19 Listening to Concerns
Biographical-narrative Anamnesis

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> The doctor must encourage the patient to speak freely, because only the patient can tell him what he has experienced.
>
> Morgan, Engel 1969/77: 41

Abstract: After the first trust-building step of establishing a relationship between doctor and patient has been taken (§ 18), the patient must be given the floor in a second conversational step (§ 19.1) in order to be able to convey his or her concerns to the doctor in his or her own words. Here, the choice of certain types of *opening questions* can already set the first "course" (§ 19.2). In the further course of the conversation, it should initially be assumed that *listening* to the doctor takes *precedence* over *questions* (about details), without the two forms of medical intervention being "played off" against each other. Listening cannot be reduced to mere silence, but comes into its own in various forms of listener feedback, with which the patient's speech should be supported as much as possible and interrupted as little as possible (§ 19.3).

Following the *dialogue feedback model* already presented above (§ 17.4), forms of *relevance negotiation* between doctor and patient will be differentiated and explained using empirical examples, in which relevance downgrading or relevance upgrading of patient initiatives occurs, for example, through *topic change* versus *active listening* by the doctor (§ 19.4). Despite the general primacy of the doctor's listening, specific questions to ensure understanding always have the highest priority when ambiguities need to be cleared up in time so that both interlocutors do not expose themselves unnecessarily to communication disruptions that could be based on mere misunderstandings (§ 19.5). What was first illustrated with the relevance negotiations in selected shorter

example sequences will then (§ 19.6-8) be differentiated in *comparative* conversation analyses on longer conversation developments in which the doctors conducting the conversation tend to pursue an *interrogative* or *narrative* style of conversation. In later chapters (§ 20.9, 24.7. 25.4), forms of *cooperative narration* will be shown that go beyond forms of active promotion of patient narratives, which involve a joint construction of narrative by both conversation partners.

> Good clinical practice involves listening with a diagnostic ear focusing on disease management, an emotionally aware relational ear focusing on the patient's experience of illness, and a contextual ear focusing on each patient's unique life circumstances.
>
> Epstein, Beach 2023: 3

19.1 Manual: Step 2: Listening to concerns

As has been repeatedly explained in advance with the justification of a *biopsychosocial* and at the same time *dialogical* medicine (§ 4, 7, 9), the patient should be given sufficient opportunity to express his concerns in his or her own words. For this reason, the doctor should largely allow the patient to speak, especially at the beginning of the conversation. Particularly 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 visit in such a way that he or she can express his or her concerns with their *individual* significance and scope in a communicative form that is appropriate for him or her. The most important thing here is to promote free patient speech, for which the relevant forms of communication are compiled as an overview in the second step of our communication manual (Fig. 19.1).

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

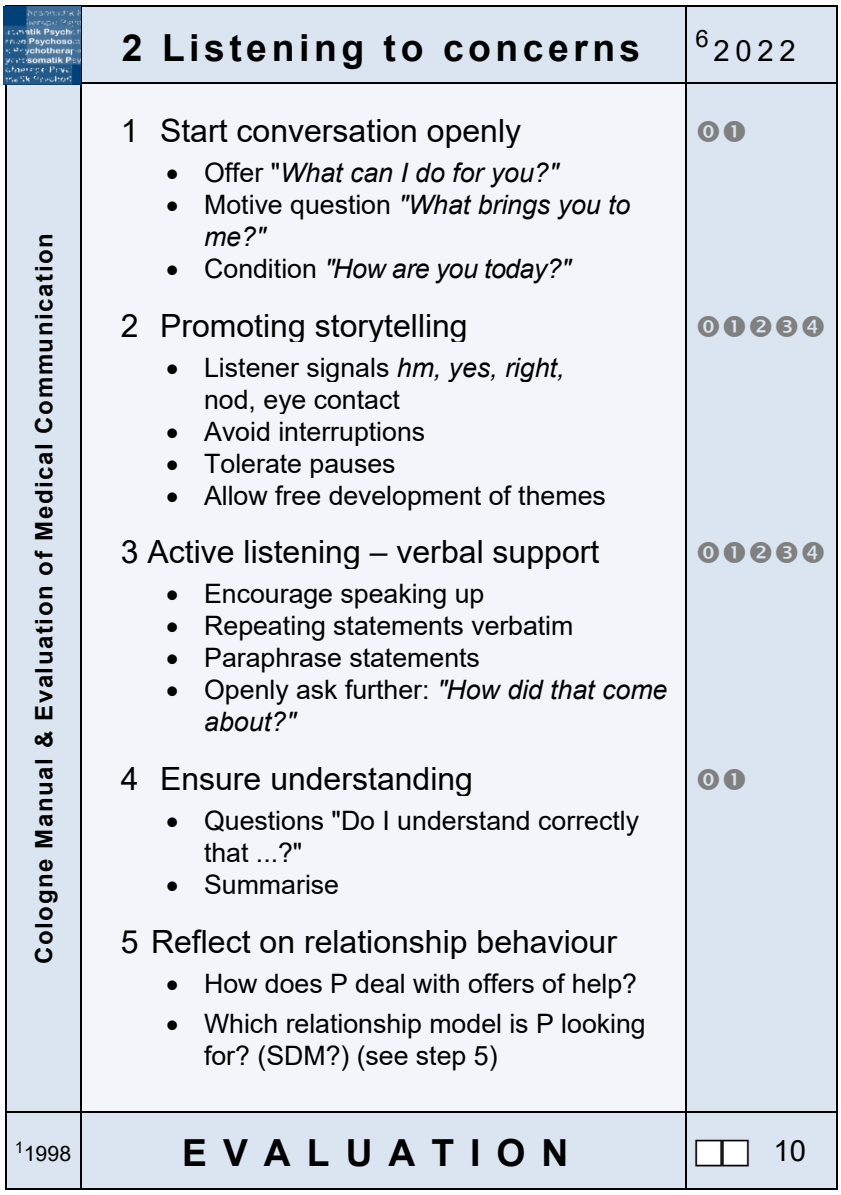

Fig. 19.1: Excerpt: Step/function 2: "Listening to concerns".
(The complete manual can be found at the end of the chapter, Fig. 19.10)

Because of its importance for communication theory in particular, the aspect of *relationship reflection* (2.5) is included here, although this is beyond direct observation. Nevertheless, it can of course be referred to in feedback (e.g. in OSCE examinations) (§ 13.6, 41), if necessary with reference to critical relationship developments, which can be reflected in critical (observable) discussion developments, for example as manifest defensive behaviour or as a specific relationship offer by patients who, for example, recognizably seek out their doctors as "service providers" in

medical decision-making (§ 10), etc. This aspect of manifest relational behaviour is to be addressed with examples in between and later separately (§ 22).

19.2 Types of conversation openers

With the opening of the conversation and the specific opening question, the doctor should follow up on the common level of knowledge with the patient and then let the patient take the initiative in speaking and talking about the topic as much as possible. Since there is no common history of interaction and usually no prior knowledge during the first conversation, the conversation should be started as openly as possible. Especially in the first contact, openings should be kept open so that the patient can present his or her concerns as freely as possible, in his or her own words and coherently.

In doing so, the doctor should know and observe the *preformulation function* of opening questions, with which the patient can be more or less committed to a certain answer format already at the beginning. In this respect, different types of opening questions can be distinguished (Tab. 19.1), which are differently suitable for opening depending on the initial situation.[1]

The typology presented here (Tab. 19.1) follows a classification according to both *situations* (initial contact, consultation, ward round) and *functions*, each of which is determined by a specific *focus* on the *patient as a person*, his/her *body*, the *relationship* with the doctor, the *right to speak*, etc. The typology has proven itself for teaching purposes because it can be used to show the opportunities and risks of different ways of opening a conversation. It invites to try it out, even if certain openings seem to have already proven themselves in the routine practice of conversation.

1 From the extensive research on conversation openings, we refer here by way of example to Spranz-Fogasy 2005, Robinson 2006, Heritage, Robinson 2006, Menz et al. 2008 and the further literature on this topic given there in each case.

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

Table 19.1: Types of conversation openings

In the case of a direct *reference to the body,* the problem arises of an early fixation on a *biomedical* model of care, the supplementation or expansion of which in the sense of *biopsychosocial* medicine tends to be obstructed by a question about complaints, because *physical* complaints are usually associated with this. The following example (E 19.1) is problematic in several respects.

E 19.1		"Where are your ... main complaints?"	Comment
01	D	[both sit down] so Mrs A, what brings you here? .	2.2: Opening question: reason for consultation
02	P	so, in general now um ... [Looking up to the left, pondering].	Beginning of the answer
03	D	what are your main problems, what/or main complaints, what do you come for? .	Early Interruption/Funneling
04	P	I have often had heartaches, i.e. sharp pains in the region of the heart.	Focus: "chief complaints“
05	D	since when have you had this pain? ... [3] ...	4.1: Detailed exploration: Time

The doctor first asks an opening question according to the usual type 1 ("reason for consultation"), which the patient tries to use for an answer, which she introduces with a vague phrase: "so, in general now um ...". Apparently this beginning of the answer is too "general" for the doctor; in any case, the doctor interrupts as soon as the patient has begun and reformulates his opening question in two steps. First he asks about "main problems", before he further specifies these in his self-correction to "main complaints", with the result that the patient makes the appropriate body-related complaint offer ("heart pain") to this new focus, which favours the then appropriate follow-up question about the beginning of the complaints, which leads into the middle of the detailed exploration. In this way, the doctor has already made use of a *funnel technique* at the beginning of the conversation, with which a start is made to an "interrogation conversation", the course of which we will return to in detail (§ 19.6).

Likewise, a doctor should be aware that by asking a *deficit question* (type 4: "What's wrong?"), he more or less conditions the patient to formulate his request as the elimination of a deficiency, whereby physical

"deficits" are also usually associated here. If such a narrow thematic focus is to be avoided right at the beginning of the conversation, other types of conversation openings are more appropriate. A frequently used type (2) is the direct question about the *concern*, which is often asked in the following form (E 19.2):

E 19.2		"What's up?"	Comment
01	D	Mrs X, what's up? .	2.2: Opening question: concern
02	P	with the heart . (difficult to understand) . the last time . I also don't know if it's excitement or w . if it's from what it comes .	Beginning of the answer

If both conversation partners are well acquainted with each other, a *dialectal* variant (from the region) can also be used here, which can be an expression of the familiar togetherness. However, you should also know your partner's dialect, otherwise it can seem "artificial".

E 19.3		"Mr W, what's up? (wat jiddet?)"	Comment
01	D	come in . please take a seat	1.4: Situating
02	P	[Patient sits down]	
03	D	Mr W, what's up? .	2.1: Opening Q: Concerns
04	P	yes ... well, I feel empty somehow	Beginning of the answer

Another, also common type (4) is the doctor's *offer of a relationship,* who makes himself completely available to the patient as a helper for his concerns, as in the following example:

E 19.4		"What can I do for you?"	Comment
01	D	Mrs Z, what can I do for you? .	2.1: Opening Q: Offer
02	P	yes, I'm supposed to get in touch again today ... I was fine until yesterday, when I had it with my heart again, but ... [pointing gesture]	Start of patient offer 1: "Heart

		. it happened so quickly one after the other.	
03	D	yes .	2.2: LS
04	P	when I wanted to sit down with the newspaper .	
05	A	yes .	2.2: LS
06	P	afterwards it was gone again ... and today it's back, probably the next migraine ...	Patient offer 2: "Migraine“

As can be seen from the example, this is a follow-up conversation. If there is already a shared history of interaction between doctor and patient during the consultation or visit, it is advisable to build on the shared knowledge and ask a non-specific *question about the patient's* state of *health* (type 9: "How are you?") or, depending on the specific knowledge of the situation, to ask more specifically: "How did you sleep today?" etc. In the following opening of the conversation, the doctor also refers to a common knowledge, which the patient can also refer to directly ("breathing ...").

E 19.5		"how are things this morning?"	Comment
01	D	how are things this morning? .	2.1: Opening Q: Condition
02	P	breathing is better, but I'm still coughing [clears throat].	Start Patient Offer 1

In the case of specific questions about sensitivities, the focus is always on a narrower topic that refers back to the known history. In contrast, a *narrative invitation* (type 7) can open up a wide range of topics, even if there is already a common history of interaction to which reference can be made. In the following example (E 19.6), a narrative invitation (type 7) is additionally linked to the doctor's offer of a relationship as a helper (type 4).

E 19.6		"tell us a bit about ..."	Comment
01	D	(...) tell us a bit about what's going on and how we can help you.	2.1: Opening: Invitation to tell and offer of relationship
02	P	so . in October . I was . no . yes . at the be-	Start patient nar-

		ginning of October . I was here again in the pen because of the breast . you had recommended me at that time the Dr. ...	rative
03	D	Miller .	Name addition
04	P	Dr. Miller . who then did the breast reconstruction.	
05	D	hm .	2.2: LS
06	P	and in October I had to go back because of the . Then I went to Dr. Schulze for follow-up care and it was determined that the tumour values were not OK.	Continuation of patient narrative
07	D	hm .	2.2: LS
08	P	and then I had all the examinations done . all the CT scans and all sorts of things [winks] . and unfortunately (...)	Continuation of patient narrative

Here, the patient's narrative is only "interrupted" by an addition of a name (03 D), which the patient was apparently looking for herself, and otherwise kept going by listening signals through which the doctor expresses his attention and interest (§ 19.3.3), Although communicative action rarely leads to automatisms of action (§ 19.3.1), it can nevertheless be generalised that the type of open *narrative invitations* is more likely to open up a wide range of topics for patients than, for example, the deficit or complaint question. These types of openings can easily be understood as a doctor's interest primarily in body-related descriptions of complaints, as apparently in example (E 19.1), in which the patient answers succinctly and concisely ("quite often heart pains ...") in accordance with the doctor's question after the interruption.

Which type of opening question is ultimately appropriate in which situation towards which patients must be decided and tested anew from case to case until the situation assessment and choice of question becomes routine. Many physicians report good experiences with completely open forms of speech, such as non-verbally (type 8) by means of an inviting gesture or verbally by simply addressing the patient ("Mrs. X!") (type 9), which leaves the patient a great deal of room for opening.

E 19.7		"soo Mrs R"	Comment
01	D	so . please take a seat . maybe if you move your things to the side ... then we can better	1.4: Situating: Convenience

		...	
02	P	yes sure .	
03	D	soo . Mrs R ...	2.1: Opening: Right to speak: Addressing
04	P	the . Dr. Schmitz had sent me here because, uh, I had been to see him because I had quite severe abdominal pain and, um, yes, and they wanted to check what was wrong with a laparoscopy, but it seemed to be nothing physical . there didn't seem to be anything physical there, and since I was otherwise (...)	Patient offer 1

In other cases, simply waiting (with or without gestures, nodding) is sufficient (type 8), so that the patient takes the initiative in the pause, as in the following example (E 19.8), in which the patient uses the right to speak after about 5 seconds.

E 19.8		"..... (5) ....." [Pause approx. 5 s]"	Comment
01	D	you can sit down .	1.4: Situating: Convenience
02	P	thank you ..... (5) ..... uh I have uh so pain here in the neck so . and I could not go to work this morning . it extends to my elbows . [corresponding movement] .	2.1: Opening: Leave the right to speak through a break
03	D	hm .	LS
04	P	and I ... I've had it for a few days now, but then it was still so, so bearable, but now it's, [shakes his head] ... always so ... always like this .	Patient offer 1

However, the pause behaviour should not be "overused" either at the beginning or during the conversation, which we will come back to. Some patients need a strong start signal, especially at the beginning, so that they can be sure to have the doctor's full attention. In the following example (E 19.9), this attention is expressed by a doctor with a particularly apt *metaphor,* with which she describes her "exclusive" listening role.

E 19.9		"so . now I'm all ears"	Comment
01	D	so . now I'm all ears .	2.1: Opening: Metaphor
02	P	yes . so . I do go to the gym now and then . but I've noticed lately . I'm not feeling well at all . I always have such pressure here [pointing gesture] . I haven't talked to my wife about it . but now I've told her the truth . now I have to see a doctor after all . I want to have a total check-up .	Patient offer 1
03	D	hm . aha .	2.2: LS
04	P	that's why i'm here .	Patient offer continued
05	D	hm .	2.2: LS
06	P	i am now (...)	Patient offer continued

Obviously, the doctor must have been somewhat absorbed in her attention beforehand if she marks the change "now" so clearly with this beautiful metaphor ("now I am all ears"). This expresses the patient's full attention, which the patient knows how to use to the full even after further listening signals and verbal interventions by the doctor, which we will return to in detail under the aspect of empathic conversation (§ 20).

As a rule, conversation openings are less metaphorical, but move within the spectrum of the previously differentiated opening types. According to our observations (in further training courses with video recordings from consultations), doctors have developed their individual preferences for certain standard openings in their conversation practice, but occasionally vary them and are also willing to try out previously unfamiliar openings. Although types such as the *complaint* and *deficit question* should rather be avoided because they are often associated with a *biomedical* thematic focus, the choice between the more explicit *conversation openings,* in which for example the *reason for the consultation* or the *concern* is asked or *help is offered* etc., and the more implicit *speech openings* can certainly also be adapted to *individual* patients. Since these are not yet known in initial conversations, more "conventional" openings (reason for consultation, etc.) are recommended here,

while in follow-up conversations, in which a trusting relationship has developed, a more informal variant ("Wat jiddet?"= “What’s up”) can reinforce this trust.

If improvements can be hoped for or deterioration must be feared, questions about the current "state of health" are certainly appropriate because they are directly goal-oriented. However, any pressure of expectation ("Are you feeling better now?") should be avoided in questions of this type. This problem of suggestive interview techniques does not only apply to opening questions, but we will also encounter it in detailed exploration (§ 21.2). In all cases, the patient should first be allowed to develop the topic freely, and his flow of thought and speech should be *encouraged* by *active listening and interrupted* as little as possible, before specific topics can be focused on by a more *doctor-centered* communication.

> Verbal expressions of listening may not only increase the extent to which people *feel heard*, but also the extent to which they are *being heard*, in positive feedback loops amidst live conversation
>
> Collins 2022: 5 (emphasis there)

19.3 Listener activity and interruptions

Like all verbal activities of the doctor, medical listening is to be further differentiated, which cannot be reduced to mere silence of an *understanding* but *speechless* listener. In forms of more or less *active listening*, the (primary) listener can still "interject", as it were, during the ongoing speech of the (primary) speaker without claiming the (primary) right to speak himself. The current listener restricts himself to minimal activities by uttering "hm" or "yes", for example. These particularly frequent listener signals belong to a subclass of listener activities that have been studied in conversation analysis as "auditor back-channel signals" (Box 19.1). These include short forms (*hm*, *yes, ah*, etc.) as well as longer forms (*sure*, *right*, *exactly*) or sentence-valued utterances (*I understand*, *I can understand that well*, *that's terrible,* etc.). The primary speaker can often continue in his speech without being "interrupted" in any relevant sense.

19.3.1 Speech continuations "as if uninterrupted"

In this conception of certain listener activities as feedback, it is assumed that the primary listener provides information to the primary speaker and that the speaker continues in his speech "as if uninterrupted" ("speaker-auditor interaction during speaking turns") (Duncan 1974, Flader, Koerfer 1983). Without claiming the right to speak (Box 19.1), information on (lack of) understanding and comprehension is nevertheless continuously conveyed to the speaker.

Box 19.1 Function of listener feedback

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

Duncan 1974: 177

With this conception of listener feedback, the concept of "*interruption*" is to be examined, as it is used for example in the highly regarded study by Beckman, Frankel (1984), according to which doctors interrupt their patients after 18 seconds on average. This study was later reviewed on a different data basis (Marvel et al. 1999), with a slightly different result (23 seconds). Compared to the study by Beckman, Frankel (1984), corrections, modifications or recoding have been suggested in more recent research, apparently to account for category errors (in the sense of Ryle 1949) or application problems in coding (Marvel et al. 1999, Makoul 2003). Nevertheless, it often remains controversial what is to be "counted" as an "*interruption"* (of what kind), especially when the listener activities in question are realised relatively briefly or simultaneously to the primary speaker (as "overlaps").[2] All in all, the primary listener can talk

[2] Overall, the substitution of "interruption" by "redirection" as well as the introduced or modified categories (such as *closed question, elaborator, recompleter, statement, etc.*) are not sufficiently selective and exhaustive, which in practice leads to application problems in coding, which we will return to in our conversation analyses on interruptions for purposes of research-based learning (§ 13.4). This is not to claim a research concept already, but to achieve a practicable sensitisation to the common maxim of

"in between" in very different ways, which must be differentiated according to the form, function and context of listener activities.

19.3.2 Polyfunctionality of listener signals

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

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

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

A necessarily abstract typology can only partially satisfy the dynamics of the uses of listener feedback in real conversations. As the multiple

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letting patients talk as freely as possible while interrupting as little as possible.

assignments in various dimensions make clear, certain (forms of) minimal listener feedback have a relatively extensive functional potential. This polyfunctionality can be used in concrete conversations by the participants precisely in terms of interaction strategy in order to vaguely satisfy the various communication requirements. In these cases, it is not (and should not be) possible to decide whether a minimal listener feedback such as "hm" should primarily express "go on" or "I understand" or "I accept" etc. In other cases, however, the polyfunctionality is sufficiently reduced by the form and context so that certain interpretations can be excluded.[3]

Before returning to the dynamics of the use of *minimal* listener feedback in real conversations, illustrative descriptions of the uses of the doctor's "OK" from a professional perspective and below on psychotherapeutic uses of "HM" from the patient's perspective will be given here in advance.

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

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

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

3 In the empirical conversational analyses, certain (simple, reduplicated) forms and (rising, falling, falling-rising, floating, etc.) tone structures have to be largely disregarded, as they have only been recorded in exceptional cases with our standard transcriptions (§ 2.3) (cf. Ehlich 1979, 1986, Koerfer 1979, Flader, Koerfer 1983, Kliche 2015). Because of the inconsistent concepts and terminology (listener activity, listener feedback, listener signal, interjection, etc.), different usages are also used here depending on the context.

