21 Exploring Details
Completing the Medical History

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> The inquiry through which you elicit medical data from the patient is a collegial dialogue, not an inquisition.
>
> Platt, Gordon 2004: 17

Abstract: After a concrete picture of the patient and his illness has already emerged in the first steps of the conversation, the knowledge gained in this way must now be detailed, supplemented and deepened. Whereas the competences of *active listening* (§ 19) and *empathic feedback* (§ 20) have been in demand up to now, the doctor's questioning competences are now increasingly coming into play, with which the detailed exploration of the complaints can be forced and the *gaps* can be closed to *complete* the anamnesis.

After the overview of the 4th interview step of the manual (§ 21.1), the forms, contents and functions of medical questioning are to be differentiated (§ 21.2). In doing so, the risk of *manipulation* through questions that may also be experienced as *obscene* by the interviewee should be minimised as far as possible. From the point of view of detailed exploration, the questions should be goal-oriented without unnecessarily limiting the patient's scope for answering. However, the traditional distinctions between *open* and *closed* questions are often not very helpful, especially when they are identified with *word* or *decision questions.* In a *didactic model,* the various uses of the doctor's questions are to be shown by means of anchor examples taken from developed conversational contexts. Finally, the selected examples can also be used to identify *suggestive* information questions, which should continue to be frowned upon if *authentic* information from the patient is to be important.

In a further step towards the analysis and didactics of medical questioning, it should be worked out that *interpretations are* often offered as (answers to) *questions of meaning* (§ 21.3). The questioning character of

interpretations corresponds to their *hypothetical* claim to validity, which can also be "disputed". With interpretations, the questionable is put up for discussion, so that the perspective offered can be accepted, but also rejected or modified in processes of negotiating meaning. The negotiation of meaning should be conducted in a communication as *open* as possible, without, however, overtaxing the patients or even embarrassing or hurting them with an inappropriate choice of words. Insofar as the *authority* of doctors or therapists is always weighed in the balance in professional interpretations or interpretations, it must be checked through communicative feedback to what extent the patient's agreement is based on *persuasion* (i.e. *conviction*) and not on *suggestion* (i.e. *manipulation*) qua medical authority.

When exploring the details of patients' specific complaints, various *dimensions* should be taken into account, including the *locality* and *temporality* of the complaints, their *intensity*, *quantity* and *quality*, the *conditions* of their occurrence and their *accompanying signs*, and finally the patients' *dysfunctions* and *impairments* in their daily lives (§ 21.4). However, the exploration of the dimensions of complaints should not be carried out in a specific order, but should remain oriented towards the spontaneous flow of topics and speech of the patients, who often convey a lot of relevant information without being asked. However, if a patient remains vague or ambiguous, the ambiguities should be eliminated in between with targeted enquiries, also about word meanings, when describing the complaint. In doing so, the practical everyday limits of the principle of "expressibility" should be taken into account, which should be applied *narratively* when conceptual clarifications threaten to fail.

A special task is the exploration of patients' *subjective ideas* (§ 21.5), which must be sufficiently known to the doctor if his therapy suggestions are not to bypass patients' interests, attitudes and preferences. These patient conceptions refer to concepts of a "healthy" lifestyle (marriage, occupation, leisure time, etc.) as well as to explanations of health in general and to so-called *subjective disease theories of* chronic or current diseases in particular.

These topics on patients' "subjective theories" about their past or future life can also be seamlessly followed by the *completion* of the *anamnesis* (§ 21.6), in which the gaps are to be closed that patients may have left due to a different assessment of relevance, but also for reasons of forgetfulness, repression or shame regarding "sensitive" topics (sexuality, addiction, violence, drug abuse, etc.). As already explained in the context of *empathic* communication (§ 3, 17, 20), it is precisely with

"sensitive" topics that a specific tact is required, which instead of a *confrontational* approach relies on a *tangential* approach to the conversation that holds back certain insistent questions until the conversation and the relationship have matured accordingly for further impositions.

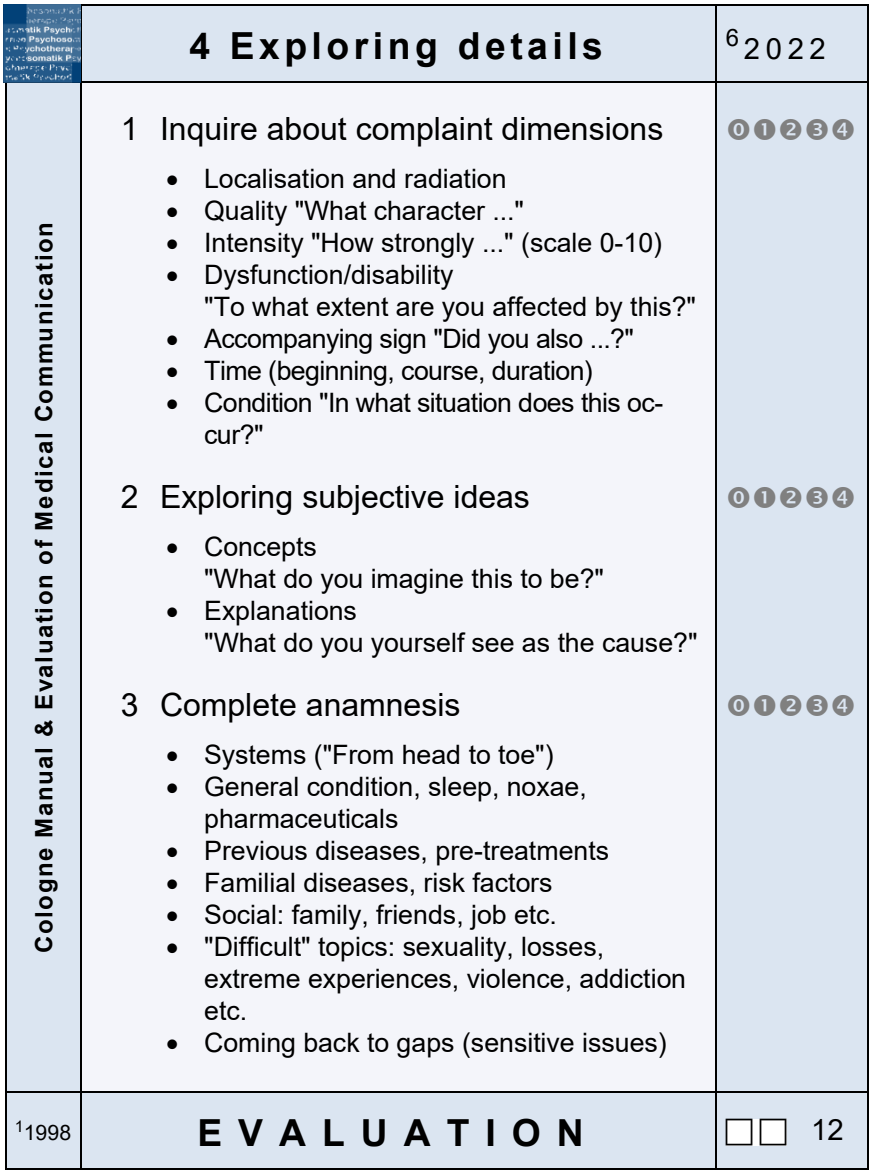
21.1 Manual step 4: Exploring details

The doctor's questioning is considered the best approach in communicative access to the patient. However, this path should not be taken unilaterally and should allow for many side paths and detours that allow the patient to express his complaints, problems and concerns in his own words. In doing so, the doctor often finds himself in a conflict between asking questions and listening: On the one hand, with Rehbein, "The doctor's question is the key to the patient's knowledge" (1993: 321). On the other hand, Balint's well-known dictum must be taken into account: "*If you ask questions, you get answers to them - but nothing more*" (1964/1988: 188). Undoubtedly, the epistemological opportunities associated with the opening-up function of questions should not simply be given away. However, the conflict cannot be reduced to the simple alternative between asking questions at all and listening in silence.

With the *art of listening* described by Balint at the same time, which requires an "inner conversion of the doctor", he will soon become aware "that there are no direct unapologetic questions that could bring to light what he wants to know" (1988: 171). Balint's dictum is not directed against medical questioning in general, but above all against questioning "in the style of the usual anamnesis" (ibid.). Taken to an extreme, this style of conversation manifested itself in the *interrogation conversation* analysed above (§ 19.6). The abolition of an extremely *interrogative* style of conversation, which is dominated by doctor's questions, is not, however, exhausted in listening as a mere "doing nothing" towards the patient, who could be left to do the conversational work without doctor's "intervention".

Rather, the intended *associative* representation and narration of patients is to be promoted through *active listening*, which is itself already realised in question forms of literal *repetition* and *paraphrasing* (§ 19.3-5). *Addressing*, *naming* and *clarifying* emotions also often takes place in question forms of empathic communication (§ 20.5-6), in which even

when *interpreting*, a merely hypothetical claim to validity is often raised in a questioning manner, with which the doctor puts possible answers to potential questions of meaning at the patient's disposal in a joint conversation. During the detailed exploration, these indirect forms of medical questions then become specific questions under different dimensions of patients' descriptions of complaints, which need to be concretised, supplemented and deepened. The subsequent exploration of patients' subjective ideas and the completion of the anamnesis is also essentially carried out through specific questions, without the patients having to be deprived of their narrative possibilities.



4 Exploring details — 6 2022

Cologne Manual & Evaluation of Medical Communication

1 Inquire about complaint dimensions — 0 1 2 3 4

- Localisation and radiation
- Quality "What character ..."
- Intensity "How strongly ..." (scale 0-10)
- Dysfunction/disability
  "To what extent are you affected by this?"
- Accompanying sign "Did you also ...?"
- Time (beginning, course, duration)
- Condition "In what situation does this occur?"

2 Exploring subjective ideas — 0 1 2 3 4

- Concepts
  "What do you imagine this to be?"
- Explanations
  "What do you yourself see as the cause?"

3 Complete anamnesis — 0 1 2 3 4

- Systems ("From head to toe")
- General condition, sleep, noxae, pharmaceuticals
- Previous diseases, pre-treatments
- Familial diseases, risk factors
- Social: family, friends, job etc.
- "Difficult" topics: sexuality, losses, extreme experiences, violence, addiction etc.
- Coming back to gaps (sensitive issues)

1 1998 — **E V A L U A T I O N** — ☐☐ 12

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

As in the previous manual steps, the fourth step (Fig. 21.1) is limited to *observable* interview behaviour (§ 3.3-4). In the ideal case, 12 out of a total of 50 points of the *Cologne Evaluation on Medical Communication* (C-EMC) (see Fig. 21.3, cf. § 17.5 and § 44) can be achieved for *detailed exploration.* In our OSCE examinations (§ 13.6), students often get a high score here because they already intuitively and reinforced by the teaching ask the "right" questions about the specific diseases and the person of the simulation patients if the "degree of difficulty" of the case is not set too high compared to the students' previous clinical knowledge.

21.2 Forms and functions of medical questioning

The act of asking questions can become a "delicate" matter in many situations. The questioner can more or less "hurt" the interviewee with his questions, in everyday life as well as in specific institutions (court, school, etc.) and even in medical consultations. Questions can "expose" the interviewee, not only when it comes to personal, intimate matters, but also when he has to "prove" his general or specific knowledge. If an examinee has to "pass" on exam questions or a candidate on a knowledge quiz, this can mean his or her "elimination" from the social process. Questions are "feared" as "interrogation questions" not only by the commissioner, but also by the doctor, for example, when patients finally have to "confess" their *non-adherence* (e.g. diet, sport, smoking, alcohol, etc.).

Although the doctor in the consultation not only traditionally enjoys a special *listening privilege* (§ 9, 19), but also a designated *questioning privilege,* which is generally also granted to him by the patient, here too "one must not push it too far", as this was repeatedly discussed in advance under the aspect of the *fit* in the communicative action of doctors (§ 3, 17, 20). It was also about the balance between *under-* and *over-stimulation* in the conversation, in which the right "dosage" has to be found. Asking the right *questions* at the right time is part of the *art* of conducting medical conversations (§ 17), which is to be further elaborated here according to theory and practice.

21.2.1 Maxims for formulating questions

Asking questions is certainly one of the main activities of the doctor. Medical questions should promote the more or less spontaneous "statements" of the patient, but also structure and complete the information received so far, where this is necessary in the interest of both conversation partners. As for the conduct of the conversation as a whole, recommendations can also be made for medical questions, which form an essential part of the conversation maxims for the medical *art of conducting* the conversation. As in the previous section (§ 1, 3, 17), we would like to borrow from the "classics" of clinical conversation research and didactics and use their "rules" for the formulation of medical questions as an introduction (Box 21.1). These "rules" are set up by Morgan and Engel for students, but they are to be generalised for the medical interview.

Box 21.1 "Rules" for the formulation of questions

A question must be easy to understand. It must not influence the patient's answer. It must be formulated in such a way that the patient begins to report spontaneously. Therefore, the following rules apply to the formulation of questions:

1. The questions must be short and simple. If the student finds himself having to explain a question, he must think again about what he actually wants to know (...)
2. The patient must be able to understand the questions effortlessly. The student therefore takes into account the patient's education and background and avoids medical terms that the patient does not know or misunderstands, such as pleural pain, jaundice or paralysis. Instead of such terms, he briefly describes the symptom to the patient: "Did you feel pain when breathing?" (...)
3. The student must never ask several questions at the same time, but only one. If he combines several questions or asks about several things at the same time, the patient does not know what to answer first.
4. The student must always begin a topic with open questions. He uses specific questions only to fill in gaps, to remove ambiguities and to substantiate certain facts. Questions that the patient can answer with a simple "yes" or "no" are avoided as far as possible,

because otherwise the patient stops reporting spontaneously and only waits silently for the next question.

5. The student takes over the patient's expressions, at least until he understands what the patient means by them (...) If he uses another term for "feeling of pressure" on his own initiative, e.g. "pain", he may thereby change the patient's intended expression. It is particularly confusing when the patient needs the term "pain" for another sensation.

Morgan, Engel 1977: 48f.

Before we go into the individual "rules" for the formulation of questions in several steps, the reference given in this context by Morgan and Engel to an exemplary conversation, which they cite in the appendix of their excellent textbook as a wording protocol, should be reinforced in advance. However, the conversation, which was certainly excellent overall (like probably all conversations), also contains weaknesses that indicate how difficult it is to implement conversation rules in practice. As emphasised several times (§ 1, 13, 17), more or less successful conversations can serve as starting points and templates for optimising one's own conversation management in so far as one can learn from "mistakes" or even mere "deviations" from "rules".[1]

In accordance with our previous language regulation (§ 1, 7, 9, 17), we would prefer to speak of "maxims" rather than "rules", which would have to be strictly (more) adhered to in communication. In the short term, however, the concept of the *rule* of Morgan and Engel is to be adopted in this context as in the preceding quotation. Some of these "rules" for the formulation of questions can certainly be followed easily, such as the 3rd rule on multiple questions, which are to be avoided "in principle" (Coulehan, Block 1992, Koerfer et al. 1994, 1996, Köhle et al. 2001). If questions of different content are connected in succession in the form of "question batteries", patients are usually *spoilt for choice* and often decide to answer the last question (part) in each case, so that

1 At this point, the ("older") textbook by Adler, Hemmeler (1992) is also recommended, which follows the tradition of Morgan and Engel's approach. In their textbook, Adler and Hemmeler also provide extensive transcripts of conversations, which are suitable for the critical use of examples in the classroom, for example under the aspect of the "suggestiveness" of questions (see below), which probably cannot always be avoided even by "seasoned" doctors.

the previous question content can easily be forgotten again by both interlocutors.

The *simplicity*, *brevity* and *comprehensibility* of questions for patients, which are required in the first two rules, taking into account their "education and background", are taken up elsewhere in the textbook (§ 10, 26, 27, 28). That compliance with these rules is not a matter of course is made clear, for example, by examples from research on visit communication (§ 24), in which doctors in a team communicate with each other over the heads of their patients by continuing to speak their specific (specialist) language, in which they then also turn back to their patients with questions. In principle, however, these are "rules" to ensure understanding, which do not present the team members with "unsolvable" tasks in the practice of conversation. Likewise, it contributes to better understanding if, according to the 5th rule, the doctor first adopts the expressions introduced by the patient (e.g. "feeling of pressure") before - if at all necessary - changing or replacing them in a *recognisable way,* if necessary, so that the "correction" remains *transparent* and comprehensible for the patient. A "tacit", non-transparent "correction" of the vocabulary once it has been introduced would be tantamount to uncontrolled "influencing" of the patient, which should already be avoided by way of introduction according to Morgan and Engel (Box 21.1), to which we will return immediately as a *basic rule.*

Other specific "rules" pose problems of application, such as when decision questions that could be answered with a "yes" or "no" are to be "avoided" as much as possible. Here, the 4th rule is too strict or not formulated in a differentiated enough way. Decision questions are also used in *active listening* (§ 19.4), in *securing understanding* (§ 19.5) or *clarifying emotions* (§ 20.6), but also for further *detailed exploration,* as is already clear from the example given by Morgan and Engel themselves under the 2nd "rule". For example, a patient could simply answer the doctor's question ("Do you have pain when breathing?") with "No" and then "just wait silently for the next question". In the other case, more than a simple "yes" is expected from the patient, so that the doctor's question is often "acknowledged" with a longer patient answer, which still needs to be discussed under the aspect of "surplus" when asking questions (§ 21.2.4). The situation is similar with other questions on detailed exploration (e.g. "Do you smoke?"), which we will come back to.

Furthermore, the general rule of Morgan and Engel can be agreed with in principle, as it was sent out at the beginning (of Box 21.1) as a

preamble ("The question must not influence the patient's answer"). However, this is certainly easier said in advance in theory than done in conversation practice. The specific problem of (in)permissible "influencing" of the patient is certainly an ongoing issue for which there are no patent remedies. But here too, more or less strict maxims can be formulated according to which certain *suggestive* information questions (such as: "Appetite is normal for you?") are to be "avoided as far as possible" according to theory and practice, which also still needs to be shown with empirical anchor examples as well as the "better" alternatives (§ 21.2.6).

Under the power *aspect* of (in)permissible *persuasion*, according to which mere *influence* (instead of *conviction*) could be sufficient for patients in the sense of *strategic* communication (§ 7, 10, 17), the problem of the *obscenity* and *suggestiveness of* questions in general will be briefly outlined below, which even the interlocutors in the medical consultation cannot easily avoid (§ 21.2.2). The *suggestive* information question (§ 21.2.6) then often proves to be only a last, seemingly "tried and tested" means under the everyday pressure to act in order to avoid problems or even contradictions. Communication would then be *successful* as a strategic action only in the sense (§ 7, 10) that at the end of the conversation there is the *persuaded* or merely *obedient* (instead of *convinced)* patient who finally behaves (*complies)* out of "confusion" (*confused consent)* or "obligation" as he was told to do by the doctor.

21.2.2 Obscenity and suggestiveness of questions

Asking questions is an everyday affair with which we are well acquainted. But those who ask too much and keep asking eventually run the risk of being experienced (in the truest sense of the word) as so "pushy" that further questioning is resisted by the interviewee if possible. The interviewee then often sends clear signals that the questioning should only go so far and no further. Sometimes, however, the interviewee cannot escape the social pressure of the questioning situation and the questioner's questioning technique, although he or she begins to suffer from it and would like to bring about an end.

It is no coincidence that the psychiatrist Bodenheimer, in his treatise on the "obscenity of questioning" (2011), recalls the fate of Socrates, whose way of questioning and inquiring, which was previously described as *maieutics* ("midwifery") (§ 9.5), was apparently experienced as

so "offensive" that it was famously punished with the death penalty. In his extremely differentiated analysis of questioning, Bodenheimer (2011) identifies a number of forms and functions of questioning, of which only the so-called *reverberating double question* will be singled out here as an example (Box 21.2) in order to illustrate the suggestive function of questions with drastic examples.

Box 21.2 Reverberating double question

In terms of its effect, the self-answering double questions that continue to reverberate in the form of questions is much more than suggesting; it is: silencing (...) The rhythm already begins to come into play with the number two.

(1) WHY ARE YOU PLAYING WITH THE PEN?

(2) DO YOU ENJOY THIS?

Grammatically and linguistically, question one and question two stand piously and harmlessly side by side, and both times they are short questions, naked questions, reduced to the words that are urgently needed to describe the factual and situational behaviour. How much more insidious - not only more obscene, more insidious - it all becomes, this self-doubling, when filler words, adverbs and conjunctions are added, with their meaningful non-saying. So, for example, when it says:

WHY ARE YOU PLAYING ...? - although even that is harmless compared to:

WHY DO YOU PLAY CONSTANTLY/SO CLEARLY VISIBLE AND AUDIBLE ...? - or even: ... *WHILE I'M SPEAKING ...?*

Then it is even more than insidious or accusatory, namely condemning.

Bodenheimer 2011: 298

From such extreme examples of exposing the interviewee, where the question of *the power of the word* in an extremely asymmetrical communication arises (§ 17.1), because the questioner must be able to allow himself to ask questions in this way, it is possible to draw conclusions about the mode of action of normal forms of manipulation, which at first seem less serious. Bodenheimer's starting point for the extreme variants, which could be increased even further, are also the very "normal" questions, because they are often repeated, which we have already seen in many empirical examples from medical consultations, which at first seem more "harmless".

There, the consent of the listener was "elicited" by the speaker, as it were, by making use of a so-called *tag question (right?, or?, is'nt it?* etc.). These forms of soliciting consent are initially not a special feature of the medical consultation, but an "everyday procedure" of dialogical communication, in which they perform a variety of functions as *speech action segments* (Rehbein 1979, Koerfer 1979). Although they are part of everyday communication, they can experience special forms of *persuasion* (*convincing* to *coaxing*) in the consultation, which are to be taken into account in the following with other forms of medical questioning.

On the one hand, such "consent-asking" forms are borrowed from the upper-class standard language ("isn't it?"), on the other hand, they are common in many (dialectally coloured) short forms of colloquial speech. On the whole, the function of *tag-questions* is perceived through short forms (such as German: *ja, ne, nä, wa, gell*), but also through longer forms (*stimmt's?, verstehste?, richtig?*), with which agreement is "demanded" even more strongly in terms of content. For example, a patient concludes his urgent request for a "total" examination with a *tag question* demanding consent: "(...) that this is also being treated, yes?" (E 20.26) (§ 20.7). Although both interlocutors make regular use of such follow-up tag questions in order to get the other to agree in some way, the focus here will be on the doctor's activities as a whole (e.g. of the type: "but work really does seem to upset your stomach, doesn't it?") (E 21.27). In the following, a series of doctor's interventions will be differentiated as prototypes, ranging from "consent-arousing" interpretations to information questions that are asked more or less suggestively ("otherwise you don't take any medication?") (E 21.15) (§ 21.2.6). With suggestive information questions, the doctor runs the risk of becoming counterproductive in the intended sense of gaining information, which will be illustrated by larger excerpts of the conversation.

21.2.3 Analysis and didactics of medical questioning

Research on the forms, contents and functions of questioning in general and on medical questioning in particular is very diverse and complex. We can only touch on a few aspects here, especially since in teaching we must sensibly make a didactic reduction in the short time available,

which can only do limited justice to the state of research.[2] Experience teaches us that larger courses on grammar, for example, are not very effective for medical students and doctors, especially since motivation for details can diminish if there is no practical reference.

Nevertheless, the participants' interest in asking the right questions at the right time in conversational practice is usually sufficiently pronounced to deepen certain learning processes on specific topics. Once the difference between an *interrogative* and a *narrative* style of conversation has been taught in theory and in practice by means of examples (§ 9, 18, 19), specific problems of a well "mixed" style of conversation, in which patients can have their say in their own words without the remaining need for medical information being neglected, which can often only be covered by asking questions, also arise.

In an overview, aspects of the analysis and didactics of medical questioning will be discussed in several steps using anchor examples, some of which are taken from our preceding conversation analyses, in the context of which they are compiled for teaching purposes. The focus is on the forms, contents and functions of medical questioning, which can only be inadequately captured by the mere distinction between *open* and *closed* questions. Rather, it is about aspects of relevance, preference, selection, expansion, etc. in topic development, which, regardless of (the effect of) individual questions, also always remains an object of negotiation between the two interlocutors.

In the literature on research and didactics of medical questioning, a distinction is repeatedly made between *open* and *closed questions,* often distinguishing types of question sentences with corresponding classifications that cannot be maintained in this way on closer examination. Not infrequently, *closed* questions are identified with *decision questions*

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2 From the differentiated and interdisciplinary (social science, conversation analysis and linguistics) spectrum of research on (medical or psychotherapeutic) questions, we would like to refer to the following exemplary works over a longer period of time, some of which we will return to under specific aspects: Bergmann 1981, Mishler 1984, Dickson et al. 1991, Coulehan, Block 1992, Rehbein 1993, 1994, Koerfer et al. 1994, 1996, Dillon 1997, Stivers, Heritage 2001/2013, Lalouschek 2005, Spranz-Fogasy 2005, 2010, Roter, Hall 2006, Robinson 2006, Heritage, Robinson 2006, Boyd, Heritage 2006, MacMartin 2008, Deppermann 2009, Deppermann, Spranz-Fogasy 2011, Vail et al. 2011, Scarvaglieri 2013, Bergmann 2013, Tsai et al. 2013, Cole, Bird 2014, Spranz-Fogasy, Becker 2015, Marciniak et al. 2016, Spranz-Fogasy, Kabatnik, Nikendei 2018, Coussios, Imo, Korte 2019, Läpple et al. 2021, Gumz, Spranz-Fogasy 2022, Buck 2022.

that could be answered with "yes" or "no", and the so-called *W-questions* are identified as *open* questions (*who, what, when, where, why,* etc.). This rough distinction and parallelisation is widespread in both German and English-speaking countries, where the *yes/no-questions* are distinguished from the *W-questions* (*who, when* etc.) and the latter are often assigned to the *closed* or *open questions* without further ado. As catchy as these distinctions may be at first glance, they are misleading for conversational practice, for which they cannot be justified by arguments of didactic reduction.

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

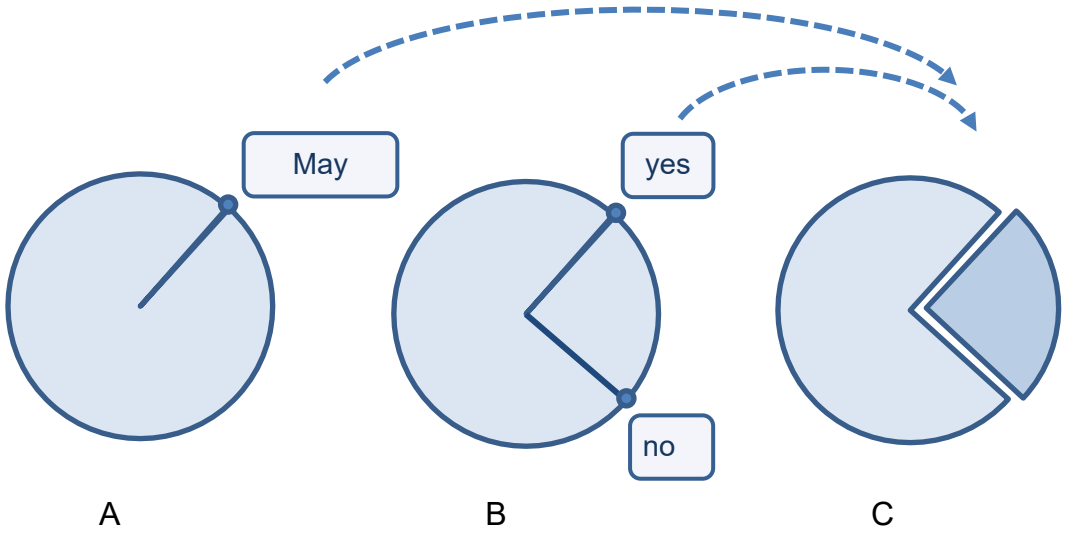

Fig. 21.2: Didactic question-answer model

Before we further explain the procedure for teaching purposes, a possible misunderstanding must be prevented: The didactic reduction is in no way intended as an attempt to depict the extremely complex world of

action of questioning in a model with three (two-dimensional) circular representations and their relations. Rather, these simplistic representations are intended to serve as a rough comparison in teaching with anchor examples that are to be discussed, if possible, in the empirical context of real conversations in which the performance of questions can best be assessed. Thus, the anchor examples are compiled into a list of materials and work, referencing contexts in conversation sources where appropriate. The list of examples consists of several parts, which here, under certain aspects, extend over several sub-chapters of this and the following textbook chapter (§ 21, 22). This "order" could also be removed in class and the examples presented "unsorted", so that the proposed "order" would still have to be worked out.

The possible uses of the anchor examples always depend on the question of time and economy in a fast-paced lesson, where questions about questions about other important topics arise, so that a selection has to be made. Thus, some of the anchor examples can certainly be discussed without context, others should be discussed in more detail in context, for which purpose some cases are highlighted here as examples to illustrate the procedure. This is a trial list with which experiences have been made in teaching or training in this or a similar way. The few alternative examples that have been "constructed" for didactic reasons are specifically identified as such. The few source references refer to the literature from which they are borrowed or mostly to our textbook chapters, where they can be followed in the (larger) context as *developed question-answer sequences.* Occasionally, "complicated" transcripts are reproduced here in simplified form to make them easier to "read". Those who are nevertheless interested in the original, as in the case of the conversation analysis by Peräkylä (2012) for *interpretation* in a psychoanalytic therapy (in Finnish, which is included there in parallel with the German translation), must then follow the corresponding source references.

Before individual examples are highlighted, it should be remembered that the general methodological problem (§ 9) is that the *conditioning of* communication should not be confused with a *determinism of communication.* Patients often answer differently and, above all, for a longer time than would be expected according to the doctor's question format, which is repeatedly pointed out in research with examples (Rehbein 1994, Koerfer et al. 1994, 1996, Stivers, Heritage 2001/2013, Spranz-Fogasy 2005, 2010, Harvey, Koteyko 2013, Spranz-Fogasy, Becker 2015, Spranz-Fogasy, Kabatnik, Nikendei 2018, Coussios, Imo, Korte

2019, Läpple et al. 2021, Buck 2022). The opportunities offered by the doctor to speak and talk are not always used by the patients in the way the doctor intended, regardless of whether the further use of the right to speak, which may lead to a narrative "surplus" (§ 9, 19), is convenient for the doctor (or not).

