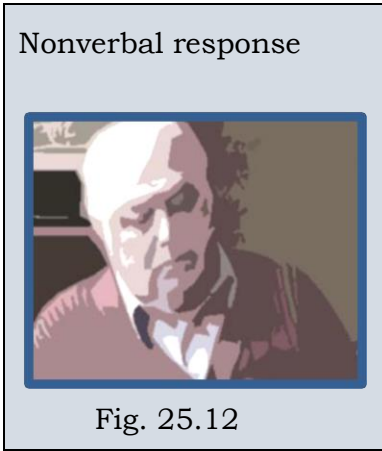
....

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 ...

|   |                    |
|---|--------------------|
| E 25.17 "how is everything else going?" | Start of narration |
|---|--------------------|

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 25.17a "how is everything else going?"   | Comment   |
|--|---|
| 29 D yes . we can do it . yes .  | Agreement<br>(+ "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<br>+ Expression of sincerity<br>+ 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   |




Turning the conversation around

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".

## E 25.17b "I have no more hope" (without eye contact) Start of narration

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).

|   |  |
|---|--|
| <p>Nonverbal response</p>  <p>Fig. 25.13</p> | <p>Beginning of the narrative</p> <p>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 .</p> <p>The patient seems isolated, no longer has eye contact</p> <p>33 D: why do you have no more hope? .</p> <p>34 P: yes, because she can no longer walk.</p> |
|---|--|

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.

For a further analysis of the conversation, see § 25.5

Table 25.2 Time grid for the morning (Mon-Fri) and afternoon (Tues and Thurs)

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.

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 interaction, 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.

#### 44. Teaching Materials on Medical Communication

| 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<br>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)

## 29 Communication with Chronically Physically Ill Patients

### Box 29.4 Questions about psychosocial risk factors

(...) numerous national and international guidelines on the diagnosis and treatment of CHD and diabetes mellitus now recommend not only looking for symptoms of psychological comorbidity, but also additionally looking for other psychosocial risk factors and providing appropriate psychosocial services if these are detected (Visseren et al. 2021, BÄK et al. 2024). The German National Health Care Guideline for Chronic CHD (BÄK et al. 2024) recommends the following formulations for this purpose, which of course already presuppose suitable topic developments that can be followed up with targeted questions.

### Box 29.4 Questions about psychosocial risk factors

#### **Low socioeconomic status**

- Are you a worker or a craftsman?
- Is your secondary school diploma or elementary school diploma (or less) your highest level of education?

#### **Social isolation/lack of social support**

- Do you live alone?
- Do you have/miss one or more people you trust and can count on for help?

#### **Occupational stress**

- Do you often feel very challenged in your work?
- Do you miss being able to influence the design of your work tasks?
- Do you receive significantly too little pay or recognition for your work efforts?
- Are you worried about your job or career advancement?

#### **Family stress**

- Do you have serious problems with your life partner or family?

#### **Hostility and tendency to anger**

- Do you often get annoyed by little things?
- Are you often annoyed by other people's habits?

#### **Negative affectivity and social inhibition ("Type D pattern").**

- Do you often feel anxious, irritable and depressed in general?
- Do you find it difficult to share your thoughts and feelings with strangers?

BÄK et al. 2024

#### 44. Teaching Materials on Medical Communication

##### E 29.3 "I'm just supposed to keep it together"

In the following case example, the physician addresses the issue of social support in a patient with inadequate blood glucose levels in type 2 diabetes mellitus.

##### E 29.3 "I'm just supposed to keep it together"

- 01 D Who all belongs to the household?  
02 P My wife and my two children  
03 D Can you talk to your wife about the diabetes?  
04 P my wife always says I should just pull myself together. Easy for her to say ... that doesn't help at all ...  
05 D I can empathize with that. What would you experience as helpful?

In the next case study, a patient with CHD needs the next stent after only one year. The patient suspects "stress" as the cause, but he is not aware of his part in the conflict situation.

##### E 29.4 "What can I do about it?"

- 01 P If I didn't have stress, I would be fine ...  
02 D Yes, stress can indeed play an important role in heart disease. Can you tell me more precisely what you mean by stress?  
03 P I had total stress at work ... much trouble with my boss.  
04 D What were you angry about?  
05 P He picks on me all the time.  
06 D How did you deal with it then?  
07 P How? What can I do about it?  
08 D Well, I can already understand your anger, but I wonder if you can find a way to defuse the conflict with the boss. That would also be good for your health. Would you like to share an occasion?

Based on the most concrete possible description of stressful situations, it is usually possible, if the therapeutic relationship is sustainable, to develop the conviction with the patient that it makes sense for him to turn to his own experience and behavior in order to cope better with certain potentially stressful situations. This process can be deepened in the sense of *basic psychosomatic care* (§ 15, 42). In selected cases, it can also give rise to specialist psychotherapy.

Fig. 29.1 Cologne Evaluation of Medical Communication –  
Diabetes and Depression (C-EMC-DD)

As already explained, we have developed a "C-EMC Diabetes and Depression" (C-EMC-DD, Fig. 29.1.) as an extension of the *Cologne Evaluation of Medical Communication* (C-EMC; see § 17), which covers the recording of six essential domains or steps of a general initial medical consultation, which extends the C-EMC by diabetes- and depression-specific dimensions (see below). The "anchor examples" for suitable questions, which each domain contains, can at the same time serve as a manual for a suitable exploration in the case of a comorbidity of diabetes mellitus with depression.