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

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

Platt, Gordan 2004: 122f

An "inappropriate" use of "OK", which could even endanger the therapeutic relationship between doctor and patient, should perhaps also be reflected upon in one's own conversational practice and corrected if necessary. Without falling into (old patterns of) *language criticism* here (especially towards the younger generation in each case), our observations in OSCE examinations should nevertheless be communicated that students sometimes make "inflationary" use of "OK" there. In extreme cases, the simulated patients (SP) concerned (§ 13, 41) have also been critical of the students in their feedback - a "privilege" that is not so easily perceived by real patients.

The use of "OK" may often be "well-intentioned" in order to fulfil the essential contact *function* of listener signals, so to speak, i.e. to prove oneself an attentive *contact person,* but the inflationary use of this and other forms is just as often counterproductive. This applies similarly to the frequent use of the German variant ("gut" [=good]). These and other listener activities often serve as closing signals, which are then used to initiate topic changes. As Platt and Gordon have already impressively described and as still to be proven by empirical examples, listener signals of this type can take on the function of a "communication stopper" (*truncator*), with which the primary speaker's right to speak is "cur-

tailed" in advance, before the doctor then carries out the change of topic.

While certain types of *shorter* listener feedback (such as "OK", "good") can irritate the primary speaker in his flow of thought and "interrupt" the flow of speech in a relevant sense, *longer* listener activities do not necessarily have to lead to an "interruption", but can be effortlessly "integrated" by the primary speaker into his current speech. This is true even for certain question-answer sequences, which do not necessarily have to "interrupt" the primary speaker in a relevant sense. Different forms and functions of "speaking in between" or "interrupting" must therefore be differentiated, for which certain formal test procedures such as the omission test can be helpful.

19.3.3 Flow of speech and thoughts: The omission method

In a first test procedure, it should be checked to what extent the primary speaker could (or could not) continue in his speech "as if uninterrupted" (in the sense of Duncan 1974). To distinguish, it is useful to have an *omission test* for the doctor interventions in question, which may or may not "interrupt" the patient's flow of speech and thought. A clear case of interruption was already example (E 19.1) from the opening phase, to which we will return in detail, while the examples (E 19.10, E 19.11) represent clear cases of a continuation "as if uninterrupted". The following excerpt from an older transcription (Flader, Koerfer 1983: 77) from a therapy session, revised and simplified here, will serve as an example of an *omission sample for* whole sequences.

E 19.10		"you did?"
01	P	(...) although that's not true at all, no ..... (6) ..... I was just taking the mickey out of him and making fun of him like that . so now I have to grin [laughing] because it brings me ( ) fun . always called him . [a nickname follows] .
02	T	you did? .
03	P	yes .
04	T	hm .
05	P	I always said that you as [nickname] must know that, no ... and then he practically turned blue [laughs] and I was really happy (...)

Following the terminology of Conversation Analysis (CA) (§ 2), to which we often refer, the example can be summarised as follows, neglecting details: After a longer speech (*turn*) by the patient (01), shortened here at the beginning, and a short pause, a short *digression* (in the sense of a *side sequence*) develops with the therapist's question (02), in which the patient (03) gives a short affirmative answer ("yes"). The therapist (04) in turn (in the 3rd position of the digression) follows this adjacent pair of utterances (*adjacency pair*) with feedback in the form of a listener signal in the simple basic form ("hm") and the function of a *reconfirmation*. This feedback can at the same time be regarded as a closing signal for the entire digression, after which the patient (05) can continue with his ("original") speech "as if uninterrupted".[4]

In other words, the patient can continue his speech "as if nothing had happened". This also becomes clear with the suggested test procedure: If one does an omission test during the rereading (and "erases" in one's mind) the interlude (02-04), one can also read (or "hear") the remaining "rest" as a "patient's speech in one piece" without having to "miss" anything here.

Likewise, one could "erase" the naming ("Dr. Miller") in the above example, which is cited again here in a longer excerpt in order to document the dialogic interplay of narration and listener feedback. Even at the first reading, the doctor's listener signals ("hm") could (tentatively) simply be "left out".

E 19.11		Name completion and listener signals "hm"	Comment
01	D	(...) tell us a bit about what's going on and how we can help you.	2.1: Opening: Invitation to tell and offer of relationship
02	P	so . in October . I was . no . yes . at the beginning of October . I was here again in the pen because of the breast . you had recommended me at that time the Dr. ...	Start patient narrative

[4] However, in conversation analysis, more complex "communication relationships" must always be taken into account, such as when questions from the listener are perhaps answered differently (for example, with a *negative*) against expectation, so that complex and longer digressions can result, which if not prevent an "as if uninterrupted" continuation, at least make it more difficult, etc.

03	D	Miller .	Name addition
04	P	Dr. Miller . who then did the breast reconstruction.	
05	D	hm .	2.2: LS
06	P	and in October I had to go back because of the . then I went to Dr. Schulze for follow-up care and it was determined that the tumour values were not OK .	Continuation of patient narrative
07	D	hm .	2.2: LS
08	P	and then I had all the examinations done . all the CT scans and all sorts of things [winks] . and unfortunately I couldn't get an appointment with you before Christmas . it was so last-minute .	Continuation of patient narrative
09	D	hm .	2.2: LS
10	P	And my son ... he was so upset ... he was so afraid for me ... so he called in Munich ... and asked around.	Continuation of patient narrative ("I was afraid for myself")
11	D	hm .	
12	P	and then I went to Munich . and they said . they could do something . and that was (...)[to be continued].	Continuation of patient narrative

The doctor (03) adds the name of the colleague (in the sense of a *joint sentence production*) relatively early, barely after the patient has taken a short break, without the "word search" or delay being "noticeable" yet. The need for support (for *cognitive* reasons) does not yet seem urgent. The doctor apparently makes the name addition here primarily in the *social* function as a *contact signal* with which he proves himself to be a competent listener who is fully "on top of the conversation" as an attentive *contact person*. Formally, however, the addition of the name could be eliminated just as formally as the subsequent listener signals ("hm").

After the "deletion" of the doctor's remarks, an "independent" patient "text" remains, which can easily be subjected to a *sense-coherence* test. Only the doubling (02, 04) of "Dr." may remain conspicuous, which is a "relic" of the doctor's listener activity (name addition). Although these, like all other listener signals ("hm"), do not seem to "affect" the patient's flow of thought and speech, in sum they keep the overall narrative going, which would not have come about without the doctor's listener activities. What may seem "superfluous" when reading texts is *constitutive*

for conversations. A primary speaker needs contact with the listener in order to be able to continue to secure the listener's attention, interest or sympathy. Should the primary speaker lose this listener contact, he would eventually (have to) "fall silent" in the hope that the interlocutor would in turn (again) take the floor, etc., in order to express his interest in (continuing) a narrative that has begun, etc. In this sense, the listener "determines" what is *worth telling* (§ 9), although his activities seem (formally) "dispensable".[5]

The *method of the omission test* is commonly used in linguistics, for example, to distinguish obligatory from optional clauses in grammatical analysis. However, the method can also be applied to entire conversations. Carl Rogers, for example, used a similar method in his early studies (1942/1985) of recorded therapy sessions to demonstrate forms of *non-directive* conversation (§ 40.2). If the professional parts of the conversation are eliminated with the omission test, the remaining "passages" in *non-directive* conversations often represent a meaningful text for which the utterances of the professional interlocutor seem to be dispensable, although the conversation would not have proceeded in this way without him. To stay with the image of the *art of midwifery* (*maieutics*) (§ 9.5) in medical conversation: After the work is done, the midwife seems (to have been) dispensable.

We have repeatedly presented and applied the method of the omission sample and will use it again here to determine the functions of utterances in context, but also to be able to identify longer pieces of patients' speech (as already in § 17.3.6), which are examined as candidates for narratives in the subsequent conversation analysis (Koerfer et al. 1994, 1996, 2000, 2005, 2010) (see below § 19.7-8, 20.9, 24.7, 25.4). In addition, the omission test contributes to the *evaluation of* conversations, which we will return to separately (§ 40.2).

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5 We will come back to specific listener activities, which are more extensive and more consequential than the "mere" listener signals, in the following narrative analyses and there in particular under the aspect of *cooperative narration,* for which, however, the method of the omission test is also proposed and applied. With regard to the previous example of the addition of names, we would like to point out again the possible complexity that could arise if the doctor "made a mistake" in naming the colleague, which could have resulted in further clarifications that could have made it difficult to continue the patient's speech as "as if uninterrupted". Communication is a "risky" undertaking that is not necessarily made more successful by the doctor's "abstinence".

However, the problems of analysing *interruptions* can only be solved to a limited extent with this *formal* procedure. Here, *functional* conversation analyses are to be connected, which can take into account the *complexity* of communication and the *polyfunctionality* of forms of communication towards specific addressees in specific contexts (Ehlich 1979, 1986, Koerfer 1979, Flader, Koerfer 1983, Mazeland 1990, Quasthoff 1990, Menz et al. 2008, Menz, Al-Roubaie 2008, Brinker, Sager 2010, Pawelczyk 2011, Hitzler 2013, Kliche 2015). Finally, in a *functional* conversation analysis, the broader effects of "interruptions" (of various kinds) in developed conversational contexts must be taken into account, which has already been addressed with the long-term "conditionings" that also play a role in extreme manifestations of an *interrogative* interview style (§ 19.5) or an *authoritarian* paternalism (§ 10, 24).

All in all, empirical studies would initially have to assume a vocabulary orientated towards everyday language, the rich spectrum of which ranges from "interrupting" to "falling into the word" or "parading" to "shutting up" or "running off at the mouth" or "silencing". In order to be able to determine the functions of listener signals in this broad spectrum, the conversation analysis must also be carried out as a *context analysis,* which not only *locally* records the neighbouring utterances ("adjacency pairs"), but *globally* records the overall structure (of types) of conversations in a *comparative* evaluation perspective.

19.3.4 Listening activities in context

In some (types of) conversations, it is *singular* interventions by the doctor that "muzzle" a patient on the spot, as is still clear in examples from ward round communication (§ 24). In other conversations, it is again *cascades* of medical interventions that gradually leave patients with only "monosyllabic" answers or, in sum, completely "silenced" (§ 19.6). Whoever as a doctor "interjects" not only occasionally but constantly, without opening up enough narrative space for the patient, is quickly subject to an "attempt at domination" in the sense of Gadamer (1993) (§ 9: Box 9.20) vis-à-vis an interlocutor who then, according to Engel, Morgan (1977) (Box 19.6), waits in *silence* for the next doctor's question, and so on. This spiral of interaction (D: *question* – *P: answer* + *silence* – *D: question* etc.) can have "devastating" effects on the overall structure

of conversations in the sense shown, which can develop in the direction of an "interrogation conversation" (§ 19.6).

As already explained for research and teaching (§ 2, 13), evaluation perspectives for doctor-patient conversations can only be gained through *comparative* conversation analyses, in which local, *sequential* structures ("turn-by-turn") in the development of the overall structural organisation of (types of) conversations are to be comparatively examined. In the process, conversation phases are also differentiated according to their specific tasks, which arise in each case from the *opening* to the *taking of medical history*, *clarification* and *decision-making* to the *conclusion of the conversation* (§ 8, 13). Attention has already been drawn to the different roles of the interlocutors in different phases of the conversation, which also correspond to the structure of our communication manual (C-MMC).

Although the task structure in psychotherapy conversations is less strongly phase-specific, the conversation partners also develop in this type of conversation a structure of division of labour that is sustainable for them in the joint conversation work, in which the therapist can initially more or less hold back with his or her activities. The patients usually tolerate this restraint of their conversation partner and initially use their "privileged" right to speak for "their" purposes, but often only up to a "critical" point at which especially patients as "novices" who are less familiar with psychoanalytic conversation begin to demand greater therapist participation. Especially in the initial phase of therapies, the "violation" of habitual everyday rules of a *dialogical* communication is complained about again and again (Koerfer, Neumann 1982). In his "Lehrjahren auf der Couch" (years of apprenticeship on the couch) Tilmann Moser (1974) very impressively describes his perspective of experience as a patient who, on the one hand, has a "high degree of freedom" and, on the other, feels a lack of responsive conversational behaviour on the part of the analyst, whose variable use of the psychoanalytic primal sound ("Urlaut" ("Hm") (Box 19.3) is described in such a nuanced way.

Box 19.3 The "psychoanalytical primal sound" ("Hm")

Or he asked cautiously, but with many modulations: "What's up?" so that I could answer with a high degree of freedom or respond or not. Or he kept to that primal psychoanalytic sound that keeps many thousands of psychoanalyses going in the world and is nevertheless still not worn

> out, the famous and much maligned "Hm". This "Hm" can be like the life preserver thrown to a shipwrecked person; or it can be like the first pillar of a bridge across a previously impassable stream, or a chasm, or it can be an encouragement, an expression of curiosity or sympathy. But it can also, if you say it questioningly or pensively or doubtfully, replace a whole host of interpretations, mean a catching. Or it is like a gnawed bone that is thrown to you and that you want to push back, yelping angrily, with the reproach: "That's all you've got today", or: "You could starve to death without noticing, you brute", or: "One more 'Hm' and I'll go for your throat".

Moser 1974: 83f

The "high degree of freedom" experienced at first obviously turns into dependence on the interlocutor experienced in this way. What Moser describes here from the patient's perspective is the "frustration" of everyday communication expectations, against which the listener feedback of the professional interlocutor can only be a weak "comfort". Because as a patient he is more dependent on the sparse feedback of his interlocutor, he is subject to much stronger interpretive constraints than is usual in everyday communication. But even there, there can be a strong communication experience of dependency, for example when parents let their children or when partners or colleagues "leave each other hanging" instead of reacting "appropriately" to communication requests from the other.

The experiential perspective of patients in psychotherapeutic conversations "feeds" on the effect of the combination of the *basic rule* (the patient's association) and *abstinence* (the analyst's). Of course, Freud anticipated resistance to the violation of rules of everyday communication, which he took into account accordingly in the formulation of his *basic rule* (§ 9). That is why the basic rule communication is at the same time an appeal to the patient to adopt a "wait-and-see" perspective, as it were, before the patient can benefit from the form of communication that is different for him: "The reason for this rule - actually the only one they are supposed to follow - they will learn and come to understand later" (Freud 1913/1970: 194). Nevertheless, it usually takes a while for patients to become appropriately "accustomed" to the "unfamiliar" conversation (Koerfer, Neumann 1982). Because of this peculiarity, systematic comparisons between therapy sessions and medical consultations in relation to everyday communication are particularly useful. The validity of rules in a certain type of conversation can best be

found out through contrastive comparison with other types of conversation (Koerfer 2013), just as the self-evident rules of one's own ("familiar") culture can only be "discovered" in comparison with other ("foreign") cultures.

Comparisons can also be made between close "relatives", as in this case with psychoanalytic initial interviews, which in their dialogue form can still be quite similar to initial interviews in medical consultations, especially with the offer of basic psychosomatic care (§ 15, 25). In both cases, it is about the exploration of medical histories, concerns and expectations of patients, who should therefore "have their say in detail", for which the doctor or therapist must meet them in a "comparable" way with his listening and questioning competence, as described as *midwifery* (*maieutics*) (§ 9.5).

In his analysis of an initial psychoanalytic conversation, Buchholz (2014) describes the "rhythmic structure" of the conversation in which the therapist's activities seem to be "interspersed" (Box 19.4). The conversation develops in such a way that the therapist's verbal and non-verbal interventions below the threshold of *classical interpretation*, which of course still has its justification, sufficiently challenge the patient and yet leave him enough room of his own to "communicate".

Box 19.4 The rhythm of "interspersed" activities

(...) one has to see that at the same time a rhythm is still intercalated: the therapist's activities seem "interspersed" and are regularly followed by a withdrawal of such activities. He retreats to prosodic "hms" over longer stretches, completes his patient's sentences and thus documents his listening activities, directs the course of the conversation with small remarks - in short, he does not permanently assert interpretive sovereignty, but allows considerable space for the patient to communicate.

Buchholz 2014: 237

This perspective of analysis for therapeutic conversations can be generalised for doctor-patient communication: in order to determine the scope for patients, the *rhythmic* structures in conversation analysis are to be examined in such a way that both the effects of individual *activities* ("tones") in the immediate context and their interactions in the *overall composition* ("score") are taken into account. In this perspective, *local* as well as *global* conversational developments are considered, in which short-term and long-term "conditioning" (in the above sense §

9.4) can be distinguished, in which individual interventions only have an effect in the cumulative interplay with others for which they have, as it were, done the "groundwork" (Koerfer, Köhle 2007, Koerfer et al. 2000, 2010). In the following, individual *conversation sequences* as well as longer *passages of conversation* and finally entire *conversation processes* are examined comparatively.

The evaluation perspective of these studies is initially oriented towards the outlined *comparative guiding idea* of conversation analysis, according to which "negative" and "positive" examples are to be contrasted. In doing so, the focus will initially be on "predominant" conversational structures (tendencies, dominances), which should in no way obscure the view of mixed forms, which are to be differentiated subordinately.

In "negative" cases, the doctor has imposed his *agenda in the* sense of Engel (1997) (§ 9, Box 9.17) with his interrogative style of conversation (*requiring reporting*). In contrast, the "positive" cases are to be contrasted (*encouraging narration*), in which the *agenda* is developed *dialogically* between doctor and patient in processes of *relevance negotiation* up to joint decision-making (§ 10, 22). The promotion or inhibition of these conversational developments in different directions will be *comparatively* investigated in the following empirical conversation analyses.

19.4 Dialogical relevance negotiations

In accordance with the research method of a *comparative* conversation analysis (§ 2, 40), which is to be continued in communication theory (§ 13, 17), the differences between a more *interrogative* conversation, which is dominated primarily by question-answer patterns, and a more *narrative* conversation, which is primarily characterised by the promotion of *patient narratives,* are to be worked out in several steps.

Likewise, relevant switches between interrogative and narrative phases of conversation will be identified, which are often accompanied by a change of topics and participation roles, such as when both interlocutors switch from the mode of *telling* and *listening* to the mode of *asking* and *answering.* These forms of communication have their justification for *clinical* reasons (sic), but each in "its time" and for "its purpose". Making the "right" choice of the form of communication here, depending on the course of the conversation, and deciding on the "right" dosage (§ 3, 17), poses challenges for doctors' *clinical-communicative*

dual competence, which they fulfil to varying degrees. Before we further elaborate the differences in comparative conversation analyses, we will describe along the conversation manual (steps 2.2-2.3) essential forms of communication that can be used to *upgrade relevance* or *downgrade* patient-side topic initiatives. First, the problem of relevance will be presented from the perspective of patients who, as laypersons, often first have to test the relevance of their topic initiatives.

19.4.1 Relevance tests: Buying "entrance tickets"

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

Box 19.5 "Story telling and ticket of entry"

But the telling is not so easy. Stories may not be told because patients fear that the stories do not meet the standards of life-and-death intensity the patients assume their doctors demand (...) If the doctor does not facilitate the story telling - if the patient is not encouraged to go on - the patient very often will not.
Facilitating the story-telling process is best accomplished when there are no strict parameters limiting or defining the patient's response. The patient's story is not limited to the first-presenting problem. Patients often state a medical complaint as a 'ticket entry' to medical care, even though the primary and most pressing concern may be unrelated to this complaint.

Roter, Hall 2006: 7

Patients' attempts to initially “buy” less relevant "tickets" reveal their insecurity and helplessness in the face of the relevance problem as it arises from their lay perspective. In concrete individual cases, patients are repeatedly faced with the decision at key points in the conversation as

to what can be classified with "good reasons" as sufficiently "relevant" (*doctorability, reasonability*) and therefore as correspondingly "worth telling" (*tellability, narrativity*) or not and should therefore remain "unmentioned" if possible (Heritage, Robinson 2006, Halkowski 2006, Koerfer et al. 2000, Koerfer, Köhle 2007, Baroni 2014, Köhle, Koerfer 2017). In this process of deliberation, it is to be expected that patients will hold back in case of doubt, so that relevant information is often lost, although it would fulfil the relevant criteria (*doctorability*, *tellability*) if it had been "brought up" by the patients.

In order to be able to cope with the dilemma at all, patients are increasingly dependent on their feedback in the ongoing interaction with the doctor, with which the relevancies are recognisably marked in a *dialogue feedback model,* which we had already presented in detail (§ 17.4). In all possible variants, a distinction can essentially be made between *upgrading* or *downgrading* the relevance.

Relevance upgrades usually lead to the continuation and deepening of topics that have been started, which can, for example, be elaborated in an experiential way in a patient narrative (§ 9). The forms of communication for relevance marking range from minimal listener feedback to explicit encouragement to continue talking to empathic feedback (§ 20). Relevance *downgrading* is usually initiated by the doctor with a change of topic, which is often resignedly accepted by the patient. Occasionally, however, patients restart their topic initiatives in the hope that they will eventually receive a positive relevance upgrade from the doctor through repetition.

In most cases, the relevance problem is *negotiated indirectly* between the two interlocutors; in rare cases, it comes up *directly,* as in the following example (E 19.12), in which the patient explicitly makes his uncertainty about the relevance of his possible topic offer to a question asked by the doctor an issue.

E 19.12		"I don't know now if this is relevant"	Comment
01	D	what was your childhood like? .	4.3: Open question on new thematic focus
02	P	my childhood? . I don't know now if this is relevant . but I had TB as a child .	Relevance test Indirect question
03	D	ah .	2.2 LS (empathic)
04	P	yes . that was bad . (...) (continued)	Start of story

Although the doctor's open narrative invitation on the topic of "childhood" allows the patient a wide range of topics, the patient expresses his uncertainty about the relevance of his possible narrative with an indirect question: "I don't know if this is relevant, but ...". The doctor's empathic feedback ("ah") represents a relevance upgrade of the topic ("TB"), which is now available for disposition without restriction. Apparently, the relevance test has succeeded and the patient can take the interest marked by the doctor's feedback as a "licence" to continue talking, which he then makes extensive use of. Similarly, in the following example, another patient first expresses his uncertainty about the relevance of a possible topic through an indirect question, which is then given a twofold relevance upgrade by the doctor.