These differences should also be taken into account in the context of teaching when the examples are discussed in detail. We can only focus here on selected cases from the list of examples of the various learning objectives of *medical questioning* that should be taught in class, and if necessary, refer to the more or less detailed conversation analyses of the corresponding transcript boxes in the various chapters. In addition, reference should be made to previous work (Koerfer et al. 1994, 1996, 2000, 2008), in which didactic aspects of their teaching were taken into account in addition to the conversation analyses.

21.2.4 Open and closed questions: The potential surplus

In the analysis and didactics of medical questions, equal attention must be paid not only to their form, but also to their content and functions in the context, in which the everyday and individual world and action (pre-)knowledge of the interlocutors is also bound. Moreover, after a certain start-up time, they can also always fall back on a common history of interaction with shared knowledge (§ 20.8-9) in order to understand the specific meaning of questions with their content words (e.g. “crazy”) (§ 25).

In the first extreme comparison, very "broad" questions can be distinguished from very "narrow" ones.[3] The first examples of broad conversation openers (E 21.1-2), in which the question content is embedded, are usually understood as invitations to talk about a wide range of topics and are used accordingly.

[3] Instead of the traditional distinction between "open" and "closed" questions, we distinguish here more often between "narrow" and "broad" questions, because this pair of opposites can be better graduated (*narrower - broader*). We can only marginally deal here with the (sometimes very detailed) questions in research as to whether certain (types of) utterances are still questions at all and what role verb position and intonation play in this.

E 21.1		"Tell us a little bit about what's going on."
01	D	(...) tell us a bit about what's going on and how we can help you.
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 to me at that time the Dr. (...)

E 21.2		"tell me once why you are now (...)"
01	D	so, Mrs PW, tell me once why you are coming to the hospital now
02	P	because i had so much heart/heart pain and by chance * the woman doctor >name< after i am in treatment with her (...)

Lalouschek 2005: 60

With such a wide range of topics, the exemplary section (according to Fig. 21.2: circle type C) may already be too small, because (almost) the entire spectrum of topics is still available. Even in the case of *direct* opening questions ("What brings you to me?" - "What can I do for you?"), a wide range of topics can be left, although even the *content words* can make a difference (§ 19.2). Again, reference is made to the example from the "interrogation interview" (§ 19.6), in which the doctor, for whom his initial formulation "main problems" probably seemed too far, corrected himself in the same utterance to "main complaints", whereupon the corresponding patient offer came ("heartache"), which then also became the dominant *biomedical* topic of conversation, without further *psychosocial* topics being able to be developed in view of the described "funnel technique" of questioning.

E 21.3		"where are your (...) main complaints?"
01	D	so Mrs A, what brings you here? .
02	P	so, in general now um ... [Looking up to the left, pondering].
03	D	what are your main problems, what/ or main complaints, what do you come for? .
04	P	I have often had heartaches, i.e. stitches in the region of the heart.

Even in conversations that have already been developed, more or less *open* or *closed* questions can be asked which, for all their selective function determined by content words or placement in the conversation, give the patient varying degrees of leeway in answering. In the case of extremely "narrow" questions in the current conversation, the clear cases should first be worked out in which, depending on the content and question format, "monosyllabic" answers are expected and are also usually given. A doctor who asks for the date of birth ("When were you born?") with an (extremely narrow) W-question may already be able to estimate the approximate age from external perception, but expects (according to Fig. 21.2: circle type A) a short and very specific answer.

This also includes all types of W-questions (or supplementary questions), which Redder (1994: 181) summarises as "bureaucratic interview questions", which also include the question: "Who is your family doctor?", which is asked right at the beginning of an *inpatient case history* as part of a "series" of questions, as the doctor herself characterises her activities (E 21.4). This "series" is followed by the specific word and decision questions about the first name and street of the GP and then about marital status ("Are you married, widowed?") as well as about children, profession and a short thematic excursus about the patient's place of origin, etc., before the "actual" anamnesis conversation begins, which is again introduced with a question about medication.

E 21.4		"Can I ask you one question at a time?"
01	D	Mrs Bittl, right?
02	P	Hm
03	D	May I therefore?
04	P	Yes, yes, (please) beautiful
05	D	(Write down a bit! Great. May I now ask you one by one?. Who is . Your family doctor?

Redder 1994: 179

Nevertheless, even with such ("bureaucratic") questions for "biographical" data, a "surplus" is to be expected, because the world is de facto more complex than is generally assumed with the corresponding questions for these formal data and is also often preferred by doctors. Nevertheless, further information that patients offer following the more or less "narrow" questions is often tolerated and honoured and taken as an occasion for further questions, which in turn are answered with a "sur-

plus" of information etc. Because of the possibilities for comparison, the communicative handling of this informative "surplus" will first be shown with a constructed alternative to the real conversation process and then with further empirical examples. In addition, empirical cases will be differentiated in which the patients are apparently very "sparing" to "deficient" in their response behaviour, contrary to the doctor's expectation, which demands further enquiries from the doctor. Here, it will be necessary to distinguish between forms of *minimum* and *maximum* cooperation, in which patients react rather "reservedly" or rather "in advance".

The surplus after medical questions

In the following example (E 21.5), which is taken from the model interview by Morgan and Engel (1977), the doctor's questions and enquiries about the patient's place of residence and her family are in fact answered "monosyllabically" (according to Fig. 21.2: circle type A-B). But other, longer answers (than those apparently already expected by the doctor) could also be possible here, if the questions were answered in the negative by the patient, for example, or in a modifying way ("not always", "not all"), because the patient and various family members had "then" lived in several places or had moved several times, etc., which becomes clear here in the alternatively *constructed* course of the conversation (E 21.6: 06).

E 21.5		"Where were you living then?"
01	D	Mhm. Where did you live at that time?
02	P	In G.
03	D	You have always been in G.?
04	P	Yes.
05	D	And your family is from G.?
06	P	Mm. Mhm.

Morgan, Engel 1977: 252

E 21.6		(Constructed) alternative answer: "Originally ... but".
04	P	Yes.
05	D	And your family is from G.?
06	P	Originally also from G., but then we were scattered in all direc-

tions, so that today it is difficult to keep in touch . that is very unfortunate, because I had a particularly good relationship with X, who always stood by me (...) I miss that very much, because (...)

With the patient's alternative continuation of the conversation (constructed here for didactic reasons), the equally alternative topic developments would already come into play, which could grow into small narratives (according to circle type C), in which the occasions, motives, hurdles, problems, solutions etc. would be "brought up" in detail, for example, in the case of a permanent change of residence and the associated life circumstances. Thus, the course for the development of topics is set by the questioner, but also by the answerer, whose informative "surplus" (Box 21.3) can hardly be anticipated by the doctor asking the question, as will also become clear in a moment with empirical examples.

Box 21.3 Informative "surplus" after medical questions

Following the doctor's questions, the patient gives further information which, as *unasked* information, no longer has the action character of *answers* to questions, but represents relatively independent *messages* which can only be regarded as weakly conditioned by the preceding doctor's statements. The respective patient contributions (...) are not obligatory in this form, but rather optional, i.e. the patient could have chosen with good reasons a completely different kind of discourse continuation than the factual one, for which, however, a favourable placement condition is created with the respective doctor's intervention.

Koerfer et al. 1996: 119

The "chances" for an informative "surplus" already open up with simple W-questions about the beginning of the complaints, which are not only answered with a mere indication of time (according to circle type A) (year, month, etc.), but can be linked with minimal information supplements. This is what happens even in the "interrogation interview" (§ 19.6), in which the patient placed the beginning of her "heart pain" after the corresponding doctor's question (E 21.7) in the context of a tonsil operation, which then led again to another doctor's information question (about a possible "improvement").

E 21.7		"since when ..." - "is it after that..."
01	D	how long have you had these stitches? ... [3] ... [scratches his shoulder] .
02	P	it's been a little longer than that, so in 2001 it was really bad, and that's when I had my tonsils removed.
03	D	yes .
04	P	that was still the case with Dr. Müller. [+]
05	D	did it get better afterwards? .
06	P	yes, then it was better again, and then it occurred again, so now, recently.

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

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

E 21.8		"This dizziness, did it start when ..."
01	D	this dizziness, did it start when you found out about this diagnosis [= daughter has MS]? .

02	P	yes, I think so ... once I had something in my head at night, uh ... I never told my husband, once I had something in my head at night, really bad ... I woke up ... I thought: "Oh dear, oh dear, what's wrong now?" ... once I got really sick in bed at night ... I fought it, always did everything at her house, took care of the household, until it was no longer possible, no ...

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

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

E 21.9		"Children?" - "unfortunately no children"
01	D	are you married? .
02	P	yes .
03	D	children? .
04	P	unfortunately no children .
05	D	hm . marriage good? .
06	P	have been married for 20 years now (...)

Under the aspect of "deficient" empathic communication, we had already explained (§ 20.4.4) that the doctor should have taken up the additional information conveyed condensed in the short expression of re-

gret ("unfortunately") instead of levelling the topic potential with a *suggestive, elliptical questioning technique* ("Marriage good?") to the normative expectation format of a "good marriage". Instead of using simple forms of active listening ("You say, unfortunately?") to use the topic potential offered by patients ("Regretted childlessness"), the opportunity is finally "given away" when the doctor then subsequently asks about the wife's profession.

Enquiries with minimal cooperation

Independent of the *surplus potential of* doctor's questions, these have a specifically dialogical function, with which certain minimum *answer* obligations are imposed on the respondent, as they also apply in everyday communication. If certain (types of) decision questions (*yes/no)* are answered in a certain (positive) direction, the answerer often assumes certain obligations for detailed answers. Thus, in the case of the everyday question ("Can you tell me the way to the station?"), we can expect more than a mere "yes" in the positive case, but can expect directions from the respondent without further solicitation. Accordingly, in the case of an affirmative answer to his typical doctor's question about alcohol consumption ("Alcohol use?") (E 21.10), the doctor can expect more than a mere "yes" - even if he then has to ask again ("Can you define that") because of the vague answer (P: "Hm:: moderate I'd say"), as in the present case. It should only be noted here that the laughter seems to be a *sign* that this is a "sensitive" topic even for the professional questioner.

E 21.10		"Alcohol use?" - "Hm:: moderate I'd say"
01	D	Alcohol use? (1.0)
02	P	Hm:: moderate I'd say. (0.2)
03	D	Can you define that, hhhehh (laughing outbreath)

Boyd, Heritage 2006: 174

In these cases, it is already part of the everyday knowledge of patients socialised in medical consultations that the medical question about *alcohol consumption,* if it is not clearly answered in the negative, requires more than a mere affirmative answer. This applies similarly to the following question about "marital status", which can generally be regarded

as "innocuous". The fact that responding patient behaviour can also be directed against the doctor's expectations is also illustrated by a (simplified) example (E 21.11) by Boyd and Heritage (2006), whose immediate commentary (Box 21.4) on this example will be added here immediately.

E 21.11		"Are you married" - "No"
01	D	Are you married? (.)
02	P	No. (.)
03	D	You' re divorced (currently??)
04	P	Mm, hm,

Boyd, Heritage 2006: 172

Box 21.4 Communication in the absence of cooperative response
The patient's unelaborated "no" response is less than cooperative in relation to the objective of the question. And the physician is left with the possibility that the woman is single, divorced, or separated. His follow-up question nominates a likely, and relatively "best case," alternative and is, once again, designed for "yes" answer, which it receives, in fully preferred fashion.

Boyd, Heritage 2006: 172

The fact that questions about marital or family status can (unnecessarily) embarrass the respondent (as well as the questioner) can be quickly recognised by the fact that "adolescent" patients, for example, are "spared" such *decision-making questions* with this content ("Are you married?") from the outset, because they would express an inappropriate expectation. But even with adult patients, such questions should be asked with caution and certainly not in a suggestive form that strongly indicates a preferred answer ("Are you married?") (B. 21.17), which we will come back to. Questions about marital status should at least be asked in the form of a "real" decision question (with verb-initial position: "Are you ...") and should, if possible, also be "adapted" to "today's" times in the choice of words, by asking about *partnerships*, *relationships*, *friendships* etc.

Nevertheless, the "reserved" response behaviour of patients remains a problem that should be given special attention in communication. As a rule, yes *answers* to decision questions (of this type) already require

an informative "surplus" (in the direction of circle type C from Fig. 21.2), the absence of which can be significant. Thus, it may be surprising at first that the patient merely answers the doctor's question (E 21.12: "Are you otherwise receiving treatment?") in the affirmative with subsequent silence, so that the doctor has to ask specifically with a specific why-question, through which the conversation takes an extended topic development with a larger topic focus (according to circle type C).

E 21.12		"Are you otherwise receiving treatment?" - "yes"
01	D	are you otherwise receiving treatment?
02	P	yes ...
03	D	why? .
04	P	I was (...)

In retrospect, the patient's hesitant response can be explained "for good reasons", which initially guided him: As the course of the conversation makes clear, the patient obviously did not want to be asked about what he considered to be a "sensitive" subject, but was then prepared to do so at length. Although questions about treatment elsewhere can always be "sensitive", they are part of routine medical treatment, which should help to complete the medical history (§ 21.6).

Exploration of emotional experience

Certain questions remain risky simply because of their content, for example when possible *emotions* are made a topic. Of course, the doctor's question (E 21.13: "Are you a little scared and worried?"), which is formulated in a weakened way anyway ("a little"), is a decision-making question that could in principle be answered in the negative - and with indignation ("Not me!"). But its function as a suitable topic offer for a relatively broad topic focus (according to circle type C) is just as clearly understood and also de facto accepted by the patient in this context.

E 21.13		"are you a little scared and worried?"
01	P	I always feel a bit- [exhales air, facial expression and gestures of helplessness].
02	D	are you a little scared . and worried? .

03	P	yes also . [smiles sheepishly]
04	D	hm .
05	P	also . [smiles] my father was/my grandfather died of cancer . my grandmother died of stomach cancer . my father had a heart attack . he was 62 when he died . in our family everyone died at an early age . and that also plays a role (...)

The patient's factual reaction is a good example of the high accuracy of medical questions in clarifying emotions (§ 20.6-9). Even though the patient answers hesitantly at first ("yes, too"), he finally uses the doctor's question for a series of dramatic events and experiences from his family environment (§ 20.7), which make his "fear and anxiety" for his own life understandable.

While in this case a single question to clarify emotions has already contributed to a considerable expansion of the topic, in other cases a greater doctor's communication effort of questioning and enquiring is necessary. Potential topics of emotional experience are often only opened up through a combination of insistent questions from the doctor, which was preceded by many examples of the development of patient narratives, for example, which required whole *cascades of questions* before the patients could get into a narrative flow (§ 19.8, 20.8, 20.9). As an example, we recall the doctor's painstaking dialogue "detail work" (§ 20.9), with which he can only gradually "elicit" from his patient the corresponding topics on the emotional experience of the *mother-child relationship with the* combination of decision questions or W-questions, to which we will return shortly.

In the given context, it makes little sense to make a *fundamental* distinction between *W-questions* and *decision questions* under the specific aspect of *openness* versus *closedness of* questions. As we will see in a moment, certain decision questions can be more "open" than their W-question siblings with comparable content (§ 21.2.5). Beforehand, the selective and productive interplay of these question types should be illustrated once again by the extensively analysed conversation phase in which the two interlocutors begin to negotiate a new topic after the doctor had concluded the old topic and "reshuffled" the "topic cards" with the *decision question* ("Any other changes?") (towards circle C of Fig. 21.2). We reproduce this topic negotiation phase here in abbreviated form with a focus on the doctor's questions (E 21.14a) and refer to the larger context (§ 20.9) in which the development of an *empathy-in-interaction* was analysed.

E 21.14a		Theme negotiation
01	D	so now we've talked about a change . are there any other changes? .
		(...)
07	D	it's been 10 years since your mother ... and what was it like for you?
		(...)
10	P	I didn't have such a good relationship with my mother.
11	D	not such a good relationship? .... (4) .... how was it, [quieter] the relationship? .... (4) ....
12	P	yes, it was always some kind of tension with my mother....
13	D	did you not feel well cared for as a child? .... (4) ....
14	P	maybe that's the way to put it, yes .
15	D	hm, hm ..... (6) ..... in what [quieter] respect? ...
		(...)
19	P	and were you always disadvantaged there [quieter] ( ) .

In the alternation of *word questions* (07, 11, 15) and *decision questions* (01, 13, 19), it is above all the *content words* ('other changes', 'not feeling well cared for', 'being disadvantaged', etc.) of the questions which, at the same time as their placement in the conversation, have a *guiding function when the* doctor asks, for example, directly after the preceding patient statement: 'How was it, the relationship?"or: "In what respect?", whereby the last, elliptically formulated question can be fully understood and paraphrased in the context as: 'In what respect did you not feel well cared for?' In this case, the patient's acceptance of the preceding question content ("maybe that's the way to put it, yes") had already become sufficiently clear, so that it is now only a matter of further elaboration.

In the combination of these doctor's questions, which increasingly increase the pressure on the patient to react, the conversation finally takes a thematic turn, in which the patient has a relatively broad thematic focus (Fig. 21.2: circle type C) available to him on a specific complex of topics ("mother-child relationship"), which he then also uses for his narratives from childhood for specific self-exploration (§ 20.9). In the further verbalisation of his emotions about his childhood experience, the patient is again actively supported by the doctor, up to a specific *interpretation* (§ 20.9.5), to which we will return separately (§ 21.3.4). At

this point, the conversation should be summed up like this for the time being: With the combination of (types of) medical interventions, not only were *offers of topics* made, which the patient could easily refuse and which he initially also "reservedly" accepts, but also *obligations to act* were introduced, through which the patient was increasingly forced into further *elaboration* of the topics in question, in the further development of which both interlocutors were then in turn cooperatively involved in the interpretative conversation work.

21.2.5 Exploratory and explanatory questions

The *combination of decision questions* and *word questions* is a complex matter that we will encounter more often. It always plays a role in how the choice between these two types of questions can be justified in the first place at a particular point in the conversation when it comes to further *detailed explorations* (§ 21.4-6). That the preference for a decision question over a W-question is often justified and the W-question would be out of place can have several good reasons, whereby "action-logical" and "psychological" aspects can be distinguished, although they often work together.

Logical and psychological aspects of questioning

The connection becomes obvious with the well-known joke about the judge who asks the accused point-blank: "How many times a week do you beat your wife?", whereby the interviewee must then reply indignantly: "Listen, not at all!" The interviewee must therefore reject a *presupposition* that the questioner has already made (*co-assertively*) with his question. In order to avoid the "embarrassing" or even just unnecessary "entanglements", a certain order in the use of question types should also be followed in the medical consultation, such as in the following pairs.

- Do you smoke?
- How much do you smoke?
- Have you ever been treated for this?
- Where have you been treated for this before?
- Are you taking any medication?
- What medication are you taking?

It is obvious that it makes sense to ask the first and then the second questions, i.e. to start with a decision question, which can be followed by W-questions if the patient does not take the initiative for further information (*surplus)* after answering the corresponding decision question in the affirmative (Fig. 21.2: Circle B). So although in many cases the prerequisite-sequence relationship of question types seems to be relatively clear, there are nevertheless problem cases depending on question content where the order could or should be decided differently, such as with certain types of questions about sexuality:

- Do you (already) have sex (sexual contacts)?
- What about (the) sexuality?
- Do you have sexual intercourse with one partner or with changing partners?
- With how many partners do you (currently) have sexual intercourse?

Exploratory questions about sexuality are considered a "delicate" matter that requires a cautious approach (§ 21.6). Here too, there are certainly no patent remedies, but there is a person-, culture- and age-specific variation in the use of the corresponding question types. The decision question ("Have you (already) had sex?") may be just as appropriate with adolescent patients as it may be inappropriate with adult patients. As far as the *psychological* side of asking questions is concerned, the word question would probably be less "compromising" with adult patients in relation to the decision question, not least because of certain expectations of probability and normality. If the last two questions already become necessary, then the decision question should certainly be asked before the word question, which can only become unavoidable if the decision question has only been answered "yes" with minimal cooperation.

Since we will deal with the problem of dealing with *sensitive* issues separately (§ 21.6), the focus here will be on *exploratory questions* about patients' *subjective ideas*, which can be characterised as specific *explanatory questions*, for which decision questions should also be preferred over W-questions. Physicians who ask their patients for possible *explanations* for their illness should, again primarily for *psychological* reasons, avoid putting the interviewees in any particular *need for explanations.* Patients often have no explanations or do not dare to "come out" with them - for whatever reasons (shame, irrelevance, etc.). There-

fore, the doctor should also exercise caution when asking specific explanatory questions of the following kind:

- Do you have an explanation for this?
- What explanation do you have for this?
- Why is that (in your opinion)?

Here, too, it is obvious that it is easier to deny the decision question than to reject the presupposition associated with the word question, especially if the lack of an explanation were to be experienced as an *exposure*. Thus, in addition to the *need to explain,* there would also be the *pressure to apologise* if patients had to answer with an expression of *regret*: "Unfortunately, I don't know that either" or more explicitly "I'm sorry, I have no explanation". Here, the pressure to act and apology compulsion would undoubtedly be weaker with a corresponding decision question. This type can be characterised as a *conditional explanation question* (Box 21.5), in which the doctor, with the form of the decision question, despite all preferences for the *yes-option,* nevertheless takes the no-option into account in a way that is recognisable to the patient.

Box 21.5 Conditional explanation question

A characteristic feature of this type is that the "actual" explanatory question is embedded in a decision question, which is obviously intended to exert less pressure to explain than direct forms of realisation (e.g. with: "Why do you think it is like that?"). While a question of the type "What explanation do you have for ..." or "Why do you think it is like that?" already presupposes *that* the respondent has an explanation, this is left open with the decision question. The decision question thus facilitates a negative answer. The possibility of a patient's not knowing still lies within the expressed expectation range of the doctor's question, in other words: an expectation expressed by the doctor does not have to be specifically disappointed.

Koerfer et al. 1996: 122f

This basic structure of the *conditional explanatory question,* which keeps a *real* yes/no *option* (according to circle E of Fig. 21.2) equally open, will be illustrated by a short example which is also particularly suitable for teaching under the aspect of patients' subjective theories of illness (§ 21.5). Here, we will only deal with the form and function of the

doctor's question, which is answered by the patient, at first hesitantly and then at length, with an attempt at an explanation (E 21.14b). At the beginning of the conversation, the patient had spoken of heart-related complaints combined with "anxiety" and casually mentioned her "low" blood pressure, which is now taken up again as a topic. Although the doctor's question directly follows the communication of the current "non-intoxicating" measurement results, it refers to her entire crisis situation, as can be seen from the patient's further thematic statements, which will only be reproduced here in the first part and later in more detail, when it becomes clear what all the patient had to "process", as she herself puts it.

E 21.14b		"do you have an explanation why ..."
01	D	do you have an explanation why this is the case now? .
02	P	I don't know, sometimes I imagine that somewhere/that this is more of the ... (2) .. from the soul than from the body. because (...)

As is often the case with answers to exploratory questions by doctors, the patient also begins here with a *relativisation,* which starts with the declaration of *ignorance* or uncertainty ("I don't know"). Her *uncertainty* ("I don't know"), then emphasising *subjectivity* ("sometimes I imagine"), before she begins the "actual" explanation with self-corrections and delays, in which she then specifically mentions "trouble in the family" and a "miscarriage" after another doctor's question, which we will come back to later (§ 21.5.3). For the *question-answer structure* of this conversation sequence, it should be noted overall that the type of *conditional explanatory question* embedded in a decision question can prove to be less restrictive than the corresponding direct word question ("Why is it like that?") due to its specific presupposition structure. If one wants to stick to the traditional distinction between *open* and *closed* questions, in such cases the decision question is more "open" than the word question, with which the option between alternative areas of knowledge or topics already seems "closed". With the decision question, the questioner is still examining what he or she obviously already assumes to be decided with the word question.

Flexible questions

In an intermediate consideration, the *decision question,* which is often undifferentiatedly frowned upon as a "closed" question, is to be "rehabilitated" here. Analogous to the preceding examples, decision questions can be the "better" alternatives in relation to word questions (of the same content), which, if necessary, build up less pressure *to act* and *apologise*, relatively independently of their forms of realisation ("Do you have an explanation for the fact that ...?" or "Can you explain, say, remember when/who/why ...?" etc.). Thus, in many cases (with specific contents and contexts), decision questions can definitely be used sensibly and expediently in comparison to their word question siblings and should not be rejected simply because decision questions ultimately risk *yes/no answers,* which are undifferentiatedly assumed to be *narrowly* thematic, which should be *unanimously* avoided. In any case, even with "narrow" and "broad" *word questions,* one must reckon with corresponding "rejections" of "insinuations", which can be associated with a disproportionately higher communication effort, which can include both *action-logical* and *psychological* costs of "repair".

The necessary differentiations in medical questions are to be conveyed in teaching at least as a correction of the all too vague or categorically formulated maxims of the type "Ask open questions" versus "Avoid closed questions", especially when these are identified with *word questions* versus *decision questions.* The rigid adherence to *form-oriented* maxims can lead not only to communication blockades in spontaneous conversational practice, but also to undesirable effects in the avoidance of linguistic forms regardless of their manifold functions in conversation. The fact that even in the case of so-called *suggestive questions* certain differences must be taken into account will be worked out below with the help of further anchor examples for teaching.

21.2.6 Suggestive questions

If the *logical* aspects of *action* could hardly be separated from the *psychological* aspects in the previous examples, their interaction is even stronger in the case of suggestive questions. The addressee of suggestive questions is supposed to accept insinuations or conclusions that are hardly open to question. If the suggestive compulsion of the ques-

tions is not simply accepted, the possible repair work proves to be more or less costly from both the *communication-economic* and *-psychological aspects.*

The suggestive information question

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

Box 21.6	Function and communicative means of the leading question

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

Koerfer et al. 1996: 115

Of course, a recognisably expected consent can always be refused as long as communication is maintained in principle. However, non-acceptance and rejection is associated with additional communicative effort, which may also cost *psychological* strength, because patients have to respond against the *expectation* expressed by a medical *authority.* The following example (E 21.15) from the final phase of an initial consultation, in which the doctor is probably already "pushing the pace", seems "harmless" at first, because the necessary "repairs" can be made without problems and integrated into the conversation.

E 21.15		"Appetite is normal for you?" - "no medication?"
01	D	hm ... appetite is normal for you? .
02	P	yo, it is normal .
03	D	nothing has changed there either? .
04	P	no, nothing has changed.
05	D	otherwise you do not take any medication? .
06	P	yes, I have to [name of drug X] uh have to/ [name of drug X] I already said, [name of drug Y) because of the too high cholesterol level .
07	D	yes ... (2) ... Well, then we'll just ... examine you now .

In this example, all three of the doctor's questions are asked as *suggestive questions in* a small conversation space, although only the first two questions are answered in the sense of the doctor's expectation. Because of the specific negation in the third suggestive question (05D: "otherwise you do not take *any* medication?"), the expectation on the part of the doctor to take medication must first be rejected on the part of the patient with an increased communication effort, namely by an expression commonly used in such cases of objection ("yes"), before the correction is then made by the corresponding factually correct answer.

The problem of suggestive questions arises not only with topics on which, at first glance, "purely" *biomedical* information is to be obtained, but also with *psychosocial* information questions about the patient's living conditions, which should likewise not be asked suggestively. Again, reference is made to the example where the doctor not only fails to include the topic of childlessness, which is regretted by the patient ("unfortunately") (E 21.16), but at the same time expresses his expectation of a "good marriage" by following up with the elliptical question ("marriage good?"), which also complicates the possible thematisation of other problems (than childlessness).

E 21.16		"Marriage good?"
01	D	are you married? .
02	P	yes .
03	D	Children? .
04	P	unfortunately no children .

05	D	hm . Marriage good? .
06	P	have been married for 20 years now (...)

In another case, the doctor already assumes that the patient is married when asking about marital status, which the doctor first has to correct and modify in an awkward way before further questions follow, some of which are suggestive and need to be corrected accordingly (E 21.17). All in all, the doctor's questions (elliptical) are asked briefly and succinctly as in a telegram (or more modern: as in a text message) and answered accordingly, so that there is hardly any room for independent development of topics.

E 21.17		"You're married?"
01	D	you are married? .
02	P	I am not married, I am divorced.
03	D	hm . for a while? .
04	P	I have been ... divorced ... for ... a year now.
05	D	because of the workload? .
06	P	no, it has grown apart like that.
07	D	hm . Children? .
08	P	none .
09	D	hm ... new partnership? .
10	P	yes . it's there ...
11	D	yes? . and ... that goes well, works? .
12	P	is good (...)

Before we formulate individual alternatives for the preceding examples as examples for teaching, it should be stated at this point: In cases where the doctor is dependent on the *authentic* information of the patient, because he himself as the questioner cannot de facto "know" whether, for example, the appetite or sleep or digestion of the interviewee is "normal" or whether a patient is (or is not) taking further medication or whether he is married and how, if applicable, the relationship is assessed from the patient's point of view, suggestive forms should continue to be frowned upon in the formulation of questions. Nevertheless, possible "exceptions to the rule" will also have to be discussed for teaching.

Risks and alternatives of the suggestive question

The correction work on the patient's side, which can prove to be quite time-consuming compared to a doctor's suggestive question, is not only a *communication-economic* problem, but also a *communication-psychological* problem, if the patient has to answer against the expectation expressed by the doctor with an assumed *authenticity.* Although in the previous example (E 21.15) the question about taking medication seems innocuous, misinformation and information deficits must be expected even on this topic.

If the doctor here obviously wants to close only *minimal* and, moreover, still *preformulated* answer spaces as soon as possible, even for the patient, he runs the risk with this kind of *relevance setting* of possibly only receiving information about "prescribed" medicines. A patient who, as in the example (E 21.15), in view of the pace and topic structure presented by the doctor, "gets confused" even when making the necessary correction and mixes up two (names of) medicines (06P), will hardly take the time for "unasked" information, for example about his occasional or regular self-medication for back pain or headaches, etc., especially if the doctor declares the conversation to be over immediately afterwards with the announcement of the examination.