Fig. 29.1: Cologne Evaluation of Medical Communication – Diabetes and Depression (C-EMC-DD) (see next page)

44. Teaching Materials on Medical Communication

| Cologne Evaluation of Medical Communication - DD  |        |             |  |  |       | C-EMC-DD                                      |
|---|--------|-------------|--|--|-------|---|
| OSCE checklist for physician discussion of co-morbidity: diabetes, depression   |        |             |  |  |       | <sup>1</sup> 2009                             |
| © Department of Psychosomatics and Psychotherapy, University of Cologne   |        |             |  |  |       | <sup>2</sup> 2018                             |
| No.   | Course | Interviewer | Date   | Patient (SP)   | Rater | Sum:  |
|   |        |             |  |  |       | <input type="text"/> <input type="text"/> 73  |
| 1 General anamnesis   |        |             | <input type="text"/> <input type="text"/> 18                   | 4 Additional symptoms depression   |       | <input type="text"/> <input type="text"/> 7   |
| <b>1 Establish a relationship</b> <ul style="list-style-type: none"> <li>Greeting and introduction</li> <li>Situating and orienting (time, goals)</li> </ul> <b>2 Listen to concerns</b> <ul style="list-style-type: none"> <li>Encourage storytelling</li> <li>Actively listen and support</li> </ul> <b>3 Allow emotions</b> <ul style="list-style-type: none"> <li>Respond empathically</li> <li>Promote emotional openness</li> </ul> <b>4 Explore details</b> <ul style="list-style-type: none"> <li>Exploring dimensions of complaints</li> <li>Complete general medical history</li> </ul> <b>5 Coordinate procedure</b> <ul style="list-style-type: none"> <li>Clarifying information and expectations</li> <li>Negotiate therapy plan (SDM)</li> </ul> <b>6 Draw a conclusion</b>        |        |             | 0 1<br>0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4<br>0 1 | <b>1 Concentration</b><br>"How about your ability to concentrate (at work, reading the newspaper)?"<br><b>2 Self confidence</b><br>"How would you rate your self-esteem (self-confidence)?"<br><b>3 Guilt</b><br>"Do you often blame yourself?"<br><b>4 Future prospects</b><br>"How do you see your future - more optimistic or more pessimistic?"<br><b>5 Sleep</b> "How (good) is your sleep?"<br><b>6 Appetite</b> "How is your eating behavior and appetite?"<br><b>7 Suicidality</b> "Do you sometimes think that you'd rather be dead?"   |       | 0 1<br>0 1<br>0 1<br>0 1<br>0 1<br>0 1<br>0 1 |
| 2 History of diabetes   |        |             | <input type="text"/> <input type="text"/> 20                   | 5 Anamnesis Depression (cont.)   |       | <input type="text"/> <input type="text"/> 12  |
| <b>1 Symptoms</b> <ul style="list-style-type: none"> <li>Thirst, nausea, etc.</li> <li>Hypoglycemia, nocturia, etc.</li> </ul> <b>2 Start and course</b> <ul style="list-style-type: none"> <li>Diagnosis made when, by whom?</li> <li>Phases (condition, findings)</li> </ul> <b>3 Preliminary examinations</b> <ul style="list-style-type: none"> <li>Referrals (specialist)</li> <li>Briefings (current occasion)</li> </ul> <b>4 Pretreatments</b> <ul style="list-style-type: none"> <li>Therapy plans (nutrition, insulin, etc.)</li> <li>Therapy success (adherence, coping)</li> </ul> <b>5 Complete medical history</b> <ul style="list-style-type: none"> <li>Risk factors (CHD, cholesterol)</li> <li>Concurrent / secondary diseases (CHD, retinopathy, nephropathy, etc.)</li> </ul> |        |             | 0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4  | <b>1 Onset and course</b> <ul style="list-style-type: none"> <li>Beginning "When did this start?"</li> <li>Phases/episodes "What were the worst times?" "Were there times of improvement?"</li> </ul> <b>2 Subjective ideas</b> <ul style="list-style-type: none"> <li>Concepts "What do you imagine depression, etc. to be?"</li> <li>Explanations "Do you see causes yourself?"</li> </ul> <b>3 Findings and pretreatments</b> <ul style="list-style-type: none"> <li>Diagnoses with comorbidity "What have you been in treatment for (depression, anxiety, etc.)?"</li> <li>Therapies (medication, psychotherapy)</li> </ul>  |       | 0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4           |
| 3 Anamnesis depression  |        |             | <input type="text"/> <input type="text"/> 4                    | 6 Coordinate procedure   |       | <input type="text"/> <input type="text"/> 12  |
| <b>1 Introduction open</b><br>"How are you doing mentally?"<br><b>2 Suspected diagnosis: 2-question test</b> <ul style="list-style-type: none"> <li>Main symptom 1 "Have you felt mostly down, sad, or depressed in the last 14 days?"</li> <li>Main symptom 2 "In the past 14 days, have you mostly lost interest in things that usually bring you joy?"</li> </ul> <b>3 Follow-up question after affirmation</b> <ul style="list-style-type: none"> <li>Main symptom 3 "Did you feel mostly tired and exhausted during this time?"</li> </ul>   |        |             | 0 1<br>0 1<br>0 1<br>0 1                                       | <b>1 Clarify expectations</b> <ul style="list-style-type: none"> <li>Ideas, wishes, fears "What do you think might help?"</li> <li>Control beliefs "What can you change about your lifestyle (diet, exercise, etc.)?"</li> </ul> <b>2 Communicate information</b> <ul style="list-style-type: none"> <li>Info Need "Do you have any questions?"</li> <li>Diabetes sequelae/prevention</li> <li>Comorbidity: "During depressive episodes, you seem to be extremely neglectful of your self-care."</li> </ul> <b>3 Negotiate therapy plan (SDM)</b> <ul style="list-style-type: none"> <li>Adherence or change of therapy</li> <li>Psychotherapy or consult</li> <li>Topics/targets for follow-up appointments (rounds)</li> </ul> |       | 0 1 2 3 4<br>0 1 2 3 4<br>0 1 2 3 4           |
| 0 1 [0 = not met; 1 = met] 0 1 2 3 4 [0 = not met ... 4 = fully met]  |        |             |  |  |       |   |

## Box 30.1 Depressive experience

Depressive experience is a significant theme of human life, at any time and in any culture. However, the concept of depression has been subject to considerable changes throughout history (Böker 2011). As "melancholy" (black gall), a physically caused - and thus no more than a depressive state of mind sent to humans by the gods - was already described in ancient Greece in the Corpus Hippocraticum (Hippocrates, De morbis I, 30). The term "depression," however, did not find its way into medical terminology until the early 19th century. In this context, Kraepelin's paradigmatic description of "manic-depressive insanity" as a disorder of thought, mood, and will (Kraepelin 1899) led to the "triumphant advance" (Böker 2011) of the concept of depression, replacing melancholia after two and a half centuries. However, Kraepelin's concept that depression was only a partial manifestation of a manic-depressive illness entity was contradicted and finally the independence of unipolar and bipolar affective disorders was postulated (Wernicke 1900, Kleist 1953). Jaspers described a "deep sadness" and an "inhibition of all mental activity" as the core of depression (Jaspers 1913/1965). Until the introduction of the WHO classification system in the tenth edition (ICD-10, 1992), etiopathogenetic model concepts served as the basis for classifying depressive disorders, most recently into reactive, neurotic, and endogenous depression. Today, the strictly operationalized concept of depression is understood in a purely symptomatic-descriptive way.

