17 The Art of Medical Communicating
Flexibility and Creativity

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> For communication teaching to be pedagogically and clinically valid in supporting the inherent creativity of clinical communication, it will need to draw from education theory and practice that have been developed in explicitly creative disciplines.
>
> Salmon, Young 2011: 217

Abstract: In this introductory chapter to the *manual-based* practice part, an orienting *interim balance* is to be drawn, in which we resume and concretise topics that were discussed in advance under theoretical and didactic aspects and which will be further elaborated in the following with empirical examples. First of all, the "power of the doctor's word" is to be shown once again, which can be used in a wide spectrum entirely to the benefit, but also to the detriment of the patient (§ 17.1). In a second step, we present our *Cologne Manual on Communication*, which is intended to be a guideline for teaching and practice, but only in the sense of a *variable application*, for which a specific fitting competence of the doctor is required (§ 17.2). With this medical fitting competence, the balancing act between a structured and flexible conversation must be mastered (§ 17.3). In an evaluative perspective of conversation analysis, a number of aspects of "good" conversation management are to be differentiated, according to which the patient is given sufficient opportunities to participate without neglecting the concerns of optimal patient care that are relevant from the doctor's point of view. Subsequently (§ 17.4), in a *dialogue feedback model* of doctor-patient communication, *types of doctor feedback* are differentiated, with which the *relevance* of the thematic (informative, emotive, preferential) patient offers is appropriately appreciated, so that overall the balance between the spontaneous *associations* of the patient and the *guidance of communication* (anamnesis, decision making etc.) can be maintained. Finally (§ 17.5), practical advice on the use of the communication manual and the empirical anchor examples (*best practice*) will be given, which will make up the practical part (§ 18-23).

17.1 The power of the medical word

The power of the word is also evident in the consultation and ward round. In a wide spectrum, the medical word moves between the extremes of a healing and harmful effect, with all the shades and colourings between these extremes. In everyday communication, too, words can have more or less positive or negative effects, which may be more or less intended or merely accepted. Sometimes it is not so important to the speakers what they "do" with their words. In the consultation or ward round, however, the doctor's words should be "chosen carefully", because here the effects are often serious. Here, words can "make a difference" that is decisive for the further shaping of the relationship.

17.1.1 Words and effects

With language, one can pursue very different purposes and cause very different effects, which can be extremely negative or positive, which is what different sciences have dealt with (Koerfer 1994/2013). We have already dealt with this in detail in the presentation of the scientific traditions, which have already been discussed in detail for the development and justification of a *dialogical medicine* (§ 7).

From the perspective of understanding sociology, Alfred Schütz (1932/1974) developed a theory of *understanding others*, according to which we can only ever understand each other *approximately* in all social mediation of language and communication. Thus, even in the content-filled "we-relationship", in which we are already very familiar with each other, we often have to be content with a partial sense of partial actions of our interlocutor's (draft of) overall action in relation to the sense-making of our interlocutor. From an epistemological and semiotic perspective, Georg Klaus (1968) examined under the eponymous title "The Power of the Word" how this power can work differently in different (types of) scientific, technological, political, religious discourses or texts. From a linguistic-psychological perspective, Hans Hörmann (1978) has explored the difference between "meaning and understanding" to the point of "re-accentuating" the question of the speaker's intentions into the question "What does the listener do with the sentence?" A *listener-centered* perspective, as is particularly pertinent in *narrative* (§ 9, 19), has been asserted in philosophy by Gemma Corradi Fiumara (1990) as well as by Walter Schmitz (1998) in communication studies.

In the tradition of analytical philosophy of language, John Austin (1962/1972) and John Searle (1969/1971) have already worked out that we not only perform *speech acts* (such as assertions, requests, promises, etc.) with linguistic utterances, but also achieve *effects,* the so-called *perlocutionary* effects (such as frightening, intimidating, confusing, but also comforting, reassuring, convincing, etc.) (§ 7.3). These perlocutionary effects, which can therefore be *negative* (intimidating) as well as *positive* (reassuring) or are evaluated in this way, can also occur relatively independently of the speaker's intentions (Koerfer 2013). Thus, as a listener, I may be hurt or offended, although my "good" friend had *meant* her utterance ("We are late") merely as a request that we should hurry and not as a *reproach* to me for being late (again) for the appointment with her, as I *understood* it.

Similarly, in a shared flat, a certain statement by A ("The rubbish bin is overflowing again") can be *understood* by B as an accusation of neglecting kitchen duty, although A's original statement was *meant* as a justification for a subsequent suggestion to buy a bigger rubbish bin, etc. What in this case turns out to be "harmless" because it is clarified accordingly in further communication between A and B can have fatal consequences in another case if a statement is not only understood as an accusation, but also in principle as a "breach of duty" with all the implications of questioning the partner's cognitive or social competences.

Such accusations of incompetence can escalate to mutual blame in the case of problems of understanding and communication, in which, as is well known, at least two parties are involved in their respective roles as speakers and listeners (Koerfer 2013). In this context, the accusation of not being able to "listen properly" can sometimes weigh more heavily than the original failure to act in question itself, etc. In this way, characteristics and behaviours of people themselves can become the subject of conversation until the relationship between the actors is finally itself put to the test. What can happen here in everyday communication also applies to doctor-patient communication, especially since what is "at stake" here is often assumed to be of even greater importance and responsibility.

17.1.2 Healing and harming

During consultations and ward rounds, the effects that the doctor achieves with his or her words can be dramatic, because after all - to put it pathetically - it is often a matter of "life and death". But even "normal" cases of "careless" choice of language can lead to considerable communication problems, as will become clear in our conversation analyses. For the time being, only those (types of) effects of words will be considered here that the cardiologist Bernard Lown differentiated in his treatise on "The Lost Art of Healing" (2002), namely, on the one hand, "words that can be devastating" and, on the other hand, "words that can heal", which he paraphrases as follows (Box 17.1):

Box 17.1 Devastating and healing words

- Inappropriate remarks can be as devastating as a physical attack (...) I find it disturbing that I encounter such devastating words more and more often. Sometimes they can be easily brushed aside by patients, but occasionally they cause endless grief (...)
- I know of few remedies more powerful than a carefully chosen word (...) Conversation, which can be therapeutic, is often underestimated as a tool in a doctor's kit. Medical experience provides repeated examples of the healing power of words. (Lown 2002: 64)

Lown 2002: 52f., 64

Lown gives many detailed case reports for these extreme types of different (effects) of medical conversational behaviour, to which we can only refer here. An exemplary excerpt from Lown's conversation was already reproduced in advance when the connection between *emotion* and *information* in the *art of medical education* was discussed (§ 10.5). The fact that words can "help" more or less immediately can be proven later with examples of conversations in which patients declare themselves to be "really reassured" or "in good hands". For long-term effects in the sense of a healing success, reference has already been made to outcome research (§ 8), which is to be discussed again under the aspect of evaluation (§ 40-43). Otherwise, catamneses are also needed in individual cases, which we will report on if necessary after analysing the interviews.

Here, brief examples will first be given of "damning words" by doctors whose "iatrogenic" effect stems, for example, from "scary" technical terms (as in Box 10.14 in § 10.5) or standard utterances when giving a diagnosis or counselling, which Lown (2002: 53ff) noted down and collected in his long professional life, as they are compiled below (in Box 17.2) as examples:

Box 17.2 Scathing, fearsome, tactless words

- They live on borrowed time.
- You are going downhill fast.
- Your next heartbeat could be your last.
- The Maloch amoveth (angel of death) hovers over you.
- You are a walking time bomb.

- The thought of your anatomy makes me shudder.
- This constricted blood vessel is a widow maker.

Lown 2002: 52f

Such examples should "actually" be outside any discussion if they were not taken from the observation of an experienced clinician and had to be considered authentic manifestations of a common conversation practice between doctors and patients. Cynicism is often an expression of helplessness. This may also play a role when doctors "hide" behind their specialist terminology, e.g. when they talk noticeably over the heads of the patients in the team during rounds, who can hardly follow their communication and are irritated and unsettled for this reason alone (§ 24). Technical terms are often dispensable or substitutable or explainable if they are unavoidable from the point of view of *education* and helpful for understanding the disease or treatment (§ 10.5). Because of their special importance, we will return to the role of technical language communication and everyday language translation separately (§ 27).

Here, Lown's drastic examples were only intended to sensitise attention to the fact that a "careless" choice of language, which can already cause "worry", "sorrow", "annoyance" etc. in everyday life, can trigger "disastrous" effects in the specific institutional context of the consultation or ward round (§ 24, 25).[1] In order to prevent this, a special maxim for the "cautious" handling of the "power of the word" is required here, which ultimately means nothing other than a cautious approach to the patient. Since the impositions in medicine are often difficult enough in themselves (illness, death), the linguistic impositions should not make matters worse. However, "sparing at all costs" would be the wrong alternative. Here we will explore the problem in other contexts (§ 16, 36, 38, 43) that conflicts of maxims (such as *sparing* versus *clarification*) are often institutionally established as alternatives, although "careful clarification" need not be a paradox.

1 The effects Lown describes do not only refer to mental or emotional reactions of the patients, but extend to "cardiac events" with lethal outcomes. For example, a patient dies (apparently unexpectedly, against medical expectations) after she had fallen for a misunderstanding in which she had understood the chief physician's statement that this was a case of "TS" (=tricuspid valve stenosis) as an abbreviation of a completely different kind, namely for "terminal situation", as she had still confided full of concern to Lown, the young ward physician at the time, following the chief physician's visit, cf. Lown (2002: 50f.).

17.1.3 Words that make a difference

Besides the great effects that words can have between the extremes of healing and harm, the (many kinds of) words with smaller effects are to be differentiated, which can nevertheless grow into greater effects when they interact with further words. *Active listening* (§ 19) and *empathic feedback* (§ 20) can lead to *synergetic* effects that favour a helpful conversation and relationship with the patient. In this sense, words can be so well dosed and placed in the context of an ongoing conversation that they *make a difference* that is of considerable relevance to further conversation development.

It is no coincidence that a series of articles was launched in 2001 (in the *Annals of Internal Medicine*) in which renowned authors on the research and didactics of doctor-patient communication compiled outstanding examples of words whose communicative relevance is evident under a certain category of analysis and evaluation. Under the guiding title "Words that make a difference", the series was introduced with the following motivating, explanatory and critical words (Box 17.3), which can certainly be adopted for communication theory as a whole.

Box 17.3 Because they "do not know what to say", they avoid the challenge.

The spoken language is the most important diagnostic and therapeutic tool in medicine, but physician-in-training as well as experienced clinicians report that even when they wish to focus on the patient, they lack to do so. Because they "do not know what to say", they avoid the challenge (...) Developing a repertoire of carefully refined words is useful, and the mastery of language plays a recognized role in educating physicians to interview patients (...) Often one request to the patient - "Tell me about yourself" - will suffice. No one phrase works equally well for all physicians or all patients, and a skilled interviewer will titrate the language to the patient and the circumstances.

Platt et al. 2001: 1079f.

Certainly, recommendations on the choice of "appropriate" words can contribute to accepting the "challenges" of good interviewing. In this handbook, we borrow from recommendations such as those made by the Platt et al. (2001) group of authors in general on the *patient-centered interview* or by Coulehan et al. (2001) specifically on *empathic*

communication (§ 20), just as we have already borrowed from classics such as Morgan and Engel (1969/77). Their recommendations had already been compiled as a catalogue of conversational maxims in the introduction to the formulation of learning objectives (§ 3.4.1). However, since conversation recommendations or maxims can initially only be formulated in relatively general terms, their context-specific application remains a "challenge" for the concrete conduct of medical conversations in real conversation situations. Here we had already pointed out the possibility and necessity of weighing up relevance in conflicts of maxims (§ 3.1), in which, for example, an interruption in the case of ambiguity can be justified if clarification has priority in the given case, so that a maxim on the right to speak ("avoid interruptions") (§ 19) can certainly be violated.

What may be an appropriate continuation of the conversation must be decided just as context-sensitively as the use of general phrases ("Tell me about yourself"), which are certainly often and in many different contexts, but not in all cases conducive to conversation. This also applies to a number of other standard phrases as recommended by Platt et al. (2001) as a verbal repertoire of medical conversation in various phases of conversation, whereby here (Box 17.4) only a selection from the original will be made as an example.

Box 17.4 Repertoire of carefully refined words

- Before we get to medical problems, I'd like you to tell me a little about yourself as a person.
- How would you describe yourself?
- What sort of troubles are bothering you?
- What else?
- Tell me more about X, Y, Z.
- What has this illness been like for you?
- Since you've had this problem, what are you no longer able to do?
- What do you think is causing these headings?
- What are your concerns about it?
- How does that make you feel?
- What is most worrisome?
- What did you think we ought to do about this?

Selection from Platt et al. 2001: 1079f.

Such a repertoire of standard verbal interventions is certainly useful for communication theory and practice and should therefore be further differentiated in the presentation and application of our conversation manual, which has been revised in several editions since 1998, but above all been underpinned with empirical anchor examples in a practical and context-specific way. Of course, Platt et al. (2001) also point to the context-dependency of the use of such phrases ("No one phrase works equally well for all physicians or all patients") and therefore already recommend in their above plea (Box 17.3) a "titration" of the language towards the patient and the conversational conditions.

Thus, the "challenge" to good medical conversation management is still to apply conflicting conversation maxims, which can certainly be concretised with standardised phrases, but also empirical anchor examples, in a context-specific manner. In this sense, we also present our conversation manual as a *structuring aid* which, with appropriate medical fitting competence, allows individual and flexible communication management.

17.2 Communicative competence and creativity

The desideratum in the teaching and practice of medical interviewing was already pre-formulated by Platt et al. (2001) when they summarised above (Box 17.3): "(...) a skilled interviewer will titrate the language to the patient and the circumstances". “Titration" by a "skilled interviewer" already raises an issue that was intensified for debate a decade later with an article by Salmon and Young (2011), which addressed the question of the relationship between *skills* and *creativity* (Silverman et al. 2011, Lefroy, McKinley 2011, Salmon, Young 2011, Skelton 2011, Silverman 2016). We can only give a rough outline of the sometimes polemic discussion here before we present our communication manual and show its "creative" application perspective.

17.2.1 Clinical communication as a *creative art*

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 ..."