Although in this example it can be assumed that "at the end of the day" "everything turned out all right", the doctor has hardly omitted a "communication error" in the confined space of the conversation, which could well have had "worse" consequences if the factual circumstances had been different. Thus, for teaching purposes, it can be *counterfactually assumed* that it would have been a patient with eating disorders who would have been asked the questions about eating behaviour as in this conversation. To put it dramatically: To ask an anorectic the question about eating behaviour in the same suggestive form ("Appetite is normal for you?") can have potentially fatal consequences. Such diseases are often misdiagnosed by the general practitioner because he or she fails to ask the right questions in the right form in good time.

Since patients with a specific clinical picture (*anorexia*, *bulimia*) have difficulties anyway in making their eating behaviour a topic on their own initiative, a sensitive conversation is needed, in which the topic should certainly not be "cleared up" in the form of a suggestive question, with which the expectation of normality of eating behaviour is already expressed by the doctor. In the worst case, the doctor's suggestive question (01D: "Your appetite is normal?") would simply be answered in

the affirmative by an eating disordered patient. In a favourable and authentic case, the patient would have to answer correctingly something like: "No, doctor, on the contrary, my appetite is anything but normal, because ...". However, to answer against the *expectation of normality* already expressed by a medical *authority* requires a *mental* feat of strength that patients with certain clinical pictures are often not able to muster.

If the introduction to a topic is not exactly made easier, it should not be made more difficult for the doctor by asking suggestive questions. Instead, suggestive information questions should generally be replaced by alternative forms of questioning, as can be well illustrated in the previous example (E 21.15) precisely because of its density of suggestive information questions.

Regardless of the time possibility of deepening this topic in teaching, the *better* alternatives should in any case be reflected upon with the students, formulated and possibly practised in a role play. As a result, a *constructed* or acted dialogue of the following type could be achieved, whereby here only the alternative doctor's statements are focussed on (E 21.18). Here, on the topic of eating behaviour, in addition to the "better" alternative of the decision question with verb-initial position (01': "Is your appetite normal?"), the "best" alternative of the open word question (01'': "How is your appetite?") is also included.

E 21.18		Alternative conversation (cf. E 21.15)	Comment
01	D	hm ... appetite is normal for you? .	Leading question
01'	D	hm ... Is your appetite normal?.	Decision question
01''	D	hm ... How is your appetite? .	Word question
01'	P	(...)	
03	D	nothing has changed there either? .	Leading question
03'	D	has anything changed?	Decision question
04	P	(...)	
05	D	otherwise you do not take any medication? .	Leading question
05'	D	Are you taking (any other) medication? .	Decision question
06	P	(...)	
07	D	yes ... (2) ... Well, then we'll just ... examine you now .	Call termination
07'	D	Do you take other medicines, regularly or only occasionally?	Alternative Continuation of the conversation

As must be emphasised again and again in teaching, there are hardly any patent remedies in medical conversation that always lead to the desired success. If patients cannot or do not want to do otherwise at first, all kinds of *denial* of illnesses are to be expected. For example, in the case of medication abuse, even the decision-making question ("Are you taking (further) medication?") must be expected to be answered in the negative, just as in the case of an eating disorder, the question about eating behaviour ("How is your appetite?") could be answered succinctly with "It's normal" if patients do not want to take advantage of the opportunity. An "open" word question on a decidedly psychosocial topic such as the "quality" of a partnership ("How is your marriage?" - "How are things in the new relationship?") can also lead to "monosyllabic" answers ("good") if patients do not (yet) want to engage in a larger topic development at this point in the conversation, even with appropriate follow-up questions. Certain "better" questioning techniques are no guarantee of success for a communication that is "open" in every respect, which would be determined exclusively by *authentic* answers. But it does make a considerable difference whether a possible response is *made easier* or *more difficult* by the doctor's questioning behaviour, because patients first have to *overcome the suggestive* communication hurdles set up by the doctor's authority.

Exceptions to the rule?

If in the case of the suggestive information question "as a rule" the better alternatives can be clearly formulated, the question still arises in which special cases "exceptions to the rule" can be considered. Thus, it can be discussed with the students to what extent so-called taboo questions (such as sleeping pills and painkillers, alcohol, drugs, sex, etc.) can be formulated *suggestively* after all, for which interesting variants and justifications can arise in the discussion.

A suggestive question such as "You (then) (certainly) take painkillers, yes?" towards a pain patient may facilitate the affirmative answer just as much as the question "What kind of painkillers do you (then) take?", which already *presupposes* as a matter of course *that* the patient also takes painkillers. Should a correction become necessary here, the patient could "easily clear up the mistake" without causing a "loss of face" for either interlocutor ("No, doctor, I don't take painkillers at all, I al-

ways try to get by like this"). Although a decision-making question such as "Do you help yourself with medication in severe relapses?" may serve the same purpose in a "neutral" way, the (open) thematisation (of problems) of a possible behaviour/issue etc. in such cases is at the same time always linked to expectations regarding the probable behaviour/issue. In this respect, completely risk-free questioning is an illusion, as already discussed with the *obscenity* of questioning in general (§ 21.2.2). But even from this point of view, there are gradual differences which, depending on content, form and function, must always be taken into account in the overall context of questions (Box 21.7), the fit of which must be proven vis-à-vis individual patients in developed conversations.

Box 21.7	Question type: "What problems do you have with/at ..."

However, this type of question cannot be applied to all possible topics and placed at any point in the discourse. Thus, the presuppositions made with questions of the type "What kind of problems do you have in marriage/at work/in bed/with alcohol/with drugs etc.?" *that* the patient has corresponding problems, can under certain circumstances be rightly rejected with indignation or even lead to hardening in the case of denial. It always depends on which expectations the doctor expresses to which patient in which situation on which topic at which stage of the discourse and in which form.

Koerfer et al. 1996: 116

Because of contextuality, conversational maxims on the choice of question forms must be used flexibly: If possible, those who do not want to engage in experiments with "risks" should stick to simple decision-making questions (such as: "Do you (then) take medication?"), provided the interest of the question allows this in the given context. Since expectations are always built up through the choice of certain contents in precisely these contexts, which are often implicitly transported with a long chain of motives ("Take medication because ..." - "To (have to) help oneself through medication so that ..."), the search for the absolutely "neutral" question could lead to a "content-less" dead end.

No matter in which form the questions are asked: As is generally known, they can make one "unpopular" as a questioner - especially in the medical consultation, whose intimacy requires a sensitive approach to the patient so that he or she does not experience the doctor as "over-

charging". In this sense, questions that are intended to contribute to the understanding of the other-psychic can often be perceived as more "invasive" than physical examinations and interventions. In this respect, it is also worthwhile in communicative action to use certain (under certain circumstances "minimally invasive") *filigree* "instruments" of conversational guidance, which take small differences into account in order to give the patient sufficient room for decision and response.

21.2.7 Words that make a difference

In communicative access to the patient, the choice of words also plays a role and can make a greater or lesser difference. It is not only the "meaningful" *content words*, as used in direct questions in empathic communication ("are you afraid and worried") (§ 20.7), but also the apparently "less meaningful" *function words*, which include the often so-called "filler words", which can nevertheless be significant for the further development of the conversation. In everyday life, for example, it makes a considerable difference whether one says: "Come here (please)" or: "You better come here", which is meant and understood as a threat.

In order to awaken sensitivity for the subtle differences in the choice of words in the consultation, we will first give an example. In a didactic and at the same time empirical study, the difference in the use of "something" and "anything" in questions was worked out, with which further concerns and issues of patients were to be made explicit ("elicited") in an advanced stage of the conversation. We will limit ourselves here to the summary by Robinson (2011) (Box 21.8), who in turn refers to the study conducted with his participation (Heritage et al. 2007).

Box 21.8 "Something" versus "anything

The question is: Can physicians be trained, within realistic parameters (e.g., one half-day or less), to employ specific interactional practices as identified by CA? Heritage, Robinson, Elliott et al. (2007) designed a study to reduce the frequency with which patients leave visits with unmet medical concerns, or concerns that patients intend/want to have addressed during visits but that do not get addressed. Through a five-minute training CD that physicians watched alone on their office computers prior to seeing patients, Heritage et al. achieved 75% success in training physicians to ask one of two specifically formatted questions

immediately after patients finished presenting their chief concern: (1) Is there anything else you want to address in the visit today?; or (2) Is there something else you want to address in the visit today? Compared to the control condition (in which physicians were not trained), the Some-question condition, which involves a linguistic preference for a Yes-type answer, significantly reduced the occurrence of unmet concerns (The Any-question condition, which involves a linguistic preference for a No-type answer, was not significantly different from the control condition.

Robinson 2011: 515

The rapid training successes achieved with little training effort are obviously astonishing. It is worth pointing out possibilities here with which patients can be encouraged to further elaborate their concerns and issues. For example, a conversation in which the patient initially presents his heart-related complaints and vehemently demands specific physical examinations takes a turn for the worse when, after about one minute, the GP asks him a specific transitional question ("How does it look otherwise?") with which he can "elicit" the emotional sensitivities of his patient.

E 25.19		"what else is it like, what else does it look like?"
23	D	yes ... let's do it .
24	P	ECG again ...
25	D	let's do another ECG, let's do another check .
26	P	and the blood times .
27	D	yes ... we'll take your blood pressure again.
28	P	no . also lose weight, let's say, also control .
29	D	yes . we can do it . yes .
30	P	yes .
31	D	what else is it like, what else does it look like? ...
32	P	yes . Doctor, I want to tell you honestly now . I have no more hope for my wife.

The example is still to be reconstructed in its entire conversational development, as it can be possible within the framework of basic psychosomatic care in the family doctor's practice, without creating special organisational and temporal structures for this (§ 25.6). While this example stands for an ad-hoc development towards a new quality of conversation, the following examples will focus on the continuous develop-

ments in the negotiation of meaning between doctor and patient. In the joint conversational work, questions of meaning arise again and again, the answers to which become part of the specific interpretative work of doctor and patient, in which it is also a matter of small differences made by the respective speaker and also understood by the respective listener as their reactions indicate.

For the initiation of meaning negotiation, the doctor often makes *offers of interpretation* that the patient can accept or reject. The offers of interpretation are often made explicitly in the form of questions ("Could it be that ...?"), but also in the form of speculations ("Maybe X also means Y"), in which the "question of meaning" is "unmistakable" for the patient, although it is not presented in the form of a direct question. Nevertheless, something is put up for discussion by the doctor here, which "demands" agreement according to the recognisable preference, but does not exclude rejection. To begin with, the following examples are compiled, which will be discussed in their nuances in the following for teaching, whereby the extended contexts with source references from the literature or chapters of this textbook will be added in each case. Here, at first, only a selection in short forms of interpretations or interpretations, whose commonalities and differences will be differentiated subsequently (§ 21.3) in the long version of the contexts.

- where I mean, it remains the same? I think you will also feel something (...) (Buchholz 2014: 234).
- yes, so that you always have the feeling that you're selling yourself short, right? .
- yes ... figuratively speaking, one could say (...) (Scarvaglieri 2013: 153)
- well, it seems that work really does affect your stomach, doesn't it? .
- not an easy life .
- that means you're in a real fix .
- yes, on a deeper level it means that the mother was not the father (...) (Peräkylä 2012: 377)
- (...) that has something to do with your early programming (...)

This spectrum from simple interpretations to complex interpretations already indicates the variants with which something can be "put up for disposition" as a *question of meaning* without having to ask directly. This "dual character" of medical or therapeutic action is to be discussed

below for teaching purposes in a further series of anchor examples in expanded contexts, which are about a detailed exploration of a special kind, with which the patient's emotions are again brought into focus. Aspects of *emphatic* communication (§ 20) are thus taken up again and deepened under the specific question of the forms in which doctors want to "bring" their interpretive perspective (as a possible "view of things") to their patients in order to ultimately also be able to "influence" them.

21.3 Meaning questions and interpretations

Morgan and Engel (1977) had previously formulated an *anti-manipulation maxim* ("The question must not influence the patient's answer") as a preamble to good interviewing (Box 21.1). Such an *anti-manipulation maxim* is to be followed above all in the detailed exploration of specific contexts, in which specific symptoms according to certain clinical clinical pictures must be clarified by questions, in which the doctor should not more or less "put the answers in the patient's mouth", as this was made clear in advance on the basis of specifically suggestive information questions (such as: "Appetite is normal for you?").

If the doctor wants to continue to rely on the patient's *authentic* information in the conversation, *suggestive questions* (such as: "Otherwise, you do not take any medication?") should always be avoided in order not to "influence" the answer in advance in the sense of Morgan and Engel.[4] In these cases of interview examples, in which it is primarily about collecting *authentic* information to complete the anamnesis (§ 21.6), the influencing should be minimised as much as possible, even if it was equally clear from the examples as a whole that the *steering function* of information questions is always already perceived through the selection of specific topics.

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4 The problem of suggestion was previously formulated even more sharply by Morgan, Engel (1977): "He [the doctor] must not, however, suggest or even impose his ideas on the patient (1977: 41) (cf. Box 17.16). Previously (§ 17.4), the problem had already been discussed in the relationship between *association* and *guidance,* for which the appropriate balance must be found conversationally, leaving the patient his or her individual autonomy.

The situation is different with medical interventions, which have already been defined as *interpretations* (§ 20.6-9). Their essential *guiding function is to stimulate* the patient to new processes of thinking and experiencing, which should ultimately contribute to a *change* in his or her illness or health behaviour. In doing so, the doctors or therapists often make their interpretations available more or less questioningly, so that in case of doubt they can be rejected or modified by the patients without major verbal and psychological communication effort. When doctors or therapists make *interpretive offers* to their patients, the *preference* for accepting the interpretation is usually recognisable: otherwise, they would not be made available in the way they are finally offered to the patient. The attempt to "influence" thinking and experience is "unmistakable" for patients - and this is, after all, the *constitutive* meaning and purpose of interpretations.

With interpretations, questions of meaning can be posed or assumed, or even their possible answer can be attempted. Since interpretations are always connected with the *authority* of the doctor or therapist, whose weight is always already in the balance, the *hypothetical* character of interpretations must be maintained. *Authority* and *apodictics* should not enter into an "unholy alliance". In the end, the patient should give his or her consent, which is quite *preferable* in interpretations, out of *conviction*. Compared to mere *persuasion*, which could be due to obedience to medical authority, the *rejection* of the interpretation would be the better alternative. Finally, persuasion would not be effective because it is not sustainable in the long run, which is often enough manifested in the *non-adherence of* patients. In the knowledge of possible doubts and reservations, interpretations are formulated as "negotiable" offers of meaning that first have to prove themselves in the long run in a joint interpretation work.

On the basis of further anchor examples, it will be worked out in several steps how interpretations and interpretations in concrete conversational contexts are shaped and placed in terms of content and form in order to lead to further elaborations in interpretative negotiation processes between the interlocutors.

21.3.1 Persuasion and hypothetical claim to validity

Anyone who offers his or her interlocutor an interpretation is trying to "influence" him or her to a greater or lesser extent. The attempt to *influence* should remain sufficiently *transparent* and the interpretations *negotiable,* so that in the end the interlocutor is less *persuaded* than *convinced.* This difference is only inadequately captured by the traditional term *persuasion*, since the term can convey both meanings (*conviction - coax*). In order to prevent misunderstandings, the *rationality (rational persuasion*) is often emphasized, with which the interlocutors must meet if the patient's *conviction is* to be achieved in the end (Bigi 2011, Rubinelli 2013). Since it is precisely in *interpretations* that the patient's *emotions* are "addressed" at the same time, however, one must also reckon with diverse defence processes on the part of the patient, which can make exclusively rational communication difficult. It is part of the art of conducting a medical consultation (§ 3, 17) to find the balancing act between *rational* and *empathic* communication, which can also consist of a change from a more *confrontational* to a more *tangential approach.*

Accordingly, interpretations cannot be arbitrarily placed and shaped in terms of form and content, but must be adapted to a *maturing process* in the conversation and, if necessary, readjusted several times before an interactive "*alignment*" *of* the patient's reactions to the doctor's interpretations is established (MacMartin 2008, Vehviläinen 2008, Peräkylä 2012). As will be shown by way of example, such interactive alignments can extend over long stretches of conversation or several conversations, especially in the case of *interpretations*, in which the interlocutors develop a shared *interactional history* of negotiating meaning (§ 20). Under certain circumstances, interpretations below the classical interpretation must be repeated several times or renewed, changed and extended "with other words" before they can be accepted by the patient. If the acceptance of an interpretation is also usually preferred and honoured, its rejections and modifications should also remain permissible - if they do not want to be subject to the suspicion of *persuasion* (in the negative sense of *coax*).

In advance, a broad concept of interpretation was used, which is still below the classical *psychoanalytic interpretation.*[5] Interpretations in the broader sense also include the specific psychotherapeutic actions with which specific cognitive and emotional processes are to be stimulated in the patient in the sense of so-called "*reflecting*", which are to lead to new thinking and feeling on the basis of the known "old". It is a defining characteristic of interpretations that they are meant by the doctor or therapist as *offers of interpretation* and are (supposed to be) understood as such by the patient. Accordingly, it is also a constitutive part of an "offer" that it can (and may) be rejected. Although interpretations can also be rejected completely, their claim is nevertheless "tendentious" in a certain way, because the patient's thinking and experiencing processes are ultimately to be "steered" in a certain direction.

Due to this *guiding function,* the scope for understanding and communication is definitely narrowed, because unrestricted open interpretations would be meaningless because they would be uninformative. They should sufficiently stimulate the patient's self-reflection without *apodictically* claiming a *truth.* However, they are not only aimed at understanding and comprehension, but also at acceptance: the offers of interpretation are meant seriously insofar as the doctor or therapist submits "suitable" offers of meaning for examination, which are to be subjected to an equally serious examination by patients in order to accept the interpretations - according to the preferred tendency - if possible, whereby the dispreferred alternative of rejection or modification is not to be excluded.

As with *empathic responding* and *addressing*, *naming* and *clarifying emotions*, which can be seen as interpretative precursors (§ 20.5-8), *interpreting* (§ 20.6.4, 20.9.5) also makes use of diverse forms of realisation, which can only be recorded here as examples for teaching purposes. Like their "preparers", interpretations often only pose implicit questions, whereby the claim to validity can be relativised by many linguistic

5 As in the previous section (§ 20.6-9), we use a broad concept of interpretation without being able to compare it with related terms (such as: *reflections, (re-)formulations, focussing, verbalisation of emotional experience=VEE, interpreting, etc.*) from psychotherapy research. Those interested in (terminological and conceptual) details are referred by way of example to: Streeck 1989, Ehlich 1990, Weingarten 1990, Dickson et al. 1991, Dickson 1997, Peräkylä et al. (eds.) 2008, Pawelczyk 2011, Scarvaglieri 2013, Grimmer 2014, Marciniak et al. 2016, Schedl et al. 2018, Läpple et al. 2021, Buck 2022, Gumz, Spranz-Fogasy 2022, Scarvaglieri, Graf, Spranz-Fogasy (eds.) 2022.

modifications in a predominantly *hypothetical* linguistic style (*believe, assume, (er)seem, maybe, somehow, a bit, actually, would, could,* etc.). Such means of communication, which can be compiled in an initially heterogeneous list of examples for teaching purposes,[6] have a similar function as in other (institutional) communication situations, such as in higher education, where, for good reasons, relativising language use in a *hypothetical* language style is also predominant.

Similarities and differences in dealing with the *claim to truth* in different institutional contexts (school, university, court, consultation hours, etc.) must be taken into account, which can only be referred to here with a *comparative* perspective (Koerfer 2013). For example, essential differences between a lecture or seminar on the one hand and a medical or psychotherapeutic consultation on the other are obvious: while in academic discourse the potential public is constitutive in intersubjective exchange, the patient enjoys the privilege of an intimate "dialogue" with the doctor (§ 9, 18). If in academic discourse personal experiences of the discussants can only enter the argumentation as exceptions, the individual experiences of the patient in the consultation are the original source of the joint conversation. While personal impositions should be more or less frowned upon in the academic context, they are unavoidable in the consultation, even if there the doctor must constantly readjust the limits of what is individually reasonable here and now in order to achieve a personal change in the patient (attitudes, behaviour, etc.) without overtaxing him.

Nevertheless, the claim to truth is also asserted to a greater or lesser extent in medical and therapeutic consultations. Precisely because interpretations are always subject to the proviso of their provisionality, they are themselves often *questioningly* put up for disposition, so that they are treated as specific "questions of meaning" in the joint conversation work between doctor and patient. This conversational work proceeds in circular processes of negotiating meaning, in which "dialogical screws without end" can arise (§ 7.2). Interpretations may not only represent answers to questions, but may raise these questions on their

6 In a first heterogeneous working list of relativising means of communication, the following expressions can be collected: "know", "believe", "assume", "(it) seems", "probably", "perhaps", "certainly", "somehow", "a bit", "merely", "actually", "would", "could", "should", etc. It remains to be seen whether the introduction of terms such as *modal verbs, modal particles*, etc. is useful for "sorting" the examples in medical teaching in addition to the commonly used distinctions (*indicative*, *subjunctive*).

own initiative, the answers to which are then attempted in the joint conversational work of doctor and patient, whereby in turn new questions may arise that challenge new answers in further conversational work, and so on. In this sense, interpretations are interrogative "preludes" to joint interpretative conversation work.

As in the previous section, the wide spectrum of variants of interpretations is to be illustrated by further empirical cases as an addition to the list of anchor examples, which would have to be discussed in more detail for the respective teaching purposes in the given conversational context. In this part of the list of examples, too, the transcripts are partly reproduced in a simplified form, deviating from the original sources. Again, for didactic reasons, we occasionally add the "better" or "worse" alternatives, which are then also specifically identified as "constructed" examples.

Since the examples come from both medical consultations and specific psychotherapy sessions, there are certain thematic differences, which, however, are of little importance under the comparative aspects of interpretation relevant here. In any case, there are fluid transitions between a GP and psychotherapeutic consultation hour in interview practice, for example in *basic psychosomatic care* (§ 15, 25). Overall, the "hypothetical quality of verbalisation" (Ehlich 1990: 219) remains even when an *interpretation* is claimed. Due to its propositional character, the claim to validity of *interpretations* in general and of *interpretations in particular* is considerably limited, which is manifested precisely in the manifold linguistic forms of "attenuation" or "understatement" that have been pointed out (Wrobel 1983, Ehlich 1990, Weingarten 1990, Bergmann 2013, Scarvaglieri 2013). In order to facilitate the conditions for the patient's consent, the corresponding hurdles are lowered to a greater or lesser extent, without the level of consent being completely levelled in terms of form or content.

21.3.2 Talking openly: The wording between litotes and hyperbole

In the negotiation of meaning, doctor and patient often move between interpretative extremes. In the process, both interlocutors also make certain differences in their *choice of words,* which are ultimately based on the difference between *self-interpretations* and *interpretations by others*. While patients should speak as "openly" as possible ("as they like it"), a doctor should exercise a certain "caution" in his choice of words

without losing his *authenticity*. Here, the maxim of conversation could be roughly formulated in advance: What patients are allowed to do in their self-attributions is by no means permitted for the professional interpreter in the attribution to others.

Thus, it is also the right of a suffering patient to dramatise his suffering and to use exaggeration (*hyperbole*), such as the patient's dramatic narration of her experience of night-time dizziness ("deadly bad") (E 21.19), for the complete reproduction of which we refer back to the detailed analysis of narration and conversation (§ 19.7).

E 21.19		"deadly bad"
01	D	this dizziness, did it start when you found out about this diagnosis [=daughter has MS]? .
02	P	yes, I think so . there was something in my head once at night, uh . I never told my husband, once at night in my head it was very strange in my head, deadly bad . I woke up . I think: "oh dear, oh dear, what's wrong now?". there was one time when I got really sick in bed at night . (...)

In the case of *empathic feedback* (§ 20.5), "strong words" from everyday language are quite appropriate, such as those chosen by the doctor following the childhood story of the patient who had been "unwanted" as a child (E 20.38: doctor: "that's ... hard for a child", "oh, but that's bad"). Such emphatic feedback, borrowed from everyday language, often serves, as in this case, as a "precursor" for interpretations or interpretations, which we will return to later under the aspect of interactive *alignment* (§ 21.3.4).

In another case, reproduced here in abbreviated form (E 21.20), in which the patient complained at length about her retirement life with her husband, the doctor, in the sense of the *designation* (§ 20.6), expressed the emotions with a *hyperbole* ("huge disappointment"), as was clear from the patient's modified adoption.

E 21.20		"a huge disappointment"
01	P	(...) because, as I said, when I'm a pensioner, we do so many things ... and it's just the opposite .
02	D	a huge disappointment .
03	P	yes . a real . real disappointment! I have to say, he's doing his

	garden . but . he's already doing everything, yes . but then there's always the drinking and then (...)

With *hyperboles* of this kind, emotions can be pointedly expressed in advance of interpretations. Nevertheless, the doctor should be cautious about "exaggerating" too much, especially when it comes to general life evaluations. Thus, the patient could fully agree with the doctor's (elliptical) view of her life so far (E 21.21: "not an easy life") when, following the doctor's choice of words, she immediately and also relativisingly replied: "no, it wasn't always so easy . that is right". It remains to be seen whether the patient would have agreed unreservedly in the same way if, instead of the "understatement" (*litotes*), the doctor had spoken, for example, of the "particularly difficult life", which, in view of the patient's entire biography, would have been "justifiable on the merits" if, in addition to "unemployment", the many other "burdens" were taken into account (§ 20.8). In order to promote sensitivity to the forms and contents in teaching, the spectrum of alternatives can be expanded in an extreme comparison (E 21.22), which, with the participation of the students, can lead to suggestions in a range from "not a particularly fun life" to "a (very) difficult life" to "a totally shitty life" or "a life full of agony", etc.

E 21.21		"not an easy life"
01	P	(...) I have been unemployed (...) since (...) .
02	D	not an easy life .
03	P	no, that wasn't always so easy . that is right

E 21.22		(Constructed) alternatives
01	D	not a particularly fun life
02	D	not a very easy life
03	D	a hard life
04	D	a very difficult life
05	D	a messed-up life
06	D	a totally shitty life
07	D	a life full of agony

According to the students' judgement, their own extreme suggestions (01, 05-07) are also rejected as "inappropriate", with a wide range of justifications ("too casual" - "too drastic", "humiliating"). While patients sometimes judge their lives very self-critically on their own initiative in their everyday language and tend to "exaggerate", a doctor should precisely not get "carried away" with such extreme "assessments", which does not mean that he or she cannot (citing) (and if necessary distancing himself or herself from) the assessments once introduced by patients. Thus, in an example from a psychotherapy, which we will come back to (§ 21.3.4), a common history of interaction with an established *wording* can be assumed when the therapist makes the absence of the patient's father a topic, who had not only been absent "because of work obligations" but also "because of boozing". In any case, dealing with the topic of alcohol in the consultation is a "delicate" problem (§ 21.6), which should certainly not be *trivialised* with a *diminutive* form ("a little glass" instead of "glass"), but also not in *vulgar language* ("How much do you drink/swallow a day?") when the conversation is still in the first exploration phase.

In general, the *wording* should be adapted to the previous course of the conversation, both according to the "objective" level of information and according to the state of the relationship between doctor and patient. Longer, trusting relationships in particular can tolerate a frank word ("straight talk"), which can then also be understood and received with humour. But even in well-developed relationships, it "must not be pushed too far". As explained above (§ 3, 17), the art of medical conversation consists in the balancing act between a *tangential* and *confrontational* style of conversation, whereby the "right balance" between extremely positive or negative alternatives must be found in the wide spectrum of "evaluations" (of this type). In doing so, one must free oneself from the idea of a "neutral" form of expression in every respect. In the preceding contexts of the examples, the general *steering function* of medical interventions is also always perceived through the specific choice of words, which could also have turned out differently in individual cases, as the examples constructed as alternatives to the empirical case (E 21.22: 01-07) suggest.

It is no coincidence that the real doctor in the empirical example used the rhetorical figure of the *litotes* ("no easy life") in the consultation, just as we all make use of it in everyday communication, in order to *acknowledge* the burden of our counterpart (§ 20.5), but without at the same time unnecessarily increasing the compromising risk through

personal "injury" with a confrontational sharpness.[7] At the same time, patients have a right to medical *authenticity* and *care*, which offers them protection from avoidable injuries. In this sense, a *careful* explanation should also be possible (§ 10, 16) without *truth* and *protection* having to contradict each other.

Existentially threatening facts should not be "trivialised" by "glossing over" (*euphemism*) if, for example, "dying" is replaced by "passing away" or "going home", although this may also be perceived as personally appropriate in confessionally oriented clinics. In any case, it must not be ruled out that a doctor speaks to the relative that the patient has "peacefully fallen asleep", etc. Here, too, sensitivity in teaching for the linguistic spectrum can occasionally be achieved by extreme typological comparisons ("falling asleep" - "perishing"). Here, if necessary, a litotes ("not just died easily") could also be appropriate, without standard recommendations being able to be given here independently of concrete situations and persons. If dealing with *death and dying* in a communicative way is a special challenge anyway (§ 38), the appropriate choice of words is not only difficult in interpretations where *questions of meaning* arise more acutely.

Not only in the case of "death and dying", but also in the case of "difficult" living conditions of patients and their "burdens", the interlocutors should be treated with respect without "underplaying" or "exaggerating" in the choice of words. Dramatisation in the direction of "catastrophisation" would be as inappropriate as it would be counterproductive if the

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7 Again, we refer to the detailed analyses of the rhetorical figure of the *litotes* by Bergmann (2013) based on psychiatric admission interviews. Bergmann discusses it following his description of the "fishing" technique and comes to the following critical comparison: "In the same way that the utterance format of "fishing" leaves the implicit question unformulated, the litotes also leaves unnamed what it wants to denote. Not only do psychiatrists avoid asking directly about something, they also avoid naming that "something" (2013: 183f). What the alternative ("better") conversational practice could or should look like in each case would certainly have to be subjected to a case-by-case examination (not only in teaching). Bergmann's critical overall assessment, which is summarised under the heading "Psychiatric Discretion: Uptight between Medicine and Morality", can again only be referred to here as a suggestion for teaching. As further literature on the "fishing" technique, exemplary references are made to the following works on doctor-patient communication or psychotherapy: Vehviläinen 2008, Pawelczyk 2011, Harvey, Koteyko 2013.

discussion of emotions is to remain a step towards self-enlightenment. Instead of questioningly inviting "open" communication, interpretations in which the wrong word is chosen at the wrong time can reinforce defensive processes. In other words, an empathetic conversation that also takes into account the sensitivities of patients in the choice of words does not make any "lazy" compromises with regard to the truthfulness and veracity of interpretations.