E 19.13		"I don't know if this belongs here now"	Comment
01	D	what medicines are you taking? .	4.3 Detailed exploration: Medication
02	P	Beta-blockers, ACE inhibitors and cardiac ASS and then stomach tablets.	Information on taking medication
03	D	hm ...	2.2 LS
04	P	I don't know if this belongs here now .	Relevance test
05	D	yes? .	2.2 LS (question intonation)
06	P	my GP wanted me to stop taking beta-blockers.	Information
07	D	why? .	4.3: (medication)
08	P	well, I told him that I had difficulties ... I had erectile dysfunction . and I wanted to stop taking the pills . so that it would get better again . I felt like half a human (...)	Narrative start: Relevance to everyday life

There is no question that the relevance to the patient's life, which he expresses in a strong metaphor ("I felt like half a human"), is at the same time of professional relevance. It is a potential conflict between patient preferences motivated by life and evidence-based requirements of medicine (§ 10, 22), which already had to be taken into account in the pre-treatment by the general practitioner. The doctor who is currently treating the patient first upgrades the relevance of the question

by asking "yes" and then by asking "why", which the patient has more or less successfully "provoked" beforehand.

As explained above, patients and doctors can "condition" each other in their interaction (§ 9.4). By expressing uncertainty in relevance assessment, patients seek to acquire a doctor's "licence" to (re)tell, which may or may not succeed. While explicit relevance tests usually lead to relevance upgrades of topics, implicit offers of topics by patients often remain "unheard", even if they are repeated (§ 17.4), which then often leads to *resignation* on the part of the patient.

In this handbook, we will encounter the relevance problem as a permanent problem of doctor-patient communication, which will be exemplified here for conversation steps 2.2 (*encouraging narration*) and 2.3 (*active listening)* using "negative" as well as "positive" examples (*best practice*). First, shorter examples of *downgrading* (§ 19.4.2) and then *upgrading* of relevance (§ 19.4.3) will be given, before larger conversation excerpts (§ 19.6-8) will be analysed from the point of view of the extent to which patient narratives are *promoted* or *inhibited* or even *prevented.*

19.4.2 Downgrading: Change of topic

In the case of relevance downgrading, passive forms of refraining from upgrading can be distinguished from active forms which, for example, lead to a change of topic with or without speech interruptions. In the passive forms, doctors lapse into silent listening, accompanied at best by minimal listener activity ("hm"), which is used extremely sparingly. Thematic patient initiatives are tolerated to a certain extent, but not encouraged further. Thus, patient narratives are listened to but not "heard" and certainly not developed further (§ 19.7). The subsequent continuation of the conversation is often framed by the doctor as if the patient's narrative had not taken place at all. The relevance is either *misjudged* or *ignored* (§ 19.7) (narrative "deathly bad"). In other cases, patient narratives are nipped in the bud, as it were, because the doctor relies on a question-answer pattern, which patients then follow more or less willingly in the sense of "conditioning" (§ 9.4), as in an "interrogation" (§ 19.6). In addition, there are many mixed forms in which relevance upgrades and downgrades alternate, which will be worked out in the following (§ 19.6-8) using longer conversation sequences.

Here, brief examples of the downgrading of relevance through a change of topic by the doctor will be given, which will also serve as initial, partly "negative" anchor examples for step 2 of the communication manual (C-MMC). The first example is about completing the psychosocial anamnesis (§ 21), in which the doctor first asks about possible problems in the patient's parental relationship.

E 19.14		"are there any problems?"	Comment
01	D	(...) how is it with/with the parental home . are there {any problems . or .	4.3 Detailed exploration: completing the medical history
02	P	{ no, not at all . there used to be . but- .	
03	D	they live near here too?	4.3 + 2.2: Interruption
04	P	they also live in [place name]	
05	D	or any illnesses . been in the environment . Parents .	4.3 Detailed exploration: Familial diseases
06	P	{noo not at all .	
07	D	{Siblings .	4.3:
08	P	yes, my father has asthma	Range of topics
09	D	he has asthma .	2.3: Repeat verbatim
10	P	an emphysema [swallows] [looks at D] .	Thematic expansion
11	D	Circle of friends something ..... (5) ..... nothing?	4.3 Complete anamnesis

The completion of the anamnesis takes place in fast motion. Possible topic expansions are not waited for or even encouraged, but the anamnesis is reduced in telegram style to a keyword communication, which is predominantly conducted in elliptical one-word sentences ("parents", "siblings", "circle of friends"). Characteristic is also the too early interruption of the patient's possible addition to the topic, who is interrupted by the doctor as soon as she begins to qualify her first statement ("not at all") ("used to be, but-"). Similarly, the doctor in a hurry is already with the "siblings" while the patient is still delayed in her thoughts and

thematically with her parents or her father. Although the doctor's upgrading of relevance (9D: literal repetition: "he has asthma") reactively leads to an expansion of the topic to the father's illness (10P: "emphysema"), this upgrading is immediately levelled out again with the subsequent downgrading through the abrupt change of topic to the "circle of friends". At the end of this short conversation sequence, the doctor has hardly gained any relevant information that could contribute to completing the psychosocial and family history.

The possible issues of stress due to a previous "problem" in the parental relationship as well as the subjective significance of the father's illness for the patient remain underexposed. This underexposure is particularly noticeable in emotion-related topics, where doctors often lack the necessary empathic competence (§ 3, 17), which we will return to in detail with examples (§ 20). To begin with, here are brief examples where doctors react to patient formulations of *concerns* (E 19.15) and *worries* (E 19.16) as well as *subjective theories* (E 19.17) with a more or less abrupt change of topic.

E 19.15		"until I can finally sleep again"	Comment
01	D	hm .	4.3: Complete medical history
02	P	yes . that didn't help me either . until my friend gave me [the name of the medicine] . and that helped me . I can sleep because of it ... I only want to take it for the time being, until I can finally sleep again .	Formulation of need for help and concerns
03	D	what do you do for a living	Change of subject 4.3 Occupation
04	P	I work at [company name]	
05	D	are you working at the moment too? .	4.3 Occupation
06	P	yes ... so no, not at the moment (...)	

E 19.16		"a bit more serious, isn't it?"	Comment
01	D	and you saw starlets, did you say? .	2.3: Literal reprise "starlets ..."
02	P	yes, that's what happened earlier, I was... I was down here in the pharmacy, I got some ointment, some handplast. ointment... I drove	

		up the mountain... really cold, blew, and then into the warm room, then all of a sudden... stars-	
03	D	dizziness? .	4.1: Accompanying signs
04	P	yes .	
05	D	hm .	2.2 HS (reconfirmation)
06	P	I thought to myself, this is a bit more serious, isn't it? .	Concern ("being more serious")
07	D	are you otherwise in treatment? .	Change of topic 4.3: Pre-treatment
08	P	yes .	
09	D	why? .	4.3: Pre-treatment

E 19.17		"that this somehow has something to do with"	Comment
01	D	hm .	2.2 LS
02	P	... and I can't imagine... I was totally fit regarding my circulation, and all of a sudden there's this crap, right? ... ... and I can't help thinking that last week I was in the [factory name] and had to work there, and all the fumes were there without a mask .	Patient-side formulation of a subjective theory
03	D	hm .	2.2 HS
04	P	that this somehow has something to do with it .	subjective theory
05	D	but you don't have shortness of breath? .	Topic change: 4.1: Accompanying sign
06	P	I have no shortness of breath .	
07	D	hm .	2.2 LS

The alternative ways of conducting the conversation are obvious in all three cases: Instead of mere ignorance by abruptly changing the topic, such topic offers from patients are to be taken up and appreciated in the "here and now" of the conversation, even if the underlying problems cannot yet be conclusively assessed or even have to be solved differently

than may be intended by the patient initiative. For example, a patient request for sleeping pills (E 19.15) may have to be rejected if this is not consistent with evidence-based medicine (§ 10.3). For the same reasons, *subjective theories of illness* (E 19.17) put forward by patients may need to be rejected, corrected or modified (§ 21.5).

The "rejection" or mere correction etc. of ideas, concerns and convictions of the interlocutor is, however, to be preferred to mere "ignorance". Repeated disregard of content can also grow into a personal devaluation of the interlocutor, which according to Watzlawick et al. (1967/2011) can lead to considerable relationship problems (§ 7.4). From a relational point of view*, ignorance* of the patient's topic initiatives can run counter to the doctor's own interests. For example, the "best" medicine without knowledge and appreciation of the *subjective theories* remains "ineffective" if patients behave non-adherently for reasons that are not recognised because they have not been sufficiently addressed. In this sense, topic initiatives of the patient must be taken up by the doctor not only to avoid disturbances on the *relational level*, but also to be able to take into account *relevant contents* that need to be affirmed or, if necessary, completed, modified or corrected, and so on.

19.4.3 Upgrading: Promoting narration and active listening

While in the previous cases (E 19.12, B19.13) a relevance test was explicitly carried out, in which the patients had made relevance an issue by using appropriate vocabulary ("belong here", "be relevant"), there are indirect forms with which the patients initiate a relevance action. One possibility of empirical entry into the problem/topic of relevance action is the following anchor example, which can be used in teaching to quickly gain intuitions about the relevance of the relevance problem in the medical consultation.

The example (E 19.18) stands for a form of cooperation on a "medium", yet economic level of effort. The patient has already described a series of somatic complaints ("palpitations" etc.) before she now makes another thematic "patient offer".

E 19.18		"a facial paralysis?"	Comment
01	D	(...)	

02	P	(...)[-] Here [points to right eye] I always have a pressure in it. and exactly: I had [+] facial paralysis [1] [1: puts finger to mouth] last year in February....	Initial Range of topics "Facial paralysis
03	D	facial paralysis?.	1. upgrade: Literal repetition (=2.3)
04	P	yes, the doctor Meyer said it was due to the flu. A nerve was inflamed here [points to neck].	Expanded range of topics
05	D	hm . a facial paresis .	2. upgrade listener signal (= LS) + technical language para-phrase (= 2.3)
06	P	I suppose, if that's what it's called .	Conditional approval
07	D	hm . how was that . how . {did (that) make itself felt? .	Detailed exploration (=4.1: Qual)
08	P	{so the left side- the left side was paralysed (...)	Theme continuation: "Facial paralysis"

In the present case, the patient tests the relevance of her topic offer "instantly" in the interaction process. She makes her further offer, which obviously occurs to her spontaneously ("and exactly ...") and then pauses "expectantly": she first prospectively gives the *turn* (speech turn) to the doctor by making eye contact (= "[+]"), whose reaction she can simultaneously check in her field of vision: The patient ends the turn by demonstratively putting her finger to her mouth, which she closes "visibly" with this gesture, so that the pause becomes clearly "recognisable" as a pause that has been left. The formal-dialogical message to the doctor is: "It's your turn" and the content-related-interactional function is the clarification of the indirect question of relevance (for example: "Is what I just told you relevant to you?"). The previous patient offer must now be accepted by the doctor as a topic or else rejected. In the further factual interaction, the patient's offer then undergoes a threefold gradation *of relevance on the* part of the doctor, whereby the new topic is particularly distinguished:

1. Upgrading through the elliptical question ("facial paralysis?"), with which the propositional core of the description of the complaint is *literally taken up again* (Manual 2.3), i.e. reflected back like an *echo,* as it were,
2. Upgrading then by a listener signal ("hm") (Manual 2.2 LS) and then a paraphrase in the form of a technical language translation ("a facial paresis"), by which the complaint is given a special medical recognition (as it were a "terminological consecration") (Manual 2.3), and finally
3. Upgrading through the relatively open exploration of details ("what was that like?") (Manual 4.1: Qual), which the patient immediately takes up willingly in order to further elaborate on the now "properly" introduced topic.

With her triple relevance upgrade, the doctor has thus granted a *license* for further *rapport*, in which the patient can for the time being "lament her suffering" without restriction. Her previous relevance test has been successful and her initiated topic of conversation has now been sufficiently *ratified,* which is subsequently further expanded by both interlocutors as the extent of the life impairment caused by the facial paralysis (when drinking, laughing).

The various means of upgrading relevance are to be differentiated in the following conversation and narrative analyses and illustrated here only with a few conversation sequences as examples. Simple verbatim repetitions and paraphrases are the tried and tested means of medical conversation management/active listening that can "work wonders" if the patient's speech is to be set in motion and held.[6] Verbatim repetitions or paraphrases represent specific "*reflections*" with which what has just been said is once again brought into the focus of attention, from which it can be further perspectivised. The doctor's intervention usually follows on its heels, i.e. immediately after what has been said, as in the previous example (P: "... facial paralysis" - D: "facial paralysis?"). In the following example (E 19.19) from an opening phase of the

6 From the long tradition of broader and narrower terms and concepts of "active listening" over a period of several decades, reference is made to Dickson et al. 1991, Dahmer, Dahmer 1992, Koerfer et al. 1996, Hugman 2009, Pawelczyk 2011, Martin et al. 2017, Rodat 2020, McKenna et al. 2020, Collins 2022, Kishton et al. 2023, Epstein, Beach 2023, Tustonja et al. 2024. Cf. on specific empathic relevance upgrades § 20.

conversation, the doctor also merely repeats (with a question intonation) the central expression ("empty") from the patient's first topic offer, which the patient then expands on.

E 19.19		"Empty?"	Comment
01	D	come in . please take a seat .	1.4: Situating
02	P	[Patient sits down]	
03	D	Mr. W, what's up? .	2.1: Opening Q: Concerns
04	P	yes ... well, I feel somehow ... empty .	Beginning of the answer
06	D	empty? .	2.3: Active listening: Repeat verbatim
07	P	yes ... at work, well, I don't know, somehow ... nervous ... and ... how should I put it ...? agitated, stomach cramps ... headaches . sweating ... so at the moment ... I don't know what's wrong with me... Either it's... either it's the stress at work at the moment, it's always so hot, dusty and everything ... I don't know ...	Confirmation ("yes") + continuation of the complaint description + and subjective theory offers

Paraphrasing has a similar effect to literal repetition, in which what is said is "mirrored" in different words, but also. In the following example (E 19.20), this happens when the doctor takes up the patient's topic offer in a slightly modified form by replacing the expression "isolating oneself" with "withdrawing".

E 19.20		"You want to withdraw?"	Comment
01	D	(...) .	
02	P	yes, yes! . that is the whole ... environment... I don't feel like going anywhere or so ... I'm at home most of the time, I hardly ever go out. I... I shut myself off so completely that I can't hear or see anything and...	Range of topics "Unhooking"
03	D	you want to withdraw, yes? ...	2.3: Active listening: Paraphrase

			(*shut myself* → to *withdraw*)
04	P	yes yes . and then I brood and think ... yes, what should you do (...)	Confirmation (yes, yes) and topic expansion ("brooding")

In contrast to *literal repetition, paraphrases* can also be used to introduce further aspects, with which a more interpretative quality is associated, as claimed with specifically *empathic* interventions (§ 20). Empathic interventions usually presuppose an advanced conversational development in which patients have already begun to tell their medical history. In order to promote this process, forms of *active listening* are to be applied beforehand in a targeted manner, which are to be used repeatedly and in combination. In the following exemplary excerpts of the conversation, the patient, who right at the beginning of the consultation expresses the wish to have her blood pressure measured and complains of "goofiness in her head" (E 19.21), is repeatedly encouraged to continue talking freely until an essential theme emerges with which the core concern of today's visit to the doctor emerges with reference to the long-standing medical history. With a focus on the doctor's interventions, the longer patient narratives are reproduced here in three parts in a highly abbreviated form.

E 19.21		"I thought, you're not crazy"	Comment
01	D	yes, tell me first that I can understand a bit .	2.3: Keep talking
02	P	and then I must have, uh . with my head now, no . I'm taking more of the medicine for it, I brought it with me, so you can see . in the morning and in the evening [searches in the bag] .	Theme offerings (head, medication)
03	D	yes .	2.2 LS
04	P	here this - otherwise I have ... pffff [exhales air] ...	Expression of helplessness
05	D	and now you've come quite spontaneously? . what's going on - what happened?	2.3: Ask further questions openly
06	P	I... I just couldn't... I felt so strange, I thought I would at any moment, so... I thought, I've	

	taken so many pills, I thought, you're not crazy . this morning, what's going on, huh? .	Resumption of the doctor's formulation: "what's going on"

Without succumbing here to an over-interpretation of phenomena of the "conditioning" of communication, which were discussed previously (§ 9.4), attention should be drawn to the literal reprise with which the patient repeats the question put to her by the doctor (05D: "what's going on") as a question put to herself at the end of her speech (06 P: " I thought (...) what's going on"). Such agreements in the sense of a common vocabulary are often (pre-)signs of an understanding on a common topic in the consultation, which in the present case is concretised by further narratives that deal with threatening events from the patient's family life.

E 19.22		"I have been so done"	Comment
01	D	(...)	
02	P	(...) and I was at that point fourteen days . three weeks ago that I really would have called you, something happened to us in . one week, it was unbearable.	Announcement of an "unheard of event"
03	D	what was there? .	2.3: Ask further questions openly
04	P	the brother-in-law was taken to the hospital with the ambulance in the morning (...) on Sunday morning the brother-in-law falls down . and we couldn't get an emergency doctor, we had to call here in [town name], yes and they just took him to the hospital, no .	"Unheard of Event" Dramatic narrative [abridged here]
05	D	and what has become of it? .	2.3: Ask further questions openly
06	P	well, they sent him home again, then he had to go to Dr. [name] again, and then he (...) I was so done, that I didn't throw up, that was all . soo sick was I .	Further narration [abridged] Evaluation of the narrative: "done", " throw up"
07	D	you were miserable then, yes .	2.3: Active listen-

			ing: Repeat verbatim
08	P	and then I said to her ... one of you is lying in the corner and on Sunday mornings she comes screaming "Mum, come!", the [first name] has fallen down . I said, see, now we've all seen it, I said that, on Friday ... but I was so done ... I couldn't/no one was allowed to speak to me about it, so my tears were running down . my nerves . I thought, I'm breaking down . I don't know if it all comes out now, when you calm down a bit, but (...).	Direct speech Evaluation of the narrative Subjective theory Further narration [abridged]

Here, the patient's narrative activities experience a multiple relevance upgrade through the doctor's listening activities, which can be perceived by the interlocutor as narrative invitations. These functions of listening activities as narrative invitations will be elaborated in more detail in specific narrative analyses (§ 19.7-8, 20.9, 24.7, 25.4). In the present case, the (foreign) narrative (*alter)* about the dramatic story of the brother-in-law is developed by both actors into a common theme, to which the patient introduces further narratives about the *early* or *sudden death* (*heart attack*, *stroke*) of relatives (parents, siblings), which explain her own worries about herself (*ego*). This transference is elaborated in a comparative perspective of experience by both interlocutors (partly in a *joint sentence production*) (02-03), which can only be reproduced here in short excerpts.

E 19.23	"yes . it all came down to me"
01	D	and you think it's happening to you too...
02	P	now I always think ...
03	D	now it's your turn .
04	P	somehow when something happens. (...) [further narration about relatives] a nursing case, couldn't speak any more, couldn't walk any more, nothing (...) for three days . we didn't know . he always said "ouch ouch . here" ... yes and .
05	D	that all went through your head? .
06	P	yes, that's it . that's what happens to me on such days, so I always think that can't be true, so you're not stupid, you're/. so I thought, now I'm going, I've been putting it off for so long, now

		I'm going to the ECG and here to .
07	D	that's when you have to consider all that .
08	P	yes .
09	D	yes, what happened there.
10	P	yes .
11	D	and what happens to you.
12	P	yes . it all came down to me, I had to/ I was always the stupid one who had to go, my mother called me at night, every time (...) [longer narration] then my brother died of a heart attack at the age of 36, how long ago was that now? .... yes . ten, fifteen years ... and the mother a few years before that .
13	D	you've been through a lot too, yes.

With the longer, here abbreviated stories about the many life-threatening events in her family, the patient can vividly convey to her doctor her own fears of an "unheard-of" event (*sudden death*, *heart attack*, *stroke*, etc.). In doing so, the narratives serve not only to communicate with the interlocutor, but at the same time to help the patient understand herself (§ 9). In particular, the most recent event (brother-in-law in hospital), which is currently having an effect, allows the patient to arrive at a *subjective theory* about herself (E 19.22, 08P: "I was so exhausted (...) my nerves . I don't know if it all comes out now, when you calm down a bit"). Such subjective theories of patients often cannot be "elicited" by mere questions from the doctor, but only by encouraging narratives.

The doctor first promotes the patient narratives several times through *active listening* (E 19.21 and 19.22) before both partners further process the meaning and purpose of the narratives with regard to the subjective meaning for the patient (E 19.23). In doing so, the doctor takes up what the patient has already suggested, namely the change of perspective from the protagonists of the narratives to the narrator herself (E 19.23: 01 D: "and you think it's happening to you too..."), which in turn triggers new narratives in the same comparative narrative perspective (of *alter* and *ego*).

The entirety of the narratives reveals that the patient, due to the many threatening events in her family, is also always a sufferer and co-sufferer in her narratives, from her childhood to her old adulthood. This kind of permanent burden is finally acknowledged by the doctor with an *empathic recognition* (E 19.23, 13D: "you've been through a lot too, yes"). Such a further processing of narratives is not a matter of course, as will

be shown by empirical analyses of conversations in which the emotional potential of narratives is hardly exhausted (§ 19.7, 20.4). Before this, other forms of relevance upgrading will be discussed, which at the same time serve to secure comprehension.

19.5 Ensuring understanding

Securing understanding is a special form of upgrading relevance in that the speaker of a question of understanding pays full attention to his or her counterpart, who should not miss anything essential. Understanding is the very first prerequisite for successful communication. Non-understanding or misunderstanding is the first source of disturbances in communication, which can become so entrenched that it leads to a systematic permanent disturbance of understanding and communication (§ 7), which can hardly be "cured".