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 (§ 3, 13) and justification of a dialogical medicine (§ 7).[2] A broad notion

2 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 (over five decades and across the disciplines): 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,

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).[3] It may be exhausting to listen

Grimmer 2014, Hannawa, Spitzberg (Eds.) 2015, Jünger et al. 2016, Thistlethwaite 2016. Kiessling, Fabry 2021.

3 Depending on the situation, it would be particularly "inappropriate" to simply leave the boss standing. Without overusing such examples, the "creative" aspect is limited here. For all their agreement with Salmon, Young (2011) and Skelton (2011), their concept of "creativity" sometimes seems overgeneralised (Salmon, Young 2011: "Communication is inherently creative"): There is even a certain redundancy in "*creative art*" (Skelton

patiently to a patient who talks "like a waterfall" and is obviously talking "nonsense", 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, which we will come back to in detail. Likewise, failures should not be characterised as "uncreative" but as "inappropriate".

If the difference between *suitable* and *unsuitable* conversation alternatives is to be specifically marked, we will first use the concept of medical *fitting competence* as introduced above (§ 3.2) as a *self-reflective meta-competence* (in the sense of Uexküll and Wesiack 1991) and which will be presented below in the fitting model of medical conversation in its routine function (§ 17.2.4). If the art of medical conversation is essentially described as routine, this is not to deny the "creative" role of *key* medical *interventions*, which often stimulate a new quality of conversation in which doctor and patient initiate a new development of the relationship (§ 17.3.5). Although such key interventions, as the name suggests, are relatively rare because they are specific, they are an integral part of professional action, which can of course also be raised to a "high art" and recognised accordingly, which usually requires a longer period of professional practice - with appropriate further training and education (§ 15, 16, 42, 43).

If the aspect of *creativity* is to be emphasised in the following, then essentially in the sense that the teaching of conversation techniques, as they can be formulated in a manual on conversation management, should contribute to the formation of a communicative competence which can ultimately only be *acquired* and *deepened* in conversation experience in real or simulated conversation situations (§ 13.5). For this reason, our conversation manual (C-MMC), which will be presented below, is intended as a structuring aid to *stimulate* "creative" use.

2011), although the use of a pleonasm is sometimes useful, for example, when we talk about a *particularly white mould,* or feel *lonely and alone*, or promise something for *ever and ever,* etc. So it also remains sensible to emphasise the *creative* aspect in the art of medical conversation in special cases, but not as a rule. In any case, however, the *communicative* competence must be brought to bear in a way that fits in with the *clinical* competence (§ 3.2, 17.2).

17.2.2 Cologne Manual of Medical Communication

As mentioned above (§ 3.4), we have developed two instruments at our Cologne Dept. for Psychosomatics and Psychotherapy for the teaching and examination of medical interviewing, which build on each other with different functions:

- The *Cologne Manual of Medical Communication* (C-MMC) serves as a catalogue of learning objectives for teaching, but also as a guide for further training and self-learning.
- The *Cologne Evaluation of Medical Communication* (C-EMC) is used to check learning objectives, for example in examinations according to the OSCE method with standardised patients, but can also be used to evaluate real doctor-patient conversations.

The C-EMC was developed analogously to the manual (C-MMC) in order to be able to follow the basic idea that only what was previously taught should be tested. For practical reasons, the communication manual was designed in the form of a booklet that should fit into the "coat pocket" of students and (prospective) doctors. The evaluation sheet has a simple DIN A4 format (see § 17.5) and can be used as a rating instrument by examiners during direct observation of interviews or afterwards during video recordings. We have chosen an integrative presentation of manual and evaluation sheet here and in the following practical part (§ 18-23) (Fig. 17.7 at the end of this chapter) in order to make the connection between teaching and examination clear. [4]

As already explained (§ 13.6), the total number of points that can be achieved (50 points) can also be reduced in the evaluation form if, for

[4] Since 1998, the *manual* and *evaluation form* have been developed in several editions (currently 2022) in the Medical Didactics Working Group under the leadership of Karl Köhle and applied in OSCE procedures and are still regularly used in teaching and examinations at our clinic under the leadership of Christian Albus (§ 3, 13-14). For further presentation and application of the manual and evaluation questionnaire within our clinic, we refer to Koerfer et al. 1999, 2004, 2005, 2008, Köhle et al. 2010, Köhle 2011, Albus Albus 2022), for direct or critical-comparative use outside our clinic, we refer to Petersen et al. 2005, Schweickhardt, Fritzsche 2007, Henningsen 2006, Lengerke et al. 2011, Mortsiefer et al. 2014, Nowak 2015, Schröder 2019, Coussios et al. 2019, Scarvaglieri 2020.

example, in the first clinical semester, certain conversation steps or functions such as "agreeing on the procedure" were largely omitted from the teaching, so that the examination aspect is omitted here accordingly. In advanced semesters or in further training, the full use of the evaluation form is then a matter of course.

With the manual and the evaluation sheet, we have tried to structure and concretise conversation maxims as learning objectives down to the concrete level of doctors' conversation behaviour and to achieve a calibration through empirical anchor examples, which will be a main concern in the practical part (§ 18-23). There it is a matter of selecting examples from real consultation hours and ward rounds, which are in principle preferable to merely constructed examples because of their authenticity (§ 2.3).

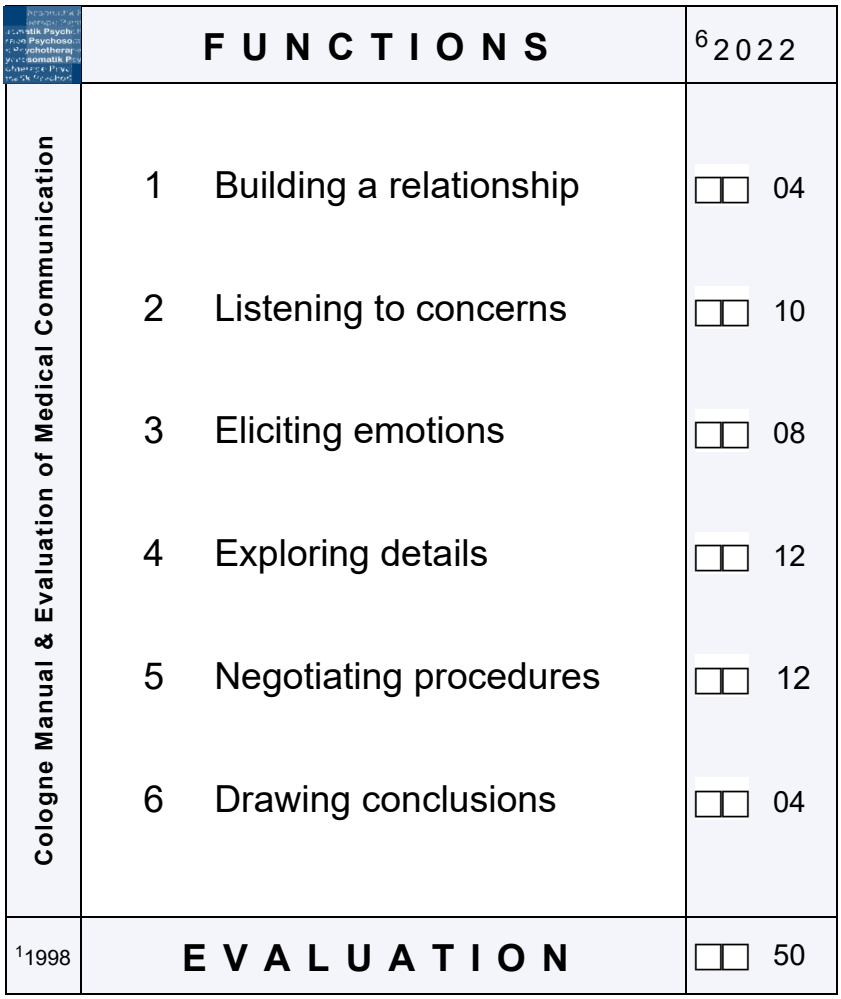

Fig. 17.1: Cologne Manual & Evaluation of Medical Communication
(Cf. the complete Fig. 17.8 at the end of the chapter)

The manual and evaluation form are divided into six conversational steps, each of which is aimed at certain conversational functions. These can be further differentiated at the level of observable conversational behaviour, such as *active listening,* which can be realised as *verbatim repetition* or as *paraphrasing,* etc. Before we go into more detail with examples, we will first give a brief overview of the sequence of steps, which is oriented towards the ideal-typical course through the manual, which can be deviated from in many ways in the practice of conversation (§ 17.3).

Conversation steps 1-6

At the beginning, the patient has the floor. Especially in the initial contact, but also in follow-up consultations, the patient should have the opportunity to influence the agenda of the current consultation or ward round in such a way that he or she can introduce his or her concerns with their individual significance and scope in the forms of communication that are appropriate for him or her.

Accordingly, the doctor should initially hold back on influencing the agenda, i.e. leave the first important opening moves largely to the patient. In this sense, a patient-centred interview form is initially chosen, in which the patient, after the 1st step of *establishing the relationship* (greeting, etc.) (§ 18), can formulate his or her *concerns* from his or her subjective experience perspective in a 2nd step (§ 19). In this context, communicative forms of narration are to be promoted, above all through *active listening* by the doctor, which open up access to the *individual reality* of the patient with all his or her *emotions* (worries, fears, expectations and hopes, etc.), to which the doctor not only has to lend his or her open ear, but also, through communicative feedback in a 3rd step (§ 20), develop an *empathic* understanding to promote the patient's further emotional self-exploration.

After a 4th step (§ 21), in which further *details are explored* with a rather doctor-centered interview form by means of precise questioning techniques and the still open gaps in the anamnesis are closed, the further *procedure* is then jointly *agreed upon* with the patient in a 5th step (§ 22), i.e. the pending decisions about further examinations and therapy measures are made together if possible (*shared decision making*). In the 6th concluding step (§ 23), the results are *summarised* and the necessary agreements are made to ensure the continuation of the initiated

relationship until the follow-up appointment and the prerequisites for the realisation of the examination or treatment plan.

In terms of developmental logic, steps 1 (building a relationship) and 6 (summing up) are at the beginning and end of the conversation. In contrast, the individual steps/functions 2-5, which form the core of the conversation, are not realised in a strictly linear sequence, but in a dialogical, circular exchange process with the patient, whereby the super maxim could initially apply: Follow the patient offers as they come. After a certain saturation, the doctor should both give and take opportunities for differentiation, deepening and expansion in order to be able to check initial hypotheses and derive proposals that he or she can then present to the patient for joint decision-making.

Complex learning objectives

Before we present the manual or the evaluation sheet in the practical part and empirically support it with anchor examples, the specific possibilities of using such instruments within the framework of an overall concept of clinical communication teaching (§ 1, 3, 13, 14) should be emphasised. In the use of manuals and evaluation forms, possible misunderstandings should be avoided, which have already been addressed in the controversy about "skills teaching" versus "creativity".

According to this, the teaching of communication should by no means be exhausted in the manualised teaching of skills. The meaning and purpose of a conversation manual cannot be developed in isolation, but can only be conveyed in the context of a *biopsychosocial* and *dialogical* medicine, which requires a specific way of conducting conversations (esp. § 3, 4, 7, 9, 10). *Active listening* is not an end in itself, but is embedded in a *hierarchy of learning objectives,* as we explained in the formulation of the learning objectives (§ 3.4) and the conception of medical communication didactics (§ 13.2).

Thus, if *verbatim repetitions* or *paraphrases* can be regarded as empirical "manifestations" of *active listening* at the level of *fine learning goals*, these are always to be taught in communication theory with higher-order learning goals that are located at the level of *coarse-* and *guidelines* (13.2). In this context, the hierarchy of learning objectives can be captured in a chain of *by-relations*, with which the superordinates and subordinates as well as the additive links (*and)* and the alternatives (*or*) are formulated in a differentiated way (Koerfer et al. 2008).

This type of hierarchical representation of learning objectives is exemplified in excerpts from the manual (Step 2: "Listening to concerns") (Box 17.7).

Box 17.7 Learning objective taxonomy for "Listening to concerns" (extract, cf. § 19)

The doctor practices a *biopsychosocial* approach to care
- by taking a *biographical-narrative case history,* among other things.
  - 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 herself as a helper ("What can I do for you?").
      - or by (...) (cf. § 19)
    - and by *promoting the patient narrative*,
      - by giving listening signals (*nodding*, *hm*)
      - by avoiding interruptions
      - by tolerating pauses
      - by allowing a free development of themes
    - and by *actively listening*
      - by encouraging them to continue speaking
      - by repeating statements verbatim
      - by paraphrasing utterances
      - by asking further questions openly (e.g. "How did that happen?").
    - and by ensuring understanding
      - by asking questions
      - by giving summaries (cf. § 19)

The fine learning goals of conversational behaviour are thus always located at the end of a chain of by-relations at a level whose verbal or non-verbal manifestations are directly accessible to observation. This applies analogously to all steps/functions of the manual, which are further elaborated in their sequence with empirical examples in the practical part (§ 18-23). The manual is only intended to assume typical sequences and focal points in the conduct of conversations, which for good reasons can experience many variants in the reality of conversations, which are to be differentiated according to subtypes (§ 17.3.2). These good reasons have to do with the individuality of patients, their

personalities, their illnesses, their concerns, expectations, hopes and fears, to which their doctors must *flexibly adapt* with a *fitting competence.*

17.2.3 Variable application practice

In addition to conveying concrete learning objectives at the level of observable conversation behaviour (e.g. interruption and pause behaviour, listener feedback, etc.), this also involves (self-)reflective learning objectives for conducting conversations, the fit of which can only be assessed relative to the possibility of shaping the process structures of conversations. In doing so, doctors must once again be able to take into account the individual *dynamics* of concrete conversations with their *fitting competence* (§ 3.2), the development of which cannot be predicted but can only be shaped in *dialogue* depending on the conversation partner.

Here, above all, the aspect of the *circularity* of conversations must be taken into account, which can hardly be depicted in a *linear* presentation of a manual. Since such a manual, especially with its further subdivision (§ 18-23), must by its very nature initially follow a linear arrangement, which in our culture runs from left to right and from top to bottom, it is obvious that this linear representation can only do limited justice to the *circular* complexity of communicative processes, even in medical rounds and consultations. This concerns both the order and the ranking of the 6 steps/functions.[5] Although it is clear that a relationship (1) with the patient cannot be established only at the end of the conversation and that a summary (6) cannot be drawn at the beginning, the middle steps/functions (2-5) can also be perceived in a different order and in circular communication processes.

