1 Clinical Communication Education

Introduction and Overview

Armin Koerfer, Christian Albus

1.1	The communicative approach to the patient	2
1.2	Reform of communication education	5
1.2.1	Structural deficits	
1.2.2	Integrative reform approach	
1.3	General and individual learning objectives	10
1.3.1	Development of self-reflexive competence	
1.3.2	Targeted learning through critical self-observation	
1.3.3	General learning objectives and individual feedback	
1.3.4	Solidarity-based group learning	
1.4	Structure and function of the handbook	21
1.4.1	Flexible and structured learning opportunities	
1.4.2	External and self-evaluation	
1.4.3	Application perspective	
1.5	Further information	25
1.6	Cologne Manual & Evaluation of Medical Communication	26
	References	26

> Indeed, in my view, the interview is the most powerful, encompassing, sensitive and versatile instrument available to the physician (…)
>
> George L. Engel (1988: 115)

Abstract: By way of introduction, the topic of learning to conduct medical consultations will be presented in a problem-oriented manner and information will be provided on the objectives and structure of the handbook and its possible uses. What is to be explained further in the course of the handbook will be briefly outlined in this overview: Firstly

(§ 1.1), the importance of the communicative approach to the patient is emphasised with George Engel, with whom the necessity and direction of clinical communication training can be justified (§ 1.2). In this communication training, general learning goals for the promotion of a communicative competence are to be pursued, which can initially be taught on a cognitive level in the form of a conversation manual. In order to overcome the discrepancy between knowledge and skills in conversational practice, a self-reflective competence must first be developed, with which the unconscious deficits of routine behaviour must be recorded, before individual learning objectives can be pursued, which, with individual feedback, should aim at tailor-made communication with individual patients. Critical self-observations and observations by others, which are carried out within the framework of solidarity-based group learning, serve to control and correct conversational behaviour (§1.3).

The possibilities for using the handbook can either be freely chosen on the basis of interest or can be used chapter by chapter in accordance with the learning structures designed and the focal points set according to theory, didactics, practice and evaluation (§ 1.4).

Following further information, which should encourage further reading (§ 1.5), the *Cologne Manual on Medical Communication* (C-MMC) (in the variant as an evaluation instrument = C-EMC) is cited (§ 1.6), which will later serve as the basis for the didactics and analyses in the practical part (IV). Overall, the handbook should be understood as a learning offer that can be used both in group lessons and in individual self-learning to promote and test communicative competence.

1.1 The communicative approach to the patient

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.

Emergency situations in which doctors have to limit themselves to non-verbal action because the patient is “unresponsive” are the exception. As a rule, hypotheses and tentative diagnoses must first of all be obtained through *conversation* with the patient and then tested by physical or laboratory examination, the results of which are in turn incorporated into the conversation with the patient, etc. 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 specific (sub-)functions that the doctor has to perform in dialogue with the patient. With this, we have gained a first set of guiding *ideas* both of the conduct of dialogue itself and of its research, which we want to bring here first, as closely as possible, to Engels' formulation in an overall paraphrase "to the concept" (Box 1.2), which seeks to divide the original text analytically into meaningful components. The numbering is only intended to facilitate orientation and later reference.

Box 1.2 Main and sub-functions of the dialogue

According to George Engel (1988: 121) (see above), the doctor's dialogue with the patient as a whole (1) and in detail (2-5) serves as a

1. *Basis of scientific work* in medicine
2. Integral component of the process whereby the clinician *gains knowledge* of the patient's condition (= state of health, complaints)
3. Means of cognition vis-à-vis the patients' inner experiences that had led them (= *reasons for consultation*).
    a. to consider themselves ill (= experiencing illness)
    b. to get medical help (= need for help)
4. *Reconstruction* (with the patient = co-operation) of a plausible sequence of events (= anamnesis)
5. *Development of hypotheses* (= diagnosis), which in turn are to be further explored through dialogue and other means (= physical examination, laboratory, etc.).

Analytical overall paraphrase of Box 1.1

With this overall paraphrase of the dialogue functions according to Engel, we have first formulated guidelines for the (study of) medical dialogue, which we will take up again and again later and differentiate (esp. § 3, 4, 7-10, 17-23). Before we return to the details of the functional definitions, also with empirical examples, with which the *specific* functions (2)-(5) mentioned by Engel are to be substantiated, attention should first be drawn here to the *relevance of the dialogue* in general, which is usually the starting point and very first source of data not only for taking the medical history, but also for further diagnostic and therapeutic steps. These next steps, in turn, can only be explored by the doctor and patient through *dialogue,* because they can only be taken by mutual agreement after a *dialogue-based* decision-making process (§ 10). Here, the complex interplay of *communicative* and *instrumental* action (examination, medication, etc.) will have to be reconstructed in joint interaction stories between doctor and patient (§ 8), who meet from different participant perspectives but essentially as equal *dialogue partners* (§ 7).

Here, too, the *understanding of the roles* of patient and doctor will have to be reconsidered with a fundamental distinction by Engel (1997), who must meet the patient not only through *observation* ("outer view-

ing"), but above all through *introspection* ("inner viewing") and *dialogue* ("interviewing") in order to be able to do justice to the patient's *active* participatory role (§ 9.2). In order to grasp the patient's state of mind, need for help, concerns and further interest in his or her recovery, the *communicative* approach must at the same time prove to be an *empathetic* approach to the patient (esp. § 3, 7, 9, 17, 20). The patient must feel sufficiently *understood* and *respected* as a sick person in order to be able to open up to the doctor in further conversations in a *trusting manner.* At the beginning and end of this circular process of mutual understanding there is always dialogue, in which the patient should have the "first" and "last word", in order to finally place the jointly "agreed" therapeutic action on a sustainable basis.

As will be explained in detail from the perspective of interdisciplinary conversation research, the *communicative turn* in medicine coincides with its *participatory turn* (§ 2). In the dialogue with the patients, they should not only be granted more *formal* rights to speak, which could be reflected in a larger share of the conversation with more total conversation time, but at the same time their chances of participation in the entire diagnosis and therapy process should be strengthened *functionally* and in terms of *content.* Such an objective, however, requires special *competences* in medical communication, which do not come about automatically in the later, everyday practice of care, but often have to be laboriously developed, changed or expanded in training and continuing education (§ 13-16).

1.2 Reform of communication education

Because of the outstanding importance of dialogue in medicine, it should be self-evident that medical competence in *communicative* action with the patient is trained just as effectively as it has always been standard in the *instrumental* action of the doctor (measuring blood pressure, surgical intervention). However, this objective of quality assurance in communicative action has by no means been fulfilled yet.

The resistance to a fundamental reform is not least related to the *biomedical* self-image, which, according to Engel (Box 1.3), continues accordingly in medical teaching, if the teaching and supervision of the interview as an original method of data collection in medicine is neglected.

Box 1.3 Rejection of dialogue in medicine

Biomedicine's rejection of dialogue as a genuine scientific means of data collection is evident in the neglect of instruction and supervision in interviewing, not to mention in clinical data collection altogether, and in the preference for the case presentations as a method for clinical teaching, one in which students may display their ability to organize and discuss findings, but not reveal the methods and skills whereby they had come by the first place, least of all their interpersonal engagement with the patient.