As we will see in a moment with further examples, a doctor can already "talk turkey" in a well-developed initial conversation with his patient if he draws a specific conclusion (E 21.23) directly after the dramatic narrative of the patient, who had made an unsatisfactory career choice after dropping out of his studies, which he puts up for disposition as an offer of interpretation in a questioning manner (with "right?" as a *tag question*).

E 21.23		"... actually selling themselves short, right?"
01	P	and do it more or less like that now, because I don't enjoy it either, unfortunately ...
02	D	yes, so that you always have the feeling that you are actually selling yourself short, right? .
03	P	that anyway . i would prefer to say (...) i would prefer to stop ... and (...)

The extent to which the doctor's offer of interpretation is a perfect match for the patient's emotional conflict situation can be seen not only in his affirmative reaction ("that anyway"), but also in his further *elaboration*, with which the patient begins to fantasise about a "retirement life" beyond his profession.

Before we return to this example under the specific aspect of how the subject of action of interpretations is presented in conversation, attention should be drawn to the risk inherent in the strong choice of words (E 21.23: 02D: "actually selling yourself short"). Under other "circumstances", this choice of words could also have meant an *insult* to the patient, especially if such a "feeling" were attributed to a person as a permanent feeling ("always"). The fact that the doctor here, as a family doctor, can already "stick his neck out" after a few minutes of an initial conversation is certainly a "good sign" of a trustingly developed communication that can already tolerate such a strong foreign interpretation as a personal imposition. It certainly requires more conversational experi-

ence to develop a *communicative competence* with which the *accuracy of fit* (§ 3, 17) of verbal interventions can be decided at all from case to case and from moment to moment.

21.3.3 Subject of action and negotiation of meaning

Before a professional helper behaves in an "inappropriately" *confrontational manner* ("like a bull in a china shop") towards the patient with his interpretations, a *tangential* style of conducting the conversation (§ 3, 17) should be preferred in case of doubt, which puts rather moderate interpretative offers at disposal. With all *relativising modifications,* the claim to validity of interpretations is certainly preserved, even or especially if the personal subject of action (the doctor) of interpretations is completely withdrawn, which can give them an "objective coating". Since in a dialogue it is clear anyway who is the "author" or "agent" of a speech contribution, certain "indirect" utterance formats with personal subject expression (1st pers. sg.) such as: "I would say" or "I wonder if/who/when ..." etc. are not the rule, but they are also used to simultaneously emphasise the "subjective" and "hypothetical" perspective of interpretations in a marked way. It makes a difference, for example, if a doctor chooses one of the following utterance formats, which are taken from the list of anchor examples: "whereby I therefore mean ..., I think ..." (E 21.24) - "One could say ..." (E 21.25) - "The work seems ..." (E 21.27). Despite all the differences in the content of these interpretations, a gradual "order" can be discerned according to which the subject of action apparently becomes increasingly "impersonal" and the claim to validity correspondingly more "objective", which could also be worked out in teaching with the following examples and suggestions for reflection.

The authority of the professional performer

Before we continue to pursue the comparative question of the different ways in which the subject of action of the medical or therapeutic interpreter with the hypothetical claim to validity of interpretations can present itself to the patient, the longer consideration that Buchholz (2014) directly follows the example sequence (E 21.24) will be reproduced here in abbreviated form.

E 21.24		"so I mean (...) I think ..."
01	T	hmhm+ - I think so? something has to happen that is so .
02	P	exactly,
03	T	so where I mean it's staying? uh I think that, you'll feel something too? It is in! you much stronger? something: not all right, than what you can make clear to the outside, already.
04	P	yes, it must be like that or else, (laughs slightly) i don't know what's going on, so what +what that is, has
05	T	hmhm+
06	P	it is a drive potential, that's how I would like to put it, yes?
07	T	yes hmhm+
08	P	and, I don't know from which, corner +that comes from

Buchholz 2014: 234

The conversation sequence comes from an initial psychoanalytic conversation that has already developed for half an hour before this exchange now takes place. In the conversation sequence it again becomes clear how "open" the therapist can be in his "choice of words" with his interlocutor (§ 21.3.2). In his conversation-analytical study, Buchholz draws a critical comparison with everyday communication directly after this conversation sequence (Box 21.9), in which such "strong authority" as exercised by the therapist would be considered "scandalous".

Box 21.9	Licence to exercise strong authority
Just imagine that in a conversation between two previously unknown people, one of them tells the other after about half an hour that he believes that something is much more wrong with his counterpart "than what you can make clear to the outside". That would be scandalous for an everyday conversation. This is a maximum deontic activity, the exercise of a strong authority, which in everyday life would immediately be questioned and could not be legitimised. Here, however, T has worked himself into such an authority through his conversational operations that he has, as it were, acquired the licence to exercise maximum deontic authority (...).	

Buchholz 2014: 234

Under the aspects of *authority* and *autonomy,* Buchholz analyses in detail how the therapist has gradually acquired the "licence" through his "conversational operations" without the patient losing his autonomy.[8] What would remain a "scandal" in everyday life becomes routine in psychotherapy, to which the therapist is anyway "accustomed" by profession and into which patients can be "socialised" relatively easily (Koerfer, Neumann 1982). Thus, both interlocutors can perform their interaction roles in their own way, but they must always earn and serve the privileges and obligations mutually associated with them anew. To put the possible risk of therapists in Buchholz's words, the "licence to exercise authority" can, after all, also be withdrawn again if the interpretations do not "prove" themselves sufficiently from the patient's point of view - for whatever reason.

Thus, interpretations can be rejected not only because of their "indigestible" content, but also because of their "apodictic" form, but also because of a "misplacement" in the conversation, which may not yet be sufficiently mature for such *impositions,* as they are *per se* associated with interpretations. To use Buchholz's words again: Even in advanced psychotherapies, "scandals" can still occur.

As has already been made clear (§ 20) and will be the subject of repeated discussion below, interpretations or even interpretations usually require longer *stories of interaction* in which they are pre- and post-processed. In these stories of interaction, too, the professional interpreter can gain or lose *authority* with his interpretations, which depends not least on the way the interpretations are presented in language. Here, attention should be drawn comparatively to *small differences* that already manifest themselves in the selection of a few examples in which the *hypothetical* claim to validity of interpretations or interpretations is raised in different ways.

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8 Reference can only be made here to the detailed conversation-analytical investigations carried out by Buchholz (2014) under aspects of *authority* and *autonomy* as a suggestion for teaching, as well as to the underlying distinction between *deontic* and *epistemic* authority, which would probably be too strict as a dichotomy. Rather, in complex, polyfunctional speech acts such as interpreting, different (epistemic *and* deontic) aspects and modalities would have to be taken into account, which also interact in authorisation (knowing, believing, doubting; asserting, denying, questioning, answering, instructing, proposing, appealing; rights, self-obligations and obligations to others, etc.).

Interpretation offers and patient elaborations

Interpretive offers can be presented in different ways and patients can react differently. In the previous example (E 21.24), the therapist uses the subject expression (1st pers. sg.) (*I*) three times and combines it three times with a *doxastic* expression (*mean, believe),* with which the claim to truth is formulated more weakly here than, for example, with an *epistemic* expression (such as: *know*). Due to the many question marks, the question character of the interpretation is probably also manifested in the intonation.[9] What is questioningly put up for disposition here with a weak claim to validity can be formally accepted by the patient with a certain ambivalence (*slightly laughing*), without him having to or wanting to be committed to the content (with his twice emphasised *non-knowledge*) (P04, P09). His formulations are also *provisional* elaborations, which are still *tentatively* formulated as an interactive counterpart, just like the therapist's own offers of interpretation (P06: "that's how I would like to put it, yes?"). The interactive *alignment*, which we will come back to in a moment with other examples (§ 21.3.4), is still in a *tentative* stage of development, in which both interlocutors still formulate very *hypothetically.*

While in the previous example the subject of action of the interpretation was still realised in *first person*, in the following example, which is taken from Scarvaglieri's (2013: 152) study on *Communicating in Psychotherapy* [„Sprachliches Handeln in der Psychotherapie“], it initially recedes behind the anonymity of an anonymous speaker (E 21.25, TH: "one could say").

E 21.25	"you could say ..."
01 PA	(...) then there's something there. Then you did something.
02 TH	.. Yes ... In a figurative sense one could say: ((1,9s)) You need

9 We can only marginally address the (sometimes very detailed) questions in research as to whether certain (types of) utterances are still questions at all and what role verb position and intonation play in this context, and otherwise refer again to the literature already noted above. The methodological problems often begin with the punctuation in the transcription work, in which it must be decided what the unit should be, which is marked, for example, by punctuation and lower/capitalisation, and whether a question mark should be placed in the case in question (or not).

	((3s)) the others in order to ... find yourself . somewhat bearable (...)

Scarvaglieri 2013: 154

In particular, the use of the model verb "can" (here in subjunctive II: "could") leaves the listener, for his part, greater room for interpretation, which he can use on his own initiative for possible integration into his listening knowledge. After a complex analysis of this mental process, the therapist's overall utterance (E 21.25) is described by Scarvaglieri (2013) as "suggestive interpreting", which is apparently to be understood as a specific subtype of interpreting in general. Since the longer chain of interpretative therapist utterances, in which there is also an explanation in the *first person* ("by transferring I mean ..."), is initially accompanied only by sparse listener feedback, the first longer verbal reaction of the patient (even after a longer pause) can no longer be directly assigned to a specific previous utterance of the therapist. Thus, the patient's reaction cannot be added here in our collection of examples, but must be referred to the context of the longer transcript (2013: 153-156).

In order to understand the following two examples, it should be remembered that they are not taken from psychotherapy, but from a GP's practice. Although it is an initial interview, after a few minutes a relationship of such trust has developed that the doctor can take the risk of "open" communication (§ 20.3.2) in which he makes the patient's *self-esteem* the subject of discussion in a way that - to speak again with Buchholz - could be described as "scandalous" if it had been practised in other everyday or GP circumstances in less developed contexts.

In the conversation analysed in detail with the patient, who had been suffering from stomach pains since dropping out of his studies, the doctor reacted spontaneously with a consecutive connection after the end of the dramatic patient narrative, which had ended with an expression of regret ("unfortunately") (E 21.26: "yes, so that you also always have the feeling . to actually sell yourself short, right?"). This utterance, which is carried out in the sense of a *joint sentence production*, can (still) be understood as a question, especially because of the "consent-demanding" *tag question* („right?“) described above.

E 21.26		"so that you also always have the feeling ..."
01	P	and do it more or less like that now, because I don't enjoy it either, unfortunately ...

02	D	so that you always have the feeling that you are actually selling yourself short, right? .
03	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 that way . i would prefer to stop ... and maybe start studying again, just as a hobby, somehow (...).

The doctor presents his statement as an "objectifiable" "conclusion" in a *vicarious* way, as if it could have been drawn by the patient as a *subject of action* himself, in such a way that one only needs to exchange two words (marked here) and change the verb form: 'so that *I* also always have the feeling that *I am* actually selling *myself short*, right?' Through such *test procedures* of substitution and minimal modifications, the *vicarious* function of interpretations can be detected, with which the attribution of others is transformed into self-attribution. The fact that the doctor fully meets the patient's emotional situation with a high degree of *accuracy* in his interpretation can be seen from the patient's reaction, with which he not only gives a strong agreement ("that anyway"), but also (as a *surplus)* (§ 21.2.4) takes the opportunity to further *elaborate* his affective conflict situation and its possible conflict resolution (P: "that anyway . I would prefer to say ..."). This reaction of the patient already represents an anticipation of the later decision-making process (§ 19.8) of the patient, who is sufficiently stimulated here by the doctor's interpretation to reflect on his personal conditions beyond work by giving free rein to his fantasies (e.g. "hobbies").

Both interlocutors can then build on the previous joint conversation work when the doctor, after a short digression about the marriage and the wife's profession, without further ado draws an interpretative interim summary of the previous conversation with another intervention (E 21.27: "Well, but work really seems to be hitting you hard, wa?"). As before, the doctor's statement can (still) be understood as a question, especially because of the *tag question* ("wa?") that follows it, whereby the doctor's expected and preferred reaction is abundantly clear.

E 21.27		"well, but work really seems..."
01	D	well, but work really seems to be hitting you hard, wa? [=doesn't it?] .
02	P	[breathes audibly] yes . somewhere this sss feeling [smiles] of not being really needed, I find .

03	D	hm .
04	P	that bothers me so much . (...)

In this utterance, too, the doctor recedes completely as a *personal subject of action* when he adopts an "objectifying" perspective with the metaphor of his interpretive offer ("hitting you hard"), which is, however, still formulated "hypothetically" ("... seems ..."). Nevertheless, the doctor can sufficiently stimulate the patient with his "presumed knowledge" expressed "indirectly" in this way, which he does not explicitly ascribe to himself (e.g.: "I suppose that ..."), who can use the obviously fitting doctor's intervention as an invitation again for further *self-exploration* (as a *surplus*), which is then further deepened by both partners in the subsequent course of the conversation (§ 19.8).

In both of these and other examples from this consultation, the high degree of fit of the doctor's interventions, with which the patient is stimulated to further elaboration, becomes clear. The patient can accept the interpretations in a way that represents an immediate interactive *alignment* with the doctor's interpretive offers.

There are particularly successful conversations in which an unbroken chain of interpretations and elaborations by the doctor is formed by the patient in a direct dialogue sequence, so that the negotiation of meaning appears "as if from a single mould", which is characterised by a high degree of thematic and interactive continuity and congruence between doctor and patient. The two interlocutors harmonise right away and in the long run develop the necessary *understanding*, *comprehension* and finally *agreement* to be able to move on to practical actions.

Although the favourable conditions for such an "ideal" development of conversation can certainly be demonstrated in quantitative and qualitative evaluations (§ 40), there is no guarantee of success. Sometimes "difficult" doctors meet "difficult" patients (§ 34) who together have to deal with "difficult" issues (§ 21.6) for which there are no patent remedies.

It is no coincidence that psychotherapies often have to take long paths, detours or wrong turns before the first successes are achieved. In contrast to the work of interpretation by doctors, the repeated work of interpretation and resistance must engage in longer processes of working through (Wöller, Kruse 2010: 283ff). The fact that the acceptance and elaboration of an interpretation is not a matter of course is immediately made clear by an example of a psychoanalytic *interpretation* (§

20.3.4), which, as is well known, has a more difficult time being *understood* and *accepted* "right away" anyway.

Standard formulas of dialogue linkage

First of all, attention should be drawn to the special nature of *routine formulas in* dialogical linking, as they are commonplace in all *helping* professions (but also elsewhere in life). There are a number of *standard formulas* for dialogical linking, which often function as introductions to speeches, which are interpretations and have the following basic structures:

- X is Y
- X means Y
- X and Y (are related; have to do with each other, etc.)
- X yes, but (nevertheless) (also) Y
  etc.

Step-by-step empirical examples for the first three standard formulas are given below. For the *yes-but linkage*, which is an everyday routine formula (Koerfer 1979), we refer back to the example sequence in which doctor and patient first have to "awkwardly" negotiate the topic of the *mother-child relationship* before it comes to the later interpretation offer of the doctor and the patient collaboration, to which we will return again (§ 21.3.4).[10] Since we cannot cover the entire spectrum of variants of interpretation offers with examples here, but can at best illustrate them, we will first mention some variants with constructed examples in which the standard formulas can be "embedded" in interpretation offers with a hypothetical claim to validity. Leaving aside complex variants

10 The *affirmative-adversative* double function of *yes-but* constructions in the opening position of speech contributions allows all-round use at almost every point in the conversation: "Despite a possible change of topic, speech contributions introduced with *yes but* formally establish a connection to the respective preceding contributions and can at least suggest adherence to the maxim of relation or relevance" (Koerfer 1979: 26). In medical and therapeutic communication, too, there can be an accumulation of *yes-but constructions*, which can be analysed as an indicator of "turbulence" in the conversation, in which the "contentious issue" has yet to be clarified between the interlocutors, whereby they often also threaten to lose the "common thread".

(such as *negations*), the following (constructed) combinations can be given:

- I believe/suspect that X could (after all) (also) mean Y.
- Maybe X and Y are connected, right?
- Can it be that X and Y have something to do with each other?
- X possibly means Y.
- X seems to be Y (to effect etc.)
- X might mean Y, yes?
- You could also say that X comes about precisely because of Y, couldn't you?
  etc.

For dialogue linkage, the "*that-means"* formula is a particularly proven routine formula with which interpretation offers are preferably introduced in order to initiate further negotiation processes. As in the previous case (E 21.27), which was realised without this introductory formula, offers of interpretation are often presented as a *substitutional* and at the same time *objectifying conclusion.* This conclusion can be formally negated in principle like a decision question, although its preferred affirmation is "unmistakable", especially if it should still be reinforced by a *tag question* (*isn't it?, right?, eh?, no?, OK?, yes?* etc.).[11] In the following example (E 21.28), the precondition-consequence relationship is directly established by the transitional formula ("that is"), whose special quality consists in the *translation function* between the old and the new. In the preceding conversation, the patient oscillated several times be-

11 The traditional distinction between *interrogative* and *declarative* (sentence) forms often seems obsolete (because often sophistical), at least in medical teaching. The fact that speech acts realised in whatever form, such as assertions, assumptions, predictions, but also objections with and without "consent-seeking" *tag questions* (isn't it?, right?, eh?, no?, OK?, yes?) etc., can result in both affirmations/agreements and negations/rejections/ modifications in the same way as questions, can be conveyed in medical teaching without introducing complex terms such as "declarative questions". In addition, it should be noted again that even linguistically trained transcribers often have problems with the formation of units and with punctuation when they have to decide in disputed cases (among all the known information from image and sound) whether a question mark should be placed (or not). Overall, one can easily follow Bodenheimer's (2011: 136ff) observations and descriptions of *saying and asking*: "So ..., soso, tell me: The asking comes in as a saying" and "Right? [Nicht wahr?] - Isn't it? [Gell?] - The saying goes out as a questioning".

tween continuing and breaking off her partnership, while currently also reflecting on the "burdens" resulting from the possible separation.

E 21.28		"that means you are ..."
01	P	(...) if I were sitting there alone, now with a child, and um . well, I can already imagine in advance what it would look like, yes . the work would totally go over my head . um .
02	D	that means you're in a real fix .
03	P	you bet! . you bet! . (...)

As before with the concept of "tension", which was also introduced with a *"that means" formula* (§ 20.6.4) (E 20.23), the doctor now helps with the concept of a "fix" on a more abstract level in the verbalisation of the patient's conflict situation by providing the *thematic key symbols*, which then serve as "cues" for the continuation of the joint conversation work. The fact that the doctor is able to accurately capture the cognitive and emotional ambivalence of the patient's conflict situation, who is unable to assess the consequences of separating from her partner, becomes clear once again from the patient's strong agreement (04P: "you bet! . you bet!") and her further elaboration, which the doctor can also "chalk up" as positive feedback for his interpretive offer.

21.3.4 Interactive alignment

The interpretations are on a different level in terms of content, where the therapist often uses a similar *standard formula for* the introduction which, like the preceding prototype ("that means that ..."), is suitable in its "all-round function" as a *routine formula for* linking dialogue. The following example (E 21.29) is also intended to show the problem of *aligning* the patient's reaction with the therapist's or doctor's interpretation. In this example, the standard formula ("X means Y") is explicitly linked to a "deeper level" of meaning, as is typically claimed for interpretations. Although knowledge of the entire history of interaction would be advantageous for a better understanding, the phenomenon of alignment can also be well understood in this short excerpt, which is what matters most. In this example, too, the original transcript is reproduced here in a slightly simplified form to improve readability.

E 21.29		"on a deeper level, it means that ..."
16	D	Yes, (4.2) hh on a deeper level it means that (0.6) mpf that the mother (2.0) ↑wasn't the father .(2.2) mt (3.7) So the absence of the father was felt .hhh a:n:d um::, (1.8) certainly also when the father (0.3) was away because of work commitments, or because of drinking (...) (...) [omission approx. 2 pages].
67	P	Yes:: (.) It's true (.) of course, =it's the father who should have been there at the track.

Peräkylä 2012: 377-379

As Peräkylä (2012) reconstructs in his detailed conversation-analytical studies, because the patient initially reacts silently to sparingly, the therapist has to elaborate further with longer explanations of his interpretation before the patient can finally gain and formulate the corresponding insight (67P: "Yes, it's true (.) of course, it's the father who should have been there at the track"). This delayed insight of the patient is finally paraphrased by Peräkylä under the aspect of "*alignment*" (Box. 21.10), as it has become established in psychotherapy research.[12]

Box 21.10 *Alignment* of the elaboration (P) with the interpretation (A)

By taking up the analyst's contribution, the patient shows that he has understood what the analyst is about. He adopts the perspective that the analyst proposes on the events of his childhood. Whereas before the analyst's intervention his narrative focused on his dissatisfaction with his mother, now with the elaboration of the interpretation he focuses on his father's negligence. He shows that he agrees with the analyst and has even gained a new insight through the interpretation. His introduction "it's true (.) of course it's true" and the sentence structure marked in the Finnish original as well as

12 Not only because of the peculiarities of the translation from Finnish, which is carried along in the German version (2012), translated here into English, reference should be made to the detailed transcript analyses in context, in which Peräkylä (2012) reconstructs the mean history of interaction between patient and analyst over several therapy sessions.

> the emphasis on the word "father" (...) give the contribution the meaning of an insight, one: "'now I've understood, it's just as you told me'". The patient designs his elaboration in such a way that it makes *alignment*, i.e. the alignment with the analyst's perspective and his interpretation, recognisable.
>
> Peräkylä 2012: 389

Peräkylä reconstructs the fact that the alignment with the perspective of the original interpretation is not completely successful even in this case (*misalignment*) by means of the long joint *histories of interaction* between patient and analyst. This example is not the only one that makes it clear that patients do not follow the first best interpretation before they are ready to switch to the interpretative focus, which often has to be corrected and modified in painstaking "detail work". These often lengthy processes of negotiating meaning are not, however, a specific "phenomenon" of psychotherapies that are longer per se, but are also common in medical consultations, provided that a psychosomatic approach or *basic psychosomatic care* is practised there (§ 15, 25). The processes of negotiating meaning have already been highlighted as relevant in the preceding conversation analyses on *narrative* and *emphatic* communication, whereby it should not be a matter of definitional differences between *interpretations* and *meanings,* where fluid transitions should be assumed anyway.[13]

The patient's elaboration following the doctor's longer "interpretation", whose *history of interaction* we had already analysed in detail under aspects of *association* and *cooperation* (§ 20.9) (Koerfer, Köhle 2007, Köhle, Koerfer 2017), can be seen as a final "prime example" (*best practice) (*§ 13) of an "ad hoc" successful *orientation* already in an initial interview. With the interpretation that began on a very abstract level (E 21.30: "... this has something to do with your early programming ..."), but which already vividly links to the patient's professional image and "his language" with the image of "programming", the doctor can obviously "address" the patient on a very concrete level that corresponds to his dramatic early childhood experience ("not been wanted as a child").

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13 This is in no way intended to level out essential differences, as they are rightly claimed in psychotherapy research. According to this, specific interpretations such as the *transference interpretation* in the medical consultation will remain the exception. We can only refer here to the relevant literature: Thomä, Kächele (1989), Flader, Grodzicki (1982), Ehlich (1990), Wöller, Kruse (eds.) (2018), Remmers 2023.

E 21.30		"this has something to do with ..."
01	D	so, if you've done programming, yes ... hm? . then you actually have a good understanding for it . because with you it has something to do with your early programming ... the way you grew up with not being wanted and so on . you didn't notice it until your mother mentioned it or somehow it came out of the (unintelligible) . of course you still feel it as a child, yes . and ... ehm .
02	P	maybe you even feel it as an infant, because my mother always claimed that she had never seen a child that cried as much as I did as an infant . maybe it was the mother's fault, who unconsciously, when she only gives the breast . (D: yes) ... that is transmitted to the child ... I don't know how to express it. (...)
03	D	yes . you express that wonderfully (...)

Apparently, the patient can concretise the doctor's "interpretation" without "ifs and buts" in the chosen direction of interpretation. His further *elaboration* on early childhood experience extends the doctor's interpretation in the direction of the presumed ("maybe") experience in the non-verbal mode ("feels") already in infancy (P02). It is obvious that the doctor also honours this kind of *adoption* of his interpretation by the patient's elaboration accordingly, at least confirms it full of praise on his part (03D: "You express that wonderfully ..."). The fact that the *alignment* had to wait a long time before it could be painstakingly initiated, because the patient had initially been defensive about the subject of the mother-child relationship in the first place (§ 20.9), makes it clear once again that in the case of interpretations, only what has previously been "sown" can be "reaped".

21.3.5 Interaction stories: Suggestion versus Persuasion

Discrepancies between interpretations and initial reactions of patients in *alignment* are certainly not isolated cases. Rather, not only in psychotherapy, but also in medical consultations, a *deviating alignment* in the patient's elaboration as a reaction to interpretations must often be expected. Medical/therapeutic interventions are rarely effective in their first formulation, but have to be constantly *readjusted* in the further *interaction histories* (§ 20.7-9) between patients and their doctors.

In the reconstruction of interaction histories of interpretations or interpretations, a rough distinction can be made between three types of conversational developments. In the *negative* case, interpretations can suffer a permanent failure if they are finally rejected by the patient despite further conversation work with manifold corrections and modifications. In the *ideal case,* the interpretations are accepted by the patient "right away" and elaborated further. In *problematic cases,* they may finally become successful after a longer process of negotiation between the interlocutors. If one wants to put it this way first for the simple *ideal case, in* which the adoption of the interpretation by the patient occurs spontaneously with an elaboration: the patient has not been able to escape the "pull" of the interpretation. In the positive sense of *persuasion* described above, the patient has allowed himself to be *convinced.*

Although the comparison of the medical conversation with other institutional types of conversation (in school, university, parliament, etc.) is only possible to a certain extent (Koerfer 2013), with this reservation an analogy could be formed between *arguments* and *interpretations,* which would ultimately have to stand up equally to rational scrutiny: the patient's *conviction, which* makes him adopt and elaborate an interpretation, would then come about according to the "peculiarly unconstrained compulsion of the better argument" (in the sense of Habermas 1981, vol.1: 52), as is customary for *rational* communication (§ 7, 10). The fact that doctor-patient communication, which is determined by affective, often existentially threatening issues, should ultimately also be characterised by *rationality*, had already been discussed in the communication and relationship models for medical *decision-making* (§ 10.6). Just as medical educational conversations (in the narrow sense) should be conducted in harmony with *empathic* and *rational* communication, so too should psychotherapeutic-oriented conversations for the *(self-) education of the* patient.

This also applies to the *problem* of lengthy negotiation processes in the follow-up and further processing of interventions, which can become even more difficult the longer the patient's consent and corresponding elaboration fail to materialise due to a lack of conviction. In these negotiation processes, however, the risk must be taken into account that patients, despite the interim "resistance", may then "surprisingly" still "agree", which in turn may turn out to be a *pseudo-consensus* in retrospect.

This danger has already been described for medical decision-making as "*confused consent*" (§ 10.7). Doctors can also "talk their patients diz-

zy" until they finally make an expected decision under increased pressure to talk, with which they follow the doctor's presumed preferences. This kind of resignation may have many reasons, ranging from the patient's (self-)insecurity to dependence on the doctor's authority, combined with the fear of sanctions and fear of loss in the event that the doctor could "terminate" the relationship, i.e. also stop providing concrete help. The patient might then have given consent "out of fear", which "when seen in the light" would turn out to be "irrational".

Even in such problematic cases, it is part of the art of conducting a medical conversation (§ 17) to "keep a cool head" in a "confusing" web of cognitions and emotions and to put the patient's "unexpected" consent once again to a communicative test with dialogical feedback loops in which doctors assure themselves of authenticity in the declared consensus. In the critical self-observation of a *meta-physician*, as described in advance by von Uexküll, Wesiack (1991) (§ 3.1), the transitions from *persuasion* to *suggestion,* which flow anyway in the practice of conversation, may come into view, which in their effect make the difference between "convincing" and "persuading" the patient.

This brings us back to the *anti-manipulation maxim* established earlier (§ 21.2) with Morgen and Engel. With all the differences, the preceding cases also made clear the extent to which doctors seek to "influence" their patients through the choice of forms, contents and functions of interpretative offers, in which the question character has "faded", in order to set in motion new processes of reflection that can be conducive to the patient's informative, narrative or emotive self-exploration. The attempt to "influence" the interlocutor is a commonplace procedure that also serves its specific purpose in the consultation. The extent to which interpretive offers can violate the transparency requirement (§ 7, 10), because on closer examination they turn out to be part of a *strategic* communication, is always also a question of empirical individual case analysis.

As was explained in the preceding section on the *method of conversation analysis* (§ 2, 7, 9, 17), it is seldom a singular intervention that is decisive, but as a rule the sum of dominant conversation techniques that make the difference between *interrogation* and *narration* or *persuasion* and *suggestion.*

Certain forms, contents and functions of medical "questions" are not "manipulative" per se, but they become so in certain combinations in certain contexts, for example when patients cannot escape the pressure to conform to a suggestive information question about their (risky) life-

style habits (exercise, sleeping, eating, smoking, etc.) because they do not dare to contradict the *expectation of normality* expressed by a medical authority. To avoid this risk, certain types of *suggestive questions* should be *frowned upon* as a matter of principle, as demonstrated by previous examples (§ 21.2.6). Otherwise, patients should be open to the "casual compulsion" of a "good" interpretation and, if necessary, be *persuaded* by the doctor.