19.5.1 Logical and psychological understanding

Understanding itself can be differentiated in a wide spectrum. A first orientation is provided by the traditional distinction between *logical* versus *psychological* understanding, which is also specified as *empathic* or *scenic* understanding (§ 3, 9, 20). Here, the focus will initially be on *logical* understanding, where speaker and listener must first ensure that they refer to a "common world", for example, when patients tell their attentive doctor about acting persons in certain places at certain times, etc. However, the typical questions of logical understanding (*who, when, where, with whom,* etc.) will soon have to be supplemented by other types of questions of *psychological* understanding, when the primary listener also begins to ask about the intentions, motives, preferences, etc. of the actors, for example with *why-* and *what for*-questions.

Although the boundaries are also fluid here, a distinction can be made between an "outer" and an "inner" world and it can generally be assumed that understanding the "outer" world is a prerequisite for understanding the "inner" world. Despite the problematic nature of these distinctions, which have already been discussed in the epistemological justification of a *biopsychosocial* medicine (§ 4), the *logical* understanding of the "outer" world will be considered here first, and later (§ 20, 21) the *psychological* understanding of the "inner" world.

Beforehand, however, the transition from logical to psychological understanding should be marked by an example, which is often introduced with a specific type of question ("what does ... mean?"). This type of securing understanding is directed beyond the superficial clarification of word or sentence meanings to the *subjective attitudes* (fears, wishes, ideas, explanations, etc.) of patients (§ 20, 21), which may lead to complex *negotiation of meaning.* In the following example (E 19.24), the doctor's question of understanding (03: "What does that mean, psychically") can apparently be integrated relatively smoothly into the further course of the conversation without further complications.

E 19.24		"What does that mean, psychologically?"
01	D	(...) and everything is fine there now, yes? . and you get complaints again.
02	P	yes, then I can only think that it is simply psychological.
03	D	what does that mean, psychologically? .
04	P	yes that maybe when I have a lot of work . and when I put myself under stress/ stress . stupid word, I don't like it anyway . under pressure, that maybe then I somehow ... that the body resists .
05	D	resists, yes .
06	P	I think .
07	D	so that would be another possibility .
08	P	hm .
09	D	yes, that means that, uh . on the one hand, the computer tomography would, uh . uh . reassure you .
10	P	yes, because I think then I can at least say "okay . organically everything is really okay".
11	D	hm . (...)

Here, the securing of understanding has initially reached a *saturation point,* however sustainable, with which both interlocutors seem satisfied for the time being. Before we turn to more complex examples of *negotiating meaning* (§ 20, 21), simple forms of "acoustic" and "content-related" securing of understanding should be differentiated, which can usually take place in a side sequence without significantly interrupting the patient's flow of speech and thoughts. Nevertheless, there are often conflicts of maxims between the two alternative continuations of the conversation, to continue listening to the patient or to "intervene" with a question of understanding, with which the risk of a serious "interrup-

tion" and rhythm disturbance of an ongoing conversation is taken. However, it cannot be in the interest of either partner to allow a conversation to continue which one partner can only follow with difficulty or with incomprehension. Here the right converges with the duty to ensure comprehension, even if the current speaker cannot easily integrate this into his speech, so that he is prevented from continuing "as if uninterrupted" (§ 19.3). Here the current listener may come into a conflict of maxims in view of the alternative of continuing to listen or asking questions for understanding.

19.5.2 Maxim conflicts between listening and questioning

Listening and questioning skills must work together to secure understanding. The fact that listening and questioning form a unit becomes immediately clear in the question of comprehension. A good listener will ask a comprehension question if he or she cannot "follow" the primary speaker sufficiently "in terms of content", which is why he or she will then ask the familiar *W-questions* ("Who did what with whom, when and where, why and what for?" etc.) to ensure comprehension. The comprehension question is not only asked in the interest of the listener, but also in the interest of the speaker, for whom a listener must remain a competent listener. The latter is obliged to ask first and foremost if there are "acoustic" problems of understanding, as in the following example (E 19.25) right at the beginning of the consultation, in which the doctor can solve his hearing problem with a routine formula ("pardon?"). The conversation, which had already begun outside the door, is seamlessly continued by the patient after she has been seated, before she then repeats her request for a blood pressure check again verbatim after the doctor's feedback ("pardon?").

E 19.25		"Pardon?"
01	D	come on, take a seat.
02	P	yes, he's always got something ... since he's been sick, he's always, uh ... stop, stop ... can we take my blood pressure now?
03	D	pardon? .
04	P	take blood pressure again...
05	D	yes . we could do that .
06	P	hm . (...)

In order to always recommend himself in his role as contact person, the listener must, however, also remain fully on the "level of the conversation" in terms of content. The competent listener must communicate a possible lack of understanding in good time in order to protect himself and at the same time his interlocutor from momentous misunderstandings. As already explained above (§ 3, 17), conflicts of maxims can arise in medical conversation practice, for example between the two maxims of

- *Avoid interruptions* (=Manual 2.2)
- *Ensure understanding* (=Manual 2.4)

In case of doubt, the conflict between the maxims must be decided in favour of securing comprehension. If, for example, the *thread* of a narrative is lost and the *contact* with the narrator is lost, the listener is obliged to ensure comprehension. Securing comprehension by the medical listener then has priority over the patient's right to narrate, who in the case of a continuation of the speech would run the risk of talking past an "incomprehensible" listener, which would be unproductive for both conversation partners. In this case, the doctor's interruption of the patient's flow of thoughts and speech is also justified. The maxim conflict usually arises in a weak form, in which the securing of understanding can be integrated as a *side sequence* into a longer patient speech in such a way that a continuation of the speech "as if uninterrupted" (above § 19.3) seems possible. In the following example (E 19.26), the patient continues her story as if she had not been interrupted by the doctor's question ("Who is called ...?").

E 19.26		"Who is ..."	Comment
01	D	yes .	2.2: LS
02	P	(...) was here at [place name] was that uh . [name] was the name, here in [place name] . yes so-	Narration (continued))
03	D	who is [name]? .	2.4: Ensure understanding + 2.2 Interruption
04	P	uh . the doctor who did it .	Answer
05	D	hm .	2.2: LS
06	P	yes now [continuation of narration] (...)	Narrative (cont.)

Similarly, in the following example (E 19.27), the patient can effortlessly integrate two medical comprehension questions asked in quick succession (03) (05), although she has to make syntactical corrections before she can continue her narrative with a new construction altogether.

E 19.27		"Who threw you out"	Comment
01	D	hm .	2.2: LS
02	P	I couldn't do anything anymore, nothing at all (...) and he threw me out onto the street. and then they-	Narration (continued))
03	D	who threw you out? .	2.4: Ensure understanding + 2.2 Interruption
04	P	[name] closed up there, so I couldn't get in ... and then I had to-	Narration (continued)
05	D	to your flat or to his?	2.4: Securing understanding + interruption
06	P	no . at the flat of [name]	
07	D	aha .	2.2: LS
08	P	and now [continue of narration] (...)	Narrative (cont.)

In the following example (19.28), the patient's rhythm of thought and speech seems to be disturbed at first by the doctor's assurance of understanding, but here too the patient is able to integrate her own answer well into her further speech as a clarification of her own words (02: "it can't go on like this").

E 19.28		"I didn't understand it"	Comment
01	D	yes... how do you two get along, he was there now, you told so and eh .	4.3: Partnership
02	P	yeh, normally we get along quite well, but lately it's been not so good, because he's doing further training now and therefore didn't have too much time, but we've got a handle on that now, because at some point I told him that it can't go on like this, and now it fits quite well again.	Quality of the relationship: (time) problems
03	D	ehm . what can't go on like this? . I didn't	2.4: Ensure

		understand it .	understanding
04	P	yes, he didn't have much time, and the time he spent with me, he was always so absent ... and uh ... somehow you could tell that he actually preferred to have his peace and quiet ... [laughs] than to do anything with me, I mean, I could understand it somehow, but on the other hand I didn't like it at all.	Topic expansion (Time) problems in the relationship

The non-understanding of the interlocutor, which the doctor verbalises directly here (03: "I didn't understand it"), can be used and expanded by the patient in the sense of self-understanding. In the following example, too, the patient effortlessly integrates the assurance of understanding by continuing her narrative after the question-answer-feedback sequence as if it had not been interrupted ("as if uninterrupted") (§ 19.3). If one applies the method of the omission test described above (§ 17, 40), the three speech segments to ensure comprehension (03), (04), (05) can be deleted without disturbing the comprehension of the remaining "core speech" (02, 06). If the middle section had been omitted from the beginning, it would not have been missed if the patient had mentioned the name of her daughter's illness beforehand.

E 19.29		"MS"	Comment
01	D	(...)	
02	P	(...) uh the daughter is a teacher in Z, yes . at the grammar school . and it suddenly broke out with her in May .	Narration (continued)
03	D	what? .	2.4: Ensure understanding
04	P	MS .	(Taboo word?)
05	D	ye::s	2.2: LS (empathic)
06	P	now she has applied for ... she has to drive in a wheelchair (...) and it has really hit me hard (...) and it broke out with her . that's when it started with my dizziness . I couldn't cope with it . I don't have to tell you everything . now it (has) . that was in May of this year . (...) [Cont. of narration]	Continuation of the "as if uninterrupted" narrative

The omission of the disease name ("MS"), however, necessitates the intervention of the doctor, who otherwise would not be able to fully understand the meaning and purpose of the patient's narrative, which will be analysed in detail in the larger context of the conversation (§ 19.7). At this point, only the possible interpretation should be added that the unclear reference (02P: "it") and omission of the disease name ("MS") comes close to the avoidance of a "taboo word" with which the patient seeks to "protect" herself and her doctor from the "unheard-of" event of the narrative.

In the previous examples, the interventions to secure understanding were certainly necessary at different levels of understanding and for different purposes in order to ensure common understanding in the further course of the conversation. However, despite all the differences, what the previous examples have in common is that the comprehension-securing interventions hardly lead to disruptions in the flow of the conversation and the patients can continue with their speech "as if uninterrupted".

Sometimes, however, the communication situation becomes so complicated that the question-answer sequences cannot be easily integrated as digressions into the ongoing conversation, but grow into a topic of their own. Due to knowledge differences that cannot be adequately anticipated on either side, interaction loops of attempts at clarification develop, in which the misunderstandings can only be gradually clarified and eliminated. In the example (E 19.30), a misunderstanding gradually reveals itself regarding the difference between "ECG" and "EEG", which the patient is apparently not so familiar with. In addition, it becomes a matter of clarification which doctor ordered what and performed what.

E 19.30		"EEG" or "ECG	Comment
01	D	has a skull x-ray ever been taken? .	4.3: Pre-treatments
02	P	no .	
03	D	not either .	
04	P	not either .... (4)	
05	D	the Dr. [name X] examined you and only did an EEG? .	4.3: Pre-treatments
06	P	yes, the Dr. [name Y] has the ...	
07	D	EEG ordered .	2.4: Ensure understanding
08	P	yes, yes .	

09	D	no? .	
10	P	hm . they did a short ECG, didn't they? .	
11	D	hm ... ECG, no EEG? . the Dr. [name Y] can only have done an ECG .	2.4: Ensure understanding
12	P	yes .	
13	D	and no EEG .	
14	P	yes . ah .	
15	D	EEG, that's a brain wave image, only Dr. [name X] could have done that.	5.3: Inform/explain
16	P	no . he has ehm ... I don't know how he has it/at the whole body.	
17	D	hm .	2.2: LS
18	P	he gave me Ca/Ca/and then and then electricity-	
19	D	don't you think you could be a bit more overloaded lately, don't you? . what do you do apart from ... that you/formerly you were ... [profession etc.]?	Change of topic Stress, job (=4.3)

Although the clarification ("ECG" versus "EEG") is of course factually relevant, the doctor seems to resign herself here despite the insufficient securing of understanding by apparently *setting* a different *relevance* with new topics (*stress*, *profession*). This radical change of topic is problematic here in that securing understanding is not only about one's own understanding (*ego*), but also about that of the interlocutor (*alter),* whose (lay) understanding is to be checked and promoted, especially in technical communication (§ 27). The necessity of further securing the patient's understanding is manifested in the helplessness with which she reveals her uncertainty of knowledge through delays and in fragments (18: "some Ca/Ca/and then electricity-"). The doctor's interruption with a change of topic not only reveals her resignation, but also her ignorance of the patient's need to secure understanding, which would be required according to the *principle of transparency in dialogue* (§ 7, 10, 22). Securing the patient's understanding is part of the doctor's duty to inform and educate, which we will come back to with empirical examples in "negotiating procedures" (§ 22).

19.5.3 Summaries

Summaries that serve to ensure mutual understanding are often risky. Occasionally there is awkward concretisation, detailing and corrections, which may be justified, but which can jeopardise the sense and purpose of a summary because the common thread is in danger of being lost. For this reason, summaries should be well thought out in terms of content and appropriately placed in the conversation, which the doctor in the following conversation example (E 19.31) apparently succeeds in doing well despite the abundance of summarised information.

E 19.31		"and I have a feeling it won't stop"
01	D	there is the accident, the paraplegia, the inability to work, the parents' refusal to take her in, the marriage, the partner's greed for money and the death threat . one traumatisation follows the next .
02	P	and I have a feeling it won't stop ..... [pause of approx. 8 seconds] .....

The fit of medical interventions can generally be "read off" from patients' reactions (§ 3, 17-20). In the case at hand, the doctor's summary of the patient's history of suffering so far is obviously a perfect fit for her own perspective: she takes over the doctor's summary by continuing and reinforcing his sentence in terms of form and content, combined with a change of time perspective: the *iterative* structure of traumatic events already thematised by the doctor for the *past* (D: one traumatisation follows the next") is extended by the patient into the *future* (P: "... a feeling it won't stop"). After this threatening perspective (not only for the patient's life, but also for the rest of the conversation), there is a middle pause in the conversation (of about 8 seconds), which both conversation partners apparently use as a pause for reflection before continuing the conversation. We will come back to summaries at the end of the conversation separately (§ 23.3).

19.6 Interrogative Conversation

Using the example of an initial interview, the interrogative funnel technique is to be demonstrated, with which doctor and patient get into a circle of questions and answers from which they can no longer escape. In the sense of "conditioning" (§ 9.4), the course for this kind of extremely interrogative conversational style is set at the beginning of the conversation by an early interruption that focuses on biomedical topics. Insofar as narratives are nipped in the bud, possible biopsychosocial topics remain largely underexposed.

In one of our courses on conducting conversations, the following conversation was spontaneously characterised as follows: "This is like an interrogation". We want to work out under certain aspects for further teaching purposes how this impression of the conversation can arise in the first place and how possible alternatives to the conversation (of active listening, of a biopsychosocial development of themes, etc.) can be derived in detail from the criticism of such an "interrogation conversation". We first follow the conversation step by step. Specific observations are recorded in a commentary column, which, if possible, is conceptually and categorically oriented to the *Cologne Manual on Medical Communication* (C-MMC) (cf. § 17.5). Summary analyses and statistical information are given at the end. Here is the opening sequence (E 19.32) of the first interview with a patient aged about 25.

19.6.1 The early interruption and topic focussing

For teaching purposes, attention can first be drawn in particular to the doctor's questioning activities, speech organisation and gaze behaviour, with eye contact at particularly relevant points in the conversation being noted with "[+]" and its interruption with "[-]". The patient's gaze, which is directed "reflectively" (upwards to the left), is noted with "[BÜ]". Doctor and patient enter the consulting room together and take their seats. Since the doctor and the patient have already greeted each other outside, the conversation can be opened immediately after both have taken their seats. The doctor opens the actual conversation by addressing the patient personally by name ("Ms A."), which could already suffice as an invitation to talk (type 9) (Table 19.1), and then specifies this invitation to talk with a special type of opening, namely the question about

the reason for the consultation ("What brings you to me?") (type 1), thus passing on the right to speak to the patient in a content-specific way.

Patient privilege: Open form of presentation

With this opening, the patient is given a relatively wide space to answer, which she begins to use accordingly with an initially open form of presentation before she then falters slightly ("so ... generally now um ."). Attention should be paid here to the patient's gaze behaviour, who typically maintains eye contact with the doctor at first during the latter's speech, only to avert her gaze once she has finally taken over the speech. In the process, the *gradual completion of the thoughts while speaking* (in the sense of H. v. Kleist) is recognizably set in motion by the patient, both verbally and non-verbally: Through the characteristic introduction and delay phenomena *(hesitation phenomena*) ("so", silent pause: "...", filled pause: "um") and her gaze behaviour, the patient's mental efforts to "find the right words" for her initial problem presentation become clear. She breaks eye contact [-] with the doctor after the opening question and turns her gaze upwards to the left, "thinking" (=th), which is not only a clear sign of *taking* over the speech (*turn taking)*, but also of her further mental speech planning - which she should be able to continue unhindered.

E 19.32		"Where are your main complaints?" (Part 1)	Comment
01	D	[both sit down] so Mrs A, what brings you here? . [+]	2.1: Opening: salutation + reason for consultation
02	P	[-] so [+] [-], in general now um ... [Looking up to the left, thinking]	Start of the response with delays

Kleist's dictum "On the gradual production of thoughts in speech" (1878/1966) is not only valid in medical decision-making, where "time for reflection" is to be granted accordingly (§ 10.6), but also or especially in the opening phase, when patients in their social role as ill persons are to formulate their concerns, which do not even have to be clear to them in detail, to the doctor for the first time or again. In doing so, they have to weigh up between the *sayable* and the *unsayable*, the *important* and the *unimportant*, the *urgent* and the *secondary,* etc., i.e. they have to make a rational choice according to the criterion of *relevance* (§ 7,

17), without necessarily being convinced of the rationality of the choice themselves. This is related to the lay status from which the relevance of what is said has to be assessed for the expert - a *paradoxical* requirement that can be not only cognitively difficult but emotionally stressful to solve, precisely because so much depends on it for the sick person. Even in follow-up conversations, in which a certain familiarity may already exist, the new start is a recurring hurdle that has to be overcome again ("What do I say to my doctor today?"), so that the agony of choice arises anew each time.

Especially in initial consultations, in which both interaction partners initially meet as strangers, the opening of the conversation is a particularly sensitive phase, in which patients still have to find the "right words" for their patient's concerns ("How do I tell this doctor, who is new to me?"). This is a search process that is prone to failure, and failure can have particularly serious consequences because it can shape the further development of the relationship. In order to counteract this, the patient should be granted a special *right to speak*, especially at the beginning, which he or she should initially be able to use without restriction - in terms of form, scope and content.

Early interruption and biomedical focus:

In the present case (E 19.32), the patient is deprived from the outset of such a speaking privilege for an initial presentation of the problem, in that the doctor withdraws her right to speak as soon as it has been granted. With his early interruption, the doctor intervenes in her obvious act of deliberation ("generally now um ...") with a twofold *specification,* with which he thematically narrows his opening question (01D), which was initially kept relatively open, to a *biomedical* focus ("main complaints") (03D).

E 19.33		"Where are your main complaints?" (Part 1+2)	Comment
01	D	[both sit down] so Mrs A, what brings you here? . [+]	2.1: Opening: Reason for consultation
02	P	[-] so [+] [-], in general now um ... [Looking up to the left, thinking]	Start of the answer with thinking
03	D	where are [+] your main problems, what/ or main complaints, what you come for? .	2.2: Early Interruption/

			Funneling
04	P	I have often had heartaches, i.e. sharp pains in the heart area. [+]	Focus: "chief complaints"
05	D	since when have [-] you had these pains? ... [3] ... [-] [P scratches shoulder]	4.1 Exploring details (time, start); Patient: Contemplative gaze of P
06	P	for a little [+] longer, so in 2001 it was really bad, and then I also had my tonsils removed . [+]	Last sustained eye contact from P to D
07	D	yes . [+]	Listener signal
08	P	that was still the case with Dr. Miller. [+]	Pre-treatment

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

- *Main issues* versus *secondary issues* and
- *Complaints* versus *problems*

With such an early and specific intervention, the doctor not only brings the patient's pensive gaze back to him on the visual communication level (03 D: "where are [+] your ..."), but on the cognitive level he interrupts her spontaneously started reflection (02 P: "generally now um ...") by directing her attention to his new question focus. If the patient now answers in the sense of the doctor's specification (03 D: "main complaints") with a physical description of complaints (04 P: "often heartaches"), then the question arises at this early stage of the conversation about the wasted opportunity for an initial *presentation of the problem* "in the patient's own words" or even for the presentation of a completely different problem, which could possibly (in the sense of *hidden agenda*) (§ 18.7) remain hidden for the rest of the conversation.

19.6.2 Taking an anamnesis as an "inquisition": The funnel technique

If we look at the subsequent course of the conversation from the perspective of the patient's further opportunities to participate, we notice the extremely interrogative interview technique of the doctor, with which he further narrows the focus of the topic that has now been reached, as if in a funnel, for example with his characteristic time question about the beginning of the complaints (05 D: "Since when have you had these pains?"). Such time questions about the beginning, duration and course of an illness are typical of the topic-selective function of the *funnel technique* (Fig. 19.2), especially when these questions - as is often the case - are asked at the beginning of the conversation. They then set the course for the further course of the conversation, which is difficult to correct again, because a mutual attitude of expectation in the distribution of the interaction roles of questioning and answering is soon established and stabilised. This repeated use of the question-answer pattern has already been described as "verbal conditioning" (§ 9.4), to which both interlocutors are subject, because patients are also waiting for the next question and accordingly no more patient initiatives come about.

In the present interview, the level of expectations once reached seems irreversible despite the doctor's best efforts. The interrogative interview style adopted finds its continuation in a *battery* of doctors' information questions with closed question forms for detailed exploration (E 19.35), which are answered by the patient in a correspondingly "concise and succinct" manner, such as decision questions (like 17D: "and does that radiate anywhere, this pain?") with typical one-word answers (like 18P: "no"). It is remarkable that even in phases of apparently factually informative questioning, communication vagueness must be expected, which calls into question the intended success of the information.