## Box 30.1 Depressive experience

Depressive states begin in such a way that things that mean a lot to one are withdrawn from feeling; one feels inwardly weak [and] unstable. One looks for some kind of support in people, things, activities. If the feeling rises again at such an anchor, the future becomes easier, one perhaps forgets oneself again completely. But perhaps there always remains a fear somewhere that the feeling will slip away again, so one does not really trust one's feeling and thus also the future.

Binswanger 1960

Box 30.2 Classification according to different characteristics

Severity

- mild
- moderate
- severe
- additional: psychotic symptoms or somatic syndrome

Course

- monophasic
- recurrent
- chronic
- bipolar

Comorbidity

- comorbid mental disorder
- comorbid physical illness

Box 30.3 Depressive Episode (symptoms)

Essential features

- Depressed mood
- Anhedonia
- Reduced energy, fatigue<sup>1</sup>

Additional features

- Low self-worth<sup>2</sup>
- Guilt<sup>2</sup>
- Hopelessness<sup>3</sup>
- Suicidality
- Disrupted sleep
- Change in appetite/weight
- Reduced ability to concentrate
- Psychomotor agitation or retardation

<sup>1</sup> Main and secondary criteria according to ICD-10

<sup>2</sup> Secondary criterion in ICD-11

<sup>3</sup> Summarized criterion in ICD-11.

<sup>4</sup> New criterion in ICD-11

Box 30.4 Communication in the acute phase

- Availability and empathic presence
- Active and supportive attitude
- Relief and reassurance
- Recognition of suffering
- Raise hope and confidence
- Psychoeducation (if necessary with reference person)
- Create treatment plan
- Address and clarify suicidality

Box 30.5 Communication in the post-acute phase

- Active, approachable and interested attitude
- Perception and differentiation of feelings
- Communication and expression of feelings
- Explore triggering situations
- Identify and handle conflicts
- Identify and work on coping strategies
- Strengthen self-worth
- Promote self-care
- Relief from feelings of guilt and shame
- Edit negative beliefs
- Reflect on the design of the doctor-patient relationship

Box 30.6 Management of suicidality

- "Have you ever felt that life was not worth living?"
- "Frequently?"
- "Could you rate the intensity (scale from 0 to 10)?"
- "Do you have a plan of how you would do it?"
- "Have you made any specific preparations?"
- "Is there anything that's holding you back?"
- "Have you ever attempted suicide?"

## 40 Problems and Methods of Evaluation

### Box 40.1 The "Black Box": Questions and Problems of Evaluation

Although the normative orientation towards theories and models is reflected in the didactic mediation up to the conversation manuals with anchor examples, nevertheless no uniform results can be expected on the level of changing concrete conversation behavior. Obviously, learners can benefit differently from education and training measures, especially since they already start at different learning levels (§ 40.3). In a paper on this topic, Thistlethwaite (2016) first places five C-terms at the center of her consideration of evaluation (*Collaboration, Cooperation, Communication, Contact, Competencies*) and then describes the complex learning process as a "black box" (Box 40.1) in which seemingly comparable *inputs* can result in different *outputs*.

### Box 40.1 The "Black Box": Questions and Problems of Evaluation

Evaluation of outcomes presupposes that there is a linear causality between input and output. However, the space between input and output has been referred to as the "black box" [Astbury, Leeuw 2010] and it is seldom apparent from quantitative approaches what is going on inside that box. Why do some students develop skills in teamwork and others not, when the intervention has been the same? How do educators ensure that students achieve the same defined learning outcomes from clinical programmes, which offer different experiences depending on location, preceptor, length, timing, and access to patients? Moreover, the complexity of health professional education initiatives is such that they are rarely binary: neither "effective" or "ineffective," and students are rarely "competent" or "not competent" to perform complex tasks, even if we can describe what competence looks like.

Thistlethwaite 2016: 8

Central here is the question posed by Thistlethwaite of how it can be 'ensured' that learners 'achieve the same defined learning outcomes.' It may not always be possible to convey and achieve all learning objectives equally; rather, as in other learning contexts, a differentiation of learning objectives must be assumed within a process in which individual learners begin at different levels and finish with different outcomes (§ 40.3). Furthermore, evaluation must take into account varying degrees of difficulty (...)

Fig. 40.1 Framework model for the Cologne Medical Communication Training (C-MCT)

Although the complex problems of a black box described by Thislethwaite in 2016 are not easy to solve, it is possible to distinguish between different levels of learning at which specific problems in the evaluation of learning processes can be differentiated. An initial orientation is provided by Kirkpatrick's general framework model (1976/1998), which has undergone diverse further development and application in medicine (St. Pierre et al. 2004, Yule et al. 2016, Parker et al. 2018, Aldriwesch et al. 2022, Alsabri et al. 2022). According to Kirkpatrick's learning and evaluation model, four levels can be distinguished (Fig. 40.1), which are already provided with specific medical learning content and learning objectives below.