Engel 1988: 122

There is no doubt that the paradigm shift from biomedicine to *biopsychosocial* medicine, which Engel co-founded and which will be discussed in more detail (§ 4), has at the same time triggered a reform process that has continued to develop, first in Anglo-American countries and later also in German-speaking countries. However, a "reform backlog" has occurred in Germany as well as in Anglo-American countries, in which the "rejection of dialogue" described by Engel can by no means be considered overcome in view of the traditional updating of medical training and care practice.

1.2.1 Structural deficits

Before we return to these developments over several decades in detail (§ 2-3, 14-16), let us draw an interim balance (Box 1.4) with Levinson and Pizzo (2011), according to which progress in the practice of doctor-patient communication has lagged far behind our state of knowledge:

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

This question is complex and not easy to answer because historical, scientific, health policy, economic, social, etc. factors interact here (§ 5). Of the many multi-layered reasons for a "reform backlog" in the practice of doctor-patient communication, two "explanations" given by Levinson and Pizzo themselves are given here in abbreviated form (Box 1.5):

Box 1.5 Two times the time factor: conversation time and training time

First, effective communication with patients takes time. "Active listening", a core skill in effective communication, requires that physicians listen deeply to patients telling the stories of their illness and how it has affected them. Even though some specific communication skills can improve efficiency, ultimately listening to patients requires time (...) Second, medical schools and residency programs provide relatively little education about effective communication skills compared with the educational time devoted to teaching science and technology.

Levinson, Pizzo 2011: 1802

While only citing quantitative arguments (“time shortage”) to explain the “reform backlog” certainly does not show the whole picture, it nevertheless makes clear what is meant, namely a wrong weighting of resources: (1) first in medical education and training, where obviously other priorities are set, as already criticised above with Engel (Box 1.3); and (2) later in everyday health care practice, where the conversation comes up short because it apparently costs too much time.

In this context, the duration of conversations plays a subordinate role, as Levinson and Pizzo (2011) already suggest. As is still to be shown under the aspect of evaluation, the conversations with patients, even if they are to "have their say" (§ 9), do not have to be significantly longer overall, but above all more effective (Köhle et al. 1995, 2001, Koerfer et al. 2004, Lussier, Richard 2006, Rothberg et al. 2012). However, the problem of the (necessary) duration of conversations will continue to occupy us, just as the "long debate" between doctor and patient was already an ongoing issue in Balint's time (1964/88).

The relative imbalances in medical conversation training and medical care practice rightly lamented by Levinson and Pizzo (2011) not only affect Anglo-American countries, but have by no means been overcome in this country either. Although the trend reversal "from silent to talking medicine" postulated early on by Lüth (1986), for example, has increasingly found expression at medical faculties in Germany, the deficiencies

in training and further education are still obvious. Compared to the clinical requirements for communicative competence, as we will elaborate in detail below (esp. § 3, 5, 6), the training has proven to be *deficient* in several respects (Box. 1.6).

Box 1.6	Structural deficits in communication education

Despite all improvements and reform efforts (§ 13-16), medical interviewing in medical training is usually (still)

- too late,
- too rare,
- too impractical,
- taught,
- practised and
- evaluated

With these critical aspects in mind, we at our Department of Psychosomatics and Psychotherapy at the University of Cologne have endeavoured to adopt an integrative, practice-based approach to reform, which, using real and simulated patients, ranges from first-semester tutorials in preclinical studies to anamnesis courses, video conferences and block internships in the clinic, to the practical year („Praktisches Jahr“ = PJ) and continuing medical education (§ 13-16).

1.2.2 Integrative reform approach

Following current reforms in medical training, we have developed a teaching, practice and examination programme with the following didactic-methodical concepts (Box 1.7), which are taken into account as far as possible in all courses at our clinic, which are essential components of the *Cologne Curriculum for Communication* (CCC) (§ 14).

Box 1.7	Didactic-methodical concepts

Medical communication training at our clinic is characterised by the following didactic-methodical concepts, which are part of an integrative curriculum (§ 13, 14); communication training is

- *theory-based* (disease theory, communication theory)
- *competence-based* (skills, abilities, attitudes)

- *problem-oriented* (interrogation vs. narration, time factor?)
- *manual-based* ("Manual on Medical Communication", C-MMC)
- *case- and practice-based* ("clinically based")
- *transcript-based* ("transcription" of conversations)
- *multimedia* (image, sound, text, graphics, etc.)
- *training-oriented* (with real and simulated patients)
- *group- and self-learning-oriented* (homework etc.)
- *self-reflective and self-evaluative* (role play, evaluation)
- *examination-oriented* (simulation, evaluation, OSCE, C-EMC)

These teaching, practice and examination concepts, which still need to be explained in detail (§ 3, 13-14, 17-23), are to be applied in an integrated way in this online handbook.[1] We can draw on many years of experience in the implementation of a teaching and examination programme on medical *communication* at our department (Köhle et al. 2003, Koerfer, Albus 2018, Koerfer et al. 1996, 1999, 2004, 2005, 2008), which has been networked in an integrative *Cologne Curriculum Communication* (CCC), especially with other psychosocial disciplines at the medical faculty in Cologne, and tested in many variants (§ 13, 14).

In this context, teaching as a whole was able to benefit from the research focus on doctor-patient communication established at our clinic, the results of which were repeatedly tested in practice in the sense of critical accompanying and evaluation research. These experiences in research and teaching on doctor-patient communication are to be taken into account in this online handbook with its focus on theory, didactics, empirics and evaluation in an integrative and interdisciplinary overall concept.

1 This integrative application is a major advantage of this online handbook, which overall seeks to combine theory, didactics, empiricism and evaluation. It should be noted at this point that there are now a number of good older and newer handbooks, both from the English and German-speaking world to which we will refer in relevant contexts (see also bibliography of the handbook and below (§ 1.5) for further references).

1.3 General and individual learning objectives

Since imparting knowledge does not immediately lead to a change in routine behaviour, which seems to have proven itself so far because of the routine, considerable resistance to learning processes is to be expected. Established *question-answer patterns* often prove to be resistant to the alternative of letting the patient *speak* on his or her *own initiative* and *actively listening* to him or her. Although the general learning objectives of medical conversation, as they are to be formulated theoretically and practically (§ 3, 13, 14, 17-23), can be conveyed relatively quickly on a cognitive level, they can often only be achieved with delay in practice. In order to overcome the discrepancy between *knowledge* and *skills,* circular learning processes must be organised, which alternate between *theory*, *reflection*, *training* and *evaluation* and are linked to individual learning levels (§ 13). The general objective is first of all the gradual development of a *self-reflection competence* of the learners (§ 3, 13, 17), with which they can also critically "scrutinise" their conversation practice in the future in self-observation and, if necessary, correct it independently, which ideally leads to a *lifelong learning process.*

1.3.1 Development of self-reflective competences

At the beginning of learning processes, it is to be assumed that deficits in one's own practice are rarely or not at all perceived by the learners without criticism from the outside. This is true for beginners, but also for professionals who already have many years of experience. Routine action seems to have "proven itself" precisely in the routine, otherwise it would not be renewed again and again through repetition. Yet it is precisely a characteristic of routine action that a lack of competence is not consciously perceived. Initially, people act without reflecting in the belief that they are doing everything right.