Example (E 19.33)

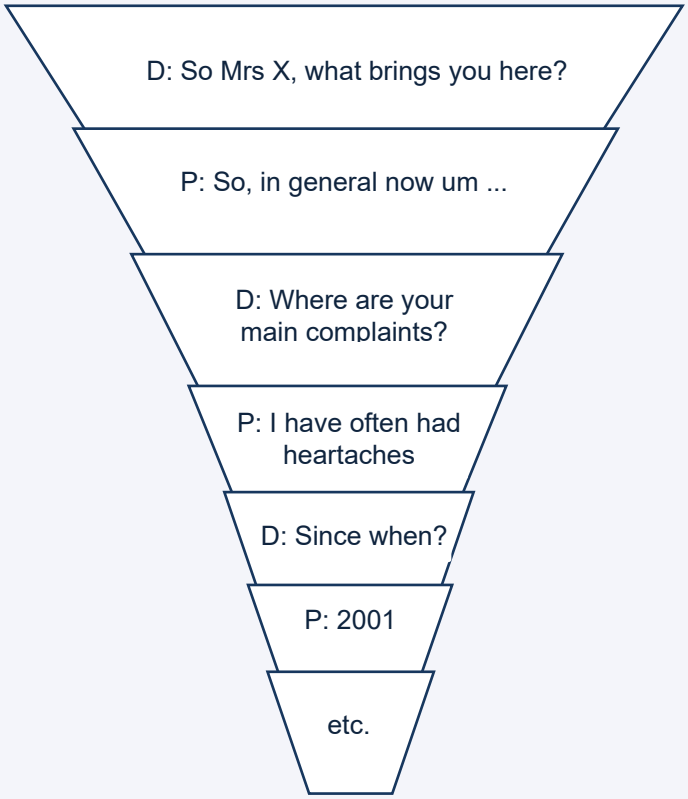

Fig. 19.2: Funnel technique

Funnel technique

The funnel technique can be used very effectively to conduct a doctor-centered conversation:
Formally through interruptions and functionally through targeted questions, the doctor very soon gains dominance of the topic in the conversation. The patient quickly learns to answer only the doctor's questions and then to wait for the next question in the sense of "verbal conditioning" (§ 9.4). In this way, he soon puts aside his own need for questions and information in favour of the doctor's need for information. While the funnel technique is quite useful in later phases of the conversation to further complete the anamnesis (§ 21), its early use can lead to a permanent inhibition of the patient's willingness to talk and self-exploration.

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

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

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

tinue on her own initiative if necessary. With a simple listening signal (*hm, yes*) the doctor could support the patient to continue speaking. Possibly the patient would expand on the topic she had started with ("a lot of work") or (with "and then ...") initiate another relevant topic, which could now concretise the previously introduced framework topic ("stress"). The doctor could also take up the topic of "stress" or "work" again himself and establish a connection, if the patient did not already do this herself, which would also have to be awaited, etc.

19.6.3 Theme progression and participation

However, these opportunities for conversation are given away by the direct interruption by the doctor. Asked about her profession (E 19.35), the patient gives a one-word answer which does not contain more than a reference to her job title ("doctor's assistant"). Instead of pursuing the patient's self-exploration that had begun (for example, on a complex topic to be developed: "Stress at work as a doctor's assistant"), the doctor makes a radical change of topic by shifting, apparently for no apparent reason, to asking for information about the accompanying signs of the symptom (27 D: "Are you short of breath?") - a turn of conversation that is difficult for the outside observer to comprehend.

E 19.35		"What do you do for a living?"	Comment
23	D	yes, how, how does the stress look? .	4.3: Stress (quality)
24	P	yes ..... [6 sec.] ..... yes a lot of work and then- .	
25	D	hm . what do you do for a living? .	4.3: Occupation
26	P	[smiling] doctor's assistant .	
27	D	[laughing] ah yes [inhales audibly] ... [2 sec.] ... um, are you short of breath? .	4.1: Accompanying sign
28	P	no . [shakes head]	

In many teaching and training events, this sequence of conversations was spontaneously criticised, with judgements ranging from "problematic" to "incomprehensible" and "unbelievable" to "curious". Especially in training groups where the case had been brought in, the abrupt change of topic was interpreted as *defensive behaviour* on the part of

the doctor, whose imagination might have been directed towards his own doctor's assistant in a process of counter-transference, with the insinuation of similar professional stresses as in the case of the patient - and perhaps, it was assumed, with the fear that his doctor's assistant might already be undergoing medical treatment with another colleague because of it, etc.

In any case, the question for an accompanying sign (27 D: "are you short of breath?"), which is surprising at this point, appears as a turning away from an *emotionally* burdening topic and towards a neutral topic, where the doctor can "move" again on what is for him familiar, "safe terrain" with the return to *biomedical* anamnesis. Such a safe space of retreat, however, plays a role not only in one's own emotions, but precisely also in the emotions of patients, which can, however, have an effect on one's own emotion regulation (§ 3, 17, 20, 25, 34). In the present case, the emotions involved are at best manifested in non-verbal communication, when the shared conversational experience, which among other things consists of the surprising realisation of a shared practical experience in a helping profession, is simply "laughed away" (26-27) before the doctor brings up the new, apparently "innocuous" topic of "shortness of breath".

The fitting problem

The relapse into a biomedically oriented anamnesis at this point of the conversation points to the *problem of the fitting* of medical interventions. Detailed information, such as on the accompanying signs, is certainly indispensable for differential diagnostic reasons (§ 21, 22). If this information is not - which should be waited for - communicated by the patient on his own, it must be explicitly asked by the doctor, but his questions must be asked in a way that fits the current state of the conversation, which is to be balanced according to the stage of development of the information and emotions reached in each case. In the present case, the doctor's intervention ("shortness of breath?") is inappropriate because it ignores the patient's just elicited information and emotions on a sensitive topic (e.g. "stress at work as a doctor's assistant"). In this way, the chances of a psychosocial anamnesis, which have only just been developed with difficulty, are given away again without necessity, in favour of detailed information (28 P: "no" = denial of shortness of breath), which could have been obtained later without any effort. In-

stead, it is necessary to follow the structure of relevance developed interactively by both interlocutors on an emotional topic, the mutually accepted saturation of which must be negotiated in the further interaction.

Interactive binding of emotions

Leaving opportunities of this type, which are characterised by emotional topics, unused can prove to be a cardinal mistake in conducting a conversation, because they cannot be easily restored later. The emotions that are interactively bound in a developed topic cannot be retrieved at will, which is why the conversation opportunities they open up should be used in actu if possible. The *interactive binding* of emotions is a *fleeting* phenomenon whose closeness to consciousness can only be established and maintained *ad hoc* through further, subsequently appropriate communication (§ 20). The difficulty of attempts at repair after the fact is already evident in the conversation's progress, when the doctor undertakes a futile restart for psychosocial issues after the detailed biomedical exploration.

E 19.36		"Are you afraid to do this?" - "No"	Comment
27	D	[laughing] ah yes [inhales audibly] ... [2 sec.] ... um, are you short of breath? .	4.1: Accompanying sign
28	P	no .	4.1: Accompanying sign
29	D	Sweating? .	4.1: Accompanying sign
30	P	yes, sweating, hm, so often . every morning ...	
31	D	hm ...	2.2 LS
32	P	very strong, and ... then during the day no more, but in the morning very strong .	
33	D	so the sharp pains don't make you sweat like that? .	4.1: Accompanying sign
34	P	no, no .	
35	D	are you scared during that? .	4.1: Accompanying sign +

			3.4: Clarifying emotions
36	P	no . [shakes head at this].	
37	D	do these pains worry you? .	3.4: Clarifying emotions
38	P	no .	
39	D	not really .	2.3: Paraphrase
40	P	[shakes head] hm-hm [smiles friendly] .... [2 sec.]	
41	D	[breathes in audibly] yes, then let's have a look . surely Dr. Miller has already done some examinations?	5.4 Examination + 4.3: Pre-treatment
42	P	yes, ECG, but that was OK .	

Despite apparently good approaches, the connection points to a biopsychosocial anamnesis interview are missed several times in the preceding interview. The potential points of connection become visible in a representation of the *biopsychosocial* development of topics (Fig. 19.3), which, however, ends in each case as soon as it begins. Thus, biotic themes ("heartache", "sweating"), psychological themes ("excitement", "stress") and social themes ("a lot of work", "professional") remain fragmented without a connection being established in the sense of *biopsychosocial* medicine (§ 4). The essential problem areas of the conversation can also be summarised for teaching purposes as follows:

- Premature *interruption* at the beginning of the conversation, which prevents the patient from formulating freely in her own words as soon as she has started speaking
- Significant *self-correction* in the new opening by the doctor, who preformulates the answer format for the patient with his choice of words ("main problems", "main complaints").
- Rash application of the *funnel technique*, which in the question-answer pattern conditions further interaction to this very action pattern (§ 9.4)
- Frequency of *closed questions* as well as *misunderstandings* due to the vague use of certain expressions ("stress", "rest"), whose respective focus (*physical* vs. *psychological* stress/rest) remained unclear.

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

Fig. 19.3: Biopsychosocial theme development

- *Abrupt change of topic* and the return to biomedical questions at a sensitive point in the conversation where a change to a biopsychosocial anamnesis should have been made at the latest in order to check the merely fragmentary topics (*heartache*, *excitement*, *stress*, a *lot of work, anxiety,* etc.) for possible connections in a complex development of topics.

In the end, these and other problematic points acquire a cumulative effect with which both partners succumb to the fixation on a question-answer pattern that they can no longer escape. In their short history of interaction together, they have developed a structure of expectations typical of interrogative interviewing, which was previously described as "verbal conditioning" (§ 9.4). The insights and warnings of Morgan and Engel should be repeated here:

Box 19.6 Conditioning through questions
If the doctor asks a series of direct questions early on when taking the medical history, he can thereby induce the patient to just wait silently for the next question.

Morgan, Engel 1969/77: 42

This leads to the formation of expectations, which are a kind of *verbal conditioning* that reinforce each other: 'I as a doctor expect you as a patient to expect me to ask you the next question' and complementarily: 'I as a patient expect you as a doctor to expect me to wait for the possibility of answering your next question', and so on. Waiting for the next question is, however, under the aspect of *participation* (§ 10), an expression of *passivisation* of the patient, which ultimately silences him: Once established, this interaction and topic structure exerts a certain compulsion to continue, as is also manifested in this conversation, in which the interrogative pattern is finally reduced to minimal questions and answers.

This restrictive pattern of action is already expressed in the representation of the formal dialogue role structure (Fig. 19.4), which shows at a glance that the patient can hardly talk for any length of time at a stretch.[7]

7 The comparative method of creating and evaluating the dialogue role structure for specific (interrogative vs. narrative) conversations is described and

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

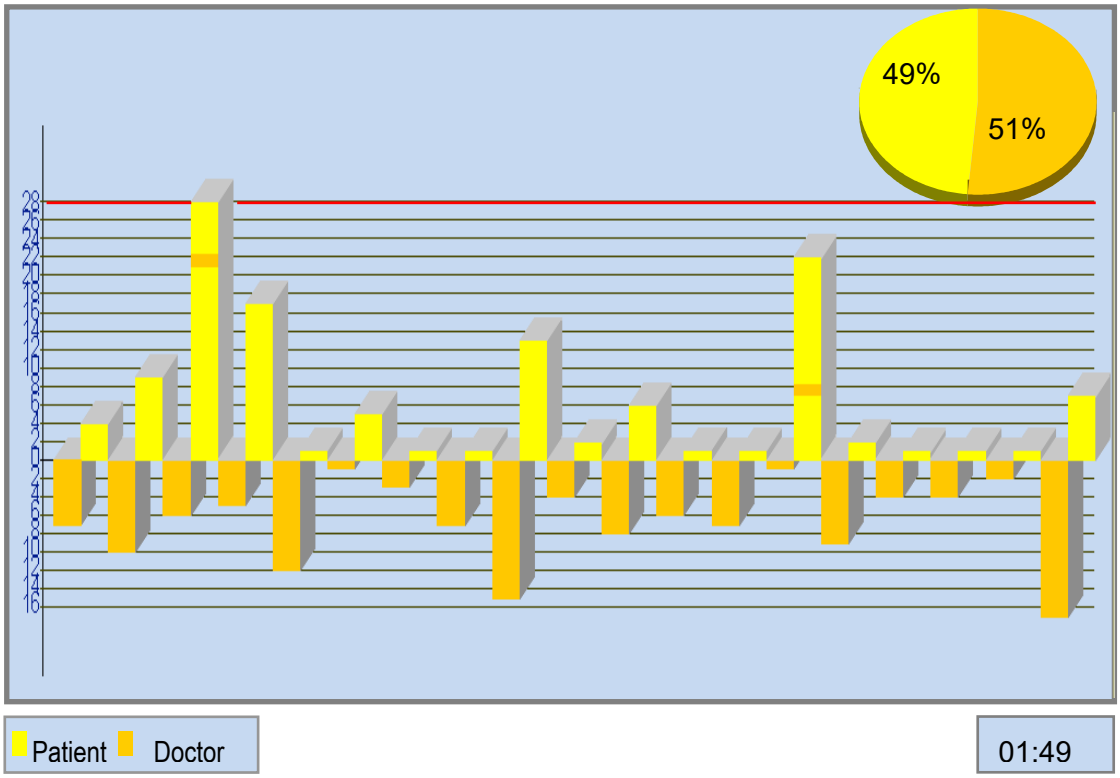

Fig. 19.4: Dialogue role structure and conversation parts of P and D

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

applied in detail elsewhere (§ 17.3, 19.7, 19.8, 25.4, 40.2) (see also Koerfer et al. 2000, 2005, 2010, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2017).

("no"). The patient chooses this *minimalist* form of answering in the negative, even though, or precisely because, at the end of the conversation, she is asked about her emotions (35-40: "fear", "anxiety") that may be connected to the symptoms ("heartache").

At the end, the conversation example clearly proves once again that the threatening *silencing* of patients can no longer be stopped even by further questioning efforts on the part of the doctor. When, after a series of detailed biomedical questions, some of which he even asks in abbreviated, elliptical one-word questions (29 D: "Sweating?"), the doctor, towards the end of the conversation, attempts to repair the situation, as it were, with a *new start for psychosocial* topics, his own interrogative interview form backfires on him: the questions he asks in the form of decision questions (35 D: "Are you worried about this?" – 37 D: "Do these pains worry you?") are only met with *monosyllabic* answers from the patient (36 P: "no" - 38 P: "no"), so that the doctor is only left with affirmative feedback (39 D: "not really"), which in turn is only reconfirmed by the patient with a listening signal (40 P: "hm-hm").

Thus, the restrictive question-answer pattern eventually leads to a *lull in the conversation,* from which the doctor can only escape by fleeing into the examination. This means that the conversation ends after only two minutes, barely after it has begun - which cannot be judged as "short and sweet" from the point of view of *evaluation.* To put it more succinctly: The conversation is not bad because it is short, but it is short because it is bad: After an unproductive "exchange of blows" of questions and answers, it becomes clear that both partners ultimately have "nothing more to say" to each other.

This *speechlessness* is also a lasting result of the conversation. The patient did not even seek a continuation of this kind of communication. After a physical examination, an ECG was taken, but this did not reveal any pathological findings that could have explained the complaints. The patient obviously did not expect any relevant results, as her comment on the doctor's last question shows (41 D: "surely Dr. Müller has already done some examinations? - 42 P: yes, ECG, but that was OK"). If her "reason for consultation" persists, she will have to change doctors until she finds a doctor who, by listening to her, gives her the chance to talk about what brings her to the doctor "in general now, um ...".

19.7 Narrative Conversation: "Deathly bad"

In contrast to the preceding conversation, in which the patient could hardly "get a word in edgewise" because of the *interrogative* way of conducting the conversation, in the following conversations the patients are able to "make their complaints, problems and concerns heard" in detail to their doctor, who in each case proves to be a good listener overall. However, the doctors engage in a narrative approach to varying degrees, which suggests different levels of development of their communicative competence with which they are able to process the narrative potential of the narrative patient offers (Charon 2001, 2006). The subsequent conversations differ in the extent to which the respective narrative can not only be promoted, but the communicative, cognitive and emotive "surplus" achieved through it can also be used productively in further conversation work. For certain concepts, terms and categories of narrative analysis, please refer back to the explanations on *biographical narrative* anamnesis (§ 9).[8]

In the following conversation, too, the patient narratives, which the doctor skillfully "elicits", are not fully processed, which is certainly also due to the time problem in a conversation that lasts 12.5 minutes. In view of the length of the conversation, we also have to limit ourselves here to the reproduction and analysis of selected sequences.

19.7.1 Description of symptoms: "severe dizziness"

The conversation with the 65-year-old patient contains a series of narratives which together form a complex life narrative which gradually takes on a concrete form with its critical life events. At first, the patient suffers mainly from *dizziness*, which she presents at the beginning of the conversation as an "entrance ticket" (§ 18.7, 19.4) for the consultation, and the extent of which she illustrates in detail with regard to her life-world impairments.

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8 The comparative approach to conversation analysis is justified and used throughout this Handbook wherever possible for research and teaching (§ 13.4, 17.3, 19, 40). For preliminary work on the following narrative analyses, exemplary reference is made to Koerfer et al. 2000, 2005, 2010, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2017.

E 19.37		" such terrible dizziness"	Comment
01	D	so, Mrs K., now describe your symptoms to me . uh . your complaints .	2.1: Opening: Complaints (Type 5) (§ 19.2)
02	P	dizziness, such terrible dizziness that I can hardly walk . you can see . my hair . hairdresser . washing my hair . nothing . I can no longer bend over, nothing (...)	First patient services: Dizziness and impairment

In opening the conversation, the doctor focuses on "symptoms" and (probably in the sense of a self-correction in everyday language) on "complaints", which he not only asks for but *directly* demands as a "description". Although this type of opening (§ 19.2) tends to open up a *biomedical* thematic focus to which the patient can immediately offer a corresponding "entrance ticket", at the same time she connects this patient offer with a dramatic relational offer with which the medical help is particularly challenged. The extent of the impairment of life is made concrete for the doctor visibly ("You can see") and clearly audibly ("Nothing") and is also substantiated in a variety of ways in the further course of the conversation.

By means of a self-comparison with an earlier situation in which the patient had already been treated by another doctor for vertigo, the increase in the current complaints is put into perspective, which far exceed the complaints of that time (E 19.38). While the comparison of "here and now" with "there and then" is a common procedure that we also use in everyday life (§ 7.2), it often takes on a special function in the consultation to show relevance, which the patient also makes use of several times.

E 19.38		"no comparison with what I have now"
03	D	have you seen an ENT doctor? .
04	P	yes .
05	D	yes .
06	P	and the neurologist, Dr. X, is on holiday until 10 December . but I have tablets from him . I was there four years ago . but it was no comparison with what I have now . but only a little bit, because my husband has a serious heart condition . and he was in

> hospital . he had a stroke . and I went to the neurologist . and he treated me wonderfully . (...)

First of all, the patient introduces the entire *thematic thread* of the consultation with a *comparative evaluation* that is biographically significant for her, which consists of the fact that a situation from back then, in which her husband, who still has a serious heart condition, had suffered a stroke, does not stand up to comparison with her situation today (06 P: "but there was no comparison with what I have now"). This perspective of comparison is repeated throughout the entire consultation in many linguistic variations, which we will return to in cursory fashion, whereby both "there and then" and the "here and now" are differentiated by the patient into further points in time and places that are subjectively significant for her.

The dates do not refer to the calendar time (date: day, month, year), but to the *lived time* of the patient, who chooses her own biographically relevant terms (e.g. "Communion Sunday") (see below). The subjective time statements are made by the patient only gradually and in a non-chronological way in the communication with the doctor, who has to "sort" accordingly while listening attentively. In the further course of the conversation, a temporal structure then becomes recognisable in which the patient's biography is arranged as a long-suffering *life course* characterised by severe *strokes of fate*, their *mastery* in relative health and finally by her own illness and failure experienced in this way. The critical life events that have significantly shaped the patient's biography are gradually brought to light in the *biographical narrative* anamnesis (§ 9), in the course of which further evaluative comparative perspectives are worked out between the past and a present in which the patient has reached the limits of her coping resources.

19.7.2 The "sudden" onset of illness in the daughter

Following the doctor's detailed exploration of the dizziness (17 D: "and has the dizziness become stronger now?" = Manual: step 4.1: Intensity, condition), the current impairment is expressed by the patient in a subjective form (E 19.39), which is oriented towards a *lifeworld* standard determined by social functional norms of the grandmother role, which she can no longer fulfil.

E 19.39		"I'm fighting hard against myself"
17	D	and has the dizziness become stronger now? .
18	P	It's so bad, doctor, I'm going fighting hard against myself . it's so bad . I can't take my daughter's children any more . and that means something .

When answering the doctor's question about the intensity of the dizziness, the basic conflict is brought to a fighting hard against myself" - a seemingly paradoxical formulation which is revealing from a *self-psychological* point of view insofar as it assumes several *selves* (cf. Schafer 1995). In her "fight" against herself ("I ... against myself"), the patient now seems to be defeated, which she later returns to in her final evaluation at the end of a self-narrative ("deathly bad"), which will be discussed in detail.

Even in the narrower context of this statement, in which the enormous effort is dramatically portrayed ("I'm fighting hard against myself"), the impending failure as self-evaluation is expressed by the patient both here and later in strongly self-critical words (18 P: "I can't take my daughter's children any more . and that means something"). The complete paraphrase of such an utterance could read: 'It already means something if I can't take my daughter's children anymore (which is my duty as a grandmother and used to be easy for me to do)' - thus establishing a contrasting relation between her abilities in the past and today ("any more"), which makes her current failure appear particularly drastic in an upward comparison. The *code-switching* into dialect (German dialect in the original: "det heißt schon wat") may be a sign of *emotional* involvement on the one hand, and a sign of the *confidential* relationship with the doctor on the other.