As soon as the patient is granted the privilege to speak and talk about topics, as suggested by Morgan and Engel (1969/1977) (§ 3.4.1),

5 At this point, reference should be made to other breakdowns, which usually range between 3 and 9 main steps/functions, with corresponding subdivisions. In the traditional *three-function model,* for example, emotions are also negotiated under the first main function "relationship building" (Lazare et al. 1995, Cole, Bird 2014) (cf. § 20). In their classic introduction to anamnesis taking, Morgan and Engel (1969/77) distinguish a total of 9 steps, with further subdivisions (dimensions), for example, for the *localisation*, *quality*, *intensity* etc. of complaints (cf. § 21). For historical-systematic overviews of various multidimensional models, see Haes de, Bensing 2009, Lipkin 2011, Brown, Bylund 2011, Papageorgiou 2016.

"unstructured" conversations are to be expected from the doctor's point of view, for example because patients often follow a different order than the one preferred by the doctor, i.e. they tell their illness story in an "unstructured" way by following their own *narrative logic* (§ 9). Thus they can choose a "stubborn" way of starting by "jumping in the door", putting their emotions first ("I have trouble at work") or immediately requesting a certain procedure ("total check-up", "gastroscopy", "antibiotics" etc.) without first leaving this to the doctor and wanting to engage in a communicative "negotiation of the procedure" (5) with him/her, etc.

If the doctor initially (sic) follows the patient's spontaneous concerns, this often results in a certain "deviant" conversational structure compared to the ideal form, in which at least the middle conversational steps or functions (2-5) are realised in *circular*, possibly *repetitive* and *redundant* conversational processes, without these therefore being qualified as "inappropriate". Since we will differentiate such empirical conversation processes in detail, we will only take into account their systematics in the form of a *hexagram* of medical conversation (Fig. 17.2), which cancels out the linearity of the manual and takes into account circular, cross-cutting and regressive connections.

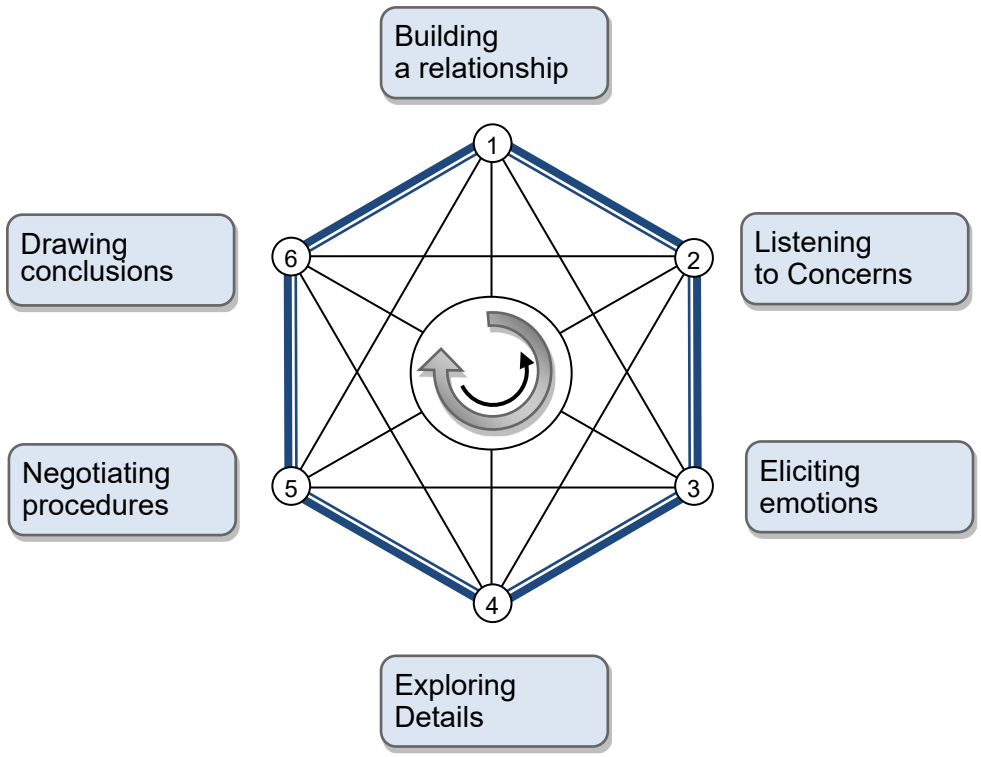

Fig. 17.2: Hexagram of medical communication

If this description initially assumes a "uniformity" of the occupation of steps/functions, this is also an ideal-typical assumption that does not necessarily apply in the first meeting. Even more so, "imbalances" must be expected in follow-up conversations, because certain functions may already be "saturated" in preliminary talks, which is why both partners can already refer to a secure stock of knowledge and decisions, which they may have already secured several times in previous résumés (6). This ability to connect new conversations to a shared history of interaction is precisely what makes up the "shared reality" (in the sense of Uexküll, Wesiack 1991, 2011) between doctor and patient (§ 4.4), in which what was once "self-evident" does not have to be made an issue again and again.

However, *communicative* "control procedures" must be built in systematically or at least at regular intervals against the risks of routine medical treatment, with which the doctor and patient can protect themselves against ingrained routine patterns of communication (D: "Everything else the same?" - P: "Everything clear!") through *dialogical* reassurances (D: "Everything really? Nothing new at all?" - P: "Well, if you ask me like that, then ..."). What is poorly illustrated here by constructed examples will occupy us in detail in the form of techniques of dialogical reassurances of understanding based on empirical examples.

From the result of these optional "digressions" of understanding and comprehension, which help to open up new thematic opportunities, current stress at work or increased sleep and concentration disorders of the patient, etc., may make new thematic rounds of anamnesis taking with corresponding deepening in all middle steps/functions (2-5) necessary, in order to finally decide in a joint decision-making process (§ 10) on a considerably modified or even completely new therapy plan, which is to take into account the new insights jointly gained by doctor and patient, etc.

In an *ideal-typical process model*, we systematically illustrated the alternation and interweaving of *repetitive* and *innovative* patterns and stages of *communicative* action (anamnesis, clarification) and *instrumental* action (surgery, medication) between doctor and patient (§ 8). At this point, it should be noted in summary that manuals do help to structure the practice of conducting conversations, but the limits of manualisability in this very practice should not be misjudged. One of the main concerns of the practical part (§ 17-23) of the handbook will be to concretise this perspective of a dynamic conduct of conversation, with which

the doctor must react *flexibly* to changing conditions, using empirical cases of conversation.

17.2.4 Conversation maxims and fitting competence

The lack of flexibility in the way doctors conduct conversations has often been lamented. Doctors tend to apply the same conversational style to all possible patients (Box. 17.8), irrespective of changing conversational conditions such as their individual illness, age, etc. This is a common problem in the medical profession.

Box 17.8 doctors *do not change*

The problem as shown by experience and research work that doctors *do not change*. Audiotaping and videotaping of multiple consultations by the same doctor show a remarkable consistency of style. A simple analogy likens us to the traditional Englishman abroad. We do not act differently - we just talk more loudly or slowly. Thus doctors say and do things in much the same way with an anxious 16-year-old coming for a termination as with a 50-year-old woman with menorrhagia or an 80-year-old woman with vulval carcinoma (...) different patients need different types of communication. We need to be flexible, and it appears that most of us are not.

Tate 2004: 12

The art of medical communication requires that clinical competences are flexibly harmonised with institutional and individual conditions. This requires a special *fitting competence,* as already explained above (§ 3.2). In a *self-critical reflection,* the doctor subjects the ongoing conversation to a concrete diagnosis of the conversation, in which he or she, for example, takes a critical stock for a possible decision to continue the conversation, about what is to be done at present or later, or what is to be completely omitted, or what is to be left for a further conversation, etc.

The object of reflection of the "conversation diagnosis" is not only the next possible *detailed question* about the accompanying symptom in the short term, but at the same time the long-term relationship with the patient him- or herself, whom a doctor must not overburden with further *details* (e.g. about the "delicate" *family* or *sexual history*) - if he or she

does not want to unnecessarily strengthen the possible *defensive behaviour* of a patient with his or her *invasive* questioning technique. In such a case, an "unrestrained" continuation of an *interrogative* style of conversation with *insistent* enquiries about *emotions would* miss the necessary fit. Rather, forms of *tangential* conversation (§ 3.2, 17.3) are *appropriate* here, with which patients are "touched" but not "hurt". A maxim such as "emotions have priority" cannot therefore be followed "without circumstance", but only *context-sensitively.*

Developing the necessary "instinctive feeling" for what is still just suitable and what threatens to become extremely unsuitable requires a *fitting competence* with which doctors can achieve at least a "more or less" good fit. The concept of fit itself is therefore not intended to imply an "absolute" but only a "relative" fit in the sense of *fitting* (Fig. 17.3), which will be briefly justified here and exemplified in the following conversation analyses.

Although verbal interventions of the doctor in the concrete conversation with this individual patient with his or her individual suffering, concerns, preferences etc. should fit "*tailor made*" if possible, possible margins of fit should be taken into account, as they have been described following constructivist and systemic-therapeutic research with the conceptual distinction of *match* and *fit* (Glasersfeld 1981/1987, de Shazer 1985/2003). According to this, a certain verbal or non-verbal action in communication with the patient does not always have to "fit" like the certain key to this one lock, but a function as a "lock pick" (*pass key*) is sufficient, with which not all, but many locks can be opened.

Thus, the "art of medical communication", which still needs to be differentiated in empirical cases, consists above all in the use of "lock picks", which fit more or less well, or at least have sufficient accuracy of fit, to open the first doors (of patients). For the doors behind them, *readjustments* may be necessary during the ongoing conversation so that doors that are particularly "locked" (by patients) can also be opened further.

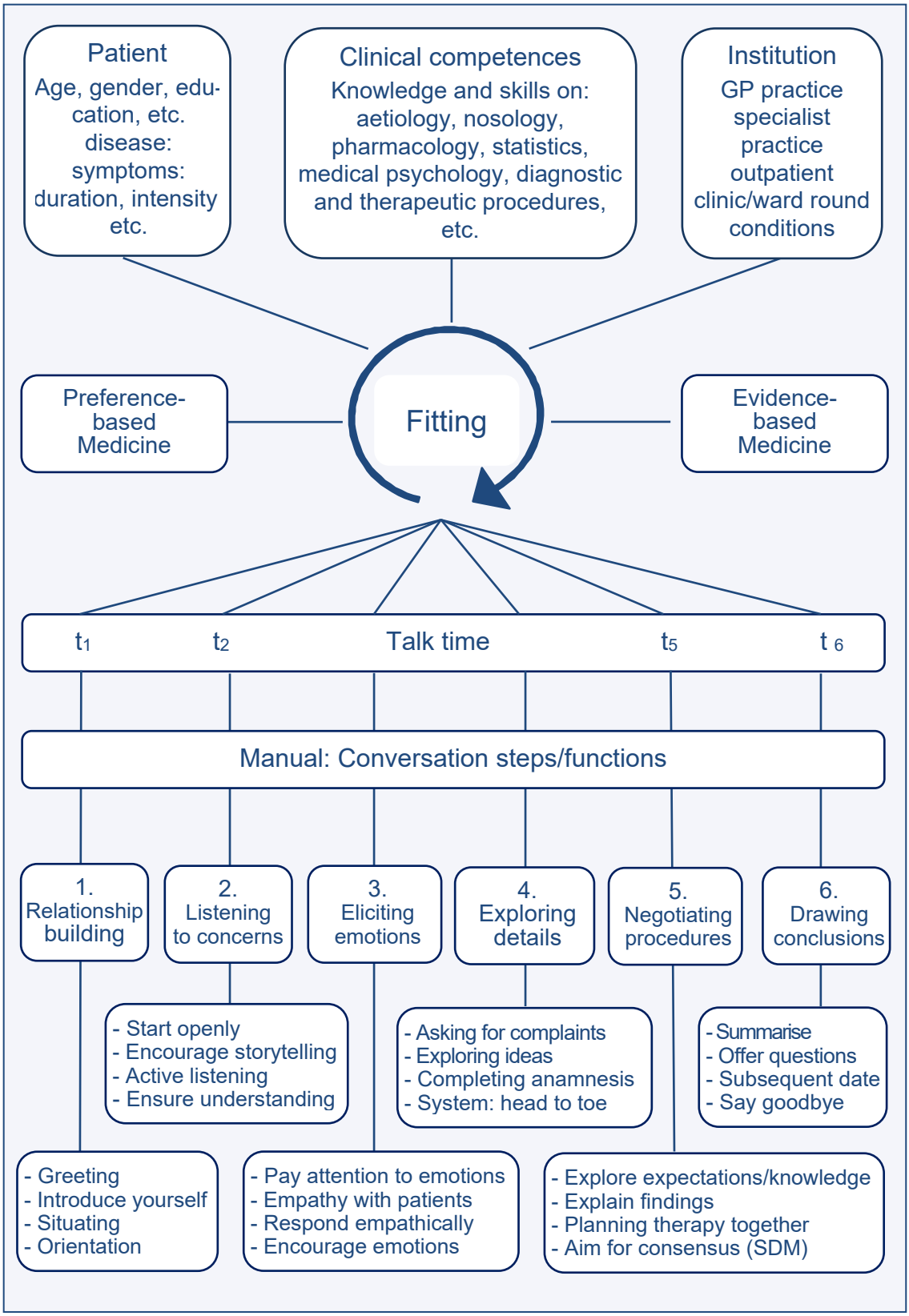

Fig. 17.3: Fitting – Communication Manual (overview) (cf. Fig. 17.8 and § 18-23)

The relative concept of accuracy of fit also corresponds to our way of speaking about *maxims of conversation*, with which it must be assumed less than with the *concept of rule* that conversations between doctor and patient would be regular in the sense of a determination. It is true that it often happens that "one word gives rise to another", but despite this, the course of a conversation (according to the sequence of speakers and topics) is not predictable, as long as it is not a matter of ritual communication (Paul 1990, Koerfer 1994/2013). Rather, with Buber (1954/1986), a concept of dialogue is also to be assumed for communication between doctor and patient (§ 7.5), according to which a "genuine conversation" cannot be "predisposed".

Nevertheless, the conversation between doctor and patient must also follow a different conversational logic than, for example, the *"small talk"* between neighbours or the *"interrogation conversation"* in court, and doctors must take these specific differences into account precisely with their multi-layered fitting competence, with which they have to adjust to the diverse (professional, institutional, individual, etc.) conditions of their actions more or less "fittingly".