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.

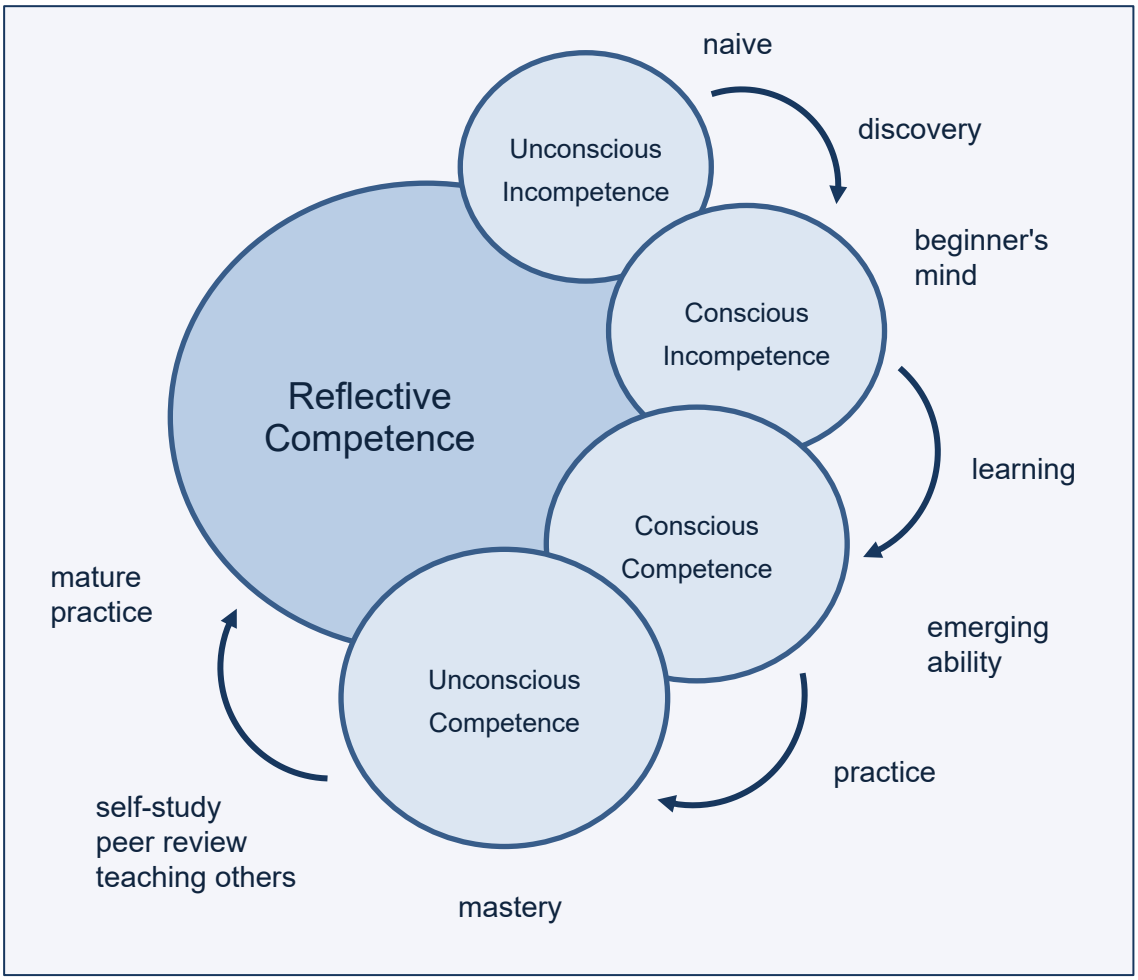

Fig. 1.1: Medical Education Learning Spiral (on Windover 2016: 95)

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*.[2] According to Windover (2016) (Box 1.8), this *reflexive competence* allows for a constant evaluation, adaptation and creative further development of innovative communication techniques in the face of

2 Here we first follow the presentation by Windover 2016, which in turn draws on preliminary work by Chapman 2007 and Taylor 2007. The concept of (*self-)reflexive competence* will later be identified with Uexküll and Wesiack (1991) as a general *meta-competence of* the doctor (§ 3, 6), which is to be justified within the framework of a *biopsychosocial* and *dialogical* medicine (§ 4, 7). A link with Miller's (1990) well-known learning pyramid is made in the evaluation section (§ 40); specific literature references to the concept of *communicative competence* are given in later chapters (§ 3, 7, 13, 17).

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. In doing so, the doctor will have to evaluate and, if necessary, correct his or her usual conduct of the conversation within the framework of biopsychosocial medicine, if he or she does not want to continue the *question-answer pattern* as routine treatment *without reflection* instead of *active listening* (§ 19), to which we will return in detail with Balint's (1964/88) criticism of the traditional taking of anamnesis.

On the long road to "mastery", the *unconscious incompetencies* that remain hidden in "naive" routine action (1st order) and are thus perpetuated without reflection must first be made conscious, i.e. first "discovered", before the new, conscious competencies can be internalised to such an extent that they are in turn practised unconsciously in new routine action (2nd order) (Fig. 1.1). However, the development towards "mastery" should also never be regarded as completed, but as lifelong learning.

The circular learning process must be repeated again and again in so far as the *reflective competence* must be kept open for further clinical and communicative experiences, precisely in the sense of lifelong learning. New experiences with other types of patients with other clinical pictures can also help to promote new reflections in the conduct of medical conversations, which lead to innovative communication practices on a trial basis, before these in turn become routine behaviour (second or third order, etc.) in further conversation practice, which must be critically reflected upon again in the light of further experiences, etc.

The general reflexive competence, which is a *self-reflective communication competence* in relation to one's own conduct of conversation, will later be shown to be the *fitting competence of* a *meta-doctor* (§ 3, 6), who in self-critical observation is the first critic of his or her own medical practice (Uexküll, Wesiack 1991). Insofar as reflective competence refers not only to *communicative* action but to medical action as a whole, which also includes *instrumental* action (medication, surgery, etc.) (§ 7, 8), it is a *key* medical *competence* (§ 6) that must be constantly developed in *lifelong learning.*

In doing so, the individual possibilities should be largely exhausted without exceeding the individual ability and willingness to learn. Since critical self-reflection competence in observation cannot be extended to all possible phenomena of *verbal* and *non-verbal* communication at the same time (§ 12, 18), a pragmatic (self-)selection must be made by which individual overstraining is to be avoided even in organised group learning in education and training. Here, the general medical reflective competence should at the same time be used for "wise" self-restraint on individual limits.