21.4 Questioning the complaint dimensions

As has been repeatedly emphasised in advance for teaching, the forms, functions and contents of doctors' questions are to be considered in the context of developed conversations. If we now turn in detail to the exploration of details through medical questions and enquiries with specific contents, we are still dealing with a wide range of topics.

The doctor must not only clarify the *onset* and *course* of a banal cold, but also a patient's shortness of breath as a possible *symptom of* coronary heart disease. Furthermore, the patient's anxiety can also be explored as a psychological *symptom accompanying* a disease (such as CHD), but also as an *underlying disease* (§ 31). In both cases, the *intensity of the anxiety* as well as the extent of the *impairment* in the patient's daily life are important.

All in all, in all these cases a *clinical-communicative double competence* of the doctor is required who, for diagnostic purposes, must already ask the right questions on the relevant topics at the right time during the taking of the medical history, depending on his (specialist) specific knowledge of certain clinical pictures. Due to his clinical-communicative double competence, the doctor will already recognise possible profiles to certain clinical pictures in the sense of a tentative diagnosis at the beginning of the detailed exploration, which can be ruled out or confirmed in the sense of a verification during the anamnesis collection by differentiated further questions in various *complaint dimensions.*

In the following, further anchor examples are to be compiled for teaching, which can be arranged according to *complaint dimensions* that guide the conduct of the conversation, whereby this "order" is not to be implemented linearly, but should be *flexibly* adapted according to the course of the conversation.

21.4.1 Clinical-communicative double competence

When taking an anamnesis, the doctor must have a *clinical-communical double competence*, which can be developed in a specific way. For example, it is part of the professional competence of a cardiologist, gastroenterologist, urologist or orthopaedic surgeon to be able to ask his patients the "right" questions in the "right" way at the "right" time and to interpret the patient's answers "correctly". Here, for example, differential diagnostic knowledge competences and communicative (questioning) competences of the doctor go "hand in hand" when he asks about the quality or intensity of pain or the accompanying signs, i.e. explores exactly those details that have to be asked in a way that fits the clinical picture in order to be able to make the "right" diagnosis as a "good" doctor and to communicate this to the patient.

The doctor must therefore have a clinical-communicative double competence, because one competence cannot be used adequately without the other (§ 3, 17). The specific clinical pictures must be known to the doctor qua professional knowledge (*nosology*) in order to be able to develop them communicatively in the concrete case (*anamnesis*). Only in the interaction of clinical and communicative competence, the patient's suffering and illness can be adequately understood and treated.

Since this interplay of clinical and communicative competence concerns us throughout this textbook, a few illustrations from clinical practice will suffice here, given to us by the classics of the "clinical approach to the patient" (Morgan, Engel 1969/77) (Box 21.11), which is also explained by them as a communicative approach (§ 1). The illustrations refer to the fit of the necessary information questions, which, according to Morgan and Engel, always already presuppose knowledge of the clinical disease patterns.

Box 21.11 Knowledge of clinical disease patterns and questioning skills

Knowledge of the clinical clinical pictures allows the doctor to ask specific questions. For example, he knows that the pain in angina pectoris occurs when walking and stops within a few minutes when resting, or that vertigo and nausea in labyrinthitis can be triggered by slight head movements. However, the wording of the questions must not influence the answers. Thus, when angina is suspected, he asks, "What is the effect of walking, sitting still or sitting down?" or when examining vertigo, "What

happens when you move your head?" "How much do you have to move until you feel the symptoms" (...) Knowing the clinical pictures of the disease allows him to search for symptoms that the patient does not mention. If, for example, diabetes is suspected, he asks the patient about polyuria and polydipsia, if he suspects that a certain pain is due to conversion, he searches for further symptoms of conversion, such as globus, hyperventilation or episodes of paralysis or anaesthesia.

Morgan, Engel 1977: 47f

Beyond the interaction of clinical knowledge and communicative action, a maxim is once again conveyed to us here from the point of view of experienced clinicians about forms of questioning in information questions, which should by no means be asked in a suggestive manner. The problem of *suggestive* forms of questioning has already been discussed in detail (§ 21.2.6), so that we will only return to this if further examples of problems arise. For the moment, it is only necessary to reiterate the above recommendation by Morgan and Engel: "The wording of the questions, however, must not influence the answers" (Box 21.11). This once again emphasises the *hypermaxime* that "unbiased", "free" or "authentic" patient information should be obtained in the anamnesis interview, i.e. that the answers should not be "put into the mouth" when clarifying questions about the "subjective" descriptions of complaints and symptoms. [14]

Under this prerequisite, the following is primarily about the topic structure of the doctor's questioning, which is oriented towards clinical interests and experiences for detailed exploration. Here we can again benefit from the "classics" when it comes to structuring the patients' descriptions of their complaints. The *seven dimensions* distinguished by Morgan and Engel (1977), which are also differentiated with variants in other textbooks (e.g. Adler, Hemmeler 1989, Fortin et al. 2012, Cole, Bird 2014), are also the basis of the 4th step of our manual (§ 21.1). Before the dimensions are explained in detail by means of anchor examples, they will be reproduced here in advance in an unabridged description by Morgan and Engel (Box 21.12).

[14] For the distinction between "subjective" (*symptom*) and "objective" symptoms (*sign),* we refer here to von Uexküll and Wesiack (1991: 19ff), who justify this distinction from a semiotic perspective (§ 7.2) and explain it using an empirical case study, the analysis of which we had also prepared in detail for didactic purposes within the framework of a *biopsychological* medicine (§ 4).

Box 21.12 The 7 dimensions for complaint/symptom exploration

Symptoms are subjective changes that the patient perceives in himself. The doctor now tries to find out from the patient's statements the physical and mental processes that underlie the symptoms. In doing so, he looks at each of the symptoms according to the following dimensions:

1. The *localisation*. Where is the symptom localised?
2. The *quality*. How is it?
3. The *intensity* or *quantity*. How strong is it?
4. The *temporal relationships*. When did the symptom occur and what was its course?
5. The *accompanying circumstances*. Under what circumstances did the symptom occur?
6. *Influences that intensify or ease the complaints*. What facilitates or intensifies the complaints?
7. The *accompanying symptoms*. What other complaints accompany the symptom?

These seven dimensions are fundamental to all diagnostic considerations. They let the doctor decide whether an abnormality underlies a change noticed by the patient, where it is localised and what is the nature of the underlying functional and structural disorders.

Morgan, Engel 1977: 38f

As Morgen and Engel go on to explain, the "experienced doctor, thanks to years of practice" routinely follows these dimensions when listening and notices any *omission* or *ambiguity* on the part of the patient. In contrast, beginners (students) must first "concentrate on having all seven dimensions in mind and clarify each symptom afterwards" (1977: 43). The difficult task of "having all seven dimensions in mind" is, however, made easier by the fact that much information is already given by the patients on their own initiative in the ongoing conversation, so that "only" the gaps have to be filled in if necessary (§ 21.6). As Morgan and Engel have already argued, a narrative approach to anamnesis conveys valuable information as if in passing, so that it does not have to be asked for.

However, the information is not necessarily offered in the order that might make sense from the doctor's differential diagnostic point of view. Patients follow their own order in describing their complaints and narrating their medical history, which is told according to the plot logic of

their history of suffering (§ 9). Such a narrative logic of action follows the anamnestic and diagnostic logic of action of the doctor only to a limited extent. Therefore, the art of conducting a medical conversation consists of a good mixture of active listening and asking questions if gaps do not close themselves. Under no circumstances should a conversation structure be enforced that rigidly follows the order of the seven dimensions.

If we (have to) choose a sequence in the following examples in the necessarily linear presentation, this is not intended to suggest a sequence in the conversation. The examples themselves are taken from developed conversations in which, for their part, no linear sequence along seven dimensions was followed, which is precisely what constitutes *flexibility in the* conduct of conversations (§ 17.1). The seven dimensions were certainly not treated in the conversations in pairs or in a focussed way, as seemed appropriate to us in the following overview along the *Cologne Manual on Medical Communication* (C-MMC) (Fig. 21.3) and for teaching. Selected examples are compiled here with a comment column whose entries correspond to the categories from the 4th step of the manual (also numerically: 4.1). We essentially follow the seven dimensions as differentiated in advance with Morgan and Engel (Box 21.12), with slight modifications (summaries, distinctions, additions).

21.4.2 Locality and Temporality

Questions about the locality and temporality of symptoms are often asked in context as soon as the complaints/symptoms in question are named in the patients' first descriptions. According to Morgan and Engel (1977: 39f), in addition to clarifying the *onset, the duration* and *course* of the symptoms are also important (worsening, improvement, relapses, etc.). Sometimes the clarification of the beginning of the symptoms is difficult because patients do not remember enough. In the following example (E 21.31), for example, the doctor follows up his question about the *location* of the "pain" with a *question* about the *time of onset* of the pain, which obviously cannot be clarified easily, as the patient's many questions and vague answers make clear, which we reproduce here in abbreviated form. Despite the abbreviation, the doctor impresses with his patience in listening and inquiring, which finally leads to relative success.

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

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

certain "subjectively" relevant date. Morgan and Engel (1977: 45f) also recommend that in the case of vague or contradictory dates, one should ask directly for other dates relevant to the patient's life (exams, work, birthday, marriage, moving house, etc.), which coincide with a change in the experience of health or illness, so that the patients can remember whether they still felt healthy or already ill up to this "subjective" point in time.

Thus the patient, who suffered from massive *dizziness,* dated her daughter's ("MS") illness with her grandchild's communion Sunday in her narratives on her own initiative and was in turn able to link the beginning of her own illness ("dizziness") with the beginning of her daughter's illness when asked by the doctor (§ 19.7). In this way, "objective" data can be reconstructed more easily on the basis of "subjective" data, which can be remembered well because of their life-world relevance. Accordingly, it is part of the art of medical interviewing to obtain clinically relevant data through detours via patients' personal, often drastic events and experiences. Since these have to be collected anyway when completing the medical history (§ 21.6), it is possible here - to put it casually - to "kill two birds with one stone".

In the preceding example with the patient who initially could not date the onset of his pain (in the armpits), there was probably the additional difficulty that the patient seemed to be "unfocused" to "disoriented", which the doctor later also indirectly makes an issue of by communicating his impression to the patient ("now something completely different ... you make a very ... worried impression . ne? [=right?]") (§ 20.6). This impression was probably based on the perception of nervousness and lack of concentration, which can be understood not only non-verbally but also from the (transcript) text. Nevertheless, the doctor proved to be a patient listener in this case, until he finally obtained a halfway satisfactory indication of the beginning of the symptoms by persistent questioning, which could at least indirectly be concluded from the indication of a time (14P: "two years ago") when "everything had been fine".

It remains to be seen whether the doctor would have been more successful with a targeted word question ("When did you last feel (completely) healthy?") or decision question ("Can you remember when ...?"). Generalised questions of this kind can also prove to be more effective in other cases when patients - for whatever reason (memory or concentration problems) - are initially unable to give any or only vague or contradictory information about the time.

In most cases, information on localisation and temporality can be obtained with less communication effort. The following example is taken from the conversation already analysed in detail (§ 19.6), in which the patient complains of "heart pain", which the doctor follows up directly with the time question ("since when ...?") (E 21.32), before he then asks about the locality ("radiation") after the question about the course ("improvement").

E 21.32		"and does that radiate anywhere?"	Comment
03	D	what are your main problems, what/ or main complaints, what do you come for? .	Manual 2.2: Early Interruption/ Funneling
04	P	I have often had heartaches, i.e. stitches in the region of the heart.	Focus: "chief complaints"
05	D	how long have you had these stitches? ... [3] ...	4.1 Question: Time (start)
06	P	it's been a little longer than that, so in 2001 it was really bad, and that's when I had my tonsils removed.	
07	D	yes .	
08	P	that was still the case with Dr. Müller.	
09	D	did it get better afterwards? .	4.1 Question: Time, Course
10	P	yes, then it was better again, and then it occurred again, so now, recently.	Improvement; relapse
11	D	(...)	
12	P	(...)	
17	D	and does it radiate this pain anywhere? ...	4.1 Question: Localisation
18	P	no [shakes head] ..... [3 sec]	

The other examples from this conversation, which was analysed as an "interrogation conversation" (§ 19.6), also impress with the rapid alternation of short doctor's questions and monosyllabic answers from the patient, whereby the two interlocutors soon manoeuvre themselves into a conversational lull due to the dominantly *interrogative* pattern of action, after which the conversation ended after about 2 minutes. But this criticism of the *interrogative* style of conversation should be "on a differ-

ent page", which can be considered separately from the questioning technique for the time being. However, it should be noted that the questions, which we will come back to in the further dimensions of the detailed exploration, would have fitted better into a later phase of the conversation if the patient had not already contributed the necessary information independently in narrative conversational spaces. At this point, however, we will only focus on the specific questions in the seven dimensions, whose early or late placement in the conversation is another topic of conversation management, which was discussed in detail earlier as a *problem of fit* (§ 3, 17, 19, 20).

21.4.3 Intensity, quantity and quality

In deviation from the classification according to Morgan and Engel, who more or less equate *quantity* and *intensity* (Box 21.12), this distinction will be retained here. It is true that the *volume* (of sputum, blood loss) or the *frequency* (of micturition, defecation) or the *number* (of seizures, attacks of pain) can be included under the dimension of *intensity (*Morgan, Engel 1977: 39). Nevertheless, the concept of *intensity* should not be applied to all possible phenomena (eating, drinking, excretion, sleep, etc.) that can be adequately captured by the relevant concepts of *quantity* and *quality.* In contrast, the concept of *intensity* should be reserved for specific phenomena such as *depression* (§ 30), *anxiety* (§ 31) or *pain* (§ 33), for which, however, gradual distinctions can also be made (*mild*, *moderate*, *severe*). The doctor should take into account that in graduation, the corresponding verbal expressions are subject to individual usages, which occasionally require a "relative" translation or specific demand for clarification, in order to be able to determine the "right measure" for this individual patient together with him.

Thus, *aggravating* patients can easily tend to a "strong" choice of words ("unbearable"), while *dissimulating* patients can leave it at a "weak" choice of words ("endurable"). In order to be able to record *inter- and intra-individual* differences in a more controlled way, the use of scales (1-10) has become established (Box 21.13), which we also propose in the manual (§ 21.1). This use of scales will be illustrated in a conversation example, which also involves the comparison of a patient's pain in the "here and now" of the consultation in relation to earlier "measurement times".

Box 21.13 Quantity

Quantification ("How bad is this?" For pain, "On a scale of 1 to 10, with 1 being no pain and 10 being the worst pain you can imagine, like surgery without anaesthesia, what number would you rate your pain?")
a. Frequence of occurrence?
b. Intensity or severity?
c. Impairment or disability?
d. Numeric description
    i. Number of events
    ii. Size
    iii. Volume

Fortin et al. 2012: 70

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

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

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

We start with the central dimension of *intensity*, which is understood here in a *narrower* sense, deviating from Morgan and Engel. This also involves the use of a (pain) scale, which will be explained in an oncological consultation. In further steps, examples will be given on the complaint dimensions of *quantity* and *quality*. Since the exploration of the *quality of* symptoms can be particularly difficult, the handling of "unclear" symptom descriptions will be discussed using examples in which the doctor's questioning competence is particularly challenged. To overcome ambiguities, not only *conceptual clarifications* are useful, which can often overwhelm patients, but also *narrative illustrations* (examples, events, experiences), whose exemplary character helps to compensate for conceptual ambiguities.

Based on selected examples, especially on the complaint dimension of *quality*, a plea will be made for the narrative application of the principle of "expressibility". After including other dimensions (condition, accompanying signs, etc.), the plea for a narrative approach, which has already been justified in the context of narrative anamnesis (§ 9), will be summed up again for detailed exploration as a whole (§ 21.4.6).

Intensity and scaling

In a conversation from an oncology consultation with a patient who is being treated for ovarian cancer, the doctor opens the conversation with the type of question about the current state of health (§ 18.2), in order to then present the patient with a corresponding *scale* after the first verbal exchange. The patient is obviously familiar with the procedure, as can be seen from the conversation. We reproduce here the beginning of the conversation with a short omission and minor shortening in two sections (1)-(2), in which the language very quickly comes to the ("bad") condition of the patient, for whom the hopes for the effectiveness of the pain therapy have obviously not been fulfilled satisfactorily (1), so that at the end of the introductory phase (2) the question of treatment alternatives finally arises.

E 21.33	(1): "it was terrible"	
01	D	so, Mrs. Schmid . now you have to tell us . how are thing going? .
02	P	bad .
03	D	is not good, ne . hm .
04	P	I was here on Monday .
05	D	right .
06	P	(...) at night (...) the drops had no effect at all .
07	D	you were already awake with pain already .
08	P	yes .
09	D	and had hoped for help directly.
10	P	yes . it was a bad night (...) it was terrible .
11	D	that is not a good record .

Due to their longer history of interaction, both interlocutors can exchange "open" words with which they oscillate between stronger and weaker evaluations ("bad" - "not good" - "terrible" - "no good record"). Despite these "small" differences in the vocabulary of emotion and evaluation between the professional helper and the patient, which we had already dealt with in principle in advance (§ 21.3.2), both interlocutors quickly find themselves in emotional and evaluative harmony, in which the doctor then aptly sums up the patient's answers to his initial question about "how things are going" as "no good record" (11D).

On the way to this summary, the patient can openly perceive the opportunities for speech offered by the doctor through an open narrative invitation, active listening and empathic feedback in several steps, in each case by complaining about the absence of the therapeutic effects she (and the doctor) had hoped for, which had particularly troubled her at night. After her summarising complaint (10P: "it was awful"), the doctor, after his own assessment (and here after a short omission) in the second section of the conversation (2), comes directly to the "scaling", knowledge of which he can obviously take for granted (03D: "You already know my scaling"), as can also be seen from the patient's verbal and non-verbal reaction.

E 21.34	(2): "You already know my scaling" - "this is not good".	
01	D	hm .

02	P	I notice that my face also tenses up like this when I'm in constant pain. It's better in the afternoon.
03	D	hm . You already know my scale . would you perhaps for the moment again . the current . [holds up scale over desk]
04	P	as it is at the moment . [bends over beforehand]
05	D	yes .
06	P	so [shows] .
07	D	that's not good, yes . do you dare to try a completely different way again . because that's not what we both wanted, that there is a bit of reassurance for you . I think we are at the point that (...)

The extent to which this is a "routine" interaction in a "well-rehearsed" team can be seen from the patient's reaction. Even during his speech, the patient is able to meet the doctor in the interaction by "interrupting" him with her spontaneous *joint sentence production* (03D: "the current situation" - 04P: "how it is at the moment"). The patient had already "physically" met the doctor by leaning forward when the doctor held the scale out to her across the desk. As not only the verbal expression "like this" but also the accompanying pointing gesture to the scale held out by the doctor makes clear, it is a variant of an analogue scale. In any case, the doctor again draws the appropriate evaluative conclusions from the "indicated value" (07D: "that is not good"), on the basis of which he then immediately submits a new therapy proposal ("a completely different way"), which we will discuss in detail later (§ 22.6) under the aspect of *negotiating* therapy plans.

Quantity and quality

While this example was about the *intensity of* a serious pain experience, which considerably limits the patient's quality of life, questions about *quantity* and *quality are* often also about "banal" phenomena, such as the clarification of intra-individual weight differences in an overall "normal-weight" patient (E 21.35) or in a "cold" with a "cough" (E 21.36). But also in the first case, the *quantity in* the "objective" difference to a "subjectively" experienced ideal weight, at which the patient begins to feel "good", must be clarified.

E 21.35		"and how much are you now?"	Comment
01	D	yes . that is, compared to others, it's not so bad.	
02	P	that's not so much, it would be ... again. mmh . so . if I had my 63 kilos again, I would be satisfied . but this ...	
03	D	and how much do you have now? .	Manual 4.1: Question: Quantity (weight)
04	P	71 ... when I weigh 63 kilos, I feel good. (...)	

In the second case of a "cold", the *quality* of the expectoration during the cough must be asked in detail for differential diagnostic reasons, right down to the "colour", until the doctor and patient agree, after a brief verbal clarification, to "listen to the expectoration" and then to stop taking an "expectorant" until the next appointment.

E 21.36		"what does it look like?"	Comment
03	D	(...) . yes .	
04	P	yes, that's clear, but the cough hasn't gone away yet and it's still a bit mucousy.	
05	D	what does it look like? .	Manual 4.1: Question: Quality (cough)
06	P	oh . what does it look like? uh ... the cough? .	
07	D	yes .	
08	P	if I spit this out? .... pff ... a bit greenish...	
09	D	greenish, yes . (...)	

In the two previous examples, clarification could be achieved quickly with little communication effort by asking questions about *quantity* and *quality*. It is usually more difficult with explanations of meaning, which Morgan and Engel also refer to under the aspect of *quality*, about which the doctor must ask appropriate questions and follow-up questions for understanding in the case of unclear terms in order to avoid misunderstandings and pseudo-understandings. Because of the differentiated and concrete recommendations based on catchy (albeit fictitious) exam-

ples, Morgan and Engel (1977) (Box 21.14) should be spoken about here again in detail.

Box 21.14 Questions and enquiries about the quality of a symptom

When examining the quality of a symptom, the doctor usually asks: "What was (is) it like?" If the patient has difficulty answering, or needs unclear terms, such as "It hurts", "Nausea" or "Dizzy", the doctor accommodates him by asking: "What do you mean by ...?" or "Was it like something you experienced before?" If these questions do not lead anywhere, he gives the patient a choice of terms: "Do you understand 'aching' to mean a sudden pain, a continuous pain or something else?" "Do you mean 'nauseous' in the stomach or all over, or what?" If the symptom is a pain, he asks, "Well, was the pain sharp, was it stabbing or dull, was it a continuous pain, or how?" without, however, emphasising any one quality over the others. In this way, he encourages the patient to find a suitable term himself. Perhaps the patient also agrees with a term suggested to him with conviction.

Morgan, Engel 1977: 44

Certainly, offering a choice between different "qualities" risks limiting the choice to just those alternatives, but as Morgan and Engel point out, the possible adoption of "proposed terms" is about "convinced" consent. Clearly, rational choice between conceptual options is a better alternative than maintaining ambiguity. The fact that patients "struggle" to respond appropriately to questions and enquiries about *quality* should not come as a surprise, but should be taken into professional calculation, which can be demonstrated by many examples.

Since further chapters of the textbook deal with specific problems in communicating with pain patients (§ 33), *depressive* patients (§ 30) and patients with *anxiety disorders* (§ 31) and *somatoform* disorders (32), four selected examples for exploring the *quality* of unclear descriptions of complaints and symptoms are given here, in which the essential categories of medical action from the manual are included in the comments column.

Attention should be drawn to the fact that patients often replace one ambiguous term with another ambiguity, so that further enquiries become necessary. If these do not lead to success, a *traditional procedure* is often used to eliminate or soften conceptual ambiguities by means of concrete *illustrations* (examples, events, experiences), with which both

conversation partners are initially satisfied as long as the negotiated meanings can carry the further conversation. These negotiations of meaning will be explained with the help of excerpts from four examples of conversations.

(1) Can you explain what you mean by that?

In the first example (E 21.37), a patient opens the conversation with a whole "palette" of complaints or symptom descriptions, which she presents to the doctor, who then has to ask for clarification ("three initial symptoms, you have to explain them to me again, nausea and ..."). No sooner has the doctor begun his attempt at clarification than the patient begins to "interrupt" him with further "symptom" descriptions, whereby the new symptom offers ("claustrophobia", "menopausal symptoms") raise further ambiguities which again make clarification necessary.

E 21.37		"nausea", "dizziness", etc.	Comment
01	D	Mrs. Schulze, what brings you to me today?	Manual 2.1: Question-type: Reason for consultation
02	P	I can tell you: nausea, dizziness, when I breathe deeply, my back right shoulder blade hurts ... then since ... Thursday, Friday, Saturday, Sunday, yoga since 4, 5 days ... swollen foot, which also hurts me ... yep, that's it ... in principle.	Multiple symptoms
03	D	... three initial symptoms, you'll have to explain them to me again, nausea and ...	Manual 4.1: Indirect question: Quality
04	P	dizziness and, yes, I don't want to say claustrophobia, but I don't know, so I have the feeling... like I'm in a phase of menopausal symptoms again at the moment.	Further symptom offers Claustrophobia Menopausal symptoms
05	D	can you explain, like, what you mean by that...?	Manual 4.1: Question: Quality
06	P	yes . how should I say ... mfh ... how should I	Uncertainties and

	put this .... means ... yes . nauseous... crying closer than anything else, in places, not always . logical .... uh ... I just don't know, I/ so I haven't had that for a long time anymore.	Concretisations of meaning Nausea and Crying

First, the patient "demonstrates" her difficulties of formulation through her multiple delays, before the formulation problem is finally also expressed (04P: "I don't know" - 06P: "how should I put this"). What she expresses is an exemplary case (06P: "crying"), which, however, continues to stand for an unclear emotional state that was formulated hypothetically anyway (04P: "I have the feeling ... like"). The dizziness is also explained later in the conversation using an exemplary incident in which her husband had to pick her up from the office because of the dizziness ("That's how everything turned"). In the further course of the conversation, the doctor and the patient then come to talk about the topic of the "old fear" of cancer, which both interlocutors recognised as dominant and which is still bothering the patient because of her pain despite an operation ("You no longer have an ovary on the left, why still?"). Without being able to go into the details of the further course of the conversation, the initial symptoms mentioned remain marginal and it is essentially about the *decision-making* for the initiation of further examinations, which are to contribute to the "reassurance" of the patient ("I just think to reassure myself"), which we will come back to in the topic of "agreeing on a course of action" (§ 22.4.4).

(2) What does it mean to be 'fluttery'?

In the second example (E 21.38), the patient, who initially comes to the practice because of her high blood pressure and heart-related complaints, reports, among other things, weight loss, which has already been mentioned to her by her relatives, which is initially also taken up by the doctor as a "huge worry", before the patient then raises another topic in a vague form ("because my nerves are a bit fluttery").

E 21.38		"with the nerves anyway fluttery"	Comment
01	D	(...) investigate further, right?	
02	P	well (...) it's from losing weight, no, it's been two years now that I've lost that weight.	

03	D	somehow you're really worried about that, eh. that there's something there, eh	Manual 3.4: Clarify emotions
04	P	yes . yes yes ... somehow... yes . yes yes ... somehow ... and since my nerves are a bit fluttery anyway ... that's how it is with me .	
05	D	and then there's this ... yes ... what does it mean to be so 'fluttery'? . like this morning, how is it then ...?	Manual 4.1: Question: Quality (meaning)
06	P	I have to take [drug name] and then everything calms down ...	
07	D	are you very restless then? .	Manual 4.1: Question: Intensity
08	P	yes . then everything calms down, then everything goes away quietly and I was ... 14 days ago... 3 weeks ago, I really would have called you, something happened to us in ... one ... one week, it was unbearable.	Narration: Start
09	D	what was there? .	Manual 2.3: Active listening: Asking further question openly
10	P	the son-in-law was taken to the hospital with the ambulance in the morning. I had still said to the daughter on Friday night, listen . you go to work like idiots (...) I'll tell her, later you'll be lying in a corner (...) I was so upset (...) on Sunday morning the son-in-law falls . the son-in-law falls down . and we couldn't get an emergency doctor, we had to call here [place name], yes and they just took him to the hospital, yes .	Narration: Continued
11	D	and what has become of it? .	Manual 2.3: Keep asking open questions
12	P	well . they have (...) [narrative continuation] (...) I had been so done that I didn't throw up . that was all . so miserable was I .	Narration (cont.) plus final evaluation
13	D	you were miserable then, yes .	Manual 2.3: Active listening: Repeat verbatim

After clarifying the emotion ("worry") about the weight loss, the patient expands the range of topics to include her general problem, which she introduces as a permanent problem ("anyway") (04P: "my nerves are a bit fluttery anyway"), which the doctor initially also classifies as a reinforcing problem ("comes with it"), before he then asks the patient to clarify the meaning in view of her "idiosyncratic" choice of words (05D: "what does it mean to be so 'fluttery'?")."). In this case, too, the patient does not offer further meanings directly, but conveys her understanding in the context of an apparently necessary medication, the "positive" effect of which is described in contrast (06P: "then everything calms down"). The patient thus establishes a contrast relation ("being fluttery with the nerves" versus "everything calms down"), which is taken up and developed further by the doctor when he subsequently asks directly about the *intensity of* the "restlessness" (07D: "are you very restless then?"). Asked in this contrasting way, the patient uses her right to speak not only for her confirmation and repetition ("yes . then everything calms down, then everything goes away quietly"), but at the same time for a (here abbreviated) narration of an *exemplary* event that was so dramatic (*disturbing*) that she almost "really" called her own doctor, to whom she is telling this experienced story in the here and now of the consultation.

With the strong *evaluative* interim summary of her own experience (08P: "that was unbearable") of the event that had not yet been narrated, she can at the same time "provoke" the doctor to invite him to continue narrating, who then also expresses his medical listening interest by openly asking further questions (09D: "what was there?"), with which the licence to continue narrating the dramatic story with the emergency medical care of the son-in-law is finally granted.

In this case, too, an *evidential function* of the narrative is perceived (§ 9), with which the story serves as a further example of the patient's "agitation", as the patient herself recognisably expresses this in the middle of the narrative (10P: "I was so upset"). As is clear from the patient's final evaluation (12P: "I had been so done (...) so miserable") and the doctor's active listening (13D: "you were miserable then, yes"), both interlocutors have gained a shared understanding of the patient's current agitation, which could be deepened in the further development of the conversation with further stories from the patient.

(3) What do you think 'nervous' is?

In the third example (E 21.38b), the patient first presents a heart-related symptom, which is introduced rather vaguely ("with the heart"), but is not elaborated on, because it can probably be assumed to be sufficiently known from the previous history, and then establishes a connection with the term "excitement", although she emphasises her own *lack of knowledge* (02P: "I also don't know if it's excitement, or w . if it's from what it comes from"). Regardless of the (merely) suspected connection, the doctor immediately asks the question about (the nature of) the excitement, which he formulates in the routine formula established for this ("What for ...?"). The conversation is initially characterised by the patient replacing one ambiguity ("agitation") with another ambiguity ("nervous bad"), so that the doctor has to ask for clarification twice (03, 09) in close succession.