In the following sequences, omitted here, in which only social data such as the age of the grandchildren and the patient's function as a "babysitter" are clarified by the doctor's (return) questions, the necessary framework conditions are unfolded, as it were, for the narrative that follows, from which it becomes clear with a certain lingeringness why the failure as a grandmother is so dramatic in view of the particular urgency of caring for the children. The following narrative sequences about the daughter's "sudden" illness already contain the essential narrative elements (§ 9) typical of this communicative large-scale form, whereby the *unheard-of event* is initially introduced indeterminately, so

that the doctor has to inquire accordingly to ensure understanding (E 19.40).

E 19.40		"It suddenly broke out with her"
22	P	uh . the daughter is a teacher in F., yes . at the grammar school . and it suddenly broke out with her in May .
23	D	what ? .
24	P	MS .
25	D	ye::s .
26	P	now she has applied for ... she has to drive in a wheelchair (...) and it has hit me hard (...) and it broke out with her . that's when it started with my dizziness . I couldn't cope with it . I don't have to tell you everything . now it is, doctor . that was in May of this year . yes . she has been in full service for 15 years . healthy . never had anything . and in May she had communion from the nine year old . and until the Friday before communion, she could walk perfectly . (...)

The *unheard-of event* that is characteristic of narratives, which has explicitly "hit the patient so hard" that she "could not cope" with it, is initially introduced communicatively only in an indirect way with a proform (it), without using the name for this event ("it suddenly broke out with her"). Either narrative routines become effective here, in which what the narrator has come to take for granted in everyday life is assumed to be common knowledge, or magical rituals of communication may come through, in which the avoidance of symbolising threatening events serves to ward off their threatening nature itself.

This kind of *magical* communication cannot and should not have much validity in a rational type of discourse such as doctor-patient communication. Here it must "fail" simply because the doctor, for reasons of responsible listening to a patient narrative, must ensure its *logical* understanding (§ 19.5). This is done here with a simple question of understanding (23 D: "what?"), which forces the patient to "call the event by its name", which she does with the abbreviation (24 P: "MS"), which is understandable in this context, so that with the explicit utterance of the possible "taboo word", finally "the spell seems to be broken".

In any case, the doctor reacts to this "unheard-of" event with an empathic, elongated listener signal ("ye::s"), which obviously encourages the patient to continue the narrative. Although or precisely because she

seeks to relieve the doctor of a larger narrative scope (26 P: " I don't have to tell you everything"), the patient uses the narrative right granted to portray the daughter's *odyssey*, whose various stages through the health care system until the final diagnosis ("MS") are fleshed out in detail narratively. In the narrative sequences (omitted here), the patient makes her doctor a *privileged listener* (§ 9.5), who is repeatedly addressed personally ("Doctor") and called upon as a *witness* to a story of suffering whose *authenticity* ("I'll tell you exactly how it was, you can check") is repeatedly asserted.

Already with this narrative about the beginning and course of her daughter's illness, the patient puts the doctor into her personal perspective of suffering, which she lets him relive, as it were, from the perspective of a mother hit hard by fate. Formally, this is a so-called *foreign narrative* (§ 9), because the protagonist is not directly the narrator herself, but her daughter, but the patient tells the story from her perspective of experience, as it were, representing the family perspective.

E 19.41		"it was terrible"	Comment
34	P	(...) and on Sunday we had communion . until then she could walk perfectly, she just threw her legs like this, yes, in church . everything held its breath, we had a pew from the communion child, every family had its pew . there she went (unintelligible) and threw her legs like this, and when she came back, she no longer knew where her place was . highly intelligent . she didn't go over to us, to another row . and I went and got her . I said: "Birgit, what/ you are sitting here" . she didn't know . it was communion Sunday . she didn't really notice communion at all, at all . it was terrible . (...)	Orientation: place, topic, subjective time Dramatisation: "unheard of" event: Scandalon Anti-climax Direct speech Subjective time Evaluation

The "unheard-of" event of the daughter's "sudden" illness is preceded here by a "normal" event that has a name in the family's subjective calendar, namely "Communion Sunday" (34 P). In a particularly contrasting relation to the normal expectation of such celebrations, which serve to stabilise families in terms of identification by symbolically tak-

ing the next developmental step with the communion of children, the "unheard-of" event in this case leads to a destabilising lack of orientation, the *horror* of which is realised by the event not only in a figurative but also in a literal sense, which is finally evaluated as "terrible".

19.7.3 The "unheard of" nocturnal event

The doctor, as a privileged listener, is already drawn into the spell of this dramatic story by the dialogue-invoking invocation of the daughter (34 P: "I said: Birgit, you're sitting here") at the beginning of the narrative, which is the prequel to the following *self-narrative,* the key theme of which is already manifested as a pre-announcement with a verbal doubling (36 P: "I can't cope with that . I can't cope with that"), the evaluative content of which becomes a starting point for further narrative (self-)explorations.

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

E 19.42		"deathly bad" - "Until it didn't work any more"	Comment
36	P	(...) the doctor did everything for her . but it's a very, very difficult case . she has to be in a wheelchair, she can't do anything anymore ... and I can't cope with that . I can't cope with that .	Emotional patient offer Resumption of "not being able to cope with it", see above P 26
37	D	this dizziness, did it start when you found out about this diagnosis [=daughter has MS]? .	4.1 Exploring details (time, condition) + narrative invitation
38	P	yes, I believe so ... once I had something in my head at night, uh ... I never told my husband, once at night in my head it was all weird in my head, deathly bad ... I woke up ... I think: "oh dear, oh dear, what's wrong	Framing, theme Orientation: Listener privilege Complication: "unheard of

	now?" ... then I got really sick in bed at night ... I fought against it, always did everything at home, took care of the household, until/until it was no longer possible, no ...	Event" Direct speech Evaluation: Mastery *versus* failure, coda

While the patient has so far told her story mainly from the family perspective, in which she was already involved as a suffering mother and failing grandmother, she now uses the doctor's exploratory question about a possible connection with her vertigo symptomatology for a self-narrative in which she tells a dramatic story about the beginning of her own illness. Despite its brief form, this narrative also contains essential functional and structural elements (see comment column), as they were differentiated earlier on the basis of the *normal form* of narratives (§ 9). By adopting the context in question ("yes, I believe so"), which the doctor had offered as a possibility, the interactive and thematic *framework* for the narrative is established, with which the patient has at the same time placed herself under a narrative constraint. The connection, which at the beginning was only conceded as an assumption ("I believe"), must now be further elaborated in the sense of a communicatively entered self-obligation, whereby the narrative, as a communicative large form, simultaneously takes on a *proving and explaining function.*

After the listener's temporal and local *orientation,* which is somewhat offset ("once at night ...", "at night in bed"), the patient lets her doctor participate in an "unheard-of" event, as it were, whose subjective-lifeworld relevance is marked several times. First of all, the doctor is made the chosen addressee of a particularly "sensitive" topic, in which the previous secrecy towards her husband is specifically emphasised in a parenthesis (38 P: "uh . I never told my husband that"). Thus the doctor becomes the "confidant" with the implicit message that can be generalised for many patient narratives: What one has to withhold from relatives or friends in everyday life, however familiar, one can certainly confide in one's doctor during consultation hours, which is certainly facilitated by the expected professional secrecy.

The doctor, thus addressed as a "privileged" listener, now becomes a first-time witness to the hitherto "unheard-of" event with which the patient confronts him in linguistically dramatic forms. The patient allows the doctor to directly experience, as it were in retrospect, a "near-death" experience ("deathly bad") in the narrative time of the speech period, so

that he is altogether *transported* into her threatening "inner world" of then and now.

This *transposition* of the listener into the speaker's own world of experience is achieved by means of narrative-specific stylistic devices, which are used to heighten the relevance of the narrative not only in terms of content ("deathly bad"). Through the rhetorical device of *direct speech,* a nocturnal event and the corresponding soliloquy are staged in a particularly dramatic way ("oh dear, oh dear"). Thus the doctor is *scenically* drawn into the spell of her own near-death fears when the patient allows her listener to think along with her the explicitly expressed thought of "there and then" in the "here and now" of the consultation ("I woke up ... I think: 'oh dear, oh dear, what's wrong now?'"). The question posed to oneself in the *contemplation time* is now re-staged in the current consultation *time* (in the historical present tense: "I think ...") and passed on to the doctor with an appellative function (see below), through which he is now challenged to make an empathetic statement.

Once placed in this subjective world of the patient, the doctor learns in the final evaluation of the narrative about the heroic attempt to cope ("I fought against it") as well as about the failure of the patient in her role as mother and housewife, who had first helped her sick daughter in her household ("did everything at home") until she reached the critical turning point ("took care of the household until it was no longer possible"). Through this self-critical evaluation, the doctor can finally gain a deep insight into the *resigned* exhaustion (in the sense of "giving up") of the patient, who also underlines this non-verbally in a corresponding gesture at the end of her narrative:

The patient lets her hands swing apart and then fall powerlessly into her lap before she leans back silently and obviously expects a statement from the doctor, who now has a dramatic picture of the current course of the patient's life before his eyes.

19.7.4 Medical versus lifeworld voice

With her narrative ("deathly bad"), which is characterised by an inexplicable experience ("it was all weird in my head" - "what's going on now?"), the patient reveals from her *life-world* perspective that she now seems to have succumbed in her initially formulated fight against herself (18 P: "I fight hard against myself"), as she suggests once again in

her final evaluation with her *anti-climax* (38 P: "I fought against it (...) until it was no longer possible, no"). In this way, she addressed the appeal, as it can be addressed more or less directly to medical helpers in the sense of Brody (1994) ("My story is broken, can you help me fix it") (§ 9), to her doctor in a very concrete way.

The final evaluation at the end of the narrative is introduced by the patient with a so-called *tag-question* ("no"), which conventionally demands a statement from the listener in the meaning of "wasn't it?" (Koerfer 1979), to which the doctor is now given the floor ("turn"). It is now up to him alone to close the communicative shape of the narrative as a listener, i.e. to accept the communicative challenge of a statement on the narrated story. This challenge to *comment is* a fundamental characteristic of communicative action (Habermas 1981, Koerfer 1994/2013), but it applies in a special way to the patient who confides in the doctor, and all the more so following such a dramatic narrative.

All the more surprising is the doctor's real continuation of the conversation, which lacks an empathetic statement. In reaction to the patient's last story, including the previous history, the doctor, as a professional listener, uses a typical procedure, namely to convert *patient's events* directly into *doctor's events* (Labov, Fanshel 1977). Instead of continuing to make the patient's *lifeworldly voice* heard in the sense of Mishler (1984) (§ 10.2), the doctor brings his *medical* voice to bear through *strategic* action (§ 7.3) by making a radical change of topic, which he concludes with an interactive move for the patient: After a short explanation and differential diagnostic clarification, the doctor asks a closed information question with a suggestive tendency ("isn't that the case with you?"), on whose *biomedical* topic the further patient offer is successfully funnelled.

E 19.43		"there are different forms of dizziness"	Comment
38	P	(...) until it was no longer possible, no .	Narrative (ending)
39	D	now there are different forms of dizziness . there is rotary dizziness, there is a position-dependent dizziness, depending on how you have the cervical spine . uh .	Medical education "doctor's events"
40	P	hm .	
41	D	how you move your cervical spine or what posture you are in . some people get dizzy	Differential diagnostic

		when they bend forward, others get dizzy when they lie down . is this not the case for you? .	clarification Closed Information request
42	P	if . when /when lying down not . I could only lie down . I could only lie down and sleep	Answer + more information

The problem of *downgrading the relevance* of the patient's *life-worldly* voice, which tries to make itself heard through its narration, can be methodically demonstrated by the *omission test,* which is repeatedly used here (§ 17, 19, 20, 25, 40). If one eliminates the narrative, then the doctor's subsequent statement ("now there are different forms of dizziness ...") would also fit any other preceding or subsequent passage in the conversation in which the patient merely mentions the symptoms of vertigo. In any case, the narrative proves to be dispensable for the subsequent medical intervention.

To prevent a misunderstanding: the clarification and differential diagnostic clarification is by no means superfluous, but at this point in the conversation of a developed biographical narrative anamnesis, the medical intervention lacks *fit* (§ 3.2, 17.2-3). Compared to the previous narrative, the intervention is a misplacement. The narrative is well elicited beforehand, but then not *further processed* and *evaluated* together (§ 9). At the end, the dramatic, emotional content of the patient's narrative is reduced by the doctor to the mere propositional content: "Patient has vertigo" - or in other words: the patient's individual medical history is used by the doctor only to a limited extent for a *biopsychosocial* approach (§ 4, 9), but is transferred into a *biomedically* oriented disease symptomatology, whereby the gain of a narrative approach just achieved here is given away again.

19.7.5 Participation and life narrative

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

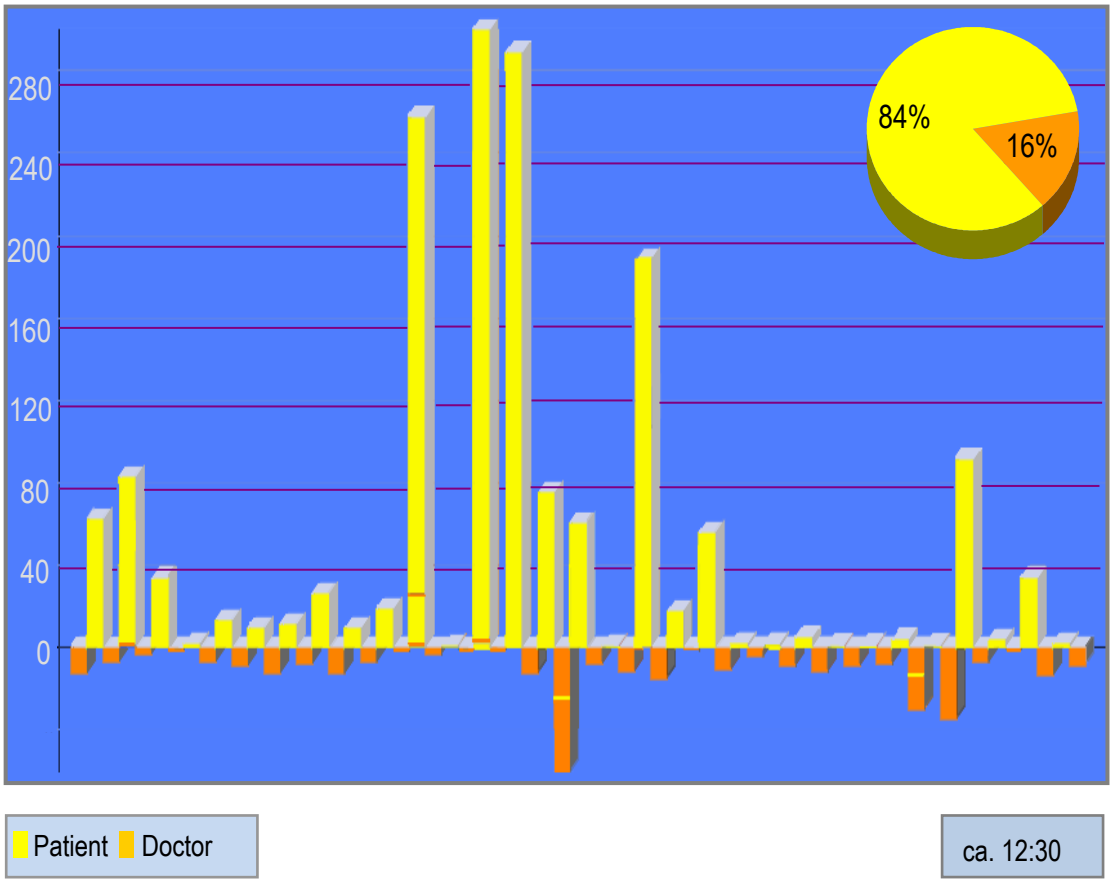

Fig. 19.5: Dialogue role structure and conversation parts of P and D

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

Measured against this formal-dialogical restraint, one can certainly also infer a restraint in the co-construction and interpretation of the narrative patient offers, which may then appear "underexposed". For example, following the last narrative ("deathly bad"), the doctor reacts with a more or less radical change of topic ("various forms of dizziness") instead of upgrading the relevance of the emotional and evaluative content of the narrative in order to process it further with the patient, etc.

Nevertheless, the doctor also proves to be a good listener in the further course of the conversation, who *lets* his patient tell her story (§ 9), so that a series of further biopsychosocial "data" emerges conversation-

ally. Thus the doctor learns not only about the patient's long-standing role as a wife caring for her husband after a stroke, but also as a grandmother who (according to her own words) "raised" her "mongoloid" grandchild. Here, the *evaluative comparative perspective* comes into play again through skillful medical enquiry, according to which the patient was able to cope well with the problems in earlier times: "I was otherwise very . stable (...) I was able to cope . when I was younger". Apparently, the patient can no longer fall back on these resources at present, as she explicitly "brought this up" in her most recent "life story".

If one condenses the stories told by the patient in a single consultation of approx. 12 minutes into a life narrative, a certain *type of evaluation* can be recognised, which corresponds to *social-cultural* patterns of storytelling (§ 9). According to this, the protagonists of narratives can be portrayed quite differently as heroes, adventurers, fortunate ones, victims, failures, guilty ones, etc. If one follows Gergen's (1998) general typology on the evaluative function of narratives, one can distinguish, for example, progressive from *regressive*, *tragic* from *comic* narratives.

As explained above (§ 9), narratives can also be differentiated on the basis of critical life events on the time axis according to ups (plus) and downs (minus), so that the individual *life curves* of patients can be represented as specific *evaluation curves* on the basis of their concrete narratives (Gergen 1998, 2002, Koerfer et al. 2000, 2005, 2010, Köhle, Koerfer 2017). In the case of the "dizziness" patient, after relatively *stable* phases, it is a *regressive* pattern of progression (Fig.19.6), which can be divided into a total of four phases as a life narrative. These phases correspond to the four essential roles that Mrs. K. perceives as grandmother, wife, mother and finally patient.

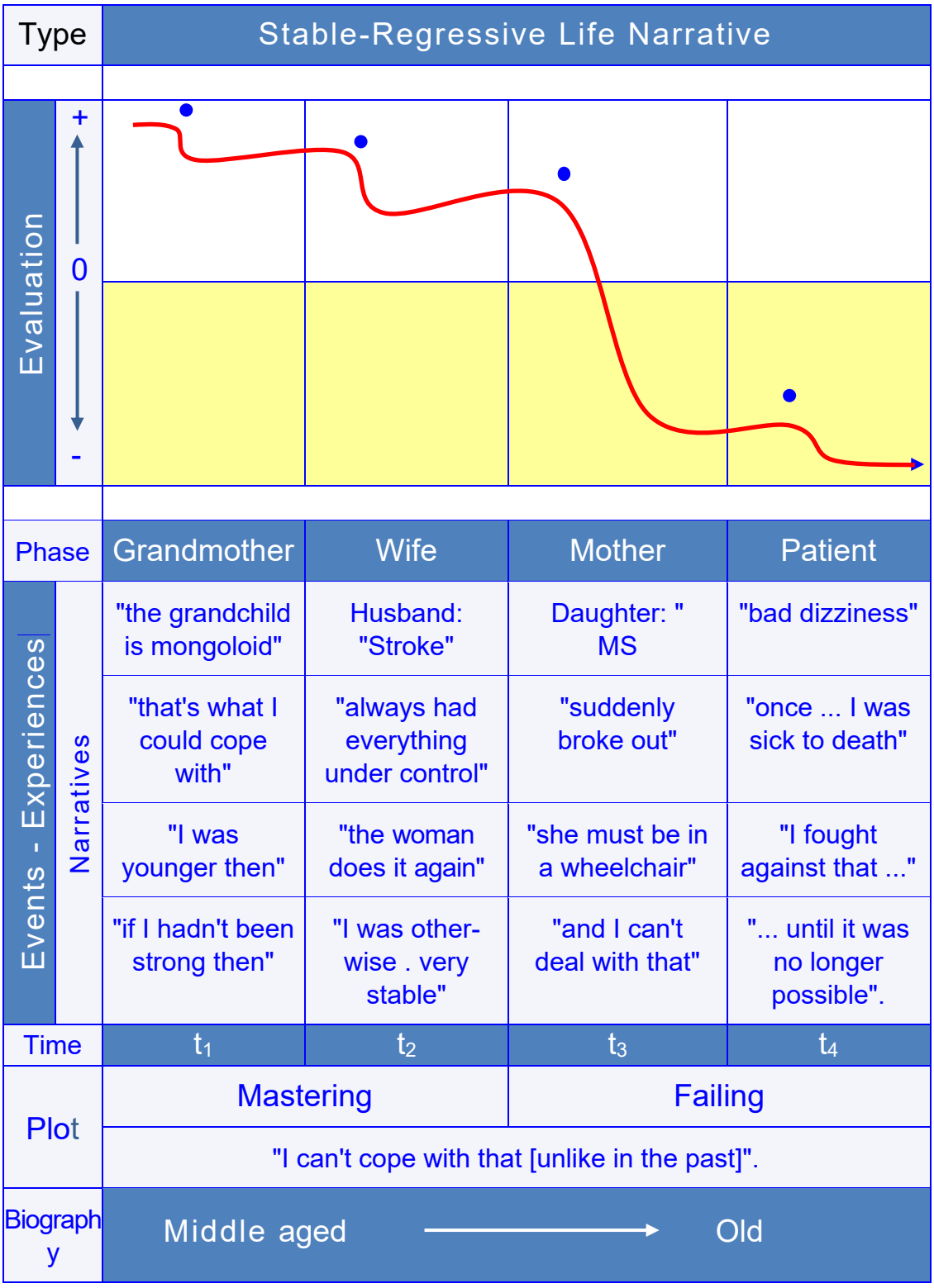

Fig. 19.6: Life narrative: "Until it was no longer possible".

After processes of *mastering* critical life events (t_1)-(t_2) ("mongoloid" grandchild; "stroke" of the husband), a rapid downward trend emerges, which extends to the serious illness of the daughter (t_3) to her own

threatening illness (t_4) with short-term attempts to cope (t_{4a}). Finally, with the final *failure* (t_{4b}) ("until it was no longer possible, no"), a serious reason for consultation is given, which is now developed into a complex topic with the *consideration time* (t_1)-(t_4) in various narrative threads during the *consultation time* (t_5).