1.3.2 Targeted learning through critical self-observation

For methodological and didactic reasons, which we will discuss repeatedly (§ 3, 13, 18), the difference between *self-observation* while acting and *external observation* by third parties must be taken into account above all. In third-party observation, the "critic" can concentrate fully on observing conversations and "scrutinise" them analytically, especially if they are recorded conversations that can still be perceived in "slow motion". In this sense, there are often "know-it-alls" in group learning who cite "good" reasons for their suggestions for improvement, but who can nevertheless find it difficult to implement them in their own conversation practice. Compared to external observation, self-observation is much more difficult, especially when the actor is currently in the action situation and has to continue acting spontaneously during self-observation.

Although *language* and *communication* are certainly original "subjects of learning" and medical conversation can also be understood as a special *art* (§ 17), specific communication training is in some respects quite comparable to other types of training.[3] Those who are made aware by the trainer of a "wrong" or, in other words, a "better" running technique or throwing technique during sports training may initially have a worse result, i.e. longer running times or shorter throwing distances are to be expected during the changeover phase. The attention-grabbing and conscious change from proven behaviour patterns to new, unfamiliar patterns can lead to *irritations*, which in an intermediate phase of learning can also lead to regressions in the level of performance (§ 40.3). Those who observe themselves in conversation may lose their usual, spontaneous *communication rhythm*. This applies equally to *verbal* and *non-verbal* behaviour in conversation.

3 We will return to the still current discussion on the question of the extent to which medical conversation is a special, i.e. "creative" art of its own kind, which is therefore completely or partially beyond the scope of teaching, in a separate chapter (§ 17) on the topic of "The art of medical conversation", so that we will only refer to the relevant literature here by way of example: Salmon, Young 2011, Skelton 2011, Silverman et al. 2011, Lefroy, McKinley 2011, Silverman 2016.

Box 1.9 Problems of critical self-observation

When students or doctors increasingly observe themselves in communication with their patients, they must reckon with certain types of disturbance:

- *Verbal communication*: Those who consciously take care to avoid early interruptions (§ 13, 19, 40) or suggestive information questions (type: "Appetite is normal?") (§ 21) may hesitate or pause in an unusual way at one point or another in the conversation or may also be prone to "self-corrections in mid-sentence" (*anacoluth*).
- *Non-verbal communication:* Those who start to pay more attention to their posture or their gestures and facial expressions (§ 12, 18) may become "tense". One's own behaviour can also be "inhibited" or "distorted" by too much concentration on the behaviour of the interlocutor.

Even if the current action can be temporarily disturbed by the *intensified* observation of one's own behaviour or also of the interlocutor, renouncing the training of self-observation and observation of others would be the wrong alternative.[4] Possible temporary "losses" compared to the previous "level of competence" may have to be accepted under certain circumstances (§ 1.3.3, 40.3), if long-term intended changes in conversational behaviour are to be achieved. However, care must be taken not to "overstep the mark". For good reasons, the scope of the specific (partial) competences that we specifically raise our awareness of should remain limited. Here it should be emphasised again that (self-) reflective competence must also serve "wise" self-restraint.

Overall, it must be taken into account that not everything that constitutes communication with the patient can be subjected to critical self-reflection and control at the same time. Since our capacities in observing and learning are limited, we have to make a *selection* of verbal and non-verbal phenomena of communication on which we can specifi-

4 To "overlook" the "questioning look" or the "frown" of the skeptical patient when suggesting therapy is certainly as much a "mistake" as "overhearing" the "quiet" or "toneless" voice of the depressed patient (§ 12, 18).

cally focus our attention without neglecting the higher-level learning context with higher-level learning goals (§ 13.14).

Thus, the selection is in turn dependent on the epistemological interest, which can only be developed gradually in a *problem-oriented* learning approach (§ 13). Accordingly, selected *verbal* and *non-verbal* phenomena can be brought into focus in critical observation when the difference between an *interrogative* and *narrative* interview style (§ 9, 17, 19) has become sufficiently clear in the context of a *biopsychosocial* medicine (§ 4). Only then, during further group learning, can the observation for individual, initially unconscious deficits in verbal and non-verbal communication be meaningfully sharpened and deepened, for example by reflecting on the restrictive functions of *premature interruptions* or *suggestive forms of questioning* in specific conversational contexts. The "damage" they can "do" can only be grasped in *comparative* reflection when the "better" and finally the "best" alternatives (*best practice*) can be "raised to consciousness" in the context of *narrative* medicine (§ 9, 17, 19). In this respect, (self-)reflexive communication training should not be confused with *rhetoric training* or a *technique drill.*

Only under this prerequisite of self-reflective learning, in which the specific (self-)observation tasks are to be set within the framework of a higher-ranking learning objective (§ 3, 17), is a concentration of attention on selected *verbal* and *non-verbal* phenomena meaningful, which are then to be specifically "illuminated" in the sense of a "spotlight technique" (§ 12, 18). As in other areas of medical conversation, an appropriate "dosage" must be chosen when promoting critical self-observation in order to avoid under-challenging as well as over-challenging the learning ability and willingness of individuals to learn. In each case, an individual learning level is to be assumed, from which different learning processes can develop (§ 40). Individual feedback is needed to initiate and further promote these processes.

1.3.3 General learning objectives and individual feedback

In evaluation studies on doctor-patient communication, as will be mentioned later (§ 40-43), individual learning progress can be demonstrated in addition to group effects. According to these studies, participants can benefit quite individually from intervention measures on doctor-patient communication. This is related to different starting levels and personal

communication styles of doctors who undergo further training in conversation management.

Reflective observation and feedback procedures in relation to ingrained medical communication practice (routine action of the first order) (§ 1.3.1) can be used, for example, to determine individual deficits within the framework of Balint group work and to obtain instructions (e.g. Koerfer et al. 2004) that are *tailored* to changing individual conversational behaviour by giving the participants individual feedback (Box 1.10). Through the targeted selection, an overtaxing of individuals or entire groups should be avoided in the sense shown. This also applies to student learning groups (§ 13, 14), but also to other types of training (§ 15, 16), where individual feedback is central.

Box 1.10	Individual feedback

According to a detailed empirical analysis (e.g. on the basis of recorded conversations), the individual feedback for individual participants in a medical training (e.g. in a Balint group) (§ 15, 42) could consist of a *selection* to be made *individually:*

- Interrupt the patient less
- Endure breaks longer
- Avoid suggestive or multiple questions
- Let the patient tell more
- Acknowledge the patients burdens more empathetically
- Educate the patient more fully
- Speak in the language of the patient
- Involve the patient more in decision-making, etc.

Such conversational instructions, which are to be derived from a *general manual of medical communication* (§ 3, 17-23), must as individual instructions always also be related to personal and situational conversational conditions, against which individual application problems of general conversational maxims can arise. *Insistent* questioning is not always a "panacea" for clarification in the case of ambiguities, especially not in the case of sensitive issues, where a *tangential* approach to conversation can prove more appropriate than a *confrontational* approach (§ 3, 17, 20). In this respect, communicative competence is also to be understood as *fitting competence* (§ 3, 17), which has to prove itself context-specifically in the face of changing communication challenges.