Contributing "one's part" to a "good" conversation from a professional perspective is certainly the main task of the doctor, although the principle claim of optimising conversations in the "common reality of conversation" (in the sense of Uexkülls, Wesiacks 1991, 2011) may often only be realised "approximately". Even if the overall responsibility for the structure, process and outcome of conversations remains with the doctor, he or she is still fundamentally dependent on the patient's participation as a "co-player", despite all the restrictions that "difficult" patients (§ 32, 34) can bring with them.

It is an essential part of the professional role of the doctor to "make" the patient a "good participant" through the way the conversation is conducted, even if this task can be difficult in different ways. Due to their personality and specific illness, patients bring very different *individual* "styles of conversation" to which the doctor has to adapt. This is where the relevant maxims (nos. 2 and 3) (§ 3.4.1) of Morgan and Engel come into play:

Conversation maxims

1. (...)
2. The *degree of guidance* needed is different for each patient.
3. The doctor must remain flexible when taking the history and *adapt* to the nature of the patient.
4 Neither should he allow himself to be *passively* swamped by numerous insignificant details, nor should he conduct the anamnesis in the manner of a *cross-examination*
5. (...) 6. (...) 7. (...) 8. (...) 9. (...) 10. (...)

Box 17.9:
from: Morgan, Engel (1969/1977: 31-75)
(selection and emphasis ours)
(see all 10 maxims in § 3.4.1).

This *flexible adaptation / fitting* of verbal and non-verbal interventions is part of the professional adaptation competence of doctors, which enables them to recognise the necessities ("indication") for the following types of conversation and to realise them conversationally:

- with some patients, the doctor can and should simply "let the conversation flow" until a certain "saturation" is reached,
- with others, you have to "help" earlier to "get the conversation going" in the first place,
- with more patients, the doctor has to "put on the brakes" because otherwise the conversation threatens to "derail",
- or the doctor has to "intervene" in a more structuring way, because otherwise the "common thread" could get "lost" for both conversation partners,
- or the doctor must change from a "confrontational" to a "tangential" way of talking (§ 3.2, 17.3.4), because otherwise defensive behaviour could endanger the relationship,
- or the doctor has to "finish for today" because otherwise the patient would "not find an end", etc.

Since patients (like all people) bring their own personality traits into a conversation and can communicate very differently as ill persons, the "good" doctor can also use (a)typical conversation processes as a possible diagnostic tool when a patient

- enters the room "hesitantly" or "briskly",
- shakes hands with you "powerfully" or "powerlessly",
- when he or she "talks like a waterfall" (logorrhoea)
- or appears so "impertinent" and "demanding" that the doctor is seemingly left with no choice.
- or when a patient is so "obdurate" that "you have to drag everything out of him or her",
- or when he or she speaks so "softly and sluggishly" that you can hardly understand him or her,
- or he or she roars so "loud and shrill" that you flinch,
- or if the patient constantly lowers his or her gaze so that you cannot get eye contact with him or her, etc.

Some of these conversations cannot run "smoothly" with the "best will in the world" of the "good" doctor, but the (various) "frictions" are precisely constitutive components of the conversation, which can serve further (relationship) diagnostics, especially with "difficult" patients (§ 29, 32, 34). Since the "loud", "intrusive" phenomena of communication are usually "unmistakable" or "unmissable" anyway, the doctor's observation should concentrate all the more on the "quiet" or "small" communication phenomena. The "demanding" patient can also "scratch nervously", "tremble with excitement", etc., perhaps because he or she is "not so sure of his or her case" as it appears "at first glance", etc.

Overall, it should be part of the doctor's observation routine to perceive the patient on "all channels", as they are also differentiated in non-verbal research on doctor-patient communication (§ 12, 18). Ultimately, under the aspect of completing the anamnesis, the objective is to gain a sufficiently "good overall picture" of this individual patient. The art of medical communication is to open up enough room for the "life-world" concerns of the patient, i.e. his or her concerns, hopes, fears, preferences, etc., without neglecting the medical concerns of optimal care for the patient.

To meet this double challenge, the doctor has to find a balance between a sufficiently structured and at the same time flexible conduct of

the conversation, with which the inadequacies of the patient's spontaneous (self-)representations can be overcome in the sense of a systematic and approximately complete taking of the patient's medical history.

17.3 Structured and flexible communication

Striking a balance between structured and flexible communication can easily lead to conflicts of maxims (§ 3.1, 17.2). Allowing the patient to speak in detail without interrupting him or her in order to clear up any ambiguities may entail the risk of having to leave certain gaps in the anamnesis which, from the doctor's point of view, urgently need to be filled. In this respect, the *conduct* of medical *conversations* often remains a balancing act in which the unity of *conversation* and *guidance* is endangered (§ 7.5), because either the conversation as a dialogue can come up short or the lack of guidance may leave medically relevant topics unclarified.

In the context of the discussion outlined above (§ 17.2.1) about the supposed opposition of *skills* and *creativity,* Silverman (2018) (Box 17.10) has emphasised the *paradox* that only structures can open up certain freedoms to deviate flexibly from fixed paths.

Box 17.10 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

What is emphasised here for both conversation theory and conversation practice is the condition of *appropriateness* ("when appropriate"), which must be fulfilled in order to be able to justify the flexible *deviation* from structures as well as the *return* to structures. The concept of "*appropriateness*" or "*fittingness*" has already been identified as central to our model of fittingness (§ 3.2, 17.2) and we will constantly encounter it in

empirical conversation analyses when it comes to the fittingness of verbal and non-verbal interventions in medical conversation in conversation sequences.

In the process, *sequential* structures (when the speaker changes) are initially recorded at a *micro level* of the conversation, which, however, must always also be examined at a *macro-structural* level, which is concerned, for example, with the interactive and thematic *participation of the conversation* partners in the overall conversation or in specific *phases of the conversation* (§ 17.3.2, 40.2). This is the only way to recognise the more or less "abrupt" changes of topic when doctors, for example, switch from "emotions" (Cologne Manual (C-MMC): step/function 3) directly to the further "procedure" (5) in order to then return to the "detailed exploration of complaints" (4), and so on.

These changes sometimes appear "arbitrary", but they can also fulfil their specific functions, which in the above sense of Silverman (2018) can be carried out in different phases of the interview. There may be "good" reasons for realising the changing functions in a way that deviates from a certain basic structure, and following these reasons is precisely what constitutes flexibility in medical interviewing. Under this evaluative aspect, qualitative and quantitative analysis perspectives are to be shown below, which are then to be concretised for the later empirical interview analyses with anchor examples for the manual.

17.3.1 Temporal framework

A first controversy about "good" reasons can already arise at the opening of the consultation, where the relatively simple question arises about how to deal with consultation time in the medical consultation or ward round. For example, "good" reasons can be given for explicitly disclosing the limitation of consultation time, which would be in line with the *requirement of transparency* in medical practice (§ 10.5). However, "pragmatic" decisions often have to be made because the "necessary" time cannot always be adequately anticipated and early assessments have to be changed. In addition, specific time indications (by minutes) are likely to have different effects on patients. For example, the information given to the patient can serve as a "structural guideline" for both conversation partners for better "orientation" (§ 18.7), but it can also become a "shackle" if it is misunderstood by the patient or cannot be

adhered to for other "good" reasons, because the doctor him- or herself still has an urgent "need for clarification" etc.

The problem of communicating conversation time arises less as an "objective" time problem than as a subjective experience of time. It is often assumed that good conversations usually have to be longer than less good ones. It is true that there are factual "outliers" of extremely short or long conversations (§ 19.6-7). However, as a result of Cologne studies in a pre-post design for the evaluation of Balint group work, we can anticipate that the conversations improved after further training without becoming significantly longer (Köhle et al. 1995, 2001, Koerfer et al. 2000, 2004, Koerfer, Köhle 2009). It thus depends on how the scope of a conversation is used both *formally* (right to speak) and *interactively* (narrating - listening) as well as *thematically* (according to bio-psychosocial topics), which is not least a problem of the *participation* of both conversation partners in the course of the conversation.

Before this problem of participation is discussed further below (§ 17.3.6, 17.4) and in the evaluation (§ 40), the practical problem of the extent to which patients should be informed in advance of the expected scope of the consultation or not (§ 18.7) should be addressed here. This raises not only the if-question, but also the how-question. The Cologne research group did not reach a uniform opinion on either question. This is due to the fact that the clinicians in our group and the doctors from the training courses have had very different experiences with patients' reactions to time statements.

Some patients react irritated to a strict time specification ("10 minutes"), apparently because they feel this is too "short and concise". Others react more calmly, perhaps because they have a different sense of time or otherwise apparently think that they can perceive their request within the announced time frame. Because it is impossible to know in advance what type of patient we are dealing with, who will either be deterred in their willingness to talk by the time given or feel invited to talk, doctors often prefer vague formulations, which we list in detail in the practice section (§ 18-23). Especially during the first interview, doctors often give their patients "enough" time "to get to know each other first" or "to get an idea", etc.

Because of the outstanding function of the initial consultation, in which a long-term relationship between doctor and patient can be established, more time is often granted flexibly, but through special structural specifications. For example, certain (longer) appointments are reserved for initial consultations in the family doctor's practice, which,

however, requires a specific practice organisation (§ 25). If the relationship is familiar and stable enough, fixed times are also set for follow-up consultations, in which the focus is on certain tasks ("blood pressure control", medication, etc.). This can lead to the *formation of focal points* in follow-up talks (§ 17.3.2, 40.2), because certain steps and functions of the talk only have to be taken care of marginally, for example if the anamnesis has already been relatively completed and "only" "changes" compared to the current status from the previous talk have to be taken into account.

17.3.2 Conversation steps and functions

In addition to the external framework (place, time) (§ 18.7), the internal structure of conversations is important, with which doctors follow the logic of traditional patterns of conducting conversations, which functionally range from *taking anamnesis* to *making* and *communicating a diagnosis* to further *clarification* and *decision-making.* We have differentiated the stages and progressions of medical conversations, examinations and treatment in advance (§ 8) and focus here on the conversation steps and functions differentiated in our manual (§ 17.2.2), which are ideally depicted in an initial conversation before the patterns can be repeated or modified in follow-up conversations.

When we presented our manual, we already pointed out that the 6 steps or functions of the conversation should not be worked through in a linear sequence, which would contradict all practical experience. Real conversations actually run differently, even if they are oriented towards ideal-typical processes. It is clear by function that a greeting is given at the beginning and a summary is given towards the end, although there can also be an intermediate summary, at least in the form of summarising *assurances of understanding* (§ 19), and so on. However, as the empirical analysis of the conversation will show, there are structures in the core of the conversation (steps 2-5) that can deviate considerably from an ideal-typical structure, and for good reasons, because the doctor adapts precisely to the communication needs of the patient with a flexible conduct of the conversation.

The doctor, however, follows the patient's need for communication in a way in which he or she meets the need for clarification in flowing topic movements if possible, but sometimes also by changing the topic. This results in *circular* structures (cf. above Fig. 17.2) in which both partners

"oscillate" with their respective topic initiatives and topic reactions between the 4 core functions that are differentiated in the middle part of the conversation manual. As a result, prototypical course structures can be indicated here as well, for which we have differentiated exemplary case types (Fig. 17.4, A-D), each with specific focal point formations, whereby 10 time units are roughly differentiated here on the time axis.

In the first type (A), we are dealing with the ideal-typical flow structure assumed in the manual, in which the sequences of steps and functions are realised more or less linearly. Slight deviations, which may be due to small excursions or flashbacks, have little effect on the main structure of the conversation, which is mostly found in initial conversations.

t	1	2 Concerns	3 Emotions	4 Details	5 Procedure	6
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Fig. 17.4-A: Ideal-typical normal structure (initial interview)

Due to their specific functions, follow-up conversations develop a momentum of their own anyway, in which reference can be made to jointly acquired knowledge, even in an abbreviated form, so that their own structures and focal points develop, as they are characteristic of the following type (B). Due to the common history of interaction, the doctor and patient can focus on *agreeing* on the further *procedure* (5) immediately after the introduction of the conversation, as this may have already been decided as an agenda in the preliminary conversation. The type with the focus on *coordinating the course of action* is characteristic for all follow-up discussions, where it is about the continuation of a therapy that has been started and possibly only the taking of medication (*adherence*) needs to be focussed on, for which the "remaining" medical history "only" needs to be updated, etc.

t	1	2 Concerns	3 Emotions	4 Details	5 Procedure	6
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Fig. 17.4-B: Focusing on "negotiating procedures”

However, there can also be initial conversations of this type (B), which are not so rare. These initial consultations are characterised by the fact that a patient "drops in" with a "request" right at the beginning of the conversation, which is tantamount to a demand for a certain procedure. Patients "request" a "complete check-up" or a "gastroscopy" or (as diabetics) a "switch to a pump" right at the beginning of the conversation. In these cases, which are still the subject of the analysis in the practical part, the doctors are contacted according to the model of *service,* as it were, which must first be laboriously converted by them into a *cooperation model* (§ 10.4), in which first the anamnesis is taken before, after further detailed exploration (4), the further procedure (5) is finally agreed upon with the patient. Here, the conversation may focus more on clarifying *subjective expectations* and *patient preferences* as a prerequisite for joint *decision-making* (§ 10). It may also be necessary to wait for further findings and to discuss what the patient needs to be *informed about* further, etc.

Since the anamnesis is always relatively complete and has to be continuously supplemented, another sub-type (C) can also develop under the aspect of updating the anamnesis, which is characterised by a focus on *detailed exploration* (4), in which, for example, the integration of therapeutic measures (diet, physiotherapy, cardiac sports, etc.) into the patient's everyday life is more important. It may be necessary to discuss corrections to the therapy plan again, which is to be adapted to the patient's realisation possibilities, etc.

t	1	2 Concerns	3 Emotions	4 Details	5 Procedure	6
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Fig. 17.4-C: Focusing on "Exploring Details”

In the fourth type (D), it is characteristic that patients address their emotions right at the beginning of an initial interview, but also in follow-up interviews ("so anxious", "done with nerves", "depressed"). Such thematisations of emotions are, of course, an indirect way of formulating a concern as a request for help, as Brody (1994) has already put it (§ 9): "My story is broken; can you help me fix it?" This is where the doctor can take up further *biographical narrative* anamnesis and detailed exploration, for example, before possibly beginning to agree on a course of action with the patient, with which a diagnosed depression (§ 30) or anxiety disorder (§ 31) can be successfully countered.