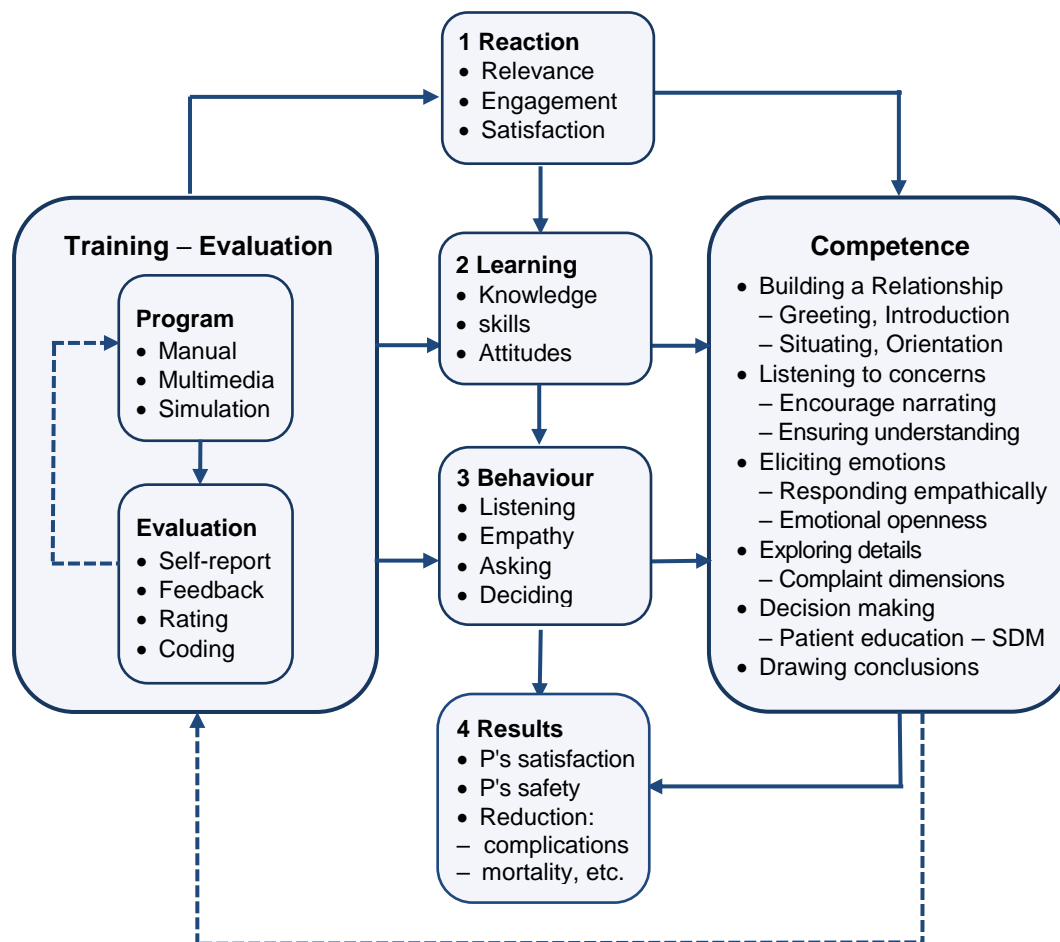


Fig. 40.1: Framework model for the Cologne Medical Communication Training (C-MCT) (cf. § 13)

Box 40.2 The "Hamlet" Drama as a mere description in numbers

The meaning and purpose of doctor-patient conversations remains underexposed, especially when the method of choice is reduced to certain *frequency analyses* according to formal categories that inadequately capture the essential actions and themes, motives and intentions of the actors. In an analogy to common category systems, Inui, Carter (1985/2013) countered the reductionist character by drawing a comparison with a "Hamlet" description (Box 40.2), in which the play is captured exclusively on the basis of formal categories that would miss the meaning and purpose of the drama.

Box 40.2 The "Hamlet" Drama as a mere description in numbers

To date, the most commonly applied analytic strategy has been to develop communicator profiles based on frequencies of behaviors of various types. This approach is analogous to describing "Hamlet" as a play with 21 principal characters, ghost, a group of players, and various numbers of lords, ladies, officers, soldiers, sailors, messengers, and attendants - one of whom is already dead, one of whom dies by drowning, one by poisoned drink, two by poisoned sword, and one by sword and drink!

Inui, Carter 2013: 116

Just as one could not do justice to a Hamlet review in this interpretation-poor way if only the actors were listed according to their rank and gender as well as their modes of death, so meager would remain in doctor-patient communication a pure frequency analysis according to formal categories, which could only insufficiently capture which topics and interests, emotions and motives, decisions and intentions the interlocutors pursue or also avert.

Just as in Shakespeare's drama the changing perspectives of the actors in the dialogue across scenes and acts are to be reconstructed as dramatic developments of conflicts, the conversational sequences and developmental phases in doctor-patient conversations must also be analyzed, which are determined by misunderstandings and understandings, acts of conflict and consensus, but also by the emotions and the atmosphere between the interlocutors.

Box 40.5 Conversation evaluation *ex negativo*

Without already assuming a specific system here, the following list of examples (Box 40.5) is intended to illustrate, at best, the spectrum of evaluative premises that can be inferred *ex negativo*: Those who, in quantitative or qualitative analyses of doctor-patient conversations, wish to "lament" or even merely "note" the deficits of a particular type of (non)-verbal intervention (e.g. "Overall (too) few listener signals/empathetic feedback") or seek to demonstrate physician competence advances in comparative pre-post design of intervention studies (e.g., "Significantly fewer interruptions/multiple questions"), already set more or less (critical) *evaluative* premises (Box 40.5) that apparently follow a theory of "good" conversation.

Box 40.5 Conversation evaluation *ex negativo*

A theory of "good" conversation is already expressed *ex negativo* when we *critically judge* individual (or many) conversations in each case when we look at them more closely:

- The doctor hardly let the patient get a word in
- The doctor interrupted the patient (too) often
- The physician asked (too) many (suggestive) informational questions
- Both interlocutors have talked past each other (too often)
- They did not speak the same language
- No common thread has been developed
- The physician did not/barely inquire about the patient's subjective theory of illness
- The physician has (deliberately) ignored (warded off) all (essential) emotional cues of his patient
- The physician gave (too) little empathic feedback
- The patient's concern remained unclear
- Likewise, the patient's expectations that might be associated with the concern, his hopes, fears, preferences, etc., remained unresolved
- The physician did not know anything/very little about her patient's pre-existing conditions/pre treatments
- The conversation ended without any discernible perspective for further action
- Overall, the discussion atmosphere was (rather) frosty
- etc.

## Box 40.6 "... it all depends"

The art of conducting a medical interview (§ 17) consists not only in asking questions of a certain type at all (§ 21), but also in acting on the basis of *form*, *content*, *function* and *placement* in the interview with this individual patient with an extensive *fit* (§ 2, 3, 17). The problem of fit is also taken into account by a "basic evaluative vocabulary", which was previously identified as constitutive for conversation analysis (§ 2.5). This basic vocabulary must obviously also be used in quantitative analyses, as Skelton, Hobbs (1999) (Box 40.6) make clear, before they use the example of eye contact to refer to the contextual conditions under which a certain behavior may or may not be meaningful.