By exchanging ideas in conversation, doctor and patient finally enter into an *interpersonal relationship* in which they meet as persons with their individual characteristics (temperament, tolerance, perfectionism, compulsiveness, etc.), which can harmonise or also conflict in different ways. Especially in the case of conflict, the overall responsibility for the course of the conversation lies with the professional interlocutor, who must subject his or her individual parts in a conversation to special, reflexive (self-)control. This requires the self-reflexive *competence* of the "meta-doctor" already mentioned (comp. Uexküll, Wesiack 1991), which we will return to under the aspect of the training of *key competences* (§ 3, 6).

While general learning goals can be formulated for group learning (§ 3, 17), which still need to be concretised in the work with the *manual on medical communication* (§ 18-23), individual feedback is required for the promotion of critical self-reflection as a whole, which at the same time ties in with the respective learning level of individual learners (§ 40). A student or a young doctor will not do everything "wrong" at the same time, but they will have very specific communicative (defence) strategies, for example, in dealing with so-called problem patients, which, however, do not have to be experienced as equally difficult by every interviewer (§ 33). For example, one interviewer may be more successful at “stopping” talkative patients, while another interviewer may be more able to "make" a reticent patient talk, and a third interviewer may be able to remain "more relaxed" with aggressive patients, etc.

Overall, therefore, different personal starting levels must be taken into account and balanced after initial learning phases, in which individual strengths and weaknesses may emerge in the conduct of the conversation, which may have to do with personal preferences and aversions in dealing with certain types of patients and clinical problems (coping with illness, therapy adherence, etc.) (§ 5, 7, 26). Thus, individual learning progress can also be achieved in group work, which according to Balint (1964/88) may be connected with a *change of attitude* in the relationship to the patient.[5]

5 Cf. on the possibilities and necessities of a "limited inner conversion of the doctor" towards his patients Balint (1964/88: 171) as well as on the corresponding continuing education Köhle et al. 2001, Koerfer et al. 2004, Cataldo et al. 2005, Adams et al. 2006, Köhle, Janssen 2011, Tschuschke, Flatten 2017, Yang, Wang 2022 as well as in this handbook (§ 15, 16, 42, 43).

This connection between *attitude*, *relationship* and *conduct of conversation* must be made a topic in teaching again and again if communication training is not to be reduced to mere rhetoric training. Through communication with the patient, the relationship is formed at the same time, and the (kind of) relationship formation determines the further (kind of) communication, etc. (§ 3). This circular process is to be controlled again and again in the reflexive self-observation of routine action and corrected if necessary.

As will be shown in more detail (§ 3, 17), the *art* of medical conversation consists precisely in this self-reflexive *fitting* of verbal and nonverbal interventions vis-à-vis specific conversational situations in which doctor and patient meet with different competences but as equal dialogue partners (§ 7, 10). If it were otherwise, we as participants or observers might critically judge (§ 3, 40-43) that it was a less "good" conversation. This criticism should be able to be expressed openly in a confidential group situation in the protection of *learning in solidarity*, so that all group members benefit from it.

1.3.4 Solidarity-based group learning

The self-evident fact that solidarity with the criticised individual must be maintained in group learning should not have to be justified specifically. The "wise" restriction of learning to selected learning goals has already been identified as part of (*self-*)*reflexive competence,* which not least serves to protect against excessive demands. This protection applies towards and between all group members. Criticism should always be welcome, also from the perspective of reflexive external observation, where the observer who has made him or herself "comfortable" in the armchair can make the most demanding suggestions for improvement. Since even the most eager "know-it-all" in the group eventually becomes the "object of observation", the necessary solidarity in criticism is usually already established through the reciprocity of the changing participation roles. The development of learning progress that is possible in self-reflective learning groups was so vividly described by Michael Balint (1964) for the *Balint groups* (later named after him) in his own way (Box 1.11) that he should first have his say in detail on this delicate topic of the group dynamics of medical learning groups of this type:

Box 1.11 Dealing with "mistakes, blind spots and limits“

Perceiving this discrepancy between our daily 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 (...) he does not feel that his mistakes and failures, however shameful 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 1964/88: 405f

In our own experience in learning groups in training and further educational events, mutual consideration for the possible sensitivities of others was only sometimes so pronounced at the beginning that criticism was just as difficult to get going. However, when someone "leads the way", a domino effect is created. Once in the flow, the "critique" then often "bubbled up" in such a way that the insights "rolled over", regardless of whether the beginning came about under a group leader or under self-instruction by the group members. The experience of being able to learn from others' "mistakes", "blind spots", "failures" and "limitations" ("however shameful they may be"), in Balint's sense, usually inspires an *initial confidence* that is "contagious". It is similar to the "doctor-patient" conversations in question: once a beginning has been made that leads to sufficient trust between interlocutors, everything is easier to say and everything said is easier to bear.[6]

Under critical and at the same time solidary observation of the group, many group members can grow beyond themselves and thus fi-

6 However, Balint does not conceal possible problems: "Of course, crises occasionally occur ..." (1964/88: 406). These crises have to do not least with Balint's demanding requirement for a "limited but essential transformation of the personality". On the way to this, according to Balint (1964/88: 407f.), the doctor must be persuaded in a "friendly atmosphere" not only to "summon up the courage to be stupid" but also "occasionally" to accept a "thorough criticism of his so-called 'stupidity'" (407f).

nally also take on the role of "pulling others along". Learning under critical observation may initially be "fearful", but in the end the shared "fun" experienced in group learning can prevail, which was even explicitly expressed in examination interviews according to the OSCE procedure (§ 13.6).

1.4 Structure and function of the handbook

Our handbook is intended as a contribution to the reform of clinical communication education and thereby to the improvement of doctor-patient communication. The handbook is easily available as an online publication for all learners and teachers and can be used for teaching in medical education and training as well as for self-learning in groups and by individual learners who want to improve their communicative competence in hospital or general practice. In order to be able to track progress, evaluation possibilities are offered, which can also be used in the form of external and self-observations.

1.4.1 Flexible and structured learning opportunities

Overall, the handbook represents a structured learning offer that sets focal points along the main structure, which can be used both in the order offered and flexibly in selection. The handbook is divided (Box 1.12) into the following main parts and chapters:

Box 1.12 Structure of the handbook

I. Problems, goals and methods (§ 1-3)
II. Theoretical foundations (§ 4-12)
III. Didactics and methodics (§ 13- 16)
IV. Manual and practice (§ 17-23)
V. Specific fields of competence (§ 24-39)
VI. Evaluation (§ 40-43)

This structure does not mean that theory can be taught without empiricism or that practice can be taught without theory. We have set thematic and problem-oriented focal points in which, for example, specific problems of understanding and communication in the dialogue between

doctor and patient are differentiated under various theoretical aspects (non-verbal communication, narratives, metaphors, technical language, interculturality, etc.), also with empirical examples. Problems of didactic conveyance of medical conversation in teaching and further training will play a role throughout this handbook, as will the associated evaluation problems, which will be dealt with in an overall reflection at the end (VI). In addition, in the separate part (V), exemplary discussion situations in specific fields of competence (Box 1.13) will be considered, in which special problems of medical discussion and its didactic conveyance arise.