T	1	2 Concerns	3 Emotions	4 Details	5 Procedure	6
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Fig. 17.4-D: Focus on "Eliciting Emotions”

The four proto-types of process structures roughly characterised above can hardly cover the wide spectrum of possible conversational processes, which must be further differentiated under evaluative aspects. It is true that deficient conversation structures in which specific focal points may leave gaps, for example in "emotion work" or "detailed exploration", can be indications of deficient conversation management as a whole. However, it must also be taken into account that "deviations" from an ideal process structure can also have "good" reasons that have to do with the changing conversation functions that have been shown, according to which initial and follow-up conversations can differ considerably.

Once a trusting relationship between doctor and patient has been established in the course of a long history of interaction together, they can also "get straight to the point", however this point is *negotiated* between the interlocutors in individual cases (§ 17.4). This problem of negotiating relevance calls for a special *fitting competence* (§ 3.2-3, 17.2.4), with which doctors know how to adapt flexibly to the individual communication needs of their respective patients while preserving "medical" concerns.

As we will see, patients sometimes develop complicated entry structures on *their own initiative* by "buying" new "entry tickets" for further topics in the course of the conversation, which remain a challenge for the doctor's guidance of the conversation to structure them according to focal points. In this case, the *super-maxime* of letting an initial conversation "run its course" can only be an interim solution, which should be replaced by stronger conversation management, at least in follow-up conversations. The fact that there does not have to be a contradiction between *conversation* and *leadership* in the conduct of medical conversations has already been explained in the justification of *dialogue-based medicine* (§ 7.5).

17.3.3 Mixture and dosage

Despite all institution-specific objectives, the same applies to doctor-patient communication that applies to conversations in general and even to life in general. Expressed in terms of concepts with which doctors are also very familiar in their everyday work: Everything is a mixing or dosing problem. What is supposed to "help" as a "medicine" can re-

main ineffective if underdosed or can be "deadly" as a poison if there is a corresponding overdose.

So, in principle, it is not true that "a lot helps a lot!", but a distinction must also be made for the art of conducting medical conversations: In addition to "less of the same", there is also "more of the same", which can, however, reach its limits because there is also "too much of the good". To illustrate it in a comparison between a medicine and the conduct of a conversation: Just as it is not helpful to empty the cough syrup bottle in one go or in one day, it is not helpful to use certain (non-)verbal conversational registers at the same time or in a short duration of conversation in an *inflationary manner.* A first normative orientation should be given in a simple tabular comparison (Tab. 17.1), for which exemplary placeholders ("ingredients") for a more or less "good" *mixture* in conducting the conversation should be given here.

Recommendations		Warnings
Less of the same	More of the same	Too much of a good thing
Speeches Interrupt Questions of information Suggestive information questions Ignoring emotions Rebuking Instructing Directing Change of topic	Silence (= letting speak) Listener feedback Comprehension questions Active listening: Repetitions Paraphrases Addressing emotions Praising Clarifying Advising Topic reactivation	

Tab. 17.1: Mixtures and "ingredients" in medical communication

This tabular overview can only rudimentarily capture the complexity of communication, especially since it is only implicitly based on maxims that only allow a gradation between "too much" and "too little" in application. Thus there are fluid transitions where *recommendations* can "tip over" into *warnings.* Accordingly, it is not possible to set a certain limit after which (as in "Sleeping Beauty" with the fairies) the 13th question

would already be "too much". This concerns the evaluative problem of how many questions (of a certain type) a "good" conversation can still "tolerate" (or not).

The fit of questions often depends on what else is going on in the conversation, into which a 13th question may still fit well under certain circumstances. However, conversations can be clearly identified as "interrogation conversations" (§ 19) if questions apparently dominate in such a way that everything else "gets short shrift", i.e. patient narratives are nipped in the bud by further doctor's questions. The "classic" maxims of Morgan and Engel (1969/77) on the one-sided "interrogative interview style" in selection (Box 17.11, No. 4-6), already mentioned (§ 3.4), should be referred to again here.

Well-intentioned but too many and badly placed questions of a certain type (e.g. *suggestive information questions*) (§ 21.2) can be experienced as "cross-examination" (in the sense of Morgan, Engel 1969/77), for which we will analyse empirical examples of whole conversations (§ 19-21). All in all, in a "good" conversation it always depends on the "good mixture", which certainly includes *targeted* questions if the information cannot be gained in any other way. These questions, however, are "usually" to be booked under "far from it" if they "help to bring to light" necessary information supplements, but cannot "really advance" the conversation in the way that *key interventions* can, which we will discuss further in empirical conversation analyses (§ 19-22).

Conversation maxims

1. (...) 2. (...) 3. (...)
4. Neither should he [the doctor] allow himself to be ***passively*** swamped by numerous insignificant details, nor should he conduct the anamnesis in the manner of a ***cross-examination.***
5. The doctor must always start a topic with ***open questions.*** He uses ***specific questions*** only to fill in gaps, to remove ambiguities or to substantiate certain facts.
6. ***Avoid*** questions that the patient can answer with a simple "yes" or "no" if possible.
7. (...) 8. (...) 9. (...) 10. (...)

Box 17.11:
from: Morgan, Engel (1969; Engl. 1977: 31-75)
(selection and emphasis ours) (cf. § 3.4).

In analysing the conversation, a mixture of quantitative and qualitative aspects must be taken into account. Certain unfortunate, misleading questions can be repeated several times, but certain other interrogative "ingredients" of a conversation cannot. If a patient is defensive, repeatedly "probing" with *insistent* questions is likely to be counterproductive because the defensive behaviour would be reinforced. In the face of further confrontation, a *tangential* approach to the conversation is recommended, as already explained above (§ 3.2) and will be further elaborated below (§ 17.3.4).

Certain "ingredients" remain *singular* interactions from the outset. After a greeting (for whatever reason) (§ 18) has "gone wrong", it cannot be repaired by repeating it three times; at best it can be compensated for by metacommunication ("Sorry, I was still completely engrossed in the phone call"). When saying goodbye, one can occasionally observe "repetitions", which are mostly caused by patients "not finding an end" and "offering" further "symptoms" still in the door frame. Here, the doctor's repetition of the goodbye often subtly fulfils the dual function of ending the conversation.

A particularly "good" mixture is required for the forms of *active listening*, which are to be differentiated according to type and frequency. Listener feedback (*yes*, *exactly*, *correctly*, etc.) is relatively frequent, but to mechanically repeat it "without sense and reason" in too regular a sequence is just as little conducive to conversation as constant word repetition, which as a special form of active listening can certainly be used productively to "keep a conversation going" (§ 19). Using word repetitions in "excess" might make the critical patient think what the courageous patient would say: "Doctor, you're not my parrot after all!" An "excess" of "positive" forms of communication is not conducive to conversation, nor is constant talking in between, which interrupts the patient's flow of speech, narrative and thought. Also, 100% eye contact would be as harmful as none (Skelton 2011). Continuous eye contact would be *too much of a good thing* because it could be experienced by patients as "aggressive staring", which research on non-verbal communication (§ 12, 18) has enlightened us about.

Likewise, too long a "silence" on the part of the doctor can be interpreted as threatening, because it can testify to incompetence or disinterest. A doctor's restraint in speaking rights must therefore be well dosed and placed in the "right" places if it is to be perceived by the patient as a well-intentioned giving of the right to speak. The distribution

of speaking rights also depends on a *good mix* in the relationship between the roles of speaker and listener, which can certainly be represented in a quantitative perspective under the aspect of *participation* (§ 17.3.6).

17.3.4 Tangential conversations

While the "right" *mixture* and *dosage* concerns the talks as a whole, these individual talks are always about certain *key interventions* that often give talks a new quality. These key interventions, however, cannot be arbitrary, but must be placed *precisely in relation* to the development of the conversation and the receptiveness of the patient, who should not "shy away" from them. To remain in the image of dosage: Even with single doses, under- or overdoses must be avoided, which requires special (pharmacological, etc.) competencies on the part of the doctor. For "decisive" interventions in the conversation, a special *empathic* competence is usually needed (§. 3.2), with which the doctor finds the right moment to force a conversation that may have been "rippling along" so far, without "losing" the patient.

From the point of view of the *empathic* competence of doctors, it is not so much a matter of avoiding verbal "lapses" as a matter of course, as we described (above) with Lown (§ 17.1.2), but rather of the problem of the *dosage* of verbal interventions in a so-called *tangential* conversation (§ 3.2). As the name already characteristically suggests, this type of conversation is intended to "touch" on "delicate" topics only to the extent that the patient is only "touched" without "penetrating" too far into him. In doing so, a doctor may have to use the "power of the word" (§ 17.1) much more "cautiously" than we should all do in everyday life. This is where a doctor's *self-reflective observational competence* comes into play (§ 3.3.2), which knows how to go beyond gross negligence and adjust the effects of the word on precisely this patient in this conversational situation at this time.

This *fit of interventions* in a *tangential* conversation still needs to be worked out in detail in the empirical conversation analyses. Here, only so much should be anticipated that tangential conversation is a general challenge that is claimed for a large spectrum of illnesses and diseases, such as specifically for *somatoform* and *functional* disorders (Ronel et al. 2007, Rudolf 2008, Schäfert et al. 2008, Lahmann et al. 2010, 2010), *dissociative* seizures (Fritzsche et al. 2012), but also for specifically

physically ill patients with advanced type 2 diabetes (Faude-Lang et al. 2010). Thus, Rudolf (2008: 13) pleads overall for an "understanding, calm and benevolent therapeutic attitude", which should use *tangential* conversation especially with somatoform patients. As Schäfert et al. 2008 (Box 17.12) vividly describe, *confrontational* conversational techniques, which can put a "lasting strain" on the relationship with the patient, should initially be put on hold accordingly.

Box 17.12 Tangential instead of frontal

Typically, longer stretches of the complaint are repeatedly interrupted by brief references to psychosocial difficulties. They should not be passed over (...), which is a typical pitfall of interviewing in primary care (...), but should be taken up by means of tangential interviewing. This means that the patient's message is carefully marked as relevant, i.e. registered and underlined. This type of conversation is called *tangential* because it only lightly touches the patient's report like a tangent touches a circle (...). Psychological topics are addressed rather *casually* with terms from everyday experience such as "burden" or "stress", which helps to discuss psychosomatic connections as free of stigma as possible. The main technique for this is *mirroring*, i.e. the emphatic reproduction of what the therapist has heard, e.g. "So that was a burden for her", "That sounds like stress" (...) In contrast, frontal, confrontational conversation techniques (...) are not advisable, as they are often difficult to accept and can put a lasting strain on the therapist-patient relationship. This category includes the interpretation of resistance and contexts, which - at least initially - should be avoided.

Schäfert et al. 2008: 255

In empirical cases, shaping the conversation between the alternatives of a more *confrontational* or *tangential* one can prove difficult (§ 20, 21, 32). In these cases, too, an initially "conflict-avoiding" or even just "conflict-reducing" conversational attitude towards individual patients in individual conversational situations requires *empathic* conversational competence (§ 3.2), with which the doctor can, if not already anticipate possible (defensive) reactions of the patient to his interventions, then in fact notice them in the conversation. As is the case with all of us in everyday life, the effect of words (§ 17.1) can also be "read" in the consultation by the reactions of patients, whether verbal or non-verbal, for example when a "half-hearted" answer is accompanied by a "pained"

smile. Here, everyday world descriptions from the metaphor area of "conversations as struggle" (Lakoff, Johnson 1980/1998) (§ 11) are meant to illustrate the possible "overdose" in medical interventions that can "cause" corresponding reactions on the part of the patient:

- The doctor has so "overrun" the patient that he or she has "given up" all resistance.
- The doctor was so "pressuring" the patients that they felt "cornered".
- The doctor "tightened" the pace of the conversation so much that he or she "lost" the patient.
- The doctor has "advanced" so far that the patient has "withdrawn".
- The doctor was so "pushy" that the patient "closed up".
- The doctor "attacked" the patient so strongly that the patient "flinched back in fright".

It is possible that in these cases the doctor was too "invasive" with his or her patient on a "sensitive" topic (marital crisis, sexuality, workplace conflict, etc.), which rather "put the patient on the defensive". It should be remembered that insistent interventions, which according to their logic do not address anything essentially new, but only repeat "old" things all too often in variations, often trigger the opposite of what they want to achieve, namely "defence" instead of "opening up" of the patient.

This resistance suggests a lack of willingness to talk on the current thematic "front". Here, the sensitive doctor may observe that the patients "keep a low profile" or "close up" because he or she has obviously "gone too far" with his or her medical interventions and has "pressed" them too much, etc. Morgan and Engel (1969/77) (Box 17.13) also described in detail what to look for in communication and how to deal with a recognisable resistance:

Box 17.13 Avoidance or postponement of "dicey" issues

The patient, who deliberately conceals information, betrays to the doctor by repeated blushing, hesitation and gestures or by an inappropriate laugh that he is touching on a dicey subject. Since the doctor does not want to break through the patient's defences, which would frighten the patient, he drops the sensitive subject for the time being and tries to return to it later by a roundabout route.

Morgan, Engel 1969/1977: 68f

We will come back to this art of leading a doctor's conversation in "dicey" or "delicate" topics in a "roundabout way" later, both with reported case studies by Morgan and Engel as well as with our own empirical examples, in which the problems of the balancing act between a rather *confrontational* and a rather *tangential* way of leading a conversation become clear (§ 20, 21, 32). To first anticipate the risks of a defence and to avoid them in the field of interaction falls within the special professional fitting competence of the doctor, who must have developed the necessary "tact" for this, not least through training and experience, in order to be able to sound out and gradually transcend the "limits of what is reasonable" for this individual patient in the *here and now of the conversation* (Koerfer 2013: 272ff.). The abandonment of "dicey" topics is only temporary, but not meaningful in the long run, for example, if self-harming patient behaviour is to be changed. Only through sufficient medical *stimulation* (§ 17.3.5) can the patient gradually overcome the limits of his or her (self-)understanding and change his behaviour if necessary.