Interview balance and catamnesis

For all the deficiencies in the conduct of the conversation, which lies in the insufficient further processing of individual narratives, the doctor proves to be a good listener who provides his patient with sufficient narrative space which she can use to present her suffering, hardships and worries. In an intensive narrative self-exploration, the patient's current *identity crisis,* which traces a change from a stable to a regressive evaluation pattern in a self-critical comparison, can be subjected to joint reflection with the doctor. In the final evaluation at the end of the conversation, in which the doctor inquires about the attitudes of the husband (P: "just sits in the corner and cries") and the daughter herself (P: "she is very, very brave"), both interlocutors agree that although the patient cannot "come to terms well" with the daughter's illness, she could "arrange" with it.

Despite this difficult perspective, the patient's narrative self-interpretation, which was promoted with the help of the doctor, was able to unfold its effect. Apparently, beyond its "catharsis function", the conversation with the doctor also contributed to the "stabilisation" of the patient herself. The catamnesis suggests that the patient was able to find her way back to her old strength ("actually it shouldn't be with me, I was otherwise . very stable"). In any case, in a follow-up interview after 7 years, Ms K. stated that she had never suffered from dizziness again since the interview.

19.8 Narrative: "thrown off track"

In the following example, the doctor succeeds in taking a *biographical-narrative* anamnesis, which extends through the elicitation and upgrading of relevance of patient narratives to their joint further processing (§ 9). However, this conversation also starts with a rather *biomedical* concern of the patient, who wants an "outpatient endoscopy" because of stomach complaints. In order to understand this concern, with which the patient initially seeks out the doctor in the role of a pure "service provider" (§ 10.4), a transformation into a *cooperative relationship* is required, in which *biopsychosocial* issues are finally discussed, which are developed in particular in a life narrative that leads the patient back to the beginning of his long history of suffering. This conversation, too, with its total length of about 8 minutes, can only be reproduced here in excerpts, focusing on selected narrative sequences.

19.8.1 Complaints and concerns

After the introductory sequence (omitted here) (greeting etc.), the patient uses the doctor's opening of the conversation (§ 19.2: Type 2: "what's up?") directly to formulate his request ("an outpatient endoscopy"), apparently visiting the practice in this context on the recommendation of a work colleague. In order to further substantiate his request, the patient then begins with the presentation of his many years of medical and treatment history, for which he finds an attentive listener, who, however, initially limits himself to brief listener feedback (*hm, yes*).

E 19.44		"endoscopy" - "stomach pain"
01	D	yes, Mr B . what's up? .
02	P	Yes, I . came here because my colleague . [name] . said that you have . uh . uh . such special examination methods . among other things you do an endoscopy on an outpatient basis and uh . determine that . what's the name . bacteria and so on .
03	D	hm .
04	P	stuff .
05	D	hm .
06	P	are in the stomach .

07	D	hm . hm ...
08	P	eighty percent of the people would have that and so on .
09	D	hm .
10	P	and I have actually always been treated for ... stomach .
11	D	hm .
12	P	but never really with the success that I can say, it is somehow gone . now I have this morning at four o'clock . uh . I then woke up and have because pain ... and so far I have taken the last twenty years [drug name-] . sachet .
13	D	hm . [nods clearly]
14	P	then, if it didn't go away after half an hour, I took [medication name], uh . suppositories .
15	D	yes .
16	P	for the pain ... (3) ... and ... (3) ... I think . let's see, not that it's something that my previous doctor didn't find.
17	D	hm . what are you thinking about, what-
18	P	[yes I don't know .
19	D	[could have been overlooked there? .
20	P	Let me tell you .
21	D	yes .
22	P	I had something like that again about a year ago, and it hurt me so badly.
23	D	hm .
24	P	then the family doctor (...) he said, had to go to the hospital (...)

The first intervention of the doctor, which is aimed at exploring the patient's *subjective ideas about the illness* (§ 21), is initially answered by the patient with a declaration of ignorance, only to be followed by information about a specific phase of his medical history, which at best could contribute to a provisional "explanation" of his persistent "stomach pains": "I also had gallstones, they took them away, but I still have stomach pains (...) I assume it had nothing to do with the gall bladder". The history of the patient's illness and treatment, which has meanwhile lasted about 30 years, is continued in the further course of the conversation with individual phases and stations (examinations, treatment measures, surgery, medication, etc.) with partial successes in the meantime, without a satisfactory improvement for the patient. The question of improvement, which mainly occurs during holidays, then leads to the topic of the professional situation, where the patient initial-

ly answers very reservedly, so that the doctor has to insistently inquire before it then comes to a central life narrative.

19.8.2 Key interventions and conversation turnaround

Whereas the conversation has so far remained attached to specific *biomedical* thematic complexes, even in its narrative sequences, in which the various stages of examination and treatment (medication, biliary surgery, etc.) were the focus, there is now a thematic turn, which, however, requires a specific battery of interventions by the doctor that precedes the subsequent patient narrative. As in other cases from our conversation corpus, the transformation from a purely *biomedical* to a *biopsychosocial* model (§ 4) often does not succeed with a single key intervention, but only in the context in which individual or several key interventions are embedded, which unfold their effect together with other, preparatory interventions in a developed conversation.

Insistent interventions

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

E 19.45		"that's no fun?"
01	D	(hm) . what do you do for a living? .
02	P	I am a civil servant in the city of A .
03	D	and what field of activity? .
04	P	I sit around in the office.
05	D	(yes) . that's no fun? .
06	P	well ... let's put it this way ... [smiles] uh ... I'm actually not the type of civil servant .
07	D	hm . hm . but rather what/what (would you say what) [quieter to silence] .

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

Scenic understanding and frame change

The doctor was obviously able to conclude from the contents as well as forms of the patient's answers about his "unwillingness" to exercise his profession. The way the patient characterises his professional activity (04 P: "I sit around in the office") corresponds to the way he expresses this to the doctor non-verbally (tone of voice, facial expressions, body posture). This is part of the *scenic understanding* in the consultation (§ 3, 9, 12, 20), in which the everyday experience of patients is also revealed non-verbally in conversation with the doctor. In any case, the doctor follows a suitable perception and intuition here when he chooses this specific intervention according to content, form and function ("this is no fun?"). The fact that he addresses a topic relevant to the patient with this reflexive and at the same time suggestive intervention is shown by the patient's subsequent reactions, which is generally true for the fit of (key) interventions; their effect can usually be well documented in the further course of the conversation, as in this case.

Before we come back to this, the interactive narrative framework needs to be further described, in which the antecedent of the narrative is presented as a process of handing over and taking over the specific right to speak. In response to the key intervention ("that's no fun?"), the patient first offers a *self-characterisation* of what he is "actually" not (06 P: "I'm actually not the civil servant type"), to which the doctor in turn

cleverly responds by asking with a contrast relation that is extraordinarily economical (07 D: "but ...?"). Obviously, the intervention already has a non-verbal effect, because the patient signals early on that he is ready to take over the speech (*turn taking*), which is why the doctor withdraws accordingly. Both interlocutors thus constitute the narrative framework before the narrative even begins. This becomes clear when sound and image are perceived in their unity and in detail.

The patient recognisably accepts the invitation to talk even before he speaks. As in this case, a *frame change* is often indicated in non-verbal communication even before it is verbally ratified by the participants in the conversation (Goffman 1974, Scheflen 1976, Gumperz 1982). Specifically, these are vocal and visual communication phenomena (gestures, facial expressions, eye contact, breathing, posture, etc.) which, in the sense of regulating the dialogue roles, concern the formal *organisation of conversation* between doctor and patient (Duncan 1974, Argyle 1975) (§ 19.3). On the doctor's side, the first thing that is noticeable in this sequence of conversations is the lowering of the volume to the point of incomprehensibility and finally to silence: (07 D) "but rather what/what (would you say what)". With this withdrawal of his speaker role, the doctor, who obviously anticipates the patient's willingness to *take over the speech*, signals in turn his willingness to *let* the patient speak - an example of a successful communicative *fit* in the non-verbal mode of organising the conversation (§ 12, 17, 18). From the external observer's perspective, too, the patient's assumption of the right to speak can be perceived in the video as a particularly meaningful unit of communication:

The patient inhales audibly and visibly in the sense of catching his breath for his subsequent speech, straightens his upper body, leans back, presses his folded hands outwards, turns his head to the left and looks "pensively" into an "inner distance", as if he could retrieve his story from there. All in all, these are clear markings of a change of position as *contextualisation indications* of a change of frame, which the patient then also manifestly carries out in the form of the patient narrative. The significance of what is to come has already been sufficiently "announced" before the first word.

19.8.3 The "crack" after "examination failure" as a scandalon

Because of the importance of eye contact during the (longer) speech and during the change of speaker, we have roughly noted in the following transcription of the patient's narrative whether eye contact exists from the patient's perspective or not, as far as this is reliably possible from the role of the external observer who places himself in the speaker and the medical listener and viewer (with "[+]" or "[-]"). In this context, attention should first be drawn to the clearly recognisable gaze behaviour of the patient, who at first obviously concentrates on his "inner" story with his gaze averted, before he makes eye contact with the doctor again for the first time in the middle of the narrative. As in the previous narrative analyses, the essential functional and structural elements of this narrative are also listed in the commentary column, as they were previously differentiated on the basis of the *normal form of* narratives (§ 9).

E 19.46		"thrown off track"	Comment
01	P	[leans back already, inhales audibly while A is still talking (see above), averts his gaze for a longer time] [-]	Nonverbal + Verbal framing, theme
		I had something completely different in mind, that ... used to be .... (4) .... it started somewhere, I thought about it, you see, you think about things like that, how do they come about, why (you ask me something like that)	Orientation (beginning) Meta-communication
		... probably I ... (3) ... got the first crack somewhere .... (4) .... I wanted to study natural sciences, had/have also started, but then I dropped out in the pre-exam [-] ...	Metaphor (beginning of suffering) Orientation Complication, scandal
02	D	hm .	LS
03	P	that threw me a little bit off the ... track ... [-]	Life metaphor
04	D	hm .	HS
05	P	I wanted to study physics, but something completely different ... and then somehow [shakes head] I completely failed the exam ... so I couldn't get anything out of myself [chokes and clears throat] ... how it is [+]	Subjective Perspective Scandalon Re-staging: Symptom

		[smiles, eye contact] ...	repetition
06	D	hm .	HS
07	P	and then I didn't dare to start again . and then I hung around . didn't know what to do [+] .	Subjective Perspective Problem, Complication
08	D	hm .	LS
09	P	and then I briefly did some administrative training on the side, I trained as a civil servant without making any particular effort at [-].....	Problem "solution Pseudo-sense concept
10	D	hm .	LS
11	P	and then do it [+] more or less like that now, because it's not fun for me either, unfortunately [continued eye contact] ...	Evaluation: Resignation, Coda Turn-over

First of all, the patient finds an attentive listener who limits himself to minimal listener feedback (5 times *hm*) during the narration in order to keep the narration going. Obviously, the doctor here follows the already highlighted *super-maxime* of not interrupting the patient in case of doubt, but listening to him until he himself recognisably signals the change of speech (§ 19.3). This listening maxim should be followed in particular if the patient averts his or her gaze while speaking, which is usually a "sign" that the current speaker still has something up his or her sleeve.

In the present case, this applies to well over the first half of the narrative, the continuation of which is manifested synchronously by a persistent interruption of eye contact, which in turn points to a specifically mental concentration on an "inner" story and the *narrative process as a communicative process* in time, which the patient "unmistakably" reveals to the doctor as listener as the *narrative time* claimed. Even after the patient, following his clearing of the throat, makes a small break in order to assure himself of the doctor's audience in a short pause in the sense of a contact function through eye contact, the doctor limits himself merely to a short further listener feedback (*hm*) and thus avoids any *overstimulation* of the narrative process (§ 17.3). Without being "disturbed" by the interlocutor, the patient can continue his narration on his own initiative over a longer period of time (of 1.07 min = longest speech contribution of the conversation) (see below), before he looks expectantly at the doctor at the end of his narration, which he leads off

with a *tag-question* ("no"), who then reacts with an appropriate intervention (see below).

In order to assess the fit of the doctor's intervention, it is necessary to look at the narrative itself, to which the doctor must undoubtedly respond in the end. If one cleans up the many false starts, restarts, metacommunicative parentheses, redundancies, corrections and repairs in the verbal mode of the narrative, which are due to the orality of this form of communication, in the reception, then the essential functional and structural elements of narratives in their *normal form* emerge (§ 9), which we have differentiated (among others with Labov, Waletzky 1973, Labov 2001) (see comment column). Overall, it is a *biographical* narrative that essentially performs an *explanatory function* in the mode of *self-interpretation* of the patient's personal experience in his wider past up to the present. It is possible that this dramatic life story is told for the first time as it is told to the doctor as a privileged listener.

The biographically formative *scandal* with which the narrator identifies himself as a *failure* (05 P:"completely failed in the exam") is brought to the medical listener's attention so drastically that the patient's perspective of suffering, which began at the age of a young man, continues to reverberate into the present of the current narrative situation of the consultation. While the patient tells of his "failure" at the time, his voice seems to fail in a *reenacting way* in the current consultation: "so I couldn't get anything out of me [chokes, clears throat]". On the verbal level, too, the narrative impresses with the liveliness and vividness of the narrative language, which is characterised by the use of relevant *metaphors to* capture the subjective meaning of the critical life event ("crack") for the patient.

19.8.4 The meaning of "personal" metaphors

As elsewhere in narratives, patient narratives are often characterised by the use of specific metaphors that can take on the function of personal self-understanding for the narrator in the process of storytelling. The relevance of metaphors to all of our everyday lives cannot be overstated, as Lakoff and Johnson (1980/98) (Box 19.7) have taught us theoretically and empirically in their seminal work ("Metaphors We Live By").

Box 19.7 The importance of metaphors for self-understanding

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

Lakoff, Johnson 1980/98: 266

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

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

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

Tab. 19.3: General concepts and personal meaning of metaphors

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

19.8.5 Fit and effect of interventions

In an interim assessment, attention is to be drawn to the *fit* and lasting *effect* of medical interventions, which can prove to be *key interventions* in the further course of the conversation (§ 3, 17). As in the present case, the effect of the doctor's intervention ("that's no fun") can initially be recognised by the narration's narrower context in which *figure differentiation* and *figure closure* are conveyed.

After a relatively long narrative, which lasts over a minute, the narrative closes with an emotional *evaluation* of the patient ("because it's not fun for me either, unfortunately"), the topic of which the doctor had just *made explicit* beforehand with his *key intervention* ("that's no fun?"). Thus, in the interaction between doctor and patient, a thematic arc is struck with a key symbol ("fun") (Fig. 19.7), which gives the narrative an interactive meaning that can be shared by both interlocutors.

The thematic arc is drawn here over the entire thematic field, which is opened with such a key term, which is introduced in a medical (negative) question form, so that a whole *spectrum of meaning* can be retrieved via the opposition relation (for example: *no fun → unhappiness*, *frustration*, *disappointment*, *despair,* etc.). Whatever the first medical intervention ("no fun"?) in combination with the second intervention ("but ...") may "trigger" in the patient from a psychodynamic aspect in detail, he finally reacts on the interaction level with a dramatic, strongly emotional *biographical narrative* of a long *history of suffering*, which after variant *metaphors* of failure, suffering, despair and giving up (Tab. 19.3) is marked in the *final evaluation,* i.e. after more than 1 minute of speaking time, by a resumption of the term in question (“because it's not *fun* for me either, unfortunately”).

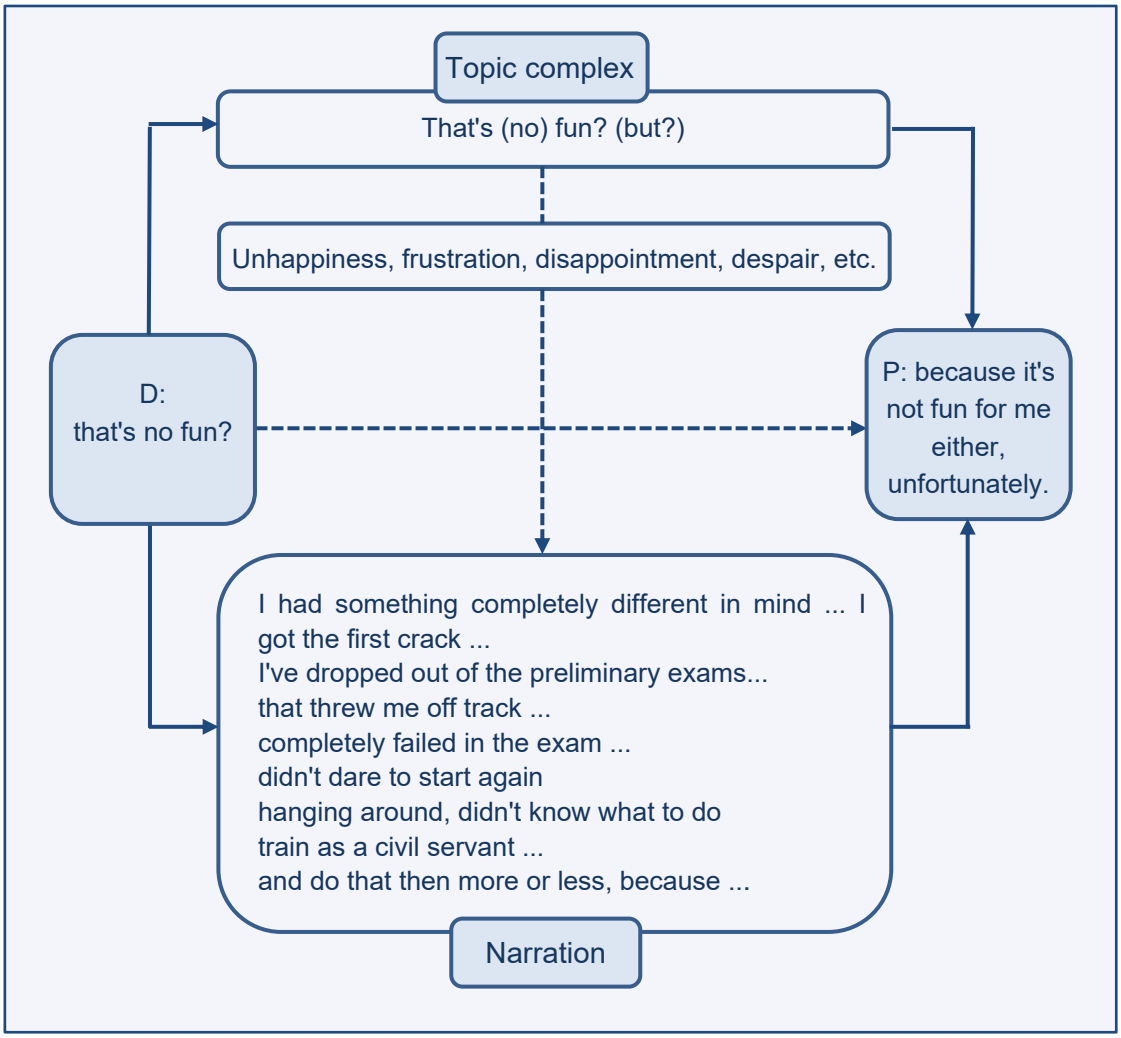

Fig. 19.7: Effect/reach of medical interventions

Apparently, the patient was able to use the insistent interventions of the doctor as a narrative invitation to a topic on which he could "make his long history of suffering heard in one piece", with which he takes himself and his listener back more than 30 years into the past, in order to give a *direct* answer to the doctor's question at the end of his metaphor-rich narrative, the validity of which leads up to the present of his current professional life ("do that then *now* (sic) more or less like this, because ..."). This problem of the patient, who has had to *cope* with a "(professional) life without fun" on a daily basis for decades, then becomes the core of the further conversation between doctor and patient.

The evaluative narrative closure of the patient, who increasingly expresses his *regret* about the lack of fun ("unfortunately") ("because it's

not fun for me either, *unfortunately*"), is strong evidence of the effectiveness of sequential organisation across larger discourse units in doctor-patient communication, the conditional relevance of which need not always be fully accessible to the immediate control of the interactants (§ 9.4). For example, the patient does not even have to be aware of his *resumption of the vocabulary* previously introduced by the doctor ("fun"). In any case, the doctor enacts emotive semantics (*fun* versus *no fun* → *displeasure,* etc.) in his interlocutor (Fig. 19.7), with which the psychodynamically relevant *narrative motivation* can be aroused in the patient and the narrative can also be developed in detail at this length with appropriate *legitimation.*

The doctor's interventions here take place in advance of the narrative, interactively anticipating and mentally anticipating with a *precision of fit* (§ 3, 17) with which the doctor seems to unerringly reach the patient's emotional state on the basis of Engel's triad (*observation*, *introspection*, *dialogue*) (§ 9.5). This kind of *art of medical dialogue* (§ 17) is not always consistently achieved, either because the doctor lacks the necessary *observation* or *introspection,* or because he cannot adequately implement his insights in dialogue with the patient. Under these aspects, the following intervention, which the doctor now gives following the patient's narrative, also proves to be appropriate.

If the doctor has already proven to be a good listener in the run-up to the narrative, he is also able to absorb the emotional content of the narrative and process it together with the patient. The patient has obviously reached the end of his story with his explicit regret ("unfortunately"), where he also looks at the doctor expectantly. This narrative is taken up again here in the transcription of the post-history so that the doctor's direct reference can be understood (E 19.47). Here the *art of the doctor's conversation management* is once again demonstrated with an intervention that fulfils several functions at the same time in terms of form and content. The form of the intervention is extraordinarily economical in that the doctor reacts to the patient's last statement ("because it's no fun, unfortunately") immediately with a consecutive follow-up that represents a kind of *joint sentence production* ("yes, so that you always have the feeling that you are selling yourself short, no").

Through the immediate empathic feedback ("have the feeling ..."), the narrative is not only upgraded in relevance, but the patient is given an opportunity to continue the topic ("... selling yourself short"), which they can then use as an invitation to tell another story.