E 21.38b		"Excitement" - "Nervous" - "Stress"	Comment
01	D	Mrs. Schulz, what's up? .	Manual 2.2: Type Opening Question: Request
02	P	with the heart . 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
03	D	what excitement? .	Manual 4.2: Quality
04	P	(shrugs) well ... all sorts of things ... Oh, it's that and it's that, it's just nervous... is ... is bad .	
05	D	is bad? .	Manual 2.3: Active listening: Repeat
06	P	yes, even with sugar is too high.	
07	D	yes .	LS
08	P	I can’t get it under control [takes booklet out of her bag] . look at that [shows the booklet to the doctor] ...	
09	D	yes... (3) ... what is it, what do you mean what is it nervously?	Manual 4.2: Quality
10	P	well, I was (...) I don't know how to put it ...	

11	D	yes? .	Manual 2.2: LS
12	P	whether the sugar is so high, so I'm worried . and I don't know now whether I should inject or not . that I have to go to hospital is that where I have to go to hospital . for? ...	
13	D	you consider that you have to inject, so to speak .	Manual 2.3: Active listening: Paraphrasing
14	P	yes .	
15	D	yes, and that you have to go to hospital and that you can't get away from it, does that worry you so much? .	Manual 3.4: Resumption and clarification of "concerns"
16	P	yes . mhm ... yes ... yes yes ... (...) (...) (...)	
17	D	hm ...	
18	P	every excitement ... now the sister has grandchildren from America, and now we don't speak English and he doesn't understand us ... and he's so wild and ... and then the brother-in-law ... all the physical stuff around it ... I never had that before...	Subjective explanation of the (reasons for the) current agitations Topicality
19	D	you can't stand it any more ...	Manual 3.3: Acknowledge Burdens
20	P	no... I... and now I have to say that my husband doesn't give me much support either, on the pension side ... I would have imagined a better retirement ... like this ... (3)	Complaining about retirement

In this example, the spectrum of clarifications runs from vague expressions of "excitement" to "nervous" to the concrete "worries" of the patient who "can't get a grip" on her diabetes and fears a stay in hospital as well as a change of therapy ("injections"). Later in the conversation, expressions such as "stress" are added, which also remain relatively vague, so that the doctor has to ask for specifics ("and what stresses you at home?"). Further exploration by the doctor leads to a series of events and experiences of the patient, who uses "stress" or "excitement" synonymously, whereby the current event of the (partly foreign-language) visit from America and the experience with the "so wild little

grandchild" is cited as *examples* ("excitement ... now the sister has"), which the patient as a whole, in the doctor's words, "can no longer stand" (19D). In addition, the permanent "disappointment" by the husband had already been an exemplary topic under the aspect of *empathic* communication (§ 20.5), who had permanently behaved against the patient's expectations according to an *iterative narrative* about their joint retirement life (20P), which the doctor later again pointedly ("That's not good for married life, no?").

All in all, the conversation is characterised by a series of unclear terms ("excitement" - "nervously bad" - "stress"), so that the doctor has to ask again for clarification in each case before both conversation partners engage in the *procedure of an exemplary narrative*, which apparently contributes sufficiently to clarification, as the further course of the conversation also shows. When asked about "stress" at home, the patient's disappointing married life, in addition to the *current* stresses and strains, turns out to be a *permanent burden,* which the patient - in whatever words - does not feel able to cope with, especially since she already has to cope with considerable *underlying illnesses (e.g.* CHD, diabetes mellitus) (§ 29).

(4) That's not so easy to explain

The problem of unclear formulations is often made an issue by the patients themselves, as already by the patient in the example (E 21.37) ("how should I express this?") as well as by the patient in the example (E 21.30) ("I don't know how to express it"). Occasionally, doctors who can anticipate such problems accommodate their patients in the interaction by acknowledging the difficulties ahead of time, like the doctor in the following example (E 21.39), in which a young patient complains of *nausea* ("I feel a bit sick sometimes") and *headaches* ("such a pressure") especially before and during school.

E 21.39		"I feel sick sometimes" - "such a pressure"	Comment
01	D	yes, please come Jana . sit down ..... (5) ..... tell . the mother is so worried that you won't say everything . now we'll try it together .	Manual 2.1: Opening Storytelling invitation
02	P	[laughs softly embarrassed] .	

03	D	now we two try this . right .	Manual 2.3: Encourage
04	P	yes, I sometimes feel a bit sick. yes . and I also have a headache (...)	
07	D	what is this pain?	Manual 4.1: Quality
08	P	yes, such a pressure .	
09	D	such a pressure .	Manual 2.3: Repeat
10	P	yes .	
11	D	listen, when you say bad . what do you mean by that? .	Manual 4.1: Quality
12	P	yes . that somehow here at the neck . [hand to the neck] that when I um...	
13	D	yes, try it . it's not so easy to explain, right .	Manual 2.3: Encourage
14	P	um . that is also definitely [hand to throat] here is the .	
	D	hm .	LM
	P	that is then ... um how should I say this now .	
15	D	that is hard . yes	Manual 2.3: Encourage
16	P	yes .	
17	D	[Hand to throat] that means you have . that's like such a feeling	Manual 4.1: Quality
18	P	yes .	
19	D	is there something constricting you or do you feel you have to vomit or...?	Manual 4.1: Quality/Options
20	P	yes . i have . but then it never is .	
21	D	this is not so .	Manual 2.3: Repeat
22	P	no . it's not like that.	
23	D	but when . in which situations does this occur? . is it in the morning . (...) breakfast (...)	Manual 4.1: Conditions

The conversation poses particular challenges in dealing sensitively with a young patient who is obviously uncomfortable to embarrassed by the conversation initiated by her mother. Here, we first deal with an excerpt of the conversation, which will later be analysed as a whole (§ 25). In

this example sequence, the doctor, after asking about the meaning of the preceding questioned expression ("I feel sick"), notices the uncertainty with which the patient makes a first attempt to answer (12P: "yes . that somehow here at the neck . that if I um ...").

In order to relieve her of this uncertainty, he combines his encouragement ("give it a try") with an acknowledgement of the difficulties he himself acknowledges with medical *authority* (13D: "it's not so easy to explain, right"). Even when the patient again falters with her explanation (14P: "um how am I supposed to say this now"), he supports her encouragingly with an acknowledgement of the problem (15D: "that's hard"). When the patient only affirms this ("yes") and does not continue herself, the doctor expands his supportive activities by offering alternative terms (19D: "is there something constricting you or do you feel like you have to vomit or ...") in the spirit of Engel and Morgan's recommendation (Box 21.14). It is interesting to note that the doctor almost mirrors himself in the neck, which is discussed elsewhere in the textbook (§ 12) under the aspect of non-verbal interaction.

Of the options offered ("constrict" or "vomit"), at least the second option is confirmed, albeit in the *as-if form* already offered by the doctor: The patient does not actually have to vomit, but she has the feeling that she has to vomit. With this preliminary clarification of the *quality* of the symptom, a certain saturation is reached, with which the conversation can then be continued with regard to other complaint dimensions, as here with the question about the conditions (23D: "situations") under which the symptom occurs.

As the conversation progresses, the two symptoms of *nausea* ("I feel sick") and *headaches* ("so much pressure") can be placed in the larger context of the patient's fear of *school*, which comes up in the cooperative narrative primarily as the student's fear of *failure*, whereby this is accompanied by a *fear of loss* in the event that she, as a student, "repeats a grade" and thus is threatened to lose her school friends. In this narrative exploration phase of the anamnesis, terms such as "pressure" then also undergo a change of meaning, which is expressed in the school context as "being under pressure".

For the detailed narrative analysis of this consultation, reference should be made to previous work (Koerfer et al. 2010), the results of which will still be considered in the later exemplary analysis on GP communication (§ 25). At this point, it should only be noted that the questioning on the *quality* of symptoms initially reached a certain saturation point, so that further questions on other dimensions proved ex-

pedient before the information thus acquired could be transferred into a *narrative* overall history.

Whereas in this example the transition to narrative anamnesis is organised fluidly, in the three previous examples it was established *ad hoc* during the clarification of vague concepts, in which *narrative procedures* of exemplary illustrations proved to be vivid alternatives to *abstract conceptual clarification* from the outset. Here, both interlocutors changed the clarification procedure at times by orienting their negotiation of meaning to concrete examples, events and experiences of the patients.

We will come back to this narrative procedure of negotiating meaning together with initially vague terms in the detailed exploration in a final résumé (§ 21.4.6), when the other dimensions for describing complaints have been differentiated, in which clear cases are also to be distinguished from unclear cases that pose problems of understanding and comprehension.

21.4.4 Conditions and accompanying signs

The questions about the conditions under which the symptoms occur, improve or worsen are often realised with a standard formula, which we have also included in the manual (§ 21.1: under 4.1): "In which situation does this occur? Compared to the concept of condition, the everyday language concept of situation is obviously easy to understand. Following the preceding introductory sequence of the conversation with the student, the doctor continues the detailed exploration (E 21.40) with precisely this type of question.

E 21.40		"In what situations does that occur then?"	Comment
23	D	but when .. in which situations does it occur like that? ... is it in the morning . what is it . at breakfast or . how is it or when you get up or ...	Manual 4.1: Conditions
24	P	it's when I get up ... and afterwards at school ... usually I get a headache ... when I get home ... then I still have it ... and then it's like that all day . when I'm at home ... then ... then I still have it ... and then it's like this the whole day ... sometimes a bit worse.	Fluctuating Complaints during the day Climax in school? ("at school mostly ...")

The doctor's question about the conditions is offered with many options, quite in the sense of Morgan and Engel (see their examples in Box 21.14), so that the patient has a choice, which is typically kept further open at the end, as it were, with an "empty" option ("or ...“). Because of its frequent occurrence, attention should be drawn to this specific discharge of one or more questions, which can also be in a paraphrase relationship, with a functional description as an open *narrative invitation,* which Bergmann (1981) (Box 21.15) already gave at an early stage on the basis of everyday conversations as well as psychiatric admission interviews.

Box 21.15 The function of open-ended utterances (with "or ...")

By correcting his question immediately after its conclusion by paraphrasing it, a speaker presents his first question as needing correction, he provides the recipient with different versions of the question and thus signals to him: 'Tell me whatever you want to tell me or can tell me, I know so little about the matter that I cannot even ask precisely about it'. Sometimes a speaker merely indicates the need for correction of his question by adding an intonationally suspended "*or-"* to his potentially completed utterance, thus making the recipient understand that the question - if necessary for the answer - can also be reformulated by him.

Bergmann 1981: 134f

As a supplement to Bergmann's observation, reference should be made back to the formulation suggestions of Morgan and Engel, who, from a clinical perspective, have in any case developed an impressive sensitivity for linguistic and communicative phenomena, which we had already made use of many times before. Although Morgan and Engel (1977) give "only" fictitious examples in the theoretical part of their introduction (and otherwise refer to an empirical model conversation in the appendix), in their last recommendation they had even attached an open *"or"* expletive in the written language formulation in order to simulate oral communication sufficiently, for instance in the multiple variant of expletive by "or something else?" and "or how?" respectively. (Box 21.14), with which, as it were, an *open placeholder* is offered for completion by patients. As can be seen in many of the preceding and following examples, an open lead-out is characteristic of numerous variants of explorative and interpretative verbal interventions that favour a proactive continuation by the patient within a wide-ranging thematic framework.

Since the doctor in the preceding example, which offers an open or-placeholder in the lead-out, focuses overall on a supplementary series that starts at the beginning of the day with exemplary question variants, the doctor's entire question contribution can be used by the patient to describe the fluctuations of her complaints in the course of the day. In view of the described fluctuations during the course of the day, it can only be recognised for the time being that a *climax* probably occurs with the start of school, where the early nausea is then joined by the headaches "usually come afterwards at school". This is the first time that school is introduced thematically in the conversation (as a future *key symbol*), the significance of which for the patient and her "illness" we had already referred to in advance and will discuss in detail later in the GP communication (§ 25).

In the second example (E 21.41), which is again taken from the extensively analysed "interrogation" with the patient who complained of "heart pain" (§ 19.6), the doctor uses the relevant concept of situation in two questions (11D, 19D). However, he attaches a second question to his first question ("in which situations does it occur?") ("does it occur during stress or-?"), which is accepted and answered by the patient (despite the open "or" ending) as the "actual" question.

E 21.41		"do you have situations where ...?"	Comment
11	D	in which situations does this occur? . does this occur during stress or- .	Manual 4.1: Explore details: Condition
12	P	no . [shakes head].	
13	D	no .	
14	P	in peace more, at rest . .	
15	D	mainly at rest .	
16	P	[nods] hm .... [2 sec.] ... (...) (...)	
19	D	do you have ... situations where you think it comes on particularly strongly? . when you are upset? ..... [6 sec.]	Manual 4.1: Explore details: Condition plus intensity ("strong")
20	P	that could be, maybe in excitement . I don't know exactly now .	

We have already pointed out the critical sequence of the conversation (11-16) in the overall analysis of the conversation, which we will focus on again here. After the open situational question, the doctor narrows the possible range of answers with his attached second question in such a way that the meant and understood content remains ambiguous. The doctor introduces the term "stress" or adopts the term "rest" without the question and answer area being sufficiently clear in each case. Thus, in the end, neither from the participant's perspective nor in retrospect from the observer's perspective can it be decided beyond doubt how the questions and answers about "stress" or "rest" were meant and understood in each case, namely as statements either about *physical* or *mental* stress/rest.

Because the doctor does not confirm his understanding of these alternatives by asking further questions, he is unable to gain any reliable information at the end of the sequence (11-16) ("He is as wise as before"). In retrospect, one can perhaps summarise from an evaluative point of view that the doctor would have been better off if he had left it at the first open situational question ("In which situations does this occur?") and waited for an answer from the patient before asking a specific question (e.g. about "physical" stress, etc.).

Apparently the doctor himself is not satisfied with the information gained so far, when he then asks the situation question with a new variant ("Do you have situations where ...?"), which is linked to the aspect of intensity ("particularly strong") and has a clearly "psychological" placeholder in the second part (19D: "When you are upset"?). This placeholder is then also filled in relatively appropriately (20P: "maybe in excitement") by the patient, who can apparently use the relatively long pause of 6 seconds in this conversation as a time to think.

While in the first part of the conversation the doctor asks about the conditions of the occurrence of the main symptom ("heartache"), in the second part he asks questions about the accompanying signs that the patient might have "with her", which will be reproduced here in excerpts (E 21.42) of the conversation, which is short anyway.

E 21.42		"Shortness of breath?" - "Sweating?" - "Fear?"	Comment
27	D	ah yes ... [2 sec.] ... um, do you have shortness of breath? .	Manual 4.1: Accompanying sign
28	P	no .	Manual 4.1:

			Accompanying sign
29	D	sweating? .	Manual 4.1: Accompanying sign
30	P	yes, sweating, hm, so often . every morning ...	
31	D	hm ...	Manual 2.2: LS
32	P	very strong, and ... then during the day no more, but in the morning very strong .	
33	D	so the stitches don't make you sweat like that? .	Manual 4.1: Accompanying sign
34	P	no, no .	
35	D	are you afraid to do so? .	Manual 4.1: Accompanying sign + Manual 3.4: Clarifying emotions
36	P	no . [shakes head at this].	

Here the doctor asks for the accompanying signs in the already established interrogative conversational style, to which the patient responds succinctly. The communicative exchange becomes increasingly "monosyllabic", which may already appear as an omen of the end of the conversation (§ 19.6). While the doctor's elliptical question about the possible accompanying sign of "sweating" is answered relatively elaborately by the patient, the question about the possible accompanying psychological sign ("fear") is merely answered in the negative. The conversation ends because the two interlocutors have nothing more to say to each other. If narrative sequences had been opened up at an early stage, the conditions and accompanying signs of the "heartache" would probably have been brought up sooner.

21.4.5 Dysfunctions and impairments

Symptom descriptions are often offered by patients "in the same breath" as functional disorders or impairments, so that in these cases they do not have to be specifically made a topic, which, however, should be supplemented and deepened by questions if necessary. Questions about

possible functional losses and impairments in the patients' everyday life can often be asked in connection with the intensity of symptoms. Depending on the severity of pain, dizziness, depression, etc., patients may no longer be able to go about their normal lives. If patients do not tell by themselves to what extent they are impaired, targeted questions on topics such as walking, household management, shopping trips, orientation in traffic, etc. are helpful. Comparative questions about previous habits and preferences that may have been abandoned can also reveal current deficits, as can questions about the help needed from relatives, friends or neighbours to cope with normal daily life.

Some questions, however, may be unnecessary because patients give the information of their own accord in the course of the conversation. When patients are allowed to tell their stories, they often share the extent of the impairments they suffer from on their own initiative. For example, the patient with the symptoms of dizziness illustrated her impairments relevant to her life with an example, which she also combined with a vivid appeal to the doctor ("You can see ...") (E 21.43).

E 21.43		"such bad dizziness that ..."	Comment
01	D	so, Mrs K., now tell me your symptoms . er . your complaints .	Manual 2.1: Opening: Complaints (Type 5) (§ 19.2)
02	P	dizziness, dizziness so bad 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 the further course of the conversation, when the doctor asks about the intensity of the dizziness, he then learns, as if in passing, about other impairments of the patient (E 21.44), which she also recounts from the perspective of her grandmother role, which she can no longer live up to from her own point of view.

E 21.44		"so it's so bad, doctor ..."	Comment
01	D	and has the dizziness become stronger now? .	Manual 4.1: Intensity

02	P	it's so bad, doctor, I'm fighting myself outrageously . It's so bad . I can't take my daughter's children any more . and that means something .	Impairment Grandmother role

Once again, attention is to be drawn to the multiple self-perspectivisation, in which the patient - paradoxically - fights a battle against herself ("I'm fighting myself outrageously"), before she admits that it is so bad that she can no longer take her grandchildren ("and that means something"). Later, in her dramatic narrative (E 21.45) about a night-time dizziness ("deadly bad"), the patient then describes how, despite great efforts, she is no longer able to help her seriously ill daughter with household chores as she used to, which she resignedly sums up in an evaluation ("until it was no longer possible").

E 21.45		"Until it was no longer possible"	Comment
01	D	this dizziness, did it start when you found out about this diagnosis [= daughter has MS]? .	Manual 4.1: Explore details: time, condition + narrative invitation
02	P	yes, I think so ... once I had something in my head at night, uh ... I never told my husband, once I had something in my head at night, really bad ... I woke up ... I thought: "Oh dear, oh dear, what's wrong now?" ... once I got really sick in bed at night ... I fought it, always did everything at her house, took care of the household, until it was no longer possible, no ...	Framing, theme Orientation Listener privilege Complication "unheard event" Evaluation Mastery *versus* failure

In further narratives, the patient also repeatedly draws comparisons between her earlier abilities and current deficits, both in co-parenting her grandchildren and in caring for her husband, who is seriously ill with a heart condition and needs her help as a nursing case (§ 19.7). This current experience of deficits in comparison to her previous performance is dated with the beginning of the dizziness, which from her point of view was triggered by her daughter's illness, which represents a caesura in

her life that she cannot come to terms with ("I can't cope with that"). In these narratives, the information about impairments was "delivered free of charge" by the patient, so to speak, without the doctor having to ask any further questions beyond the narrative prompts he had created. On the other hand, such narrative occasions can be created precisely through questions, as this is to be illustrated in summary by the type of open and at the same time targeted question about the patient's *daily routine,* with which once again a plea is to be made for a narrative application of the principle of "expressibility".

21.4.6 Narrative application of the principle of expressibility

For good reasons, ambiguities - of whatever kind - should, if possible, be avoided in advance in the consultation and, if necessary, cleared up so as not to be subject to misunderstandings or a pseudo-understanding in further communication. We are guided not only in everyday but also in institutional communication by the counterfactual assumption that in principle there are no limits to the *ideal* demand for clarity, so that the explication of knowledge and experience, attitudes and opinions seems to be only a question of time, effort and not least of sincerity (Koerfer 2013). However, in many communication situations, the principle of "expressibility" is subject to action-practical limitations that can have equally good reasons to accept.[15]

Thus, the principle of "expressibility" should not be overused in the consultation, but should be applied flexibly. It is true that for differential diagnostic reasons, doctors must ask clarifying questions and insistent follow-up questions for certain symptoms, for example to investigate the difference between positional and rotational vertigo (such as in the conversation under § 19.7). However, it will always be necessary to respect a limit of explicating the meaning so that the patient does not

15 When we speak here of a pragmatically effective "principle of 'expressibility'", then in a less pretentious sense than in speech act theory (Searle 1971: 34ff) (§ 7.3). What is meant is that, despite *ideal* assumptions, we come to the limits of what can be said and understood in understanding and comprehension (§ 7.3, 7.5), without this necessarily becoming a problem for everyday practical purposes. Although not all, but all significant words are (have to be) weighed in a special way, occasionally with the gold scale, especially in the consultation hour or therapy hour, the inescapable limits of other-psychic understanding remain, which was already a topic in *empathic* communication (§ 20.3).

at the same time exceed a current limit of what is individually reasonable.

Since *insistent* questioning always carries the risk of a tendency towards *inquisition* (Platt, Gordon 2004), patients should also be spared from a compulsion to explain meaning in the verbalisation of their suffering, which could possibly be interpreted by them as "quibbling over words". Even in the consultation, not *every* word should be *weighed in the balance,* which should only be used in exceptional cases, so as not to get caught up in one communication crisis after another. The constant questioning of the meaning of (everyday) terms would ultimately lead to the end of any reasonable communication, even in medical or therapeutic consultations.[16] The clarification of the *questionable* always presupposes certain assumptions of the *self-evident in order* not to lose all grip.

Particularly in the case of *psychological* terms such as "excitement", "stress", "nerves", "depression", "anxiety", etc., a cautious, *tangential* guidance of conversation is indicated (§ 3, 17), which leaves the patients enough initiative and room for manoeuvre in the joint interpretation work. The joint interpretation work should not be reduced to abstract conceptual work, but should be expanded to include narrative conversation work that is open to personal patient experiences (§ 9). As already explained in the justification of a *biographical-narrative* anamnesis: What cannot be captured abstractly in a term or sentence can be expressed vividly in a narrative.

In order to stimulate the personal sources of experience, doctors make use of a number of *supportive* conversation techniques, which have been described in advance with multiple forms of *active listening* (§ 19) and *empathic* communication (§ 20). Lastly, *interpretative* and *explorative* conversation techniques were differentiated, which were in-

16 Thus, the constant questioning of meanings is part of the methodological repertoire of Garfinkel's crisis experiments, which are used there for research purposes in "artificial" communication situations, for example, in order to be able to draw conclusions about the normality of communication from communication disorders. Even in academic discussion, where conceptual criticism is commonplace, or in psychoanalytic therapy, which is about the interpretation of latent meaning, there are limits to the (permanent) questioning of (everyday) concepts in communication (Koerfer 2013: 179ff). In order to clarify something "contentious", one must be able to refer to a certain extent to "self-evident things" that cannot be questioned at the same time.

tended to direct the flow of patients' thoughts and experiences in specific thematic directions for self-exploration.

At this point, attention should be drawn to another variant of conversation stimulation that can be achieved through a "targeted" and at the same time "wide" type of question, which need not be a contradiction. In order to capture the various, previously differentiated dimensions of patients' *descriptions of their complaints in* context, a general and at the same time very concrete recommendation by Morgan and Engel (1977) (Box 21.16) can be followed, according to which patients are given a wide narrative and thematic space with the particularly inviting question about the *course of the day at their disposal*.

Box 21.16 "Describe your daily routine"

In the case of general symptoms, such as tiredness or anxiety, or in order to assess the patient's burden of illness, he [the doctor] has the patient describe the entire course of a day (...) He asks the patient, for example: "Describe your daily routine last Monday, from the morning when you got up to the evening when you went to bed." He then asks him, "What would your day have looked like if you had been healthy?" It is obvious that such descriptions provide valuable information about the patient and his current life situation, and the doctor can expand on this information in the course of the anamnesis.

Morgan, Engel 1977: 45

Against such a recommendation, the aspect of communication economy may immediately be asserted as an economy of time, especially if the question about the daily routine is additionally to be asked *counterfactually* with the assumption of (*former*) health, where the patient's fantasies could "run riot". However, it is equally obvious that a lot of time can be gained by making further questions superfluous by themselves, because the relevant information is "delivered free of charge", which in the long run - to use the words of Morgen and Engel - provides "valuable information" about the patients and their life situation, the knowledge of which can "pay off" not only in the current consultation, but in the long run for an appropriate treatment of the patient.

This "surplus" of information (through questions about the *daily routine*) can be achieved at all levels of the anamnesis, whose *narrative* approach has also been linked to the approach of *biopsychosocial* medicine (§ 4, 9). As has been made clear in the preceding examples and will

be demonstrated with further examples, a common, tried and tested procedure should be chosen to eliminate the ambiguity of terms by means of *illustrations* (examples, events, experiences), especially in the face of the ambiguity of "psychological" terms. If *conceptual* or even merely *descriptive* attempts at clarification remain vague, they can be supplemented in time by *narrative* illustrations, which doctors often encourage themselves through active listening, in order to switch from rather abstract concepts to concrete symptom descriptions, to which patients should be invited with and without *questions* about the *course of the day*.

21.5 Exploring subjective ideas

A particular challenge of *patient-centered* interviewing, which is oriented towards *biopsychosocial* medicine (§ 4), is the exploration of patients' *subjective ideas*, which must be sufficiently known to the doctor if his subsequent therapy proposals are not to miss the reality of patients' lives and their interests, attitudes and preferences (§ 10, 22). These subjective patient perceptions can refer both to concepts of general lifestyle, which are concretely reflected in married or professional life, for example, and to concepts of health in general or the current illness in particular, which can be experienced and processed by patients quite individually. In order to avoid a premature generalisation of supposedly typical ideas and attitudes of patients, a biopsychosocial anamnesis is needed in which the *individual meanings* of events and experiences relevant to life are reconstructed.

The reconstruction of *individual meanings* applies to all topics relevant to life, which include not only certain positive events (success at school, marriage, promotion, etc.), but also critical life events (illness, death of relatives, divorce, dismissal, etc.), which are connected with a personal experience of patients that can turn out quite individually despite all typical expectations. Thus, the desire to have children in a couple relationship can lead to controversy, just as the well-deserved retirement at an advanced age can be both longed for and feared. What is the case in each case can only be explored conversationally, with all the associated risks of touching on taboo subjects. Despite these risks, which can also lead to a deeper understanding of the patient, the biopsychosocial anamnesis must go far beyond the mere collection of

facts (marriage, divorce, profession, unemployment, (pre-)illnesses, etc.), which will be illustrated by more or less successful anchor examples.

21.5.1 Biopsychosocial communication

The paradigm shift towards a *biopsychosocial* medicine, as explained in detail in the theory section and illustrated by a case study (§ 4), is only gradually beginning to be implemented in interview practice. With training that remains traditional, the taking of an anamnesis remains bound to the equally traditional biomedical understanding, according to which further psychosocial "data" are merely added as pure facts (such as marital status, education, profession, previous illnesses, etc.) without recording their specific meanings for this individual patient.

In contrast, Morgan and Engel (1977) were early to describe the appropriate way of conducting conversation, which had already been used in advance to formulate *maxims for conversation* (§ 3.4, 17.4, 21.1, 21.4). From their many years of clinical professional experience, they have cited many, albeit merely remembered, examples that go beyond the mere collection of "external" biopsychosocial data. According to Morgan and Engel (1977) (Box. 21.17), a *biopsychosocial case* history cannot simply be limited to the collection of *factual* changes in the life of patients, but requires a doctor's understanding of the *subjective meanings* of the changes for this individual patient.

Box 21.17 "What does this mean to you?"

Every change in the patient's interpersonal relationship, such as separations, illnesses, deaths, retirements, the doctor records with an exact date and he tries to understand how the patient experienced this change. By asking questions such as, "What does this mean to you?" or in the case of an obviously drastic event, "This must have been a difficult experience for you," the doctor learns what the patient felt and how he reacted. *To understand the patient, the nature of his or her reaction to such an event is more important than the event itself. Therefore, the doctor must never remember only the event without knowing its effect on the patient.*

Morgan, Engel 1977: 52 (there also in italics)

Although initially all personal changes "in the interpersonal relationship" are to be recorded meticulously (with "exact date"), a distinction is

made here in the *relevance of* events and their experience, which must be clarified in case of ambiguity with a specific enquiry about the individual meaning ("What does this mean to you?"). In the (*italicised*) emphasis, Morgan and Engel call for a relevance reversal, as it were, according to which the patient's "type of reaction" to events is "more important" than the events themselves. In this context, in the case of similar or even the same (types of) events in different patients, the doctor must expect individually very different to contradictory reactions that can hardly be anticipated. Even if a certain type of reaction (*grief*, *fear*) is probable on the basis of general expectations, the individual case must always be checked for deviations. As we have seen in an example (§ 20.9), even the death of a close relative (such as the mother in this case) does not necessarily trigger the grief reaction that can generally be expected for this type of event.

Life experience already teaches that people can react very differently to one and the same event. However, the validity of this experience must be especially checked in the medical consultation so that further communication is not prematurely based on social norms of expectation. *Individual* reactions can deviate considerably from *typical* reactions, which can only be clarified through discussion.

On the one hand, doctors already know from life and professional experience what a stressful life event can be, especially if these (after torture, abuse, violence, accidents, etc.) lead to post-traumatic disorders that require *special* treatment (Filipp, Aymanns 2010, Maercker, Gurris 2017). It is also part of everyday knowledge that death, separations and dismissals can be experienced as stressful. This also applies to the patients' own more or less serious illnesses and also in cases of serious illness of close relatives. For example, one patient's vertigo "went off" when she learned of her daughter's serious illness ("MS"), which she told her doctor in detail, before the connection was then made in another account of her own experience of illness ("deadly bad") (§ 19.7).