17.3.5 Stimulating conversation

The art of medical communicating is about avoiding both over- and underdosing in the sense that the doctor has to find exactly the balance in between in order to *stimulate* the patient appropriately and that means productively. These stimulations can be effective on the cognitive, emotive or behavioural level. From the dual perspective of *psychoanalysis* and *systems theory*, according to Simon (1994) (Box 17.14), three possible forms of interaction can be distinguished in principle, each of which can have specific effects:

Box 17.14 Disruptive, non-disruptive or disruptive interaction

So, in principle, there are only three forms of interaction: disruptive, non-disruptive or destructive (...) If one considers the relationship of several living systems to each other, they are parts of the environment for each other; but such parts of the environment that themselves also possess the characteristics of living systems. The behaviours of one system are potential disturbances for the other, which must be compensated. In the course of the history of joint interaction, both interaction partners constantly produce disturbances for each other, which leads to the develop-

ment of the structure of the interaction partners being coupled to each other ("structural coupling"). The process of interconnected individual developments can be understood as "conversation", a process of mutual "turning-and-turning" or co-ontogenesis of a common evolution of system and environment (...).

Simon 1994: 63f

Although *disruptive* forms of interaction are frequent enough, as we have already seen with Lown (§ 17.1), these forms between doctor and patient should prohibit themselves. However, it would be a false alternative to want to "stop disturbing" the patient in conversation as a matter of principle. Such a passive or defensive attitude to conversation would want to presuppose a quality of conversation already at the beginning which, with Simon, could at best be achieved at the end of a (psychoanalytic) therapy: "(...) successful communication between analyst and analysand, i.e. mutual understanding, is then tantamount to the end of any therapy, since both only confirm each other's structures" (Simon 1994: 64 f.). What at the end can be accounted for as the success of a therapy, which will be noticed by the interlocutors themselves in a certain saturation of the conversation, is, however, often laborious enough to work out beforehand through sufficient "disturbance".

As will be shown in empirical conversation analyses, both conversation partners finally resign because "they have nothing more to say to each other". They get into a *lull in conversation*, which not infrequently leads to the termination of the conversation (§ 19.6, 23). To illustrate an alternative, we will contrast conversations in which the doctor "touches" the patient through "creative", sometimes also carefully insistent interventions in such a way that, after a short "interaction jam", it just "bubbles out" of him or her. This often happens in the form of a longer biographically relevant patient narrative, which opens up a new perspective of the joint conversation work between doctor and patient with new "points of friction". Here, system-theoretical perspectives pointed out by Kris (1997) in his "Introduction for Psychotherapists, Psychologists and Physicians" can be applied to conversation analyses, where different types of conversation developments can be distinguished.[6] In

6 The reference to Kris (1997), who conceived his "systems theory" specifically as an "introduction for psychotherapists, psychologists and medical doctors", is to be understood here only associatively and metaphorically as a possible transfer to empirical conversation analyses, which have a heuristic value here. A systematic application of systems theory and its concep-

empirical analyses, *stable* versus *dynamic conversational* developments are to be differentiated (Fig. 17.5), which can experience many variants in conversational practice.

While in the stable type everything is in equilibrium in such a way that nothing surprising is expected from the participants, the situation in the dynamic type is so unstable that the future *development of the conversation* hardly seems predictable. To remain in the picture: It is unclear where the ball will roll and what can happen afterwards.

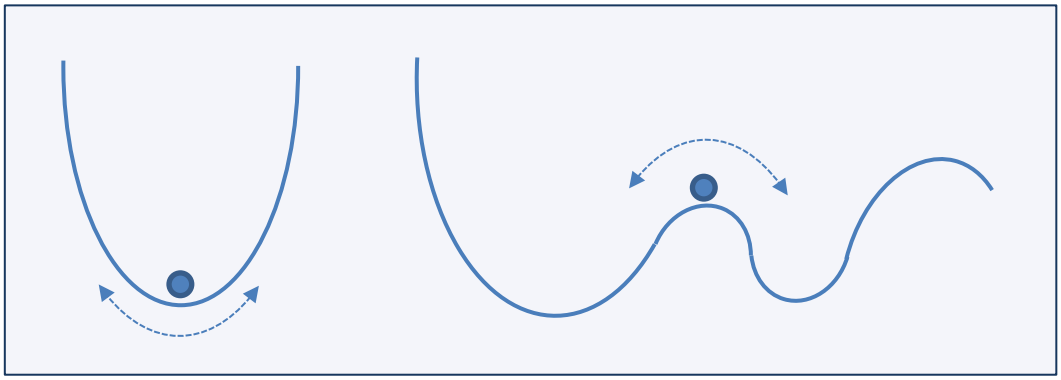

Fig. 17.5: Stable versus dynamic conversation (development) types

Cases of *stable* equilibrium can often be recognised by an accumulation of short, often mechanically expressed listener feedback ("hm", "yes") or by batteries of question-answer sequences in which, for example, patients (should) limit themselves to short answers and then wait for the next question, etc., which was already critically examined by Morgan and Engel (1969/77: 49). Figuratively speaking, the conversations "ripple" along in a familiar gait without any bumps or even cliffs to overcome.

In contrast, *dynamic* conversational developments move towards "high points" from which very different conversational directions can be taken, which can only be depicted here in a reduced form in the two-dimensional representation (Fig. 17.5). Figuratively speaking: Once the ball has rolled over a mountain, it can take unpredictable paths with the necessary momentum in a completely new conversational landscape. In this picture, it is irrelevant whether the ball is "pushed" by one of the partners or moved together.

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tualisations (*structural coupling, perturbation, attractor,* etc.) to conversation analysis is certainly still pending (cf. Koerfer 1994/2013).

Here, however, the doctor's "creative" key intervention can "come into play", with which he leads him- or herself and the patient into hitherto "unknown" terrain, in which, for example, "delicate" topics are to be dealt with that previously seemed taboo. The key intervention then proves to be "decisive" for the further development of the conversation, which leads to a higher level of self-exploration on the part of the patient, where "suddenly" emotionally occupied topics "come up", which can be of new quality for both conversation partners.

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.

Compared to psychotherapy, the processes of change in primary care may be at a lower level of development. Even if the change in general doctor-patient communication is usually less dramatic than in psychotherapy, it is often associated with a new conversational development, which certainly takes on therapeutic qualities, as should be claimed anyway with psychosomatic primary care (§ 15, 42). In empirical conversation analyses, such dynamic conversation developments are to be demonstrated, in which both quantitative and qualitative aspects play a role. For this purpose, we have developed a special analysis procedure in which the *participation* of the two conversation partners is mapped in a *dialogue role structure* with which the central switching points in the conversation can be traced.

17.3.6 Interactive and thematic participation

As already explained above (§ 10.6), in doctor-patient communication it is by no means possible to assume a *naïve* concept of symmetry in the sense of a "halving of power", according to which both interlocutors should have equal shares in the conversation in general and in certain forms of communication (feedback, questions, answers, etc.) in particular. Rather, a *discursive symmetry* is to be assumed, in which there should be approximately equal opportunities for both partners in the conversation to pursue the topics and goals relevant to them and to use the appropriate means of communication for this, as they are characteristic of an understanding-oriented conversation (questions and answers, assertions and objections, etc.). The fact that one partner tends to tell and the other tends to listen is a *functional* asymmetry that does not have to contradict the *discursive symmetry*, which ultimately has to be clarified in empirical analyses.

In order to be able to work out the *communicative forms of participation* of both interlocutors, we first developed a formal analysis procedure which is to be a first basis for quantitative and qualitative conversation analyses under the heuristic question:

> Which of the two *interlocutors* in the doctor-patient conversation does which conversation *work* at which *points of the conversation,* on which *topics of conversation* and for which *purposes of conversation*?

This question should be the guiding principle for the empirical conversation analyses, in which quantitative and qualitative aspects of analysis are conveyed. Ultimately, from an evaluation perspective, the aim is to determine relevant differences between (types of) conversations, whose potential conversation quality can often already be mapped in quantitative analyses of the speaker-listener role structure, which are then to be compared with qualitative conversation analyses.

In a formal overall representation of the dialogue participation of speaker and listener, it can first be seen at a glance which interlocutor speaks when in the conversation and for how long, and in which phase of the conversation he or she has his or her *speech domain,* if any, with which a *topic domain* is initiated, if any. 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).

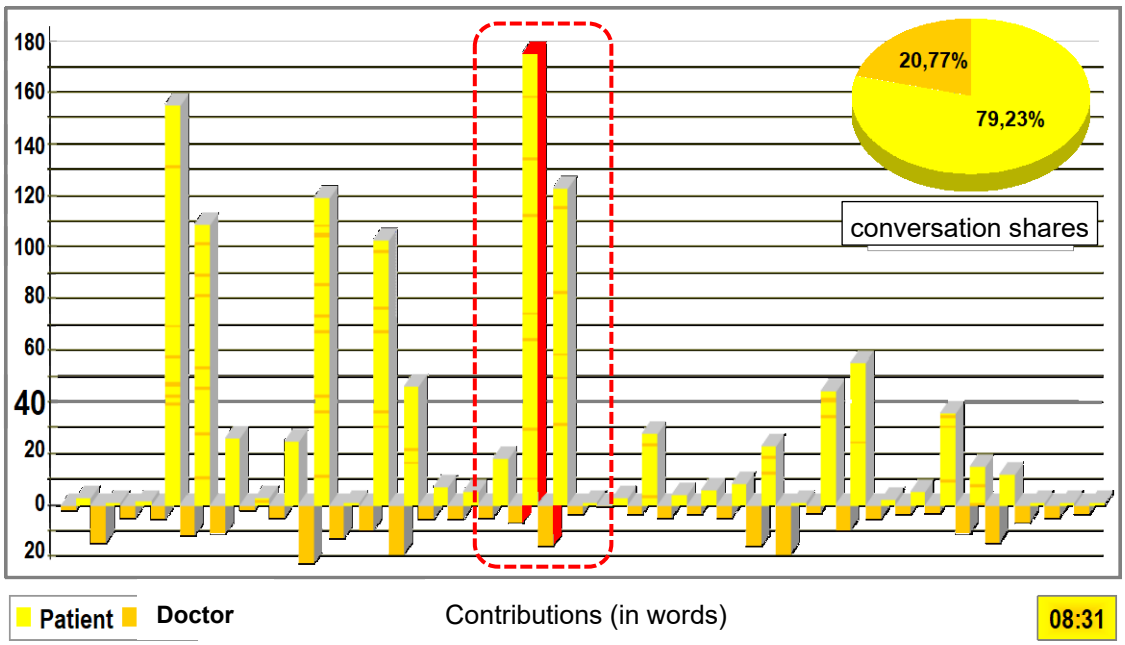

Fig. 17.6: Dialogue role structure: Narrative interview style

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".

Accordingly, the doctor's listener feedbacks are only marked by small horizontal lines (in the columns) in the representation of the dialogue role structure. Here the formal representation follows the functional analysis, according to which the doctor's sparse listener feedback does not represent an interruption of the flow of speech or narration, but rather keeps it going interactively, in that the doctor merely proves to be an attentive listener. For example, patients can tell their *narratives* continuously (§ 9) without being interrupted by their doctors in any relevant sense. An example of this is the abbreviated narrative of a patient's life (E 17.1), which we will return to in detail (§ 19.8).

E 17.1		"get the first crack somewhere"
01	P	[leans back already, averts gaze] 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 come things like that, 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 preliminary exam....
02	D	hm .
03	P	that threw me a little bit off the... off track...
04	D	hm .
05	P	I wanted to study physics, but something completely different ... and then somewhere [shakes head] I completely failed the exam ... so I couldn't get anything out of myself [chokes, clears throat] ... how it is [smiles, eye contact].
06	D	hm .
07	P	and then I didn't dare to start again . and then I hung around . didn't know what to do .
08	D	hm .
09	P	and then (...) (continue § 19.8)
10	D	hm ...

Before this narrative is subjected to an individual case study in the context of the *biographical narrative* anamnesis (§ 19.8), only the representation of the formal analysis procedure will be completed and explained here. The central patient narrative (E 17.1) is represented in the formal representation of the dialogue role structure by the red marked (longest) column (of 1.07 min.) (Fig. 17.6). While this *biographical patient narrative* is undoubtedly the focus of the sequential conversation analysis (§ 19.8), it also raises the question of the *interactive pre- and post-history* of such narratives, in which the neighbouring doctor's contributions have their considerable communicative share in the development of the conversation.

In the further qualitative conversation analysis of the narrative sequence, the specific interventions of the doctor as *key interventions* are then to be determined in more detail in their preparatory and follow-up function of narratives (§ 19, 40). For such further, qualitative conversation analyses, the formal-quantitative representations of the dialogue role structure are a methodological starting point that allows initial

conclusions to be drawn about the interactive participation structure in doctor-patient conversations.[7] In particular, longer speech contributions (=columns), in which a "right to speak at a stretch" is perceived, are often indicators of relevant change points in the conversation, which then experiences a new *diagnostic-therapeutic* quality.

In the present case of an initial interview, there is a definitive change from *biomedical* to *biopsychosocial* complexes of topics (§ 19.8), with which the original patient complaint ("stomach complaints") and patient concern ("gastroscopy") are placed in a *biographical-narrative* context ("thrown off track"), in the thematic development of which both interlocutors are interactively involved in their own way. In this first interview, which lasted a total of about 8.5 minutes, the doctor cut back to 20% of the conversation, but used this relatively small amount of speech very effectively: With his or her brief interventions, the *stimulating* function of which will be elaborated later (§ 19.8), he or she opens up narrative spaces for the patient which he or she can use in detail to present his or her concerns and his or her life and suffering story "in his or her own words", which is precisely the difference to other (types of) conversations.

The fact that participation in the conversation through "free speech at a stretch" is not a matter of course becomes clear in a contrasting comparison with conversations in which even the formal representation of the dialogue role structure shows a completely different (i.e. extremely "flat") dialogue profile of relatively short contributions by both interlocutors. In another first interview, for example, a patient cannot exceed the upper limit of 30 (!) words with her contributions, because the doctor uses his or her speech share of about 50% for an extremely *interrogative* interview style, in which the communicative patient participation is exhausted in the brief answers to specific doctor questions (§ 19.6). Such interviews tend to take on the quality of an "interrogation" interview, in which the patient's narrative approaches are, as it were, "nipped in the bud". A patient who can hardly get a word in edgewise has fewer opportunities for interactive and thematic initiative, which

7 This also applies to narratives in which doctors are more involved with co-constructions (Koerfer et al. 2005, 2010, Koerfer, Köhle 2007, Köhle, Koerfer 2017), to which we will return specifically (§ 19.8, 20.9, 24.7, 25.4). In these cases, too, the analysis should take its starting point from the patients' longer speech contributions (columns), in the neighbourhood of which the doctors' co-constructions are then to be examined.

usually requires a specific right to speak, where one must be able to "strike out" further.