## Box 40.6 "... it all depends"

The difficulties of quantitative studies are best illustrated by the frequency with which behavioral marking schedules introduce solely subjective terms, such as: "Performs the history taking and the review of symptoms properly" or "Gives appropriate advice". This shortcoming might matter less if the measurable behaviors generated were not so easily rote-learned and performed - a machine can be programmed to "greet the patient". Quantitative studies also beg the question of how much of each criterion is desirable: is a lot of eye contact better than a little? The answer can only be: it all depends.

Skelton, Hobbs 1999: 108

In addition to the *qualitative* aspect of fit, which is captured by modifications ("properly", "appropriately"), there is obviously another *quantitative* aspect to consider, which can be formulated loosely on the motto: "A lot does not always help a lot". According to Eibl-Eibesfeldt and Hass (1994), if a physician maintains uninterrupted eye contact, this can be experienced as aggressive staring (§ 18.5). Avoiding eye contact during the entire greeting scene, however, is more likely to be experienced as a disturbance in establishing a relationship, in which the patient may not feel sufficiently appreciated as a newcomer.

Fig. 40.2 Dialog role structure for conversations A-C (explanations in text)

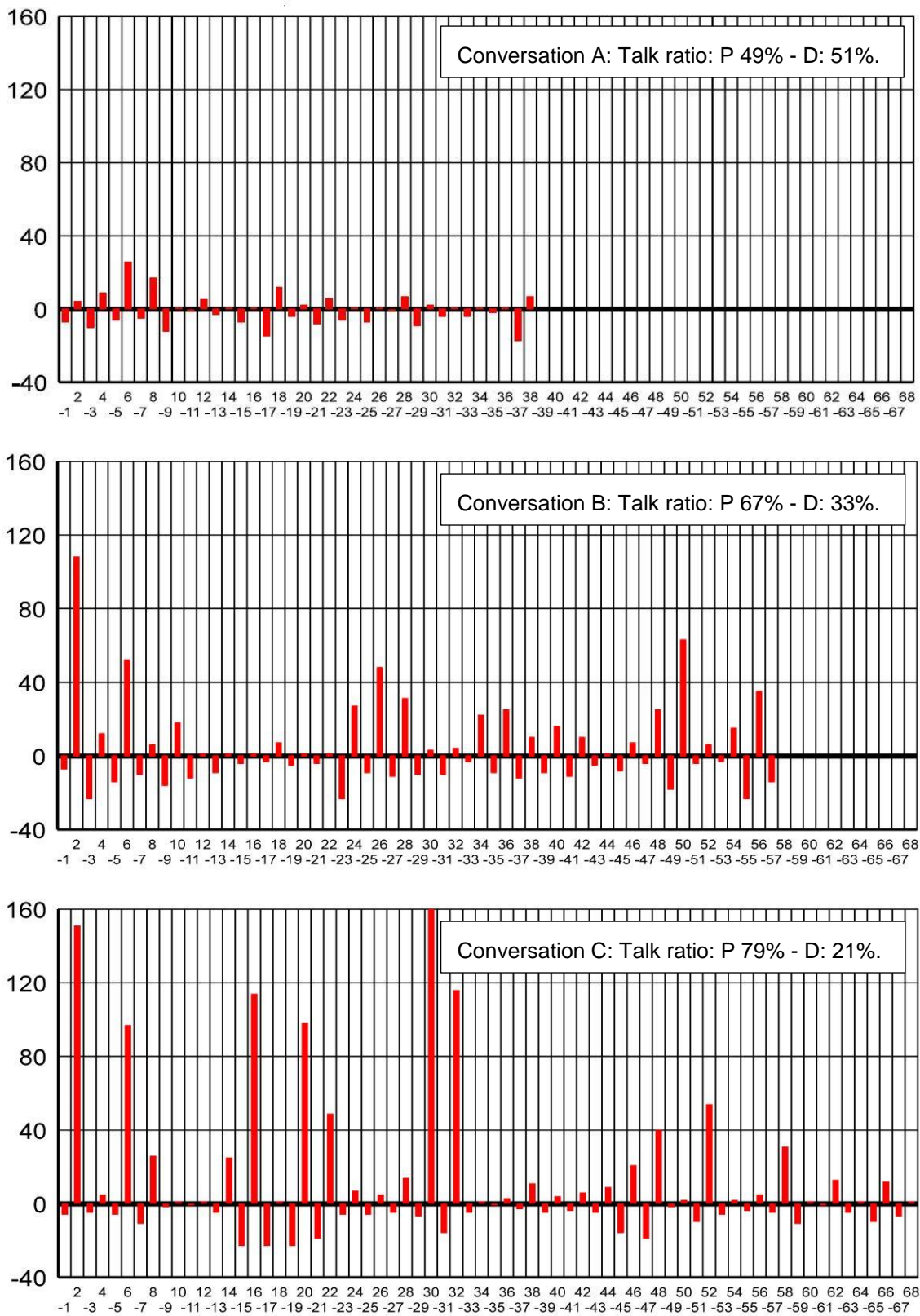
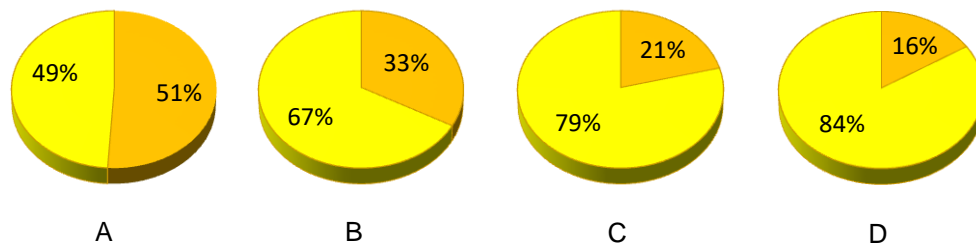


Fig. 40.4 Speech proportions of doctor and patient for conversations A - D

From an evaluation point of view, participation is relevant not only for the (discussion phase of) *decision-making*, as this has been explained in detail theoretically and examined on the basis of empirical practical examples (§ 10, 22, 26), but also for the entire course of the discussion, in which patients should be able to have their say in a sufficiently narrative manner, clarify their need for information by asking questions, or adequately express their preferences regarding alternative forms of treatment. In the participation analysis, the results of the dialogue, interaction and content analysis can already be integrated. On the basis of the share of speech in the overall conversation alone, the differences between the conversation (A), in which the two partners participate approximately in half, and the conversations (B) and (C) become clear (Fig. 40.4: A-D), in which the respective physicians withdraw to a share of speech of 33% and 21%, respectively, while another comparative conversation (D), to which we will return later, shows the extreme possibilities in the direction of a *non-directive* conduct of the conversation with a physician's share of speech of only 16%.