Box 1.13 Specific fields of competence (§ 24-39)

- Basic psychosomatic care in the *GP practice* and *ward rounds* as well as specific problems in *prescribing* (medication, risk, adherence, etc.)
- Treatment of specific, partly *chronic* diseases (CHD, diabetes, pain, depression, somatoform disorders, anxiety disorders, etc.), which often require special competence in dealing with "difficult" patients
- *Technical language* communication ("translation" instead of "med speak" etc.) and *intercultural* communication with patients with a migration background
- Communication with *surgical* patients and donors/recipients in *transplantations*
- Dealing with young patients and their parents (in *paediatrics*) and older patients and their relatives (in *gerontology*)
- Dealing with cancer patients and the dying (*oncology*, *palliative care*), etc.

In these specific fields of medical practice, special communication competences are required, some of which have to do with overarching problems (defence, understanding of illness, coping with illness, adherence to therapy, etc.) or require specific medical knowledge of illnesses in order to, for example, ask the "right" questions to "complete" the biopsychosocial anamnesis of cardiac and diabetic patients or in the case of multimorbidity (Sachverständigenrat 2009, Albus, Kreuz, Köllner 2011, Herrmann-Lingen, Albus, Titscher 2022, Kulzer et al. 2023) (§ 5, 29). These problems of *disease-specific* conversation require advanced com-

municative competence, which must build on general competences of medical communication (§ 17-23).

The chapter sequence chosen here suggests a structured learning offer, which can, however, be used according to individual interests, both in a different order and in selection and with "side entries" into individual chapters. We have tried to establish connections and thematic structures again and again by means of a distinctive reference and re-entry structure, even in the case of a side entry, which should serve as an orientation offer during the reading. Continuous and detailed references to literature may encourage further reading.

1.4.2 External and self-evaluation

As will be explained for reasons of research methodology and didactics, the examples are mostly "strictly" empirical in the sense that they are not constructed ("made up") but come from authentic conversations in real consultations and visits, which were "transcribed" according to certain transcription rules (§ 2.3). Sometimes alternative medical interventions are discussed in relation to the real continuations of the conversations, which are intended to stimulate reflection.

Furthermore, in group lessons or in the self-learning procedure, alternative interventions can be simulated and evaluated again and again (partly at specially marked conversation points) under self-reflective questions according to the motto "It's your turn, doctor" (Box 1.14), whose self-critical answers help to uncover the better alternatives.

Box 1.14 Simulated interventions and evaluation

The starting point of this learning and evaluation method (Koerfer et al. 1999, 2008) is a conversation sequence from a real doctor-patient conversation, which can be used from the learner's perspective for the following intervention and evaluation steps, after the last patient utterances in image and sound and/or text (= step 1) have first been received:

1. Last verbatim statements of the patient:
   "....."
2. "It's your turn, doctor" (simulated speech takeover)
   (how would I intervene if I were the doctor?).
3. My intervention:
   "....."

4. Playback of the real medical intervention:
   "....."
5. Comparative evaluation of my intervention in comparison with that of the real doctor.
6. Comparative evaluation of my intervention and that of the real doctor with the interventions of other participants (from my course or past courses).
7. External evaluation by experts.

In the self-evaluation and external evaluation, one's own verbal interventions can thus be compared with the real interventions of the real doctor in real conversations as well as with other fictitious alternatives (from simulated conversations), whereby "or worse" interventions can be *rated* in the critical comparison (scale 1-5). We have repeatedly had good experiences with this learning method, which is to be explained in more detail using an empirical example (§ 13.5.2), in teaching and training as well as in multimedia projects, precisely because the "competition" for the "best" intervention helps to challenge one's own resources (Koerfer et al. 1999, 2008). In "great moments" of teaching and training at our clinic, participants have been able to playfully "outdo" each other in "good" interventions. Accordingly, we also want to provide ongoing suggestions for self-reflection in this handbook, where users can choose to adopt the patient or doctor perspective.

1.4.3 Application perspective

The theoretical and didactic programme for medical communication can only be justified by its successful application, which allows differentiation at different levels of learning. However, those who already have the high opinion that they routinely follow the following (§ 3.3) preformulated maxims of the "classics" in their own everyday medical conversation practice can confidently put our online handbook aside (or more contemporary: simply click away). All others are invited to find further and more concrete suggestions here for improving their individual conduct of talks. We would be pleased if, at the end of the course, people could take personal stock of having improved their own conversation practice through our handbook in the sense of the learning objectives of our *Manual on Medical Communication* (C-MMC) (§ 17-23). In

the process, the learning success can be reassured again and again in between and in comparison with the "classic maxims".

Last but not least, a contribution is to be made here to the standardised evaluation of medical conversation, which is to be compared with other procedures (§ 40-43). In this comparative way, it will gradually be possible to develop the "gold standard" of medical consultation, against which the improvement of communication between doctor and patient can be "measured".

The super maxim that should guide us throughout should be observed: A "good" conversation can "endure" a lot if everything is done "in moderation" (§ 3, 17). In this context, the "right measure" in the *conduct* of medical conversations, in which *conversation* and *leadership* do not have to be a contradiction (§ 8, 17), allows a more or less wide scope with a bandwidth in which individual doctors with their individual strengths and weaknesses orient themselves to the individual patient, who as a sick person should in turn be accepted as individually as she or he is. For the guidance of the conversation this means that only in rare cases a standard variant can be sufficient, so that corresponding manuals and evaluation sheets can also reach their limits of use in their application (§ 17-23).

Compared to acting on a certain *pattern* "X" of medical communication, a special *fitting competence* is to be promoted (§ 3, 17), which allows a *flexible* and *tailor-made* communication with patients. *Structuring* this communication to a "certain extent" can, of course, benefit both partners and their conversation, for which we want to provide a structuring aid for (future) doctors with this handbook.

1.5 Further information

Despite the "reform backlog" in communication training described above, at the latest with the paradigm shift to a *biopsychosocial* medicine initiated by George Engel (§ 4), a long series of textbooks has also emerged on medical interviewing both in the English-speaking world and in the German-speaking world, to which we will refer in relevant contexts (see also the bibliography of this handbook). Over a period of more than 50 years, a selection (sic) and examples are mentioned: Morgan, Engel 1969/1977, Froelich, Bishop 1973, Adler, Hemmeler 1989, Dickson et al. 1991, Coulehan, Block 1992, Geisler 1992, Silverman et al. 1998, Tate 2004, Schweickhardt, Fritzsche 2009, Fortin et al. 2012,

Cole, Bird 2014, Brown et al. 2016, Koerfer, Albus 2018, Cooper, Frain 2018, Jünger 2018, Coussios, Imo, Korte 2019, Lloyd et al. 2019, Simpson, McDowell 2020, Parija, Adkoli 2020, Herrmann-Lingen, Albus, Titscher 2022, DEGAM 2022, Kondo 2022, Guy 2024, Sood, Riley 2024, Kitchen et al. 2024. In addition to specific recourse to selected textbooks, we will repeatedly return to the "classic" by Morgan and Engel (1969/1977) when it comes to the further formulation of "maxims of good medical communication" (§ 2, 3, 17).