Here, the formal comparative representations of the dialogue role structure of different conversations already open up a *comparative* analysis perspective that helps to recognise the relevant difference between *narrative* and *interrogative* anamnesis elicitation at first glance, which, however, has to be examined in detail in a qualitative conversation analysis. The heuristic detection procedure starts with the individual conversation and leads via the pair comparison of selected conversations to the systematic comparison of a large number of conversations, which can also be examined contrastively in an evaluation perspective with a pre-post design (Koerfer et al. 1999, 2000, Köhle et al. 2001, Koerfer, Köhle 2009, Koerfer et al. 2010, Köhle, Koerfer 2017). We will systematically elaborate on this interplay of *quantitative* and *qualitative* interview analyses both in the practice section as an example and in the evaluation section (§ 40.2).

From a qualitative point of view, a *dialogue feedback problem* should be sketched out here in advance, in which the doctor in particular is confronted with special challenges in his art of conducting medical conversations. Although both interlocutors meet in their specific *expert roles* (§ 7.5, 10.5-6), it is incumbent on the doctor qua his or her double competence, namely *everyday world* and *professional* competence, to anticipate problems of communication "vicariously" for his or her interlocutor and to react in good time with a kind of conversational leadership in which *conversation* and *leadership* do not have to be a contradiction. In this way, we tie in with principles of a *dialogical* medicine, which have already been discussed above (§ 7-10) and will be further concretised here in order to verify their validity in the empirical analyses that follow.

17.4 Dialogue feedback model

Cooperation between doctor and patient is required in all phases of their joint interaction history (§ 8). This already applies to the co-construction of patient histories during the taking of medical history (§ 9) and extends through the communication of diagnosis and information to medical decision-making (§ 10.4-5). In all phases, patient and doctor encounter each other as *experts* of different types, one partner

from the experience and experience perspective of his or her own illness, the other from the professional knowledge and action perspective of his or her profession (§ 7.5.3) (Tuckett et al. 1985, Smith, Hoppe 1991, Koerfer, Albus 2015). The respective competences in these expert roles should be used in a *cooperative partnership* for the benefit of both partners (*win-win situation*) (§ 10.6.1) (Quill, Brody 1996), without either having to suffer a loss of autonomy according to von Uexküll (1993: 62).

The fact that problems and hurdles arise even or especially in a cooperative *partnership,* which must be overcome together, was described with the conflict potential between *medicine* as a system and the patient's *living environment* (§ 10.2). In this context, the possibilities for cooperative solutions within the framework of a *dialogical medicine* (§ 7) had been pointed out, which has to make use of the general forms of communication of understanding and communication, which, despite all their susceptibility to disturbances, are also the tried and tested means of our everyday communication.

These means of communication do not have to be invented specifically for the art of conducting medical conversations, but the existing everyday repertoire must be used with a professional communication competence in the face of changing communication conditions. This central problem of fit, which was explained in advance in a fit model of medical action (§ 3.2, 17.2), is to be specified in a *dialogical feedback model* for doctor-patient communication, in which it is a matter of distinguishing types of *relevance feedback from doctors* in the face of changing (narrative, argumentative, emotive, etc.) offers of interaction and topics from patients.

17.4.1 The problem of relevance

The particular difficulties between doctor and patient in entering into a conversation with each other result from the problem that both conversation partners, at least at the beginning of the relationship, cannot yet sufficiently anticipate what is to be *relevant to the conversation* here and now, in what way and to what extent. The knowledge of a possible health disorder of the patient, which can only be mutually assumed, without which the doctor would not be consulted in the first place, is too unspecific to allow the interlocutors to cooperate successfully without further ado. For this reason, special relevance negotiations between

doctor and patient must be carried out at the beginning of the conversation, which, however, must be constantly checked and updated in the course of the conversation. In this context, the doctor must be very "sensitive" to his or her interlocutor in order not to overhear the patient's thematic initiatives, even or especially if they are formulated *indirectly* (§ 7.3), and, if necessary, to acknowledge them accordingly by upgrading their relevance.

Despite the best anticipation of hurdles to understanding and comprehension, the problem of *relevance* associated with the problem of *cooperation* often remains, which has been differentiated in various (sociological, linguistic-philosophical, linguistic) academic traditions for everyday as well as institutional communication situations (Schütz 1971, Grice 1975, Kallmeyer 1978, Ehlich 1987, Koerfer 1994/2013, Ehlich 2020, Iakushevich, Ilg, Schnedermann 2021, Ehlich 2022). Despite all institutional peculiarities, conversations between doctor and patient are initially subject to the same basic rules of communication as in everyday communication. Here, as there, the problem of *relevance* arises, in which the two interlocutors must decide anew at each point of the conversation about the relevance of topics with which the conversation is to be continued. In the process, the interlocutors mutually form hypotheses about the expectations of continuation for successful cooperation, which depend not least on the relevance system of the other.

This is where the institutional conditions of communication with different social and interactive participation roles of doctor and patient come into play (§ 7.5.3). The difficulties in understanding and communication, which have been demonstrated in many empirical studies, result here from the conflictual nature of the different participant perspectives, which, according to Mishler (1984), are expressed in the conflicting "voices" of *medicine* and the *lifeworld* (§ 10). The doctor and the patient often talk against each other instead of with each other, or they just talk unconnectedly one after the other and thus past each other, without achieving a sufficient coordination of the relevance of their contributions - which remains a communicative challenge for both partners.

In doctor-patient communication, it is initially a problem for the patient to follow the *maxim of relevance* ("Be relevant"), which was already discussed in advance with the philosopher of language Paul Grice (1975) in the foundation of a *dialogical medicine* (§ 7.3, 9). As a layperson, the patient often cannot adequately anticipate what might be relevant for the expert if he or she has to make a specific selection from a

wide range of topics of "*reportability*" (*tellability*), for example under the patient's question:

> What is worth telling here and now because it is relevant to my doctor here and now?

Accordingly, the doctor has to decide *reciprocally* about each new (argumentative, narrative, emotive, etc.) patient offer from the point of view of relevance, which is not always possible without further conversation work (queries, etc.). Under certain circumstances, there are more or less pronounced *relevance negotiations* between the two interlocutors in order to be able to continue the conversation in one direction or the other.

17.4.2 Types of relevance negotiations

Before we further pursue such relevance actions in empirical conversation analyses along the 6 steps of the Conversation Manual (§ 18-23), we will first describe the prototypical conversation developments whose distinctions have proven useful for our empirical analysis purposes (Koerfer et al. 2000, 2004, 2010). 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.[8]

1. *Relevance upgrade*s
   Ideally, the doctor reacts to an *initiative* (narrative, argumentative, emotive, etc.) patient offer with a suitable *relevance upgrade* until the patient soon feels sufficiently *understood* and *accepted*

8 We are not yet assuming any specific types of initiating patient offers here. In principle, the model of dialogical feedback applies to different types of patient offers (informative, narrative, argumentative, interrogative, dubitative) in the later empirical conversation analyses, for example, also to the *narrative patient* in the anamnesis conversation or the *questioning* or *doubting* patient in the clarification conversation. The term *feedback* or *responsiveness* is by no means to be understood in an exclusively behavioural sense (Suchman et al. 1997, Waldenfels 1999, Koerfer et al. 2000, 2004, 2010).

in his or her *individual* reality (Uexküll, Wesiack 1991, 2011, Engel 1996). When upgrading relevance, the doctor can use different forms, such as *active listening* (§ 19) or *empathic responding* (§ 20). Here, the spectrum of *upgrading* interventions ranges from simple listening signals ("yes", "ah so", "ah!" etc.) to verbal interventions with which the doctor explicitly ("That seems to scare you") expresses an emotion expressed more or less clearly by the patient, etc., in order to *stimulate* the patient to further self-exploration (§ 17.3.5). Ideally, the dominant pattern consists of cascades of relevance upgrades that can lead to further development and deepening of conversation topics and thus to a new quality of conversation.

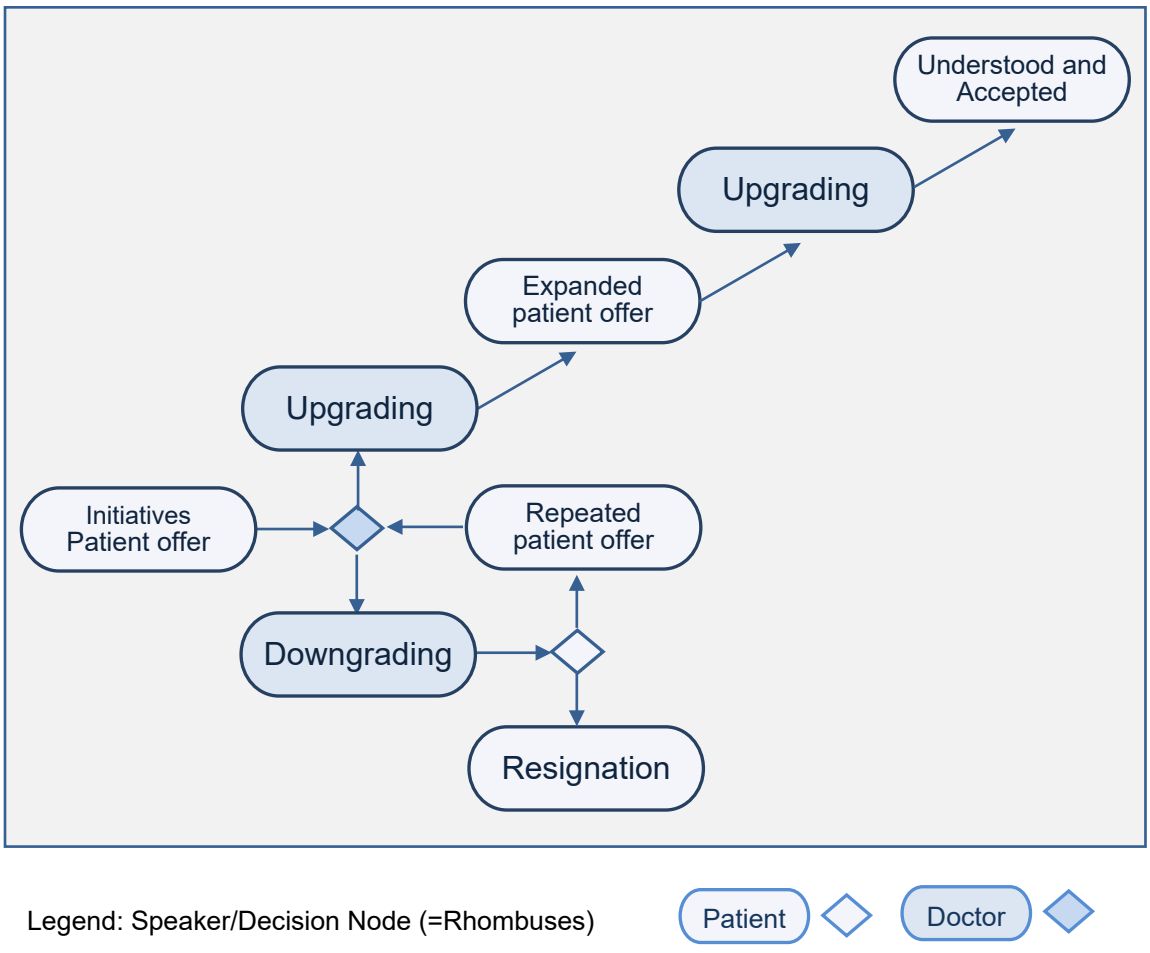

Fig. 17.7: Dialogue feedback model of doctor-patient communication

2. *Relevance downgrades*
   In the *case of conflict,* the doctor fails to hear or ignores the patient's proactive offers, for whatever reason this may happen (inattention, lack of interest, lack of time, etc.). The "inaudible" is counterfactually "overheard", as if it had not been said in the first place or as if what was said was not meant to be so relevant that the doctor would have to respond to it. Such phenomena of *overhearing* have already been problematised by Balint (1964/88) in his case reviews and analysed in detail in empirical studies (Labov, Fanshel 1977, Siegrist 1982, Mishler 1984, Suchman et al. 1997, Koerfer et al. 2000, 2004, 2010, Salmon et al. 2004, Köhle, Koerfer 2017). Thus, the doctor can elegantly bypass the "inaudible" by setting a *communication stopper* ("truncator") with "good" or "okay", for example, and then making a radical *change of topic,* with which, in the sense of a *change of relevance,* a final downgrading of the (narrative, emotive, argumentative, etc.) patient offer made previously is to be achieved. In the further course of the conversation, this often leads to *resignation on the part of the patient,* who finally "falls silent": In Mishler's (1984) sense, the "medical" voice of the doctor has prevailed over the "life-world" voice of the patient (§ 10.2). Once this pattern of a radical change of topic has become established, as has been observed in particular in empirical research on visit communication (§ 24), communicative facts are created that are exclusively in the relevance focus of a doctor-centred conversation. Instead of taking their own topic initiatives, the patient's further activities are limited to answers to doctor's questions, which the patient again waits for passively ("silently") after answering, only to answer the next question again, etc. - a kind of verbal and non-verbal conditioning to which Morgan and Engel (1969/77: 42, 37, 49) have already repeatedly drawn critical attention.

3. *Relevance upgrades after downgrades*
   In a complex *problem case,* the patient, whose initiative was initially downgraded by the doctor, may renew his rejected offer several times until it is finally heard despite previous downgrades by the doctor. In this way, a series of circular interaction loops may develop in which, in a roundabout way and with a mixture of downgrading and upgrading, an empathic understanding and

sufficient recognition of the patient's individual reality may be achieved in the end. However, in comparison to the *ideal case* (1), considerable delays and corresponding communicative frictional losses or even misunderstandings must be expected here with elaborate repair attempts, in which the interactions can run several times over the two decision-making nodes of the interlocutors (= rhombuses in Fig. 17.7). This additional communicative effort could possibly have been avoided if the doctor had withdrawn his or her "medical" voice and rather listened to the patient's "life-world" voice.