E 19.47		"selling yourself short" - "start again"
00	P	(...) [end of the narrative:] and then I do it more or less like that now, because it's not fun for me either, unfortunately ...
01	D	yes, so that you always have the feeling that you're selling yourself short, right? .
02	P	that anyway . I would prefer to say ... I would /let's put it this way . I can financially afford, let's say, not to work, let's put it this way .
03	D	hm .
04	P	I'd like to quit ... and maybe start studying again, just as a hobby, somehow...
05	D	hm .
06	P	that might be an idea of mine.
07	D	hm.
08	P	but whether I'll still be able to do it ... I'm really too old ... to study again ... just for me ... I do like (...) [longer continuation] .

The medical intervention according to narrative is impressive in terms of its form, content and function due to its *accuracy of fit* (§ 3, 17). The doctor makes a statement, which he challenges the patient to make at the same time. The challenge to the patient's opinion is reinforced by the *tag-question* ("right") and a short pause, so that the patient has the floor again.

The *accuracy* of the doctor's interventions can generally be seen directly in the patient's *reaction*, as in this case, where the patient in turn reacts with a strongly marked affirmation ("that anyway ..."). Apparently, the doctor has here, as it were, "vicariously" drawn the *conclusions* for the patient, towards whom he performs a *midwifery function* in the verbalisation (§ 9), which the patient could in principle have drawn himself (for instance in the form: 'so that I also always have the feeling that I am selling myself short'). Although this conclusion is merely 'suggested' by the doctor, which can be an essential function of interventions (of a certain *interpretative* type) (§ 20, 21), the patient can in fact 'adopt' the content of the doctor's intervention without restriction, as evidenced by the strong agreement ("that anyway").

The extent to which the doctor's intervention has *met* his patient's *feelings* can be "read" not only directly from this strong agreement, but also from the further use of the intervention as a narrative invitation for

a *wish narrative*, in which the patient anticipates an alternative way of life ("I'd like to quit and ... start again ..."), which is taken up again in the further course of the conversation.

What is formulated here in the subjunctive as a *preference* and *fantasy* ("I'd like to quit", "that *might be* an idea of mine") is later deepened as a real perspective in the further conversation between doctor and patient (see below), in which both conversation partners try to *reconstruct* the patient's story (*new story*) for the future organisation of his life.

19.8.6 Participation and life narrative

As has already become clear from the few conversation excerpts so far, the doctor and the patient are each involved thematically and interactively in their own specific way in the *(re)construction* of the patient's story. Analogous to the previous conversation analyses, which focused on the differences between *interrogative* and *narrative* conversational styles (§ 19.6-7), the procedure described and applied there for depicting the *dialogue role structure* (Fig. 19.4-5) will also be used for this conversation (Fig. 19.8).[9]

9 For the extraction and evaluation of the dialogue role structure, reference is made once again to the methodological point in this formal presentation § 17.3, esp. also § 40.2), according to which 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 speech "as if uninterrupted". This type of feedback is marked here as "cross lines" in the columns (Fig. 19.8).

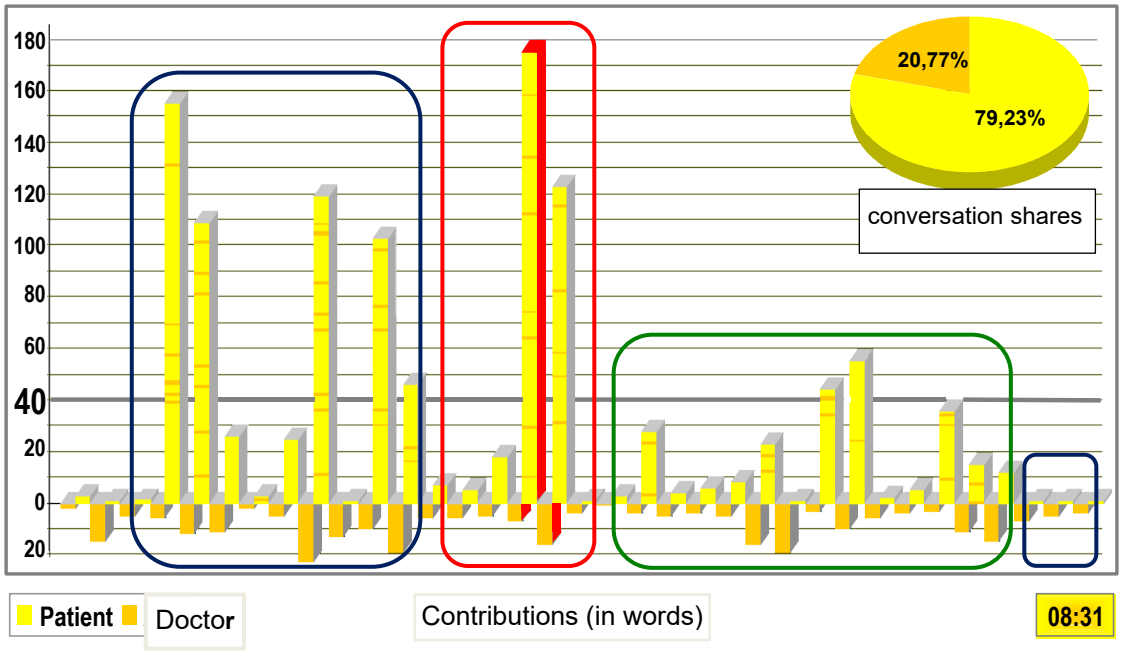

Fig. 19.8: Dialogue role structure of doctor and patient: narrative interview style

In this conversation, too, the doctor largely restrains himself with a share of speech of 21% and leaves the patient the right to speak for long stretches, which he uses for a series of narrations. After the welcoming scene (omitted in the transcript above) and the subsequent doctor's question about his concern ("yes Mr. B., what's up?"), the patient had presented his complex history of illness and treatment in longer, partly narrative conversational sequences, which were essentially limited to *biomedical* topics (outlined in blue), before the conversational turn with a *psychosocial* complex of topics (red), which leads into a *biopsychosocial* topic development of the conversation (green), is described in detail. Finally, we focussed on the longest speech of the conversation (> 160 words) (= red marked column), in which the patient tells the core of his life story with a speech time of more than one minute, whose strong (self-)evaluation was skillfully continued by the intervention of the doctor ("selling below value") (= 2nd short red column).

Compared to the evaluative life curve of the "dizziness" patient (§ 19.7.5), the *biographical* narrative of the "stomach" patient (for over 30 years) takes a different course with a different evaluative perspective (Fig. 19.9).

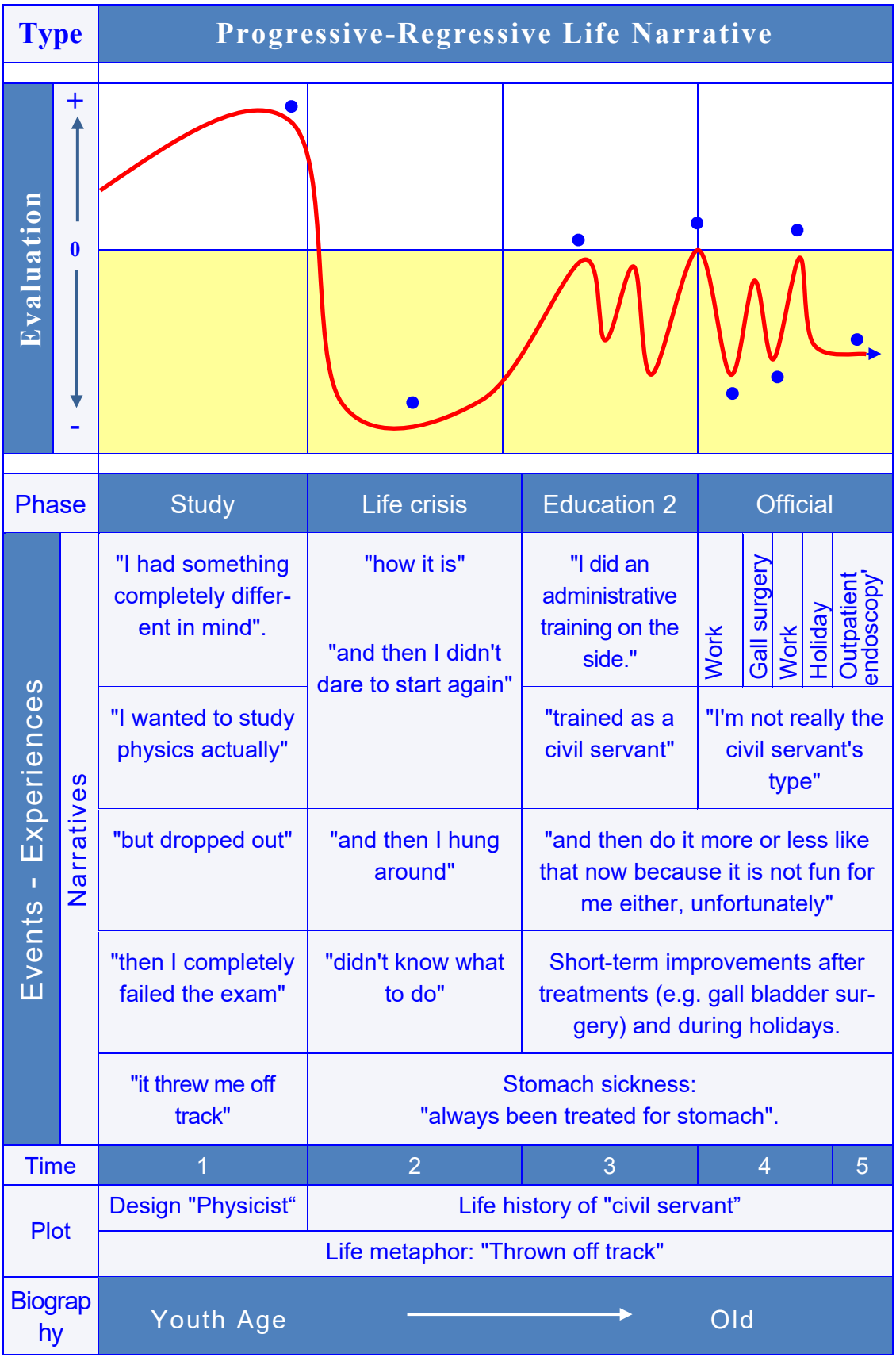

Fig. 19.9: Life narrative: "thrown off track"

The *regressive* tendency dominates in the essential period of adult life, during which the state of health in the patient's subjective experience had improved only in certain short-term phases (on holiday, after surgery).[10] After a *climax* at the beginning of his studies, which opens up a promising prospect of the desired profession of a physicist, the crash contrary to expectations occurs due to a serious exam failure (t_1), which causes the patient to quarrel with his fate in a self-critical way until the present of the consultation (t_5).

With his self-evaluation, which resembles a self-accusation, the patient, after the catastrophic low point of his existential identity crisis (t_2) ("I no longer dared (...) hung around, didn't know what to do") and a compromise formation through an "administrative history" (t_3), reveals a permanent discrepancy that arises in a constant upward comparison between the reality of his life as a civil servant (t_4) and his life plan as a physicist (t_1). This discrepancy experience manifests itself especially in the final evaluation of his narrative, in which he expresses his regret about the lack of fun at work ("because it's not fun for me either, unfortunately").

In the sense of an overall plot, which according to Ricoeur (1981: 167) turns events into a story, the narrator condenses his story of suffering with a life-guiding metaphor, according to which he experiences himself as having been "thrown off track" since dropping out of university. This experience is told to the medical listener in the narrative time of the consultation in such a dramatic way that the appeal to the doctor as helper in the sense of Brody (1994) becomes abundantly clear ("My story is broken, can you help me fix it") (§ 9.2). The patient's "story" is "broken" and needs to be "repaired" insofar as he had to give up the career of a natural scientist for a career as an administrative official through his own fault, without being able to adequately *cope with* this discrepancy between his *life plan* and his real *life course,* which continues to the present.

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[10] For the justification and application of the method of presenting the individual *life curves* of patients on the basis of their concrete narratives as specific *evaluation curves,* reference is made to preceding and following chapters (§ 9, 19.7, 19.8, 25.7, 44.5) and again to the literature (Gergen 1998, 2002, Koerfer et al. 2000, 2005, 2010, Köhle, Koerfer 2017).

19.8.7 Evaluation and reconstruction of patient stories

The patient's preceding *life narrative* ended with an *evaluation* ("because it's no fun for me, unfortunately"), which had been introduced by the doctor ("that's no fun?") and continued ("so that you feel you are selling yourself short, right"). This topic was accepted by the patient as a narrative invitation for a *wish narrative*, in which alternative possibilities of his *preferred* lifestyle were already pre-formulated, at least in the subjunctive ("I'd like to quit and ..."). With these narrative conversational developments, a possible *reconstruction of* the patient's story (*new story*) was started (Brody 1994, Matos et al. 2009), with which the patient's future life design is put into perspective.

While the alternative way of life in the wish narrative already manifests itself literally as an "idea" ("hobby"), this perspective can already be anticipated ex negativo in the life narrative from the contrast relations in the metaphor analysis of the narrative (§ 19.8.4). The *emotional* content of both (types of) narratives had been "brought to the concept" beforehand and subsequently by the doctor in his interventions by taking on the perspective, as it were, on *behalf of the patient* ("that's no fun" - "the feeling of actually (sic) selling oneself short"), which points to the productive circle of *conceptual* and *narrative* conversation work in the medical consultation; and this already in an *initial conversation* that lasts only a few minutes here. The turning point already occurred at the point where the doctor listened attentively to the patient when he characterised himself as a person ("I am *actually* (sic) not the type of civil servant") and the doctor followed up with an elegant, because economical question ("but ..."). On the way to a *new construction* of the patient's story, the "actual" has become the thing *worth telling* after only a few minutes (§ 9.2, 17.4, 19.4), which often remains hidden because it is not "heard" in the consultation.

The *narrative* would not have been *heard* if the doctor had limited himself to the *biomedical* anamnesis at an early stage and had immediately prepared the *examination* requested by the patient ("endoscopy"). The fact that things turned out differently was explained in detail in advance and will be briefly summarised by the further course of the conversation and examination.

The alternative of a different way of life for the patient, which has already been discussed, is taken up again in the further course of the initial consultation, in which further (material) conditions for its realisa-

tion are examined as well as the urgency of a change. After a short extension of the *psychosocial* anamnesis (§ 20, 21), in which the marriage, the wife's job, holidays etc. are discussed, the doctor directs the conversation with an accurate *metaphor* ("hitting the stomach") again to the job situation, which he directly connects with the patient's complaint problem.

E 19.48		"to hit the stomach" - "feeling of not being really needed".
01	D	hm . hm ... well, but the work really does seem to hit your stomach, doesn't it? .
02	P	[audibly agrees] yes . somehow this sss feeling [smiles] of not being really needed, I find .
03	D	hm .
04	P	that's what bothers me.
05	D	hm .
06	P	to be underutilised .
07	D	don't have the feeling that the work you do is valuable for any purpose? .
08	P	[shakes head, smiles] no I think the work is unnecessary . [laughs] . I think (...) [longer continuation].

With the metaphorical nature of this further key intervention, the *biopsychosocial* thematic complex is brought to a short denominator. The intervention unfolds its effect in the context of the developed history of interaction between doctor and patient, in which the metaphor (*hitting the stomach*) acquires its specific meaning (see above). In addition to the "objective" meaning of the metaphor, a "subjective" meaning for the patient is also bound up in the specific context, about which both partners have in the meantime acquired a sufficiently shared knowledge that makes the metaphor seem so plausible in the "here and now" of the consultation.

Beyond the general *knowledge of the world* that is called up with such a metaphor, the specific understanding of the metaphor is fed by the common knowledge of the interlocutors that it is not just any work that "hits the patient's stomach", such as work stress in the sense of being *overtaxed*, but it is the *underchallenge* ("not working to capacity") that causes the patient distress: a job that is "no fun" - as we all know - can generate discontent, frustration, disappointment, etc., all the way to an impairment of self-esteem. This has already been "addressed" by

the doctor ("feeling of selling oneself short") and is now obviously being "addressed" again more or less clearly on behalf of the patient, who reacts accordingly. In this conversation sequence, too, the *accuracy* of the doctor's interventions is shown by the direct feedback from the patient ("yes, somehow the feeling of not being needed"), who apparently feels fully *understood* and *accepted* with his suffering towards the end of the conversation (§ 17.4, 20.5). As before, the patient virtually prolongs the doctor's *offers of interpretation* in this sequence of the conversation, in which his own work is strongly devalued ("unnecessary"), which is tantamount to *self-deprecation*, which apparently can only be endured with a *laugh.*

At this stage of the conversation's development, when sufficient shared *knowledge* has already been gained about the patient's history of illness and suffering as well as his current life situation, the doctor can assure himself of the "material" conditions that the patient had already mentioned in his wishful narrative ("I would like to quit"). Despite the fact that it was only mentioned in passing (above E 19.49: "I can financially afford not to work"), this hint (*cue)* of the patient had obviously not escaped the doctor as a good listener, which is why he can now refer to it without further ado when he suggests the perspective ("not to work (any more)") as the subject of a "consideration".

E 19.49		"perhaps you might consider"
01	D	and financially you could actually afford not to work? .
02	P	[nods] .
03	D	hm .
04	P	ye:s, with a bit of provisions .
05	D	hm .
06	P	and so when you reduce the demands .
07	D	hm ..... (4) .... maybe you might consider .
08	P	yes .
09	D	yes, but I'm supposed to check the stomach, right? .

After the "material" conditions for an alternative perspective on life seem to have been clarified, the doctor follows up with a *weak* request which, despite being formulated in the imperative ("think about it"), has more the character of a *recommendation* for reflection ("maybe you might consider"). The topic of quitting remains implicit at this point in the conversation, but in the context ("you could actually afford not to work") it is

obvious what exactly needs further reflection. At the same time, this gives the patient a task until the next consultation, which would already be pre-structured by the resumption of the topic.

With this perspective, the content of the initial interview is concluded and the upcoming examination is briefly discussed, which was initially desired by the patient ("outpatient endoscopy") and had been renewed and agreed upon in the meantime during the interview, although the doctor had announced further questions: "yes . okay . yes, we can do it . I only have a few more questions". These questions then led to the psychosocial topic of the professional situation, which was followed by the patient's *biographical narrative* and finally his *wish narrative* through further enquiries.

In a follow-up conversation after the examination, the doctor first told the patient that no pathological findings had been found and then again brought up the unsatisfactory job situation as an issue. The alternative of *quitting* was also discussed again with the patient, whose decision in this direction already seemed more mature. In a catamnestic interview, the patient later reported that he had decided to retire early and enjoyed pursuing his hobbies; since then, no more "stomach complaints" had occurred.

19.9 Further information

Those who are more interested in the theoretical foundations of *biographical narrative anamnesis* should refer to the relevant chapter (§ 9). There, further literature on narrative in doctor-patient communication was also cited. On the specific connection between narrative and empathic communication, reference is made to the following examples: Angus et al. 2017, Habermas 1991, Habermas, Fesel 2022, Guidi, Traversa 2021 (cf. § 9, 20). For an overview of specific relationships between active and empathic listening, please refer to Rodat 2020, Collins 2022, Kishton et al. 2023, Epstein, Beach 2023, Tustonja et al. 2024 (cf. § 20).

Despite all the differences in detail, the preceding narratives were "traditional" forms of narration, which are characterised by the fact that the patients finally begin their narration after one or more triggering interventions by the doctor and bring it to a conclusion relatively independently. The narrative is told without the doctor being further in-

volved in the construction of the narrative beyond *formal cooperation* as a listener (Koerfer et. al. 2000, 2010, Koerfer, Köhle 2009, Köhle, Koerfer 2017). In these cases, only after the narrator, which patients clearly indicate, does a medical intervention follow in the function of a speech assumption, with which the doctor upgrades or downgrades relevance, so that further narratives can also be promoted or inhibited, in which the medical interventions in the preceding conversations differed. What they had in common, however, was the relatively "autonomous" narratives that can be attributed to the patient as "author" despite all the supportive listening activities by the doctor.

In addition, there are forms of *cooperative narration* in medical consultations that are characterised by a shared authorship, which initially seems to contradict the "traditional" forms of narration in everyday life (Koerfer et al. 2005, Koerfer, Köhle 2007, Köhle, Koerfer 2017).[11] As a rule, a narrative as a communicative large-scale form is attributed to a primary speaker as author, even if the latter is dependent on more or less active listener feedback from an attentive listener, whose attention serves as legitimation for the narrator to continue telling. Although narratives are always integrated into an ongoing interaction in which they perform their "dialogical" function, they themselves represent a kind of "monologue in dialogue". From this point of view, a conception of "narrative as dialogue" initially appears as a *paradox*. The problem can be solved, however, if one understands the communicative action of doctor and patient with Brody (1994) as a *joint construction of narrative*, in which the two actors are involved in different ways, which will be worked out in the following chapters (§ 20, 24, 25) with empirical examples from the *consultation* and the *ward round.*

[11] For comparative individual analyses of narratives within and outside institutions, reference is made to the anthologies by Ehlich (1980) and Martinez (2017), and specifically to the anthologies by Hurwitz et al. (2004) and Greenhalgh, Hurwitz (2005) on narrative research in the health sector. Of course, jokes or stories (e.g. about a joint holiday) can also be told by two or more people (Quasthoff 1980), but this requires a shared knowledge and experience of what is being told as a prerequisite, which is precisely not fulfilled in the medical consultation (§ 9) (Koerfer et al. 2000, 2005, 2010). If we distinguish below roughly between more "monological" and more "dialogical" narrative forms, in the construction of which both partners are more or less cooperatively involved (Koerfer et al. 2005, Koerfer, Köhle 2007, Köhle, Koerfer 2017), fluid transitions with variants and mixed forms cannot be ruled out.

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

References

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

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Cologne Manual & Evaluation of Medical Communication see next page.

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

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

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

Fig. 19.10: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)