Fig. 40.4: Speech proportions of doctor ■ and patient ■ for conversations A - D

In further interaction analyses, it is then necessary to examine how the two interlocutors use their respective parts of speech, for example, in that the patient narrates and the physician actively listens and gives empathic feedback, or both partners mutually ask questions and give answers, or in negotiation processes register or dispel doubts or objections to treatment options, and so on. Accordingly, in combination with detailed interaction and content analyses, it can be reconstructed which of the two interlocutors has taken a topic initiative and how often, to which the other has responded by responding or by ignoring it with an abrupt change of topic, i.e., has upgraded or downgraded the relevance of topics in the ongoing interaction (§ 17, 19-22).

Fig. 40.5 Ideal distribution of speaking rights for conversation phases

By no means can such an emphatically schematic representation (Fig. 40.5) meet the requirements of flexible discussion in individual cases. Here, an individual discussion dynamic is developed in each case, which leads to its own setting of priorities (§ 17.3). Far from wanting to define the speaking privilege for individual patients in individual conversational situations in "numbers", however, certain "gold standards" can be formulated at least for the distribution of speaking privileges according to conversational *phases* with certain conversational functions in order to mark a *differentia specifica*.

| %  |         | 1<br>Relationship | 2<br>Concern | 3<br>Emotions | 4<br>Details | 5a<br>Education | 5b<br>Decide | 6<br>Summary |
|----|---------|-------------------|--------------|---------------|--------------|-----------------|--------------|--------------|
| 80 | Patient |                   |              |               |              |                 |              |              |
| 70 |         |                   |              |               |              |                 |              |              |
| 60 |         |                   |              |               |              |                 |              |              |
| 50 |         |                   |              |               |              |                 |              |              |
| 40 |         |                   |              |               |              |                 |              |              |
| 30 |         |                   |              |               |              |                 |              |              |
| 20 |         |                   |              |               |              |                 |              |              |
| 10 |         |                   |              |               |              |                 |              |              |
| 10 | Doctor  |                   |              |               |              |                 |              |              |
| 20 |         |                   |              |               |              |                 |              |              |
| 30 |         |                   |              |               |              |                 |              |              |
| 40 |         |                   |              |               |              |                 |              |              |
| 50 |         |                   |              |               |              |                 |              |              |
| 60 |         |                   |              |               |              |                 |              |              |
| 70 |         |                   |              |               |              |                 |              |              |
| 80 |         |                   |              |               |              |                 |              |              |

Fig. 40.5: Ideal distribution of speaking rights for conversation phases  
(cf. Cologne Manual of Medical Communication (C-MMC), steps 1-6) (cf. Fig. 13.11)

All in all, in an ideal-typical course of conversation following the establishment of the relationship (1), patients should have more say, especially in the initial phases (2-3) of taking the medical history, which they can choose freely and use, for example, for longer narratives, before the physician, for his part, must claim more space for detailed exploration (4) as well as, if necessary, for patient education (5a) ...

Fig. 40.6 Assessment of physician-patient conversations by lay raters

In a first analysis procedure, an easy-to-use lay rating was performed, in which fifteen students of non-medical and non-psychological subjects were asked as patient-comparable laypersons (via "role taking") to rate the conversations in a random-rotation presentation format (15-item rating, 6-level scaling), leading to the following results (Fig. 40.6): Lay raters rated physician behavior or relationship quality more favorably on average for all 15 items in the *post-conversations*, and this change from the 1st to the 2nd measurement time point was significant for 5 items ( $p < 0.01$ , Fig. 40.6), in each case in the intended direction: the patient's *feeling of well-being* (1) increased significantly, while the physician's *impersonality and aloofness* (2) and *impatience under time pressure* (4) decreased just as significantly as the patient's *feeling of being left alone* (7) and *insecurity* (9).

|    | Lay rating   |   |
|----|--|---|
| 1  | The patient feels comfortable in the conversation                    | ↑ |
| 2  | The patient experiences the doctor as impersonal and distant         | ↓ |
| 3  | The patient feels taken seriously by the doctor                      |   |
| 4  | The patient experiences the doctor as impatient, under time pressure | ↓ |
| 5  | The patient experiences the doctor as engaged                        |   |
| 6  | The patient has trust in the doctor                                  |   |
| 7  | The patient feels left alone with his problems                       | ↓ |
| 8  | The patient perceives the doctor as a partner                        |   |
| 9  | The patient feels insecure and anxious when talking to the doctor    | ↓ |
| 10 | The patient experiences the conversation as helpful and supportive   |   |
| 11 | The patient feels sympathy for the doctor                            |   |
| 12 | The patient feels the doctor is interested in his problems           |   |
| 13 | The patient is satisfied with the conversation                       |   |
| 14 | The patient feels that the doctor is sympathetic to him or her       |   |
| 15 | The patient has a good relationship to the doctor                    |   |

Fig. 40.6: Assessment of physician-patient conversations by lay raters. Significant changes → pre/post  $p < 0.01$ . (Köhle et al. 2001: 303)

Fig. 40.7 Learning pyramid by Miller (1990) and modified pillar model

In his widely used model of the learning pyramid, Miller (1990) depicted knowledge as the basis of learning, which is layered in two stages (*knowledge* and *competence*) before action-related learning and assessment processes (*performance* and *action*) build on it (Fig. 40.7). As suggested by the image of the pyramid, the knowledge base of the first two levels is correspondingly broad, while the further learning processes taper in the representation through the level of *performance* to the top of *action*, in which the professional action practice is represented, which is performed in forms of both anamnesis taking and physical examination.