4. *Relevance downgrades after upgrades*
   This problematic case (3), in which the relevance negotiation between doctor and patient can be put to a "real test", must be distinguished from the unproblematic cases in which a change of topic is made after an initiative seems to be sufficiently exhausted thematically. Relevance downgrading in favour of relevance upgrading of a new (narrative, argumentative, emotive, etc.) topic initiative can be mutually acceptable. A consensual change of topic and relevance makes it clear that the individual reality of patients cannot be accessed monothematically, but only through a multitude of more or less coherent topics, such as when illness-related impairments in marriage, family, work, leisure, etc. are made a topic in the detailed exploration (§ 21). The individual topics can also be addressed separately at first ("What do you do for a living?") before they are further linked to a global topic ("Impairments") later on ("Concentration problems also at work"), etc., which can initiate new patterns of dialogue-based relevance feedback.

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. In general, it is not so much the singular relevance downgrading of topic initiatives that is decisive, although it can also have serious consequences in individual cases of ignorance, but rather the *dominance of prevailing pat-*

terns of relevance negotiation between doctor and patient, which can have a negative or positive effect on the *shaping of their relationship.* [9]

The problem of relevance will be an ongoing topic in the empirical analysis of conversations in the practice section, as doctors are often subject to the tendency to *downgrade relevance,* not least because of time pressure (§ 17.3.1). They do this in the "good" belief in a supposedly efficient conduct of the conversation, with which more time can be gained for the "actual" - and thus often only sit on the *supposedly* relevant topics because they have not listened sufficiently to the patient (his or her complaints, concerns, expectations, preferences, etc.) and given too little space. Obviously, doctors fail to find a balance between encouraging the patient's *associations* and *guiding* the anamnesis - a problem that will be summarised again in conclusion with reference to "classics" of clinical conversation research.

17.4.3 Association and guidance

It is true that patients often do not tell their medical history in the *order of relevance* according to which the doctor would have liked to organise the history taking. But through their spontaneous narratives, which signify *cooperation* by *association* (§ 9.3), patients offer a rich "conversation material" that would remain closed in a pure exchange of information with a traditional question-answer pattern - according to the dictum of Michael Balint:

> If you ask questions, you get answers to them, but nothing more (Balint 1964/88: 186).

In order to get "more" than answers to questions, the doctor must allow the patients to speak *freely at a stretch,* in which he or she can *narrate* them and their problems in *his or her own words* (§ 9). The fact that tar-

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9 Here we should refer back (also as a specific topic for teaching) to the traditional distinction between the *content* and *relationship aspects of* Watzlawick et al. (1967/2011) and Schulz von Thun (1981) and (1989) (§ 7.4). While criticism or mere disagreement, if they do not get out of hand, do not have to be harmful to the relationship because they basically imply a recognition of the interlocutor as a person, the relationship is called into question in the long term by permanent *ignorance* of expressed content because it goes hand in hand with a *devaluation* of the partner.

geted information questions by the doctor are not obsolete because of this, but rather receive their importance in the later course of the conversation, when it is necessary to close the gaps that a patient has left for whatever reason, has also been emphasised again and again by the "classics", albeit with a "relevance" hierarchy, according to which the ranking is at the same time shown as an order. Thus, according to Morgan and Engel (1969/77) (Box 17.16), the two goals of *promoting associations* and *guiding the anamnesis* are put into perspective in a kind of "super-maxime".

Box 17.16 *Promoting association* and *guiding the anamnesis*

The doctor achieves the two goals - to encourage the patient's spontaneous associations and to guide the anamnesis - if he begins each new topic with open (non-directed) questions, followed by increasingly specific (more directed) questions until the topic is clarified. Therefore, he must be clear about what details are necessary to understand the disease. However, he must not suggest or even impose his ideas on the patient. For example, he begins to explore a symptom with the request: "Tell me more about it", or "What was it like?". In this way, he allows the patient to tell, uninfluenced, what seems important to him. While the doctor listens to the patient, he pays close attention to omissions and ambiguous statements and repeatedly points out the points that still need to be clarified with questions such as "When was this?", "What was the feeling?", "What came first?". As soon as the patient has completed his spontaneous report, the doctor asks all those questions that are necessary to complete the picture. In doing so, he tries to link each question to what the patient has mentioned. So the doctor picks up the thread where the patient left off.

Morgan and Engel 1969/1977: 41f. (emphasis there).

Here, Morgan and Engel present a whole practice and analysis programme in a small space, which we will return to repeatedly. What is so convincingly summed up here as the primacy of *associations* over *guidance* will have to be followed up in detail in conversation practice and conversation analysis. While a "super-maxim" is formulated in the introductory text (*in italics*) highlighted by Morgan and Engel themselves, this is elaborated in the following text with further (sub-)maxims.

Thus the often made demand that the taking of anamnesis should progress from open to specific questions - as *e*.g. also Lipkin et al. (1995: 72: "open to close cone") - is combined with the warning to the doctor against manipulation towards the patient: "However, he must not suggest or even impose his ideas on the patient" (see above Box 17.16). Despite the difficulties in distinguishing between more or less "directed" questions, which can be more or less suggestive,[10] it will be necessary to clarify in empirical conversation analyses to what extent (in the above sense of Morgan and Engel) the patient is "allowed" to "tell uninfluenced what is important to him." Here, the exemplary doctor's questions such as "Tell me more about it" or "How was it?" undoubtedly represent a *relevance upgrade* that the patient can use for relatively free disposal.

The marked turning point from *association* to *guidance* is first of all a mental point in the doctor's listening, where he or she "pays close (attention) to omissions and ambiguous statements" (see above). Only these gaps and ambiguities entitle the doctor to intervene in the patient's *associative* narrative flow in a clarifying way, but not by abruptly changing the topic and thus the relevance, but by continuity of topic: "In doing so, he tries to tie each question to what the patient has mentioned. The doctor thus picks up the thread where the patient left off" (see above). In summary, the *art of the doctor's conversation* is to let the patient "tell the story without being influenced" and to fill in the gaps noticed during attentive listening with those questions "that are necessary to complete the picture." While the "spontaneous associations" are thus the first source of the anamnesis, this is gradually supplemented by "targeted" doctor's questions in the direction of completion.

Putting the patient's association and the doctor's guidance into perspective is a highly *individual* matter that requires a tailor-made fit in dealing with individual patients, which can also be summarised in a general maxim with Morgan and Engel (1969/77) (Box 17.17):

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10 The problem of suggestibility cannot be clarified as a form analysis (of sentences) alone, but requires a specific context analysis (§ 21.2). Our methodological proposal for the empirical conversation analysis was (17.3.) to examine the neighbouring doctor's utterances, which apparently *stimulate* longer patient contributions. However, these stimulations are not necessarily "directionless". Thus, the doctor can trigger or even only (want to) test certain "associations" of the patient precisely with key interventions, for which we will give a number of examples in the practical part.

Box 17.17 "The doctor must (...) adapt to the nature of the patient".

The degree of guidance needed is different for each patient. Some patients ramble and get stuck on unimportant things, others skip important anamnestic events and occasionally patients tell such a coherent story that hardly any intervening questions are necessary. The doctor must remain flexible when taking the anamnesis and adapt to the nature of the patient.

Morgan and Engel 1969/1977: 41

Despite this plea for an individual approach to the conversation, with which the doctor must "flexibly adapt" to the respective patient, Morgen and Engel also consider a "basic plan" for taking the anamnesis to be useful: "No anamnesis is repetitive. Nevertheless, one can stick to a general basic plan" (1977: 31). As already stated in the introduction (§ 1), the wheel (also for communication between doctor and patient) does not always have to be reinvented and can be built on the foundations of the "classics" in the teaching and practice of medical conversation. As in the theoretical part, considerable borrowing from proven traditions is to be made in the practical part, which is to be shown by references and extensive quotations where the paraphrase could not satisfy the original.

This also applies to the following justifications and differentiations of the conversation manual, which can be based on the preliminary work of the "classics" on clinical communication research and communication didactics. Instead of giving further information at this point, we refer to the literature already mentioned in relevant chapters of this handbook (esp. § 2, 3, 16, 17) and limit ourselves here to practical information on the use of the conversation manual, which will be presented below in 6 steps (§ 18-23) and further developed empirically and didactically on the basis of anchor examples and model conversations (*best practice*).

17.5 Practical advice on the Cologne Manual

In accordance with our comparative methods of analysis and learning, our *Cologne Manual of Medical Communication* (C-MMC) and *Cologne Evaluation of Medical Communication* (C-EMC) is by no means intended

to suggest a "one-size-fits-all" or *the* "royal road" of medical conversation. Rather, it is intended to take into account a *plurality of ways* of conversation through which a "shared reality" (Uxküll, Wesiack 1991, 2011) can be established in the *personal* relationship between doctor and patient (§ 4). This shared reality does not come about by itself, but must often first be laboriously worked out in conversation by first finding access to the patient's *individual* reality as a sick person, which (in the above sense of Morgan, Engel 1977) requires an individually *tailored* conversation.

Just as patients have an individual narrative style and can bring themselves into the conversation in a very personal way, doctors can also have a very individual conversational style that does not need to be "fiddled around with". But where deficits are unmistakable, a communication manual can help to improve conversation practice. In this sense, our manual is a learning opportunity to leave familiar paths of communication and try out new ways.

Communicative access to the patient should therefore not be established through a fixed "formula", as a restrictive application of a manual might suggest. Rather, such a manual can only be *a structuring and orientation aid* in the promotion of the doctor's communicative competence, who must always make sure that his/her verbal and non-verbal interventions in concrete (types of) conversational situations are *appropriate.*

We have compiled the situation features and their relationships in a model of communicative fit (§ 3.2, 17.2.4), which focuses on the *fitting competence* of the doctor, who ideally can achieve the optimal integration of all features. We will continuously revisit this problem of fit in the handbook and illustrate it with further characteristics and empirical case studies, which will serve as anchor examples for our manual on medical conversation management, which is differentiated below (§ 18-23).

Although our manual on medical communication is far from being a psychotherapy manual, we would nevertheless like to adopt the practical instructions for "handling the manual" (Box 17.18) suggested by Luborsky (1984/1988) in his "Introduction to Analytic Psychotherapy" with the distinction of six learning phases.

Box 17.18 Handling the manual

The recommendations for learning and using the manual are based on the proven principles of learning by doing (...) The clinician seeking to acquire this psychotherapy manual, whether for practice or research, should consider the following stages of learning:

1. Read the manual.
2. Treat some patients and try to apply the manual.
3. Read the manual again.
4. Treat more patients and try to apply the manual.
5. Check with a therapist colleague or with a supervisor to what extent you are really following the manual.
6. And so on until a satisfactory level of knowledge and treatment skills is achieved.

Alternating between reading and practice helps to intensively acquire the manual and its essential contents.

Luborsky 1984/1988: 21

In addition, Luborsky also recommends protocols and tape recordings of conversations for the critical review of practice. The mentioned control function with a colleague or supervisor can also take place in medical communication teaching in procedures of group learning (e.g. *peer teaching*) under more or less strong guidance of tutors and lecturers (§ 13, 14) who have made their own experiences with the communication manual and can convey them.

A manual can only prove its worth through repeated reading and application in practice, in which one's own conversation behaviour towards simulated and real patients is checked and corrected if necessary. As already mentioned, we have developed the *Cologne Evaluation of Medical Communication* (C-EMC) analogous to the Communication Manual, with which only what has been taught before is to be checked (§ 13.6, 17.2). The evaluation sheet (C-EMC) can be found at the end of this chapter (Fig. 17.8) and can be used for peer and self-evaluation in group learning, but also in external examinations (OSCE) (§ 13.6, 41).

If the Manual (C-MMC) and the C-EMC are to be conveyed step by step in 6 chapters with empirical anchor examples from medical conversation practice, it is recommended to adopt an attitude of reception according to which not only obviously less successful examples, but also so-called *best practice examples* are subjected to critical reflection.

This is more likely to succeed if, after reading the most recent patient statements, an "artificial pause" is taken in which everyone can consider for themselves what would be the best verbal or non-verbal intervention for the doctor's continuation of the conversation. We have already illustrated the reflection procedure with an example (§ 13.5.2) in the presentation of our multimedia learning programme (Koerfer et al. 1999), which will be used here (slightly shortened) as a model (E 17.2-5) for similar exercises.

E 17.2		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	been taking, if it was then . then after half an hour not gone . additionally 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.

E 17.3		"It's your turn!"	Evaluation
L1	D	[My intervention is:]	❶❷❸❹❺

E 17.4		Simulated conversation continuation: Alternative interventions	Evaluation
L2	D	How long have you had this pain?	❶❷❸☺❺
L3	D	Can you describe the pain in more detail?	❶❷☺❹❺
L4	D	What are you thinking about?	☺❷❸❹❺
L5	D	What other medicines are you taking?	❶❷❸❹☺

E 17.5	Real continuation of the conversation of the real treating doctor	Evaluation
06 D	what do you think might have been overlooked? .	☺❷❸❹❺

For reasons of space, we have largely refrained from enriching the following examples (§ 18-23) with gaps for free texts and possible alternatives, but recommend this in training and further education practice, in which, according to our own experience, a "creative" competition often develops among the participants for the "optimal" intervention, in which the designated *best practice examples* were even surpassed.[11]

Nevertheless, for methodological reasons, the critical standards must be relativised in the following sample conversations and anchor examples. The examples were created in *natural* conversation situations *in actu,* i.e. under pressure to act and in a fraction of a second, so that in retrospect and with distance one can be "wiser" from the comfort of one's armchair and easily formulate the better alternatives (as "test winners"). However, if this kind of "know-it-all-ness" from the *reflexive simulation* should also be productively reflected in the later conversation practice between real doctors and patients, this would be all the better for both partners.

The complete *Cologne Manual & Evaluation of Medical Communication* can be found at the end of the chapter. Empirical anchor examples are analyzed and discussed in the following practical parts of the handbook.

References see next page

[11] A practical approach to teaching can be to hand out appropriate worksheets (with copied examples and gaps) to the participants, in which they enter their preferred interventions, which can then be discussed in critical comparison with the intervention proposals of other participants.

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

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Cologne Manual & Evaluation of Medical Communication see next page

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

1 Building a relationship	☐4	**4 Exploring details**	☐☐ 12
1 Framing • Enable confidentiality • Avoid disturbances		1 Inquire about complaint dimensions • Localisation and radiation • Quality, intensity *(scale 0-10)* • Dysfunction/disability • Accompanying symptoms • Time (beginning, course, duration) • Condition "I 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 Introduction • 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, look • Avoid interruptions • Allow breaks, 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)		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 5 Complete documentation • Coding & conversation impressions • Topics for follow-up talks	❶
❶ [❶ = not met;❶ = met] ❶❷❸❹ [❶ = not met ...❹ = fully met]			

Fig. 17.8: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)