Current overviews of communication training and communication curricula are provided by Bachmann et al. 2022, Venktaramana et al. 2022. The specific learning objectives for *communication competence* are elaborated in didactic chapters (3, 13-16), for which the corresponding anchor examples are discussed in the practical part of this handbook (§ 17-23). For a cross-linking of our handbook with the *National Competence-Based Catalogue of Learning Objectives in Medicine* (NKLM 2.0) (2021), please refer to the handbook appendix (§ 44).

1.6 Cologne Manual of Medical Communication

The current version of the *Cologne Manual & Evaluation of Medical Communication* (2022) is attached on the last page. The evaluation instrument is used in the OSCE procedures with students and in continuing education (§ 13, 14, 41). In the practice chapters (§ 17-23) the details of all 6 steps/functions of the manual are explained in detail with empirical anchor examples.

References

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

Adams KE, O'Reilly M, Romm J, James K (2006): Effect of Balint training on resident professionalism. American Journal of Obstetrics & Gynecology 195 (5), 1431-7.

Adler RH, Hemmeler W (1989): Praxis und Theorie der Anamnese. 2. Aufl. Stuttgart: Fischer.

Albus C, Kreutz S, Köllner V (2011): Psychokardiologie als Beispiel für die Integration von kognitiv-behavioralen und psychodynamischen Aspekten. Psychotherapie im Dialog 12 (1), 2-7.

Bachmann C, Pettit J, Rosenbaum M (2022): Developing communication curricula in healthcare education: an evidence-based guide. Patient Education and Counseling, 105(7), 2320-2327.

Balint M (1964/1988): Der Arzt, sein Patient und die Krankheit. 7. Aufl. Stuttgart: Klett-Cotta (1964: The Doctor, his Patient and the Illness. London: Pitman Medical Publishing Co.).

Brown J, Noble LM, Papageorgiou A, Kidd J (eds.) (2016): Clinical Communication in Medicine. Oxford: Wiley Blackwell.

Cataldo KP, Peeden K, Geesey ME, Dickerson L (2005): Association between Balint training and physician empathy and work satisfaction. Family Medicine 37 (5), 328-31.

Chapman A (2007): Conscious competence learning model.

Cole SA, Bird J (2014): The Medical Interview. The Three Function Approach. Third edition. Philadelphia: Saunders.

Cooper N, Frain J (eds.) (2018): ABC of Clinical Communication. Oxford: Wiley.

Coulehan JL, Block MR (1992): The medical interview. A primer for students of the art. Philadephia: Davis.

Coussios G, Imo W, Korte L (2019): Sprechen mit Krebspatienten. Ein gesprächsanalytisch fundiertes Trainingshandbuch für die medizinische Aus-und Weiterbildung.(= EkiG 7). Göttingen: Verlag für Gesprächsforschung.

DEGAM (Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin) (2022): Praxisempfehlung - Das anamnestische Erstgespräch. Berlin.

Dickson DA, Hargie O, Morrow NC (1991): Communication Skills Training for Health Professionals. London: Chapman & Hall.

Engel GL (1988): How much longer must medicine's science be bound by a seventeenth century world view?. In: White KL (1988): The task of medicine: dialogue at Wickenburg. Henry J. Kaiser Family Foundation, 113-136.

Engel GL (1997): From biomedical to biopsychosocial. Being Scientific in the Human Domain. Psychosomatics 38 (6), 521-8.

Fortin AH, Dwamena F, Frankel R, Smith RC (2012): Smith's evidence-based interviewing: an evidence-based method. New York: McGraw-Hill.

Froelich RE, Bishop FM (1973): Die Gesprächsführung des Arztes. Ein programmierter Leitfaden. Berlin: Springer (Engl.1972: Medical Interviewing. A Programmed Manual. CV Mosley Company).

Geisler L (1992): Arzt und Patient – Begegnung im Gespräch. Frankfurt/M: Pharma Verlag.

Guy C (2024): The Art of Medical Communication: Bringing the Humanities into Clinical Practice. London, New York CRC Press.

Hampton JR, Harrison MJG, Mitchell JRA, Prichard JS, Seymor C (1975): Relative contributions of history-taking: physical examination and laboratory investigation to diagnosis and management of medical outpatients. British Medical Journal 2 (5969), 486-9.

Herrmann-Lingen C, Albus C, Titscher G (Eds.) (2022): Psychocardiology: A practical guide for doctors and psychologists. Berlin: Springer Nature.

Jünger J (2018): Ärztliche Kommunikation: Praxisbuch zum Masterplan Medizinstudium 2020. Stuttgart: Schattauer.

Kitchen J et al. (eds.) (2024): Handbook of Palliative Care. Wiley Blackwell.

Koerfer A, Albus C (Hg.) (2018): Kommunikative Kompetenz in der Medizin. Ein Lehrbuch zur Theorie, Didaktik, Praxis und Evaluation der ärztlichen Gesprächsführung. Göttingen: Verlag für Gesprächsforschung.

Koerfer A, Köhle K, Faber A, Kaerger H, Obliers R (1996): Zwischen Verhören und Zuhören. Gesprächsreflexionen und Rollenspiele zur Arzt-Patient-Kommunikation im medizinpsychologischen Studium. In: O. Bahrs, W. Fischer-Rosenthal, J. Szecsenyi (Hg.): Vom Ablichten zum Im-Bilde-Sein. Ärztliche Qualitätszirkel und Video-Analysen. Würzburg: Königshausen & Neumann, 109-31.

Koerfer A, Köhle K, Obliers R, Sonntag B, Thomas W, Albus C (2008): Training und Prüfung kommunikativer Kompetenz. Aus- und Fortbildungskonzepte zur ärztlichen Gesprächsführung. Gesprächsforschung - Online-Zeitschrift zur verbalen Interaktion 9, 34-78.

Koerfer A, Obliers R, Köhle K (2004): Emotionen in der ärztlichen Sprechstunde. Förderung empathischer Kommunikation durch Fortbildung in psychosomatischer Grundversorgung. Psychotherapie und Sozialwissenschaft 6 (4), 243-62.

Koerfer A, Obliers R, Köhle K (2005): Der Entscheidungsdialog zwischen Arzt und Patient. Modelle der Beziehungsgestaltung in der Medizin. In: Neises M, Ditz S, Spranz-Fogasy T (Hg.): Psychosomatische Gesprächsführung in der Frauenheilkunde. Stuttgart: Wissenschaftliche Verlagsgesellschaft, 137-57.

Koerfer A, Thomas W, Obliers R, Köhle K (1999): Multimediales Lernprogramm zur ärztlichen Gesprächsführung. Gesundheitswesen 61, 413-7.

Köhle K, Janssen PL (2011): Die ärztliche Fort- und Weiterbildung: Deutschland, Schweiz und Östereich. In: Adler RH, Herzog W, Joraschky

P, Köhle K, Langewitz W (Hg.): Uexküll: Psychosomatische Medizin. 7. Aufl. München, etc.: Urban & Fischer, 1236-47.