On the other hand, the general reaction expectations can turn out to be wrong in individual cases, if, for example, indiscriminate judgements are made along the lines of: "The death of a close relative must cause grief" or: "After a long working life, one looks forward to a well-deserved pension". In the case of many topics, neither the general life experience nor the specific professional experience of the doctor helps in the concrete attribution of individual meanings, the differences of which can only be gained through the active participation of the patients, who

alone can decide how they subjectively experience certain events of a certain type. From the many examples given by Morgan and Engel (Box 21.17), we focus here on the life-world relevant change at the end of working life, which can be experienced very differently by patients. Some patients fear the threat of *retirement*, while others long for it or even actively try to bring it about. The individually contrasting attitudes to career and retirement are to be exemplified in short excerpts from conversations with different (types of) patients, in which the doctors "draw" their patients into a conversation in a "clever" way, in which they can then reveal their emotions involved in the topic.

21.5.2 Events and experiences

One and the same type of event can be experienced by different patients as a *stroke of luck* or as a *catastrophe.* Which is the case in each case depends not least on the previous life history of patients, which can be determined by a multitude of more or less critical life events, which in turn have been experienced and processed individually. Since it is well known that many types of events can also be "seen with a heavy heart and a smile", they are often experienced with ambivalence.

In the following two cases, the reactions of the two patients to a relatively normal event such as "retirement" clearly show extremely negative or positive emotions, which they only gradually reveal in conversation with the doctor. The seemingly "harmless" question of doctors about the profession of their patients can quickly lead to a "sensitive" topic when asked, where "opinions differ" and the conversations can take very different developments.

Job as a fountain of health

For the (type of) patient for whom the end of the profession seems to be tantamount to a "catastrophe", the following example from visit communication will be cited, which is analysed in detail elsewhere (§ 24.7) (Koerfer et al. 2005). In the ward round with a patient (after a heart attack), the topic of continuing to practise the profession is addressed (E 21.46), to which the 61-year-old patient, who previously proudly tells of his early "independence" already in his youth, absolutely wants to hold

on, even if his long since grown-up sons can already continue the business "without him" during his illness.

E 21.46		"I am only healthy when I can work ..."
41	D	what do you work? .
42	P	I have a construction business.
43	D	a construction business? .
44	P	yes . with the children .
		(...)
		(...)
55	D	do the [children] already run the business without you when you are ill? .
56	P	yes, I realise that it works without me.
57	D	yes .
58	P	I can already see that it works without me.
59	D	do you like it or not so much? .
60	P	me:? .
61	D	yes .
62	P	so frankly . I'm only healthy when I can work . much, much, much work [clenches fists] .
63	D	yes .
64	P	yes . then I am happy in the evening .

The patient's marked reaction, which is reinforced after the doctor's listening signal (57D: "yes") by repeating the identical formulation, shows the subjective relevance of the statement for the patient's self-image. Although he twice makes a concession to a de facto detachment by his children (56, 58P: "I already realise that it also works without me"), one can already hear the ambivalence associated with the threatening loss of autonomy while listening. This ambivalence is also heard or inferred by the doctor, who tries to clarify the patient's emotions by asking him about his preferences in the sense of self-exploration.

Without suggestively building up an expectation pressure for a certain answer here, the doctor's clarifying intervention offers a real alternative to choose from (59D: "do you like seeing that or not so much?"), which can be freely decided by the patient. The patient at first seems or plays surprised by asking a pseudo-assurance question in amazement (60P: "me:?"), with which he perhaps wants to give himself pause for

thought, before he then responds verbally and non-verbally in an engaged manner (repetition of "a lot" and fist clenching). After a special marking of the truth content (62P: "so frankly"), the patient formulates his life motto, as it were, according to which, in his own words, he can only stay "healthy" and "happy" by working.

Retirement as salvation

While for this patient, professional work serves as an *elixir of life*, for another patient, whose original career plan (as a "natural scientist") had failed due to "examination failure", it represents a considerable *burden* from which he wishes to free himself as soon as possible. The strongly emotional narrative itself, which was analysed in detail beforehand (§ 19.8), is reproduced here in abbreviated form (E 21.47).

E 21.47		"getting the first crack"
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] .
08	P	[-] I had something completely different in mind that ... has .... (4) .... it started somewhere (...) probably I ... (3) ... got the first crack somewhere .... (4) .... I wanted to study natural sciences, had/have started, but then dropped out in the preliminary exam [-] (...) ... and then I briefly did an administrative history alongside, I trained as a civil servant (...) and then do it [+] more or less like that now, because I don't enjoy it either, unfortunately ...
09	D	yes, so that you always have the feeling that you're selling yourself short, right?
10	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

that way . I would prefer to quit ... and maybe start studying again, just as a hobby, somehow .

This example, whose narrative interaction history had already been analysed in detail beforehand, makes it clear how *empathy-in-interaction* can develop (§ 19.8, 20.4). The patient had answered the doctor's question about his profession relatively vaguely ("I sit around in the office"), which the doctor could also perceive as "sitting around listlessly" in the sense of "scenic understanding" (§ 9.2) according to his posture-posture in the "here and now" of the consultation. The stimulating *emotion word* (05D: "fun" - "no fun") had been introduced by the doctor in his empathic feedback, which is now more or less consciously taken up again by the patient as an evaluation of his dramatic narrative about 1 minute later (sic) (08P: "no fun"), before the doctor skilfully sums up the developed emotion content in a sentence completion (*joint sentence production*) (09D: "yes, so that you also always have the feeling . to actually sell yourself short, right?"). With this extraordinarily economical intervention, the doctor *reflects* on the patient's story in a split second in a way that seems to match the patient's emotional experience as a permanent feeling (09D: "always") with a high degree of *accuracy*, which the patient also clearly indicates with his affirmation (10P: "that anyway"). The complete history of the conversation can be seen in the preceding analysis of the conversation (§ 19.8), in the centre of which was the dramatic patient narrative about dropping out of university and taking up an unsatisfactory job as an administrative official, which is still being pursued today *without any enjoyment.*

If we begin the conversation history of *empathy-in-interaction* with the patient's underdetermined, because vague, answer to the doctor's questions and enquiries about the profession, then after the end of the dramatic patient narrative, which is introduced with an explicit *regret* ("not fun, unfortunately"), as well as after the current doctor's empathic intervention and the patient's affirmative feedback ("that anyway"), we are now in the 10th position of an empathic communication pattern, which then experiences multi-part continuations in the same consultation (§ 19.8). Once confronted with his permanent feeling (of "always selling himself short"), the patient is apparently sufficiently stimulated to give his fantasies for an alternative future beyond the profession appropriate space by articulating his preferences (10P: "I would prefer to quit and ..."). These preferences are taken up again and further pro-

cessed in the same and the following consultation session, in which a preliminary decision for "early retirement" was apparently able to mature.

As already documented above (§ 19.8), the patient had come to the consultation with the request for a "gastroscopy", which had been performed, but without any abnormal findings. In a catamnestic interview, the patient had later reported that he had decided to retire early and had enjoyed his hobbies. Since then, there had been no more "stomach complaints", from which he had suffered for more than 30 years.

Relevance of the topic to professional life

This whole history of illness and life would have remained "undiscovered" if the doctor had been "satisfied" with the patient's first answer (02P: "I am a civil servant in the city of A") after his question about his profession, because he might have followed the widespread cliché of the "carefree" civil servant profession. Only his insistent enquiries revealed the patient's decades-long medical history as a story of suffering, who experienced the profession as a permanent burden.

While in this case we learned that the patient also factually followed his preferences for early retirement, we do not know to what extent the other patient also continued his "happy" working life after hospital discharge. In this ward round conversation, too, the positive significance of working life for the patient in the sense of a salutogenetic perspective would have remained "undiscovered" if the doctor had left it at the patient's first answer (42P: "I just have a construction business") and not inquired further. In any case, in both conversations the patients were able to intensively use their opportunities for narrative-emotional self-exploration in cooperation with their doctors, who for their part were recognisably committed to disclosing the individual meanings of their patients on a "sensitive" topic.

21.5.3 Subjective theories of illness

Patients do not only offer their subjective ideas about general life management, which they then specify, for example, as a stressful marriage, family or professional life, but also link their life-world ideas with their lay theories about health and illness. These lay theories are also la-

belled "subjective theories of illness" in distinction to the *objective theories of illness* of the medical experts and described in terms of their relevance for doctor-patient communication (Flick 1998, Birkner 2006, Birkner, Vlassenko 2015, Wöller, Kruse 2018, Albus et al. 2018). No matter how irrational, contradictory or mystical these subjective theories of illness may be, they must be discussed in doctor-patient communication if the interlocutors are not to talk or act past each other in the long term. According to Kruse, Wöller (2010/2018), if the subjective theories of illness are not brought up independently by the patient, they must be actively asked for in the conversation (Box 21.18), without overburdening the patient with hasty interpretations.

Box 21.18 Dealing with subjective theories of illness

Patients think very intensively about the causes of their symptoms. They develop a subjective theory of the disease, i.e. an idea about the development, the course and the maintenance of the symptoms. This theory of illness initially says nothing about the real causes. For example, one third of breast cancer patients are convinced that their cancer was caused by psychological factors, while many patients with depressive symptoms speak of a hormonal disorder (...) The subjective theories of illness give us information about the extent to which patients are prepared to see connections between their life situation, conflicts and symptoms. They are to be actively enquired about in the conversation so as not to overburden the patient with hasty interpretations, but to pick him up where he is at the moment.

Kruse, Wöller 2010: 59

Picking up the patient with his subjective theories of illness "where he is at the moment" often means in detail having to deal with a number of more or less "valid" explanatory concepts ranging from "genetic" factors to the influence of "weather", from "bacteria" and "environmental toxins" to interpersonal "conflicts" and "stress" (Albus et al. 2018). Before these theories of disease can be corrected or modified, if necessary, they must first be adequately explored. Otherwise, the risk must be reckoned with that they will later "backfire", which in turn can be reflected in irrational non-adherence.

The corresponding patient offers should therefore not be rejected because they do not fit into the doctor's concept of explanation and action, but should be *elicited* - as a preventive measure, as it were: if an irra-

tional theory of illness is known in good time, possible irrational illness behaviour can be counteracted in good time. Patients offer their *subjective ideas* and *theories of illness* both when *asked* and *without being asked.* Uncertainties can resonate in both variants, which should be given sufficient space through a relevance upgrade, even if the lay theories can prove to be wrong or in need of correction even at the outset. In the following, anchor examples for forms of relevance downgrading and relevance upgrading of subjective disease theories will be given, with which patients can more or less make themselves heard.

Relevance downgrading of the subjective disease theory

In interview practice, the subjective theories of illness are often overheard or ignored, as in the following example of a *relevance downgrading* (§ 19.4), the implications of which will be presented in more detail again here. Here, the patient tries to claim environmental pollution ("all the fumes without a mask") (E 21.48) at his current workplace as an explanation for his current complaints (including "circulatory disorders", "dizziness") and fails with this attempt at the very first attempt.

E 21.48		"that somehow it has something to do with it"	Comment
01	D	hm …	Manual 2.2: LS
02	P	and I can't imagine ... I was totally fit from the point of view of my circulation, and then 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 .	Manual 2.2: LS
04	P	that somehow it has something to do with it .	Subjective theory
05	D	but you don't have shortness of breath? .	Subject change: Manual 4.1: Exploring details: Accompanying sign
06	P	I have no shortness of breath.	
07	D	hm .	Manual 2.2: LS

Although the patient still introduces his subjective theory of illness relatively hesitantly and moderately ("I can imagine/ ... what I think"), it is ignored by the doctor in a way as if he had not heard it. Without a dialogical reference back, the doctor downgrades relevance by abruptly changing the subject by asking for an accompanying sign, and this still in a suggestive form ("but you don't have shortness of breath?"). If one does an *omission rehearsal* (§ 19.2), the entire sequence on this topic could be erased without missing the corresponding utterances of the patient. De facto, the communication continues with the question and the answer to the accompanying sign as if the patient had not said anything in advance that would have been relevant in any way.

Without having to take sides here and decide whether the patient has given a "valid" reason for his complaints with the environmental pollution ("vapours without mask") or not, it can be judged from an evaluation aspect of the conduct of the conversation that the doctor should have given the patient dialogue feedback - in whatever form and with whatever content.

As with all relevance downgrading of this type, which is characterised by a radical change of topic (§ 19.4), it is not only a matter of ignoring content, but also persons who make these content offers as patients. Compared to mere ignorance, which can be tantamount to a personal *devaluation* of the interlocutor, the rejection or mere modification of the patient's subjective theory would have been the better alternative of conducting the conversation, because the discussion of content is at the same time connected with a recognition and revaluation of the interlocutor as a person. Watzlawick et al. (1967/2011) once again remind us of the connection between *content* and *relationship aspects* (§ 7.4), according to which disturbances can occur alternately at both levels of communication.

These disturbances are often initially *latent* before they become *manifest,* for example in the non-adherence of patients who, from a doctor's point of view, are often seen as "surprisingly irrational", even though they had previously cooperated so "reasonably". Although such developments are anything but in line with expectations, they can be recognised in retrospect as "initiated" because patients were not sufficiently heard with their subjective ideas.

This is not just about personal slights qua ignorance on the relational level, but on the content level about the suppression of "beliefs" that patients associate with their subjective theories of illness. If these

beliefs are "suppressed" instead of being integrated or, if necessary, corrected or modified, they continue to remain *virulent* until medical decision-making (§ 10), where a pseudo-consensus may then emerge that was based on an interim *persuasion* rather than final *conviction* of the patient.

What can only be estimated as a possible development of risk in a continued pattern of ignorance can be prevented in advance if the beginnings are prevented and the subjective theories of illness are not suppressed, but rather elicited. Patients are also learning subjects who recognise what is "appropriate" from the doctor's point of view and what is not while the consultation is still in progress. At the same time, consequences for future conversation behaviour are drawn from this learning process, which are formative for further communication and can hardly be revised, because they also elude conscious control.

The first consequence, which the patient has subliminally drawn in the course of the conversation, obviously manifests itself in the fact that he has "fallen silent" for the time being on further subjective theories of illness. Even later in the conversation, the environmental stress mentioned by the patient is no longer a topic on which he apparently resignedly does not dare to take another topic initiative. If you like, the doctor has successfully "silenced" his patient through ignorance.

What consequences both conversation partners will draw as learning subjects from their previous communication remains to be seen in further conversations. From the point of view of disclosing subjective theories of illness, the course was set in the "wrong" direction, at least in this initial conversation.

Relevance upgrading of the subjective disease theory

If subjective theories of illness are brought up by patients on their own initiative, they should not be ignored by the doctor, but respected as an offer of interpretation and integrated in the further conversation – in whatever modified form. If an ad hoc clarification is not possible, at least a later examination must be held out in prospect. In contrast to a purely defensive attitude, with which one merely reacts to the patient's offers, doctors should adopt an offensive attitude and actively ask for subjective theories of illness, as already recommended in advance by Kruse, Wöller (2010/2018) (Box 21.18).

Furthermore, from a "communication psychology" aspect of relevance upgrades, it can usually be assumed that an interest expressed in advance is a stronger relevance upgrade than an interest assured afterwards. However, the "subjective theory" should not be asked literally because patients are not familiar with this form of expression ("What subjective theories of illness do you have?"). It is better to ask for possible "explanations". The (*conditional*) *explanatory questions* already described above (§ 21.2.5) have established themselves as standard formulations (such as "Can you explain why ..." or "Do you have an explanation why ..."), which can be answered "more straightforwardly" ("no") if necessary in negation than the corresponding word questions (D: "What explanations do you have ....?"), which might have to be answered differently (P: "none"). Regardless of the form of the question, even in the case of positive attempts at explanation, it is often necessary to reckon with preceding *uncertainty markings* by the patients ("I don't know, maybe ..."), with which the "hypothetical" character of the "subjective theories" is also emphasised from the patient's perspective.

In teaching, the following longer sequence of conversations (E 21.49) was often used to reveal the subjective theory of illness, because both "light" and "shadow" sides of the doctor's conduct of the conversation can be shown here. At the beginning of the conversation, the patient had complained mainly about "anxiety" ("which comes out of the blue") and offered an initial biomedically oriented subjective theory of illness ("somewhere I think you have something wrong with your heart"). After first clarifying the quality and the conditions of the occurrence of the complaints, the doctor then addresses the following question to the patient for a possible "explanation".

E 21.49		"I don't know, sometimes I imagine that ..."
01	D	do you have an explanation why this is the case now? .
02	P	I don't know, sometimes I imagine that somewhere/ . that this is more of the ... (2) .. from the soul than from the body ... because this year ... [exhales air] was quite hard, because there was a lot that had to be processed, maybe . [I haven't really processed it yet ... that I-
03	D	[that is . you have what is called stress? .
04	P	yes, trouble in the family and ... um in June I had a miscarriage and that maybe somewhere ... is not yet so processed that I can

		say, well I am over it .
05	D	yes, this miscarriage has been very difficult for you? .
06	P	[yes that is-
07	D	[is that/do you have problems with paternity? .
08	P	no, not at all, no .
09	D	you are married? .
10	P	no, I'm not married . I do have a daughter, though, and she's already eight . I'm not married.

This sequence on the patient's subjective theory of illness is initiated by the doctor himself by asking the type of conditional explanatory question in which the *why question* is embedded in the decision question ("Do you have an explanation why ...?") (§ 21.2.5). Although the preference for a positive answer is always recognisable in such questions, because otherwise they would not be asked in this form and with this content in the first place, they could simply be answered in the negative ("no"), possibly also combined with an expression of regret (e.g. "unfortunately not"). If patients start with a positive answer, the experimental nature of the explanation is often emphasised beforehand, as in this case.

The patient reacts to the doctor's question with an uncertainty marker (02P: "I don't know"), which she could also leave at that without needing to, before she then gives a further answer with an explanation, whose "subjectivity" is once again characterised in an extremely *defensive manner* as an occasional "imagination" (02P: "sometimes I imagine that ..."). Finally, the question posed by the doctor is used by the patient to place her subjective theory of illness, which she introduces *reactively* to the question, but on her own *initiative,* in that it is she who hesitantly, but then explicitly in the emphasis ("more"), makes a change from the "physical" to the "mental". At the same time, the patient, for her part, submits further, initially still abstract, offers of topics in keywords ("quite hard", "some ... not really processed yet"), which the doctor then takes up for his part with corresponding conceptual offers ("stress") for further exploration. As a result, beyond the "trouble in the family", the event that is significant in life ("miscarriage") is also brought up cooperatively by both interlocutors as an experience (04P: "not yet so processed" - 05D: "has been difficult").

Beyond the theory of illness, which is initially offered abstractly by the patient and concretised cooperatively, it should be pointed out for further teaching purposes that there are problematic points in the en-

tire sequence, which are partly determined by hasty *interruptions* (§ 19.3) and partly by *suggestions* (§ 21.2) by the doctor. In both interruptions (03, 07), the doctor should have waited for the patient to elaborate on her own initiative, instead of prematurely addressing the patient about possible "problems with paternity", especially in the second interruption.

The extent to which the doctor is "off the mark" with this "inappropriate" intervention can be seen from the patient's reaction, who has to reject this "insinuation" associated with the doctor's question indignantly according to her tone of voice and vehemently marked several times according to her words (08P: "no, not at all, no"). Likewise, the doctor's suggestive information question (09D: "You're married"?), which should remain frowned upon as a question type in principle (§ 21.2.6), is decisively denied by the patient ("nooo, I'm not married") before she offers further information about her family situation as a "surplus" - possibly also as a strategy for preventive conflict reduction in order to dissuade the doctor from his encroaching course of insinuations.

Here it can be discussed in the teaching to what extent the doctor not only unnecessarily loses tempo and topic with his speculations on the marital status and especially on paternity, in any case falls behind the achieved level of information on the patient's subjective theory of illness, but *suggestively* pursues his own subjective theory of illness as a doctor with an *encroachment* that must be rejected by the patient with great communicative and psychological effort. The alternatives of conducting the conversation should also be discussed, with which further information on the experience of the "miscarriage" on the one hand and on the "anger in the family", which has so far remained underexposed, on the other hand could be obtained, which we will come back to again under the aspect of ending the conversation ("drawing a conclusion") (§ 23).

For this conversation, it can be concluded that after an initially successful exploration of the patient's subjective theory of illness, the possibility of further detailed exploration of the two events and experiences relevant to her life was blocked by the doctor's hasty interruptions and suggestions.

21.6 Completing anamnesis

The *ideal of* a *complete* medical history can only ever be achieved *approximately.* According to practical standards, the art of taking an anamnesis is not only to fill in gaps, but also to tolerate gaps that can possibly be filled in later and only gradually. In any case, a case history must be continuously updated because changes may have occurred between the interviews that must be taken into account.

Especially in the *first conversation,* a selection has to be made, which cannot be decided on in advance, but only in the ongoing conversation, in which, if possible, a relevance structure emerges that proves sustainable until the next conversation, in which, in turn, the gaps of the preceding conversation have to be closed, etc. In the art of closing gaps, dealing with "sensitive" topics in particular proves to be a challenge, because here patients often more or less consciously leave gaps when they try to avoid the topics that are sensitive for them.

21.6.1 The art of closing gaps: The ZWECK concept

The question of the contents of a more or less complete anamnesis often leads to a dispute between experts in which the respective specialist's own orientation seems to dominate. Moreover, with all the mutual references to the gaps of the other experts, the *myth of* a complete anamnesis could be nourished, as already emphasised by Lipkin et al. (1995) (Box. 21.19).

Box 21.19 Myth of the complete interview

Many authorities feel that their particular interest is essential and must be explored with every patient. This fantasy of completeness contributes to the myth that there is ever a "complete" interview. There is not - only a more or less effective or thorough one. Each practitioner in each given case must decide how much time is available and how most sensibly to allocate it.

Lipkin et al. 1995: 77

So even if an interview cannot be complete, it should still be effective and thorough, which is to be decided not least according to practical action. According to Lipkin et al. (1995), certain lists of questions and topics (*important topics*) can also prove useful, which can serve as a reminder and orientation in order to register open points in certain subject areas (e.g. *review of systems, past medical history, social, psychological, sexual history*).

Thus, we have also created such an orientation list in the *Cologne Manual* and *Evaluation of Medical Communication* (C-MMC and C-EMC) to *complete the* anamnesis, to which we will only refer back at this point (§ 21.1) (see Fig. Appendix § 44). The "huge item" of "systems" alone, due to the metaphorical description ("from head to toe"), makes clear the wide spectrum of possible subject areas and detailed topics with which a catalogue of questions can take on an extent that would be impossible to manage conversationally, especially in an *initial interview.* Here, too, general and specific *focal points* of the anamnesis are indispensable, which at the same time must have the necessary courage to leave gaps.

As repeatedly described above (§ 3, 17), the *art* of conducting a medical conversation requires *flexibility* towards changing patients as personal interlocutors as well as their individual concerns and medical histories, with which specific clinical pictures can be identified that require further detailed differential diagnostic explorations.

Once the conversation has been initiated and developed, the further selection and deepening of topics is based on both the ongoing patient offers and the ongoing findings of the doctor, who may have to clarify suspected diagnoses. This clarification is carried out in a continuous, circular process (German: ZWECK = Purpose) in order to successively complete the anamnesis.

- **Z**uhören *(Listening)*
- **W**ahrnehmen (*Perceiving)*
- **E**rinnern (*Remembering*)
- **C**oding
- **K**ommunikation (*Communicating*)

In this circular process, certain gaps will prove to be relevant gaps, which in turn need to be filled conversationally. The art of gap-filling therefore consists of conducting the ongoing conversation in the communicative "foreground" and, while listening in the cognitive "background", also perceiving and remembering the (deficits in) information

and finally coding them according to clinical competences in order to then actively close the gaps afterwards if they are not filled ad hoc by the patient's contributions in the further conversation.

However, some problems "solve themselves" because patients do not provide the necessary information in the *clinical logic* of anamnesis, as preferred by the doctor, but they do provide it "free of charge" according to their own *life-world logic of presentation* in their descriptions and narratives, as this became clear in many examples. For example, the patients' descriptions of their current complaints are often combined with complaints about other (pre-)illnesses for which numerous pretreatments (surgery, medication) had "not helped", etc. Likewise, when telling their stories of illness as a *history of suffering*, the patients "casually" mention their important caregivers who are worried or from whom they receive support, so that questions about family status or the role of partners, relatives, friends, etc. are just as often superfluous.

In this respect, waiting in the conversation is often the better alternative to hasty questions, the accumulation of which in any case leads to conditioning in the direction of an *interrogative* conversation (§ 9, 19.6), in which the patients soon stop their narrative attempts and only wait for the next doctor's question, which they answer briefly and succinctly in anticipation of the further questions, and so on. If, on the other hand, relevant gaps in information remain even during a *biographical-narrative* anamnesis, they must be well *perceived*, *remembered* and *coded in* the cognitive background in order to then be able to integrate them *communicatively in a* suitable way in the ongoing conversation.[17]

The gaps initially perceived during *listening* are therefore not always to be closed immediately as soon as they become categorically "visible", but are to be tolerated in accordance with the patient's initially *associative* flow of narration and thoughts, which is only to be interrupted in the urgent case of *securing understanding* (§ 19.5), so that the two inter-

17 In contrast to a mere linearity, the (ZWECK/Purpose) process must be emphasised in its circularity in order to take into account the dependence of *listening* as well as of *perception* and *remembering* on the formation of categories (*coding).* After all, listening, perceiving and remembering can only be done in categories. Likewise, everything that is ultimately communicated is subject to such category formation beforehand, which was repeatedly captured in advance with the metaphorical notion that the doctor's *communicative* and *clinical* skills must "go hand in hand".

locutors are not exposed to misunderstandings in the further course of the conversation.

The *art of medical conversation* (§ 17) thus begins in the sense of Balint (1964/88) as the art of *listening* (§ 9, 21.1), in which at the same time the gaps are noticed and noted which the patient leaves - for whatever reason, for example because of assumed irrelevance or also out of shame etc., which is why he tries to avoid the topic which is "delicate" for him (§ 21.6.3). The doctor notices this, for example, in the patient's hesitant or evasive or vague answers, which can be *signs of* (conscious) *avoidance* or also (unconscious) *repression,* which in turn is noticed by the attentive listener and categorically recognised in its *clinical* significance and coded accordingly.

Once the doctor has identified the *relevant* gaps in the conversation via the ongoing circular (ZWECK = Purpose) process of *listening*, *perceiving*, *remembering* and *coding,* he must find or create the *appropriate* switching points in the ongoing conversation where he can *place* his questions to close gaps.

21.6.2 Appropriate placement of questions

Some gaps can be closed by "elegant" interposed questions *en passant*, which hardly disturb the patient's flow of narration and thoughts, but rather promote it. Other gaps remain for the time being, so that the corresponding questions can be inserted at a later point in time when a topic seems to be saturated or a "lull in the conversation" arises, or can also be asked *en bloc* when it becomes clear anyway that the conversation is taking on a different *structural* and *thematic shape* (§ 17.3) because the doctor is still asking his "typical" doctor's questions.

These "typical" doctor's questions can be expected by the patient anyway (qua *socialisation in* consultations), even if they can hardly be anticipated in detail and can (and must) rarely be comprehended in their clinical function. As the many conversation excerpts have already made clear, patients are usually not irritated when they come to the consultation with "headache" or "heartache" and are asked about other previous illnesses (also of their relatives) and furthermore about their eating, drinking or sleeping habits or about their family or professional life. If these questions cannot be "elegantly" integrated into the course of the conversation, they are often placed by the doctor with a kind of *meta-*

communication if a suitable "switching point" arises in the conversation, which can also be actively established.[18]

Metacommunication procedures

Such an *interface* often opens up after the doctor and patient have reached an intermediate consensus on a patient's request (e.g. for an examination), as in the following example, where the doctor metacommunicatively announces "a few more questions" (03D: "I still have a few more questions") (E 21.50), after he had already agreed to the patient's request ("gastroscopy"), who had therefore already come "sober".

E 21.50		"I still have a few more questions ..."
01	D	hm .
02	P	that's why I haven't eaten (...) drunk anything (...) so I'm (...) ready.
03	D	yes . okay . yes . we can do it . but I still have a few more questions .
04	P	yes .
05	D	it's been going on for a few years now and then, right? .
06	P	that has already started more or less when I (...)

Although the doctor is already accommodating the patient's request ("okay, yes, we can do that"), his metacommunication signals to him at the same time that he does not consider the conversation to be over with this consensus, but wants to continue with a "few more questions", which is also accepted by the patient (04P: "yes"), even before the doctor (05) asks the first question. Obviously, in the next "round of talks", the doctor is interested in transforming the *relationship model* of pure *service* ("gastroscopy"), which has been offered by the patient up to now, into a *model of cooperation* (§ 10, 22). Therefore, he must also develop the *biomedical* anamnesis, which was essentially reduced to the "stomach complaints" and their pre-treatments (clinics, surgery), in the direction of a *biopsychosocial* anamnesis, which goes beyond the mere com-

[18] In addition to the following examples, reference should be made to the many preceding examples in which the doctors integrated their questions to complete the anamnesis more or less "elegantly" into the ongoing conversation (e.g. § 19.7-9, 20.5-9).

pletion of psychosocial data, which have not even been touched upon yet.

From the subsequent "few questions", which also include the specific question about the "triggers" for the complaints, and the corresponding answers, a whole series of topics develops in the second half of the conversation, which also lead to the profession of the patient, who then tells his dramatic story of dropping out of his studies, which continues with all the consequences of suffering up to the present (§ 19.8). At the end of a mere eight-minute initial interview, the balance can be drawn of an anamnesis that is not complete, but sufficiently saturated, and which furthermore already reveals a therapeutic content.

Metacommunicative procedures are used in many variants in which the doctor himself (*ego*) is the actor of future actions, as in the preceding case in which the doctor announced his "few questions", which he then realised.[19] Another variant of the metacommunicative procedure is that future actions of both interlocutors are thematised ("We still have to clarify/decide .../ do X"). Prototypes for this occur in "agreeing on a course of action" (§ 22) and "drawing up a summary" (§ 23), where it is a matter of jointly deciding on and carrying out diagnostic procedures and therapeutic measures or of making appointments. In cases where the conversation work lies and should lie essentially with the patient, who has to "perform" certain speech acts (answers, descriptions, narratives, etc.), the doctor (*ego*) passes on the right to speak and talk to the patient (*alter*) with certain restrictive obligations to act. An established procedure in this context is the *topic-specific narrative invitation*, which goes far beyond its function as a conversation opener (§ 19.2).