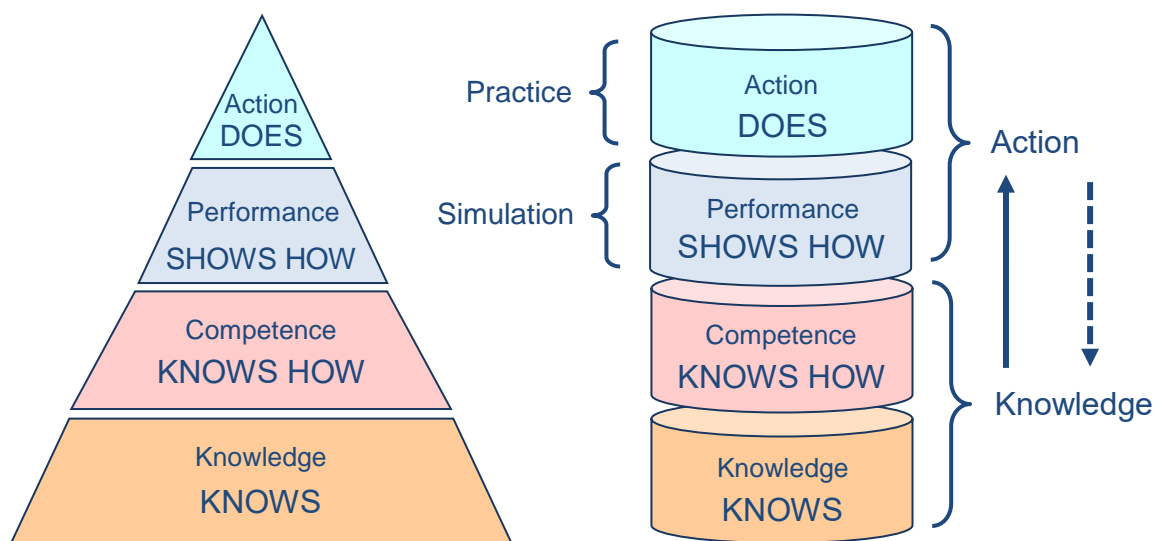


Fig. 40.7: Learning pyramid by Miller (1990) and modified pillar model

According to the image of the pyramid, the learning processes are apparently so strongly knowledge-based that they appear to be knowledge-heavy from the outset, especially if, according to the logic and hierarchy of the conceptual distinctions (*Knowledge*, *Competence*, *Performance*, *Action*), only *unidirectional* learning processes (from the bottom to the top) are assumed, which apparently do not permit any feedback between action and knowledge.

Although this asymmetry between knowledge and action should not be reversed by turning the pyramid upside down with knowledge at the top, it should be eliminated in a pillar model (Fig. 40.7). Such a pillar model can also take into account the context that knowledge is not always acquired *before* action, but also *during* and *through* action, which, as is well known, one tries to capture with the concept of *experiential knowledge* ...

Table 40.2 Learning levels

In individual self-learning as well as in group learning, different learning types, learning levels and learning curves are to be expected. In learning practice, there are numerous variants of learning progressions for individuals and in learning groups, which are to be described here in an "ideal-typical" way. However, it should be noted at the *outset* that certain (types of) learning successes can only ever occur as a function of the learning level as the *starting level*, whereby distinctions can be made across a broad spectrum from *novices* to *advanced learners* to *experts* (Park 2015) (Table 40.2), who are characterized precisely by *increasing experience*.

|   | Learning Level    | Knowledge or ability   |
|---|-------------------|--|
| 1 | Absolute Beginner | I know almost nothing  |
| 2 | Beginner          | I can do it, relying on rules  |
| 3 | Advanced Beginner | I can do it, relying on rules while recognizing elements of situations         |
| 4 | Competent         | I can do it by a set plan with an organized approach to a problem or situation |
| 5 | Proficient        | I can do it based on similar experiences                                       |
| 6 | Expert            | I can do it by intuition based on sufficient experience                        |

Table 40.2: Learning levels (mod. from Park 2015)

However, when differentiating between learning levels, it must be taken into account what is to be the *object of learning* ("it") in which learning situations and which "rules", "plans" and "experiences" can play which role in which learning contexts. According to this, in medical practice as a whole, but also in specific *communicative* practice, different "learning contents" are to be assumed, which are reflected in learning objectives with different *degrees of difficulty*.

Thus, the *rules* for a "proper" greeting (§ 18) or for an "open" opening of the conversation (§ 19) can be learned considerably "easier" and "faster" than for the *precisely fitting* change from a *confrontational* to a *tangential* conduct of the conversation ...

Fig. 40.8 Variants (A-C) of learning curves

Before the intended learning success is achieved, more or less pronounced initial difficulties with a more or less pronounced familiarization phase must be expected. The cognitive and behavioral adjustment and conversion is not always successful right away, and two variants can be distinguished (Fig. 40.8).