Köhle K, Kaerger-Sommerfeld H, Koerfer A, Obliers R, Thomas W (2001): Können Ärzte ihr Kommunikationsverhalten verbessern? In: Deter H-D (Hg.): Psychosomatik am Beginn des 21. Jahrhunderts. Chancen einer biopsychosozialen Medizin. Bern, etc.: Huber, 301-10.

Köhle K, Koerfer A, Thomas W, Schaefer A, Sonntag B, Obliers R (2003): Integrierte Psychosomatik: Beiträge zu einer Reform des Medizinstudiums. Psychotherapie, Psychosomatik, Medizinische Psychologie 53 (2), 65-70.

Köhle K, Obliers R, Koerfer A, Kaerger H, Faber J, Mendler T (1995): Evaluation des Fortbildungseffektes einer Balint-Gruppe. Ein multimethodaler Ansatz. Psychosomatische und psychosoziale Medizin 1, 6-15.

Kondo K (2022): Patient-centred communication: Discourse of in-home medical consultations for older adults (Vol. 5). Channel View Publications.

Kulzer B, Albus C, Herpertz S, Kruse J, Lange K, Lederbogen F, Petrak F (2023): Psychosocial Factors and Diabetes. Exp Clin Endocrinol Diabetes 131 (1-02).

Kurtz SM, Silverman JD, Draper J (1998/2005): Teaching and learning communication skills in medicine. 2. Aufl. Oxford/San Francisco: Radcliffe Publishing.

Lazare A, Putnam AM, Lipkin M (1995): Three functions of the medical interview. In: Lipkin J M, Putnam SM, Lazare A (eds.): The Medical Interview – Clinical Care, Education and Research. New York: Springer, 3-19.

Lefroy J, McKinley RK (2011): Skilled communication: comments further to 'Creativity in clinical communication: from communication skills to skilled communication'. Medical Education 45, 958-62.

Levinson W, Pizzo PA (2011): Patient-physician communication: It's about time. JAMA 305 (17): 1802-3.

Lipkin M, Frankel RM, Beckman HB, Charon R, Fein O (1995): Performing the interview. In: Lipkin MJ, Putnam SM, Lazare A, Carroll JG, Frankel RM, Keller A, Klein T, Williams PK (eds.): The Medical Interview - Clinical Care, Education and Research. New York: Springer, 65-82.

Lloyd M, Bor R, Noble L (2019): Clinical Communication Skills for Medicine. Edinbourgh etc.: Elsevier.

Lussier MT, Richard C (2006): Doctor-Patient Communication. Time to talk. Canadian Family Physician 52 (11), 1401-2.

Lüth P (1986): Von der stummen zur sprechenden Medizin. Frankfurt/M, New York: Campus.

Miller GE (1990): The assessment of clinical skills/competence/performance. Academic Medicine 65 (Suppl 9), S63-7.

Morgan WL, Engel GL (1969/1977): Der klinische Zugang zum Patienten. Anamnese und Körperuntersuchung. Bern, etc.: Huber (Orig. 1969: The Clinical Approach to the Patient. Philadelphia: Saunders).

Morris M, Donohoe G, Hennessy M, O Ciardha C (2013): Pro forma: impact on communication skills? Clinical Teacher 10 (5), 318-22.

NKLM 2.0 (2021): Nationaler Kompetenzbasierter Lernzielkatalog Medizin.

Parija S, Adkoli B (2020): Effective Medical Communication. Springer Singapore.

Rothberg MB, Steele JR, Wheeler J, Arora A, Priya A, Lindenauer PK (2012): The relationship between time spent communicating and communication outcomes on a hospital medicine service. Journal of General Internal Medicine 27 (2), 185-9.

Sachverständigenrat (2009): Gutachten des Sachverständigenrates zur Begutachtung der Entwicklung im Gesundheitswesen. Deutscher Bundestag. 16. Wahlperiode. Drucksache 16/13770.

Salmon P, Young B (2011): Creativity in clinical communication: from communication skills to skilled communication. Medical Education 45 (3), 217-26.

Schweickhardt A, Fritzsche K (2009): Kursbuch ärztliche Kommunikation. Grundlagen und Fallbeispiele aus Klinik und Praxis. 2. erw. Aufl. Köln: Deutscher Ärzteverlag.

Silverman J (2016): Relationship building. In: Brown J, Noble LM, Papageorgiou A, Kidd J (eds.): Clinical Communication in Medicine. Oxford: Wiley Blackwell, 72-5.

Silverman J, Deveugele M, Haes H d, Rosenbaum M (2011): Unskilled creativity is counterproductive. Medical Education 45 (9), 959-60.

Silverman J, Kurtz S, Draper J (1998): Skills for Communicating with Patients. London: Radcliffe.

Simpson SA, McDowell AK (2020): The Clinical Interview. Skills for more effective patient encounters. New York, London: Routledge.

Skelton JR (2011): Clinical communication as a creative art: an alternative way forward. Medical Education 45 (3), 212-3.

Sood S, Riley AH (2024). Health Communication Fundamentals: Planning, Implementation, and Evaluation in Public Health. New York: Springer Publishing Company.

Tate P (2004): The Doctor's Communication Handbook. 4th Edition. Oxon: Radcliffe.

Taylor W (2007): Medical education learning cycle.

Tschuschke V, Flatten G (2017): Wie wirken Balintgruppen? (How Effective are Balint Groups?) Balint 2017; 18: 105–109

Uexküll T v, Wesiack W (1991): Theorie der Humanmedizin. 2. Aufl. München: Urban & Schwarzenberg.

Venktaramana V, Loh EKY, Wong CJW, Yeo JW, Teo AYT, Chiam CSY, ... & Krishna LKR (2022). A systematic scoping review of communication skills training in medical schools between 2000 and 2020. *Medical Teacher*, *44*(9), 997-1006.

Washer P (2009): Clinical Communication Skills. Oxford: University Press.

Windover A (2016): Birth of the R.E.D.E. Model. In: Boissy A, Gilliganz T (eds.): Communication the Cleveland Clinic Way: How to Drive a Relationship-Centered Strategy for Exceptional Patient Experience. New York: McGraw Hill, 67-86.

Windover A (2016): Making Communication Resonate with Experienced Clinicians. In: Boissy A, Gilliganz T (eds.): Communication the Cleveland Clinic Way: How to Drive a Relationship-Centered Strategy for Exceptional Patient Experience. New York: McGraw Hill, 87-104.

Yang Y, Wang Q (2022): The Effect of Balint-style Group on Empathy Ability and Interpersonal Communication Skills of Rehabilitation Students. 3rd International Conference on Mental Health, Education and Human Development (MHEHD) (24-29). Atlantis Press.

Citation note

Koerfer A, Albus C (2025): Clinical Communication Education. Introduction and Overview. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung.

Cologne Manual & Evaluation of Medical Communication see next page.

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

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

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

Fig. 20.6: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)