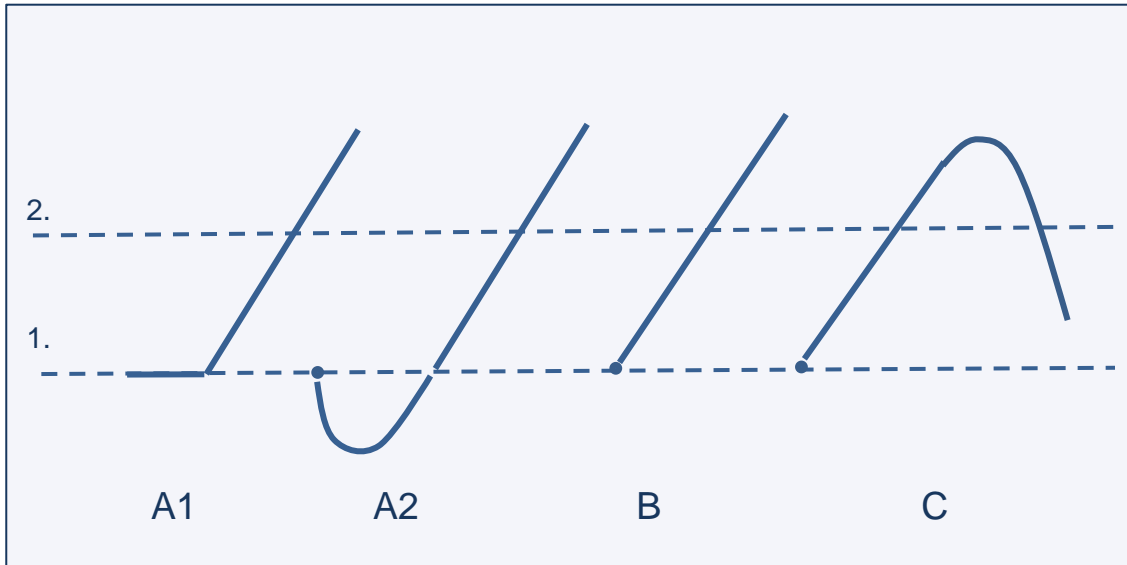


Fig. 40.8: Variants (A-C) of learning curves

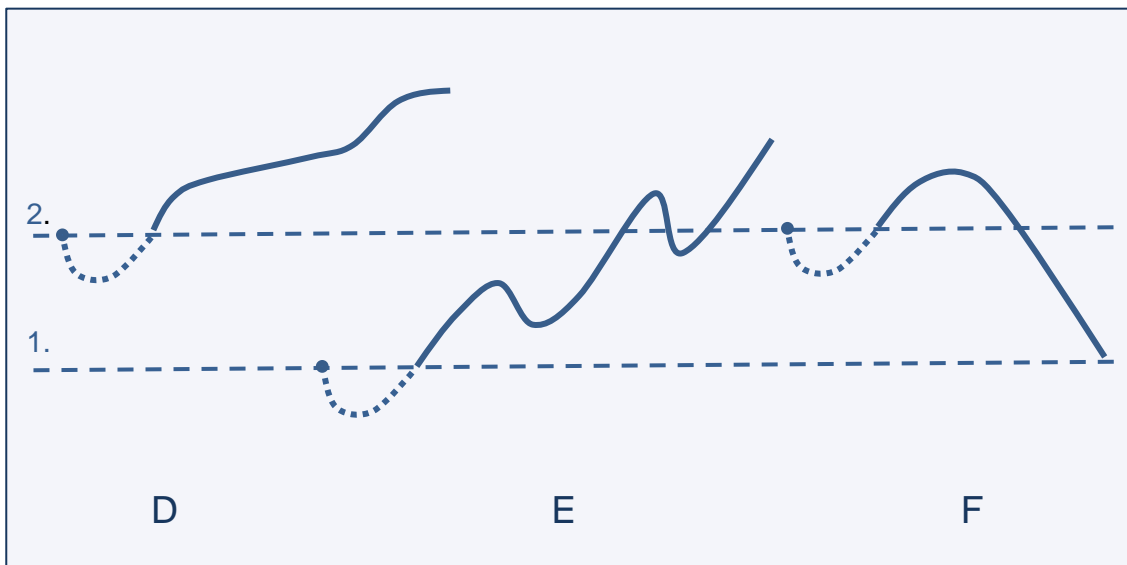


Fig. 40.9: Variants (D-F) of learning curves

Fig. 40.10 The observer paradox in learning and examination situations

In the examination situation the *observer paradox* already described comes to the fore, as it is a general methodological problem not only in social and linguistic research, which has to be considered in data collection and analysis. The dilemma is that one not only "misses" the intended object, but "distorts" it, because the behavior in question, which is the object of cognitive interest, changes under observation ...

The examination situation is now in a special way a control situation, in which the examination candidates are under an acknowledged *ensorious* observation, in which they are finally to "prove" their *knowledge* and *ability* (§ 40.3.1). If we disregard pure knowledge examinations (e.g. in multiple-choice format), medical examinations "on patients", regardless of whether they involve *real* or *simulated* patients (SP) (Fig. 40.10), must "demonstrate" something (*shows how*), which is possibly intended to meet the expectations of several observers at once.

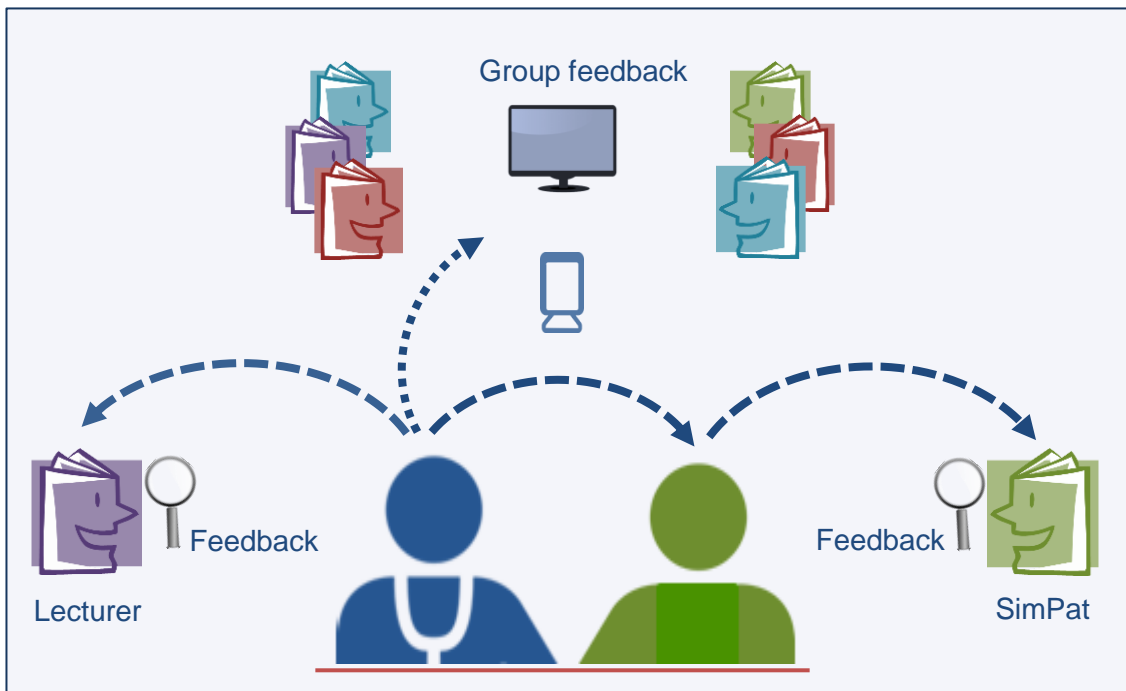


Fig. 40.10: The observer paradox in learning and examination situations

In examinations in particular, it can usually be assumed that the candidates definitely want to "give their best" from the perspective of their participation - whatever they think that means. Whether they succeed in doing so depends not least on their individual handling of the specifically *ensorial* observation, in which the observer paradox may well manifest itself in different forms ...

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