Procedure of the topic-specific narrative invitation

While a whole series of "typical" doctor's questions were announced *meta-communicatively* at an appropriate point in the preceding conversation sequence, specific *invitations* to talk about certain topics are issued at other points. Thus, invitations to talk are not only valid at the beginning of the conversation (§ 19.2), but can also be renewed again and

19 We neglect at this point to compare similarities and differences in the uses of the terms "metacommunication" and "formulation", although the term "formulation" has also been used previously in the textbook (§ 8.4, 20.4) and elsewhere to analyse institutional communication (Koerfer 2013: 150ff).

again in the course of the conversation. A doctor who issues a further narrative invitation on a topic in the middle of the conversation explicitly indicates to his patient a relevance upgrade, which opens up a wider conversational space on the topic in question in the case of an everyday-world narrative concept. Four short examples of this *procedure* of a *topic-specific narrative invitation* with different broad topic focus will be given.

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

E 21.51		"can you tell me something about yourself?"
01	D	(...) um, yes . can you tell me a little bit . I would like to get a picture of you, yes . because I first want to understand who you are and/ or can you tell me something about yourself? .
02	P	pfh .... yes, my parents ... my father used to be a craftsman, but now he retired early because he (...) couldn't work any more ... it's probably also stress-related, because ... depending on when he gets upset, it's worse than usual ... I ... am the youngest child at home [Further explanations with medical enquiries].

In the second example (E 21.52), the longer phase of detailed exploration of the patient's complaints, in which finally the monosyllabic questions are also only answered in monosyllables, is apparently sufficiently saturated from the doctor's point of view, so that he now introduces a change of topic without further ado by issuing a narrative invitation on the specific topic of "profession".

E 21.52		"tell me what you do for a living"
01	D	(...) had any tingling? .
02	P	no .
03	D	numbness in the mouth? .
04	P	no ...

05	D	tell me what you do for a living .
06	P	I am an investment consultant . at a large company in the construction machinery sector . am responsible there for (...) [detailed job description with medical enquiries] .

In the third example (E 21.53), the conversation is at an advanced stage where the next steps are to be agreed upon. During his explanation of a possible examination procedure, the doctor changes the subject and towards the end of his contribution returns without further ado to the patient's complaints, to whom he makes a direct request to tell the story ("tell me your complaints again"), and the patient complies in detail with this request to *return* ("again") to the subject of his *complaints*.

E 21.53		"tell me your complaints again"
01	D	(...) every method has its faults (...) not everything is documented (...) or a proper examination in the sleep laboratory is done . that would be a possibility . tell me your complaints again .
02	P	the complaints are snoring . quite loud . I have trouble breathing . lately . I have permanent pains in my chest (...) yes . I am not concentrated . I have microsleep as I think it is called or something . I am actually able to sleep at any time in any place . because I am totally dull (...) yes . Concentration problems . I forget an awful lot lately .
03	D	hm . what for example? .
04	P	important things . unimportant things so criss-cross .

In the fourth example (E 21.54), it is apparently difficult for the patient to remember which medication he is taking, why and since when, so that the doctor issues a wide invitation to talk about this topic (05D), probably also in order to be able to draw further conclusions about the *medication* from possible information (about previous treatments by other doctors/clinics), which also leads to partial success here.

E 21.54		"can you tell how you got there now"
01	D	How long have you been taking these medicines?
02	P	I've been getting them since... since 2004.
03	D	hm . what do you get them for? .

04	P	why do i get the ..... (5) ..... I don't know ... if I'm honest, I don't know .
05	D	yes, can you tell me a bit about this ... how you got there, who first prescribed these medicines for you?
06	P	for the first time, they were prescribed to me by Doctor [name X] or Doctor [name Y], who are doctors in the hospital.
07	D	yes .
08	P	and then I am currently being treated by doctor [name Z], who is on [name]street .
09	D	hm .
10	P	and the last thing he prescribed me was [the name of the medication] and that just completely destroys me . yes . that doesn't help me one bit, no .

The preceding four invitations to tell (E 21.51-54), which are expressed here with a broad everyday-world narrative concept (§ 9), take on specific functions here to complete the taking of anamnesis on specific topics (*person*, *profession*, complaints, *medication*). The obligations to act introduced towards the patients are conveyed in different *indirect* and *direct* forms of realisation, whereby the indirect form ("Can you tell ...?") rather fulfils a function of traditional *politeness* (§ 7.3) compared to the direct (imperative) form ("Tell ...").

In each case, the patients follow the respective request, request or invitation to tell *cooperatively* without further irritation, although the change of topic is relatively *abrupt* in three out of four cases, which usually does not pose any *acceptance problems* despite all the *asymmetry* between the interlocutors.

21.6.3 Acceptance of asymmetry in the question-answer pattern

Whereas in the last example (E 21.54), the *medication* history is continued and deepened thematically by the narrative invitation, the first three examples (E 21.51-53), despite all their differences, have in common that these narrative invitations are issued after the relative saturation of previous phases of the conversation and lead to a *change of topic*. The invitations to talk are placed at points in the conversation that seem to the doctor to be sufficiently suitable for a change of topic, for example because from his perspective a *break* ("lull in conversation", "saturation of topics") has occurred anyway.

This specific *power of definition* in thematic *situation definitions* is part of the *asymmetrical* understanding of the roles of the two interlocutors (§ 7, 10), the validity of which is generally not questioned.[20] *The general hypothesis of the reciprocity of perspectives* in social action, highlighted by Alfred Schütz (1955/1971), cannot be invalidated in principle even in *institutional* communication if a reciprocity of understanding and comprehension is to be maintained (Koerfer 2013: 102ff). However, the *general hypothesis* takes on a specific form in consultation hours and rounds, which also affects the *organisation of topics.*

The patients usually accept more or less *abrupt* changes of topic by the doctor, which may not seem sensible to them at first, without irritation and cooperatively comply with the topic-specific invitations to talk.

This *cooperation* takes place in reliance on the *general hypothesis* of joint action, according to which the doctor makes the change to a new subject for good reasons, even if these reasons cannot and need not be comprehended in detail from the patient's perspective. The privileges of medical action accepted by the medical profession allow, to a certain extent, *non-reciprocity,* which is claimed and granted in the practice of action with the expectation that the medical privileges are not exercised to the detriment but in the interest of the patient, as long as the general *transparency requirement* of medical action (§ 10.5) is essentially observed.

Although not every singular doctor's question can be justified individually, the *overall interest* in the taking of the medical history and later decision-making should be *recognisable* in good time for the patient, who must be able to understand *cum grano salis* "what the doctor's questioning should aim at", the meaningfulness of which must be proven in the long run. This is the credit of trust that the patient grants to the doctor's privileges of action and that the doctor must profitably use in the "mutual investment society" (Balint 1964/88: 335ff, 373ff) for the benefit of both and must not gamble away.

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20 The fact that doctors' privileges and competences (§ 3, 7, 10, 21) can also be directed against the interests of their patients through *strategic* action (interrogation, manipulation, suggestion, ignorance, instruction, etc.) is another (empirical) matter, which is also described in this textbook with many examples from a critical evaluation perspective. Only occasionally are the backgrounds also questioned by the patients themselves ("Why are you asking me this?"). For practical reasons, not all, but the essential topics and concerns in the consultation hour and ward round should continue to fall under the *transparency requirement* (§ 10.5) of medical action.

As has become clear in many preceding examples and in the last ones (E 21.51-54), the action-practical effectiveness of the *general hypothesis* usually manifests itself in a smooth change between topics whose "jumpiness" can still be accepted as *rational* on the manifest "surface" of the conversation because of an assumed overall sense of medical action.

However, the range of impositions must neither be formally overstretched by a dominantly *interrogative* interview, in which the patients must passively "jump after" the doctor's interrogation questions without actively taking part themselves (§ 19.6), nor be overstretched in terms of content with a confrontational interview, in which the doctor can "offend" the patient with his invasive questions.

As a rule, doctors find the individual level of imposition that is just bearable for patients due to their *solidarity-helping* conversation attitude (§ 3, 8), which will be explained in conclusion with examples of the so-called "difficult" or "delicate" topics.

21.6.4 Dealing with "difficult" topics

Topics can be experienced as "difficult" just as much as people. During consultations and rounds, dealing with "difficult" topics and "difficult" patients often coincides (§ 34). Some patients react to certain topics on the one hand (*defensively*) in an easily overheard "obdurate", "hesitant" or "evasive" manner, but also (*aggressively*) in a particularly inaudible "loud" and "clear" manner. Different topics can prove to be more or less "difficult" or "sensitive" for different patients, which cannot always be anticipated in advance, but can only become apparent during the conversation.

Life experience teaches us that people can talk openly about their marital problems, but not about their money problems, because it is a well-known fact that "the fun stops when it comes to money". However, financial problems are often a topic in medical consultations because the "worries" and "stress" of patients, for example in the case of unemployment or divorce, can also extend to material circumstances. In addition, doctors are familiar with specific problems such as *poverty in old age*, when the "co-payments" for medicines can be "painful", and so on.

Furthermore, depending on the specialist field, there are various topics that can be considered "sensitive" from the patient's perspective, such as *alcohol consumption* and *(poor) nutrition* in internal medicine,

hygiene in dermatology or *sexuality* in gynaecology or urology. In general practice or psychosomatics, of course, all "sensitive" topics can occur, so also violence, suicidality, abuse, etc.

Even though the spectrum of "difficult" topics is extensive and diverse, "classic" topics can be named, for example, in the communicative handling of *alcohol* and *sexual problems,* which will be mentioned here in conclusion with short examples and as examples for many other problems.

Communication about sexual problems

Sexuality is undoubtedly a *sensitive* topic that is often avoided, not only in everyday life but also in medical consultations. We had already emphasised in the differentiation of question types (§ 21.2) that there are no *standard questions* on sexuality that would be appropriate for all situations and towards all cultures and patients of all ages and genders. Thus, questions like the following can cause embarrassment or even indignation.

- Have you had sexual intercourse yet?
- Do you still have sexual intercourse?
- Are you (already/still) sexually active?
- How often do you (still) have sexual intercourse?
- Do you have intercourse with changing partners?
- With how many partners do you have sexual intercourse?

But even seemingly open or neutral questions like

- What about sexuality?

can already be experienced as "encroaching" and rejected as "unseemly", depending on age, religious and cultural affiliation. In view of the importance of the topic, it may be surprising that sexuality plays a marginal or even no role in the general textbooks on conducting conversations.[21] This is all the more surprising because the topic of sexuality is

[21] While the topic of sexuality was also largely left out of "older" textbooks (probably still adhering to the tradition of the time) (e.g. Morgan, Engel 1977, Adler, Hemmeler 1989, Dickson et al. 1991, Silverman et al. 1998), it is also often neglected or only marginally treated in "newer" textbooks,

not only relevant for gynaecology or urology, but also in many treatment contexts (general practitioners, internal medicine, etc.), such as chronic diseases (CHD, diabetes mellitus), in which *sexual dysfunctions* are to be expected due to the side effects of medication (Ladwig et al. 2013). Thus, in an initial interview under the aspect of *relevance treatment* (§ 19.4), it turned out more or less incidentally that a patient had already discontinued a medication ("beta-blocker") (E 21.55) in accordance with his concern due to his experience ("erectile dysfunction") in consultation with the pre-treatment GP.

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

Relevance to life is expressed here by the patient in a strong metaphor (08P: "felt like half a person"), which after discontinuation of the medication points to a serious conflict of goals: it is a potential conflict between patient *preferences* motivated by life and *evidence-based* re-

e.g. Platt, Gordon 2004, Tate 2004, McCorry, Mason 2011, Fortin et al. 2012, Brown et al. 2016, Simpson, McDowell 2020. By contrast, see e.g. Lloyd, Bor, Noble (2019) with a separate chapter on "Discussing sensitive topics", pp. 49-59.

quirements of medicine (§ 10, 22), which was apparently already taken into account in the pre-treatment by the GP, which now becomes an issue again. If the patient had not made a relevance test on his own initiative (04D: "I don't know if this belongs here now"), the conflict might have remained hidden. The example makes it clear how feared or experienced disturbances of sexuality can turn from a *latent* problem into a *manifest* main topic when, for example, conflicts of goals of this kind have to be decided under the aspect of *adherence* (§ 10, 26) while maintaining an (equal) quality of life.

While in this example *sexuality* was only moved from a *latent* problem into the *explicit* focus of the conversation through the patient's own initiative, in the following example it is in the possible range of topics of the conversation partners from the outset, but it also has to be verbally "retrieved" from latency and transferred into the manifest "surface of the conversation". The young patient had come to see the doctor because of "quite severe abdominal pain", for which the gynaecologist had referred her for co-treatment within the framework of basic psychosomatic care (§ 15, 25). The anamnesis is already at an advanced stage when the doctor, after asking questions about her partnership, also directly addresses the subject of *sexuality* (E 21.56: 03D: "Intimate life").

E 21.56		"and how is the intimate life . is it possible?"
01	D	hm... yes... so a really close relationship is already?...
02	P	yes, he is quite a bit older than me. He is now 26, a little more than 7 years old .... and ... let's see...
03	D	um... and how is the intimate life . is it possible? .
04	P	so normally no problems ... the only thing now was uh... lately I couldn't sleep with him because of the pain ... because it was too strong and uh...
05	D	that is, the complaints occurred during/above all during intercourse.
06	P	hm .
07	D	. is that the way I have to imagine it now, that this is a new addition, and it wasn't like that before? .
08	P	no, it wasn't like that before, it's not always like that now either, but sometimes more often and sometimes not ...
09	D	and then does that . does that cause discomfort in intercourse? .
10	P	hm .
11	D	in uh . may I ask further questions? .
12	P	for sure .

13	D	yes? . is that possible? . is it like that when the member is inserted or ... that ... the vagina is not moist, or what causes discomfort? .
14	P	hm . yes . so . I mean, when inserting . that eh . hurts somewhere . and eh . he probably also meant that I would then become tighter and tighter over time . so he . he wouldn't really get in anymore . (...)

Due to a relationship that has apparently already developed in a sufficiently trusting manner, the topic of sexuality can be openly addressed by the doctor here and continued by both conversation partners "without shyness". Nevertheless, the doctor is aware of the "delicate" subject matter when he quasi assures himself of the patient's "permission" when going into further detail (11D: "May I ask further questions?"). Even if this question was "only" meant as a rhetorical question, it reveals the sensitivity of the topic for both interlocutors. The special nature of this question can be seen in the *request* for *permission,* which doctors otherwise hardly ever ask about other topics, because they usually take the right of speech and topic for further detailed exploration without explicit permission. Here, the topic of sexuality retains a special status of *(in)speakability* in comparison to other "sensitive" topics, which also include dealing with (problems with) *alcohol consumption,* although "cautious" communication is also called for here in order not to risk unnecessary defensive processes.

Communication about alcohol problems

Doctors are not "moral judges" or "health apostles", but they are counsellors who also have to draw the attention of patients at risk to certain risks, which of course include first and foremost the personal health risks that generally exist with addictive diseases. This is not only about immediate health risks, for example through excessive alcohol consumption, but also about risks to oneself and others, as in the case of "drinking and driving" or also (after-) and side effects from the use or abuse of *sleeping pills* and *painkillers,* for example in the case of machine operation at work etc.

Although prevalence figures for alcohol dependence of 10-20% can be assumed in GP practices and clinics, depending on the focus of treatment (Helmich et al. 1991: 207 ff, Fritzsche et al. 2003: 296ff, Ärztekammer Nordrhein 2015: 46ff), the conversation on this topic often turns out to be difficult, if it is not already avoided completely by the patient or both conversation partners. For the communicative introduction to the "delicate" topic of "alcohol consumption", the example of Boyd, Heritage (2006) (E 21.57) should be cited again, in which the patient vaguely answers the corresponding doctor's question.

E 21.57		"Alcohol use?" - "Hm:: moderate I'd say"
01	D	Alcohol use? (1.0)
02	P	Hm:: moderate I'd say. (0.2)
03	D	Can you define that, hhhehh (laughing outbreath)

Boyd, Heritage (2006: 174)

Although patients (have to) expect the doctor's question about *alcohol consumption as* well as about *smoking* or *nutrition (*qua socialisation in many consultations), they often answer vaguely and evasively (02P: "moderate I'd say"), as in this example, so that the alternative on the doctor's side is to leave it at that or to ask specifically. In this case, the doctor's immediate question (03D: "Can you define that") was accompanied by a laugh, which is obviously a sign that this is a "sensitive" topic, both for the interviewee and the questioner. Unfortunately, we do not know how the patient finally answered the doctor's "definitional" question, as Boyd and Heritage (2006) do not report on the continuation of the conversation, nor on the doctor's level of medical knowledge in this specific case.

In the event that the "laboratory values" should "speak volumes" later on, doctors are in any case under communicative pressure to delve into the "delicate" topic and ask detailed questions, which is not by chance described as a necessary "gamma-GT conversation" (Helmich et al. 1991, Fritzsche et al. 2003/2016, Schweickhardt, Fritzsche 2007/2009). However, even with prior medical knowledge, there are no communicative patent remedies to overcome possible defence processes of the patients.

This also brings us back to the difference between *decision-making* and targeted *word questions* (§ 21.3), which must be taken into account especially in the case of "sensitive" questions. A doctor who asks a specific word question about alcohol consumption, which is already aimed at the quantity, thereby indicates certain expectations, which may already be based on a concrete "suspicion". For such cases, Coulehan and Block in their early, extremely differentiated textbook (1992) give the specific recommendation (Box 21.20) to ask a quite specific word question about the ("daily") amount of alcohol.

Box 21.20 Targeted word question on alcohol consumption

One does not ask "yes/no" questions in situations when information may be sensitive, because a lie will close off all access to that information. For example, it is not useful to say, "Do you drink alcohol?" if one suspects alcohol may be a problem; try, "How much alcohol do you usually drink in a day?"

Coulehan, Block 1992: 63f

Such a recommendation should be discussed openly in teaching: It must be left open in individual cases to what extent possible "lies" can be favoured or prevented with one or the other form of questioning in a sensitive topic such as the alcohol problem. Those who want to "avoid" medical questions because of their specific (addictive) disease can initially remain "immune" to an apparently "better" questioning technique. Thus, it may already be "booked" as a *relative* gain in information if patients admit to consuming a certain (daily) amount of alcohol at all, even if the stated amount does not yet correspond to the "full" truth.

In addition to the *form of the question, the choice of words* comes into play again, which the doctor must pay attention to under both perspectives of participation (*ego*, *alter*) (§ 21.3.2). Here the doctor should not tend to *exaggerate* his own choice of words ("booze", "swallow" instead of "drink"), nor should he unquestioningly accept *understatements* from the patient if he takes refuge in the common language phrases ("A little drink never hurt anyone..." etc.). In contrast to such a *diminutive* (german *diminutive* form: *Gläschen*), at least in the case of "trivialising" formulations ("a few small beers/wines"), the quantities should be "objecti-

fied" by means of correspondingly insistent enquiries by the doctor, recognisable to both interlocutors.

The "open" word, which should be located between exaggerations and understatements (§ 21.3.2), applies not only directly to patients at risk of addiction, but also to their relatives, for example when they have to be addressed in the role of *co-alcoholics* (Helmich et al. 1991, Fritzsche et al. 2003/2016). The patient, whose ambivalence conflict had already been addressed by the doctor with his *interpretations,* was obviously also in this role (§ 20.6). In the same consultation, the doctor had previously used the term "alcoholic" just as openly as an attribution to the partner (E 21.58), towards whom the patient was wavering between separation and continuation of the relationship.

E 21.58		" ... ever considered whether your husband might be alcoholic?"
01	D	have you ever considered whether your husband might be an alcoholic? ...
02	P	yes, yes, he is .
03	D	he is .
04	P	yes, yes, he is, that's what they already told him, uh . years ago in this therapy he was told ... that's who he is and he's also aware of that ...
05	D	what does that mean for you now? .
06	P	I don't think it's necessarily good, but on the other hand, I think it's such a widespread thing in society today. why does a person like that have to end up in the gutter?
07	D	you actually want to help him? .
08	P	yes, yes ... that was always my intention from the beginning ... I mean ... um ... I (...)

Precisely because the doctor and the patient quickly reach an understanding in clear language, the doctor can deepen the topic with his questions about the individual meaning and the patient's intentions just as quickly and work out the basic conflict together with the patient, which he then interprets later with the *thematic key symbols* ("tension", "clamp") (§ 20.6.4).With this preliminary *verbalisation* of the basic conflict at the end of the consultation, the prerequisites were created for further treatment of the topic in follow-up consultations, for which couple conversations were also arranged. The quick opening and under-

standing on this "delicate" topic was certainly due to an already well-developed relationship of trust between doctor and patient based on a jointly developed history of interaction in which the paths for *open* communication had already been paved.

The art of closing gaps on sensitive topics

In initial consultations, the hurdles for *open* communication about addiction issues are certainly higher and *denial* on the part of the affected patients, but also their relatives, is often to be expected because the reticence may be more pronounced for many reasons (pride, fear, shame, etc.) towards the doctor who is still *a stranger* at first. These hurdles in dealing openly with addiction problems can rarely be overcome *confrontationally* ("with a crowbar"), but may require repeated attempts in a *tangential* communication (§ 3, 17). In line with the recommendation of Morgan and Engel (1977), the doctor should "drop the sensitive issue for the time being" if the patient is clearly *defensive,* in order to "come back to it later by a roundabout route" (see Box 20.11) (§ 20.3.4). Therefore, especially in the case of *sensitive* issues, the motto can be followed:

"Postponed is not abandoned!"

This long-term conversational attitude of deliberate waiting requires (1) a good *memory*, (2) a lot of *patience* and (3) a fine *sense* of when conversations are sufficiently "matured" for the placement and deepening of even "delicate" topics. Such a concept of conversational attitude corresponds with the previously described circle of *listening*, *perceiving*, *remembering, coding* and *communicating* (§ 21.6.1), in which the *art of conducting medical conversations,* as explained above (§ 17) and illustrated with many examples, was last specified as the *art of closing gaps* in completing the anamnesis.

The art of guiding medical consversations, however, is first of all to keep conversations *open* (in terms of results) for a sufficiently long time in order to avoid hasty conclusions of topics. Even if, at the end of the consultation, for practical reasons of time limits, conclusions have to be reached - however provisionally - the topics that are still open should be formulated as such in the *résumé* (§ 23) and, if possible, taken up again in the follow-up consultation as a joint task for further clarification.

All in all, the art of medical conversation can only be exercised in *successive* processes and according to the patient's willingness to *ac-*

tively cooperate, which cannot be forced anyway, but can only be promoted through repeated attempts at *persuasion* in the positive sense of *conviction.*

21.7 Further information

For the task of detailed exploration, the forms and functions of medical questions were differentiated in advance using a didactic model with anchor examples. In case of further interest, please refer to the literature listed there, as compiled at the beginning (in Note 2) and taken up again under certain aspects (suggestiveness, forms, contents and functions of questions, interpretations). Those who have less time should definitely use it to read the "classics" Morgan and Engel (1977), whose excellent textbook we have also used extensively here. Those interested in subtle observations on the obscenity of questioning in general will find many suggestions in Bodenheimer's (2011) treatise, which can be transferred from everyday communication to medical-therapeutic communication.

In addition to the unsurpassed textbook by Morgan, Engel (1977) already mentioned, the older textbook by Adler, Hemmeler (1989) and the more recent textbooks by Fortin et al. (2012), Cole, Bird (2014), Lloyd, Bor, Noble (2019), Simpson, McDowell 2020 should be referred to as examples of the dimensions of complaint exploration. On the important topic of dealing with patients' subjective theories, the works of Flick (1998), Birkner (2006), Kruse, Wöller (2010), Birkner, Vlassenko (2015), Albus et al. (2018) should be mentioned.

On specific aspects of psychotherapeutic interpretations and interpretations, the volume by Peräkylä et al. (eds.) (2008) and the monographs by Pawelczyk (2011), Scarvaglieri (2013), Grimmer (2014) are again cited as examples; in addition, reference is made to the empirical works by Buchholz (2014, 2017), Buchholz, Kächele (2013, 2016 and 2017), which essentially follow a conversation-analytical approach. Such an approach is also followed by specific contributions in Scarvaglieri, Graf, Spranz-Fogasy (eds.) (2022) on specific types of conversations (psychotherapy, medical encounters, coaching, social media).

Thematic overlaps of this chapter (§ 21) exist both with the previous chapter (§ 20) on dealing with emotions, which were often subjected to detailed exploration, and with the subsequent chapter on "Agreeing on a

course of action" (§ 22), which again deals with detailed explorations of patients' subjective knowledge as well as interests and preferences in the context of education and decision-making.

As a suggestion for advanced teaching and training, we have reproduced excerpts from Freud's (1985) conversation with Katharina at the beginning of this chapter (§ 21.8), which lends itself to a complete reading in order to be able to discuss it critically as a model conversation also under the aspects and categories differentiated above.

21.8 Freud's conversation with Katharina: A teaching play

The problems and aspects of questioning and interpreting discussed above (§ 21.2-3) are to be discussed here for advanced teaching and further training using an example of a conversation which has come down to us from Freud (1895) as an excellent document of his way of conducting conversations.

Of course, it is not a document in the sense of a recorded conversation (§ 2), as it could later be used with the help of tape recordings, for example by Rogers (1942/1985) for the study of his *non-directive* conversational style (Koerfer et al. 1996, 2010) (§ 19.3, 40). Rather, it is a conversation that Freud reconstructed in retrospect from the memory of his (chance) encounter with the young "patient" Katharina and traced in writing ("The conversation that now occurred between us I reproduce as it impressed itself on my memory, and leave the patient her dialect") (Freud 1895: 185) (E 21.59). Despite all the empirical lack of authenticity, it can be assumed that the conversation took place in such a way or something similar to how it has been handed down to us by Freud.

In any case, the simulation of the oral-dialogical characteristics of a conversation allows the conclusion that it is a version of a conversation specifically authorised by Freud, which he not only reproduced truthfully from memory to the best of his knowledge and belief. Rather, it can be assumed that the reproduction of the conversation also corresponds to his normative ideas of how conversations should be conducted:

Despite the empirical "smears" on a conversation that was reproduced from memory, the *publication* at the same time represents an *authorisation* of a conversation exemplar that can be considered a model conversation for a conversation model. Otherwise it would not have

been published in this form.[22] From this point of view, we can "take the conversation at face value" - despite all the empirical-methodological limitations: the conversation allows an insight into a reality of conversation as it was finally shaped personally by Freud in his double function as a doctor conducting the conversation and as an author. On this assumption, the abridged information that Freud prefaces his rendition of the conversation is provided here for better understanding (Box 21.21).

Box 21.21 Background to the conversation with Katharina

In the holidays of the year 189* I went on an excursion to the Hohe Tauern to forget medicine and especially neuroses for a while. After a strenuous hike to the top, strengthened and rested, I sat there, absorbed in the contemplation of a delightful view, so oblivious that I did not want to refer to myself when I heard the question: "Is the gentleman a doctor? But the question was for me and came from the eighteen-year-old girl who had served me my meal with a rather grumpy face and had been called "Katharina" by the landlady (...) So there I was again in the neuroses (...) I was interested that neuroses should thrive so well at an altitude of over 2000 metres, so I continued to ask.

Freud 1895/1952: 185

We only reproduce the conversation here in highly abridged form in exemplary excerpts and recommend the complete version in the original for teaching and further training. We insert Freud's dialogue text alternately into our transcript form verbatim, prefixing the respective speech contributions with the speaker sigles F(reud) and K(atharina). Occasional comments by Freud, which represent *conversational reflections* in the sense of a "meta-doctor" (von Uexküll, Wesiack (1991) (§ 3.3)), are inserted accordingly marked (R). Short transitions between the contributions (e.g. "so I said: ..." - "you on it: ...") have been omitted here. Otherwise, everything has been taken over verbatim (according to Freudian simulations of oral speech) as in the original.

22 When assessing this type of conversation, however, the early period (1895!) must be taken into account, so that the conversation with Katharina can only be taken as typical of the later development of "psychoanalytic" conversation to a limited extent. For a brief overview of the development of conversation in this tradition, we refer to Lorenzer (2002: esp. 63ff) (with further literature there).

E 21.59		An "educational play": Freud's conversation with Katharina (excerpts)
	R	The conversation that now took place between us, I will reproduce as it has impressed itself on my memory, and leave the patient to her dialect.
01	F	What are you suffering from?
02	K	I have shortness of breath, not always, but sometimes it gets me so bad that I think I'm suffocating.
	R	Now this didn't sound nervous at first, but it immediately became likely to me that it was only meant to be a substitute term for an anxiety attack. From the sensation complex of fear, it unduly emphasised the one moment of breath constriction.
03	F	Sit down here. Describe it to me, what is such a state of respiratory distress like?
04	K	It comes over me suddenly. Then it first settles like a pressure on my eyes, my head gets so heavy and it rushes, I can't stand it, and I'm so dizzy I think I'm going to fall over, and then it squeezes my chest so tight I can't breathe.
05	F	And you don't feel anything in your throat?
06	K	My throat constricts as if I were to suffocate!
07	F	And does it do anything else in the head?
08	K	Yes, it hammers to bursting.
09	F	Yes, and aren't you afraid at all?
10	K	I always think, now I have to die, and I'm otherwise courageous, I go everywhere alone, into the cellar and down over the whole mountain, but when it's a day like this, I don't dare go anywhere, I always think there's someone behind me and suddenly grabs me.
	R	It was really an anxiety attack, initiated by the signs of the hysterical aura or, rather, a hysterical attack whose content was fear. Should there be no other content?
11	F	Do you think something, always the same, or do you see something in front of you when you have the seizure?
12	K	Yes, I always see such a horrible face looking at me, I'm afraid of it. (...) (...) [longer omissions]
13	F	If you don't know, I will tell you what I think gave you your fits. Once, two years ago, you saw or heard something that embarrassed you, something you would rather not have seen.

14	K	Oh Jesus, yes, I caught the uncle with the girl, with Franziska, my cousin!
15	F	What's the story with the girl? Don't you want to tell me?
16	K	You can tell a doctor anything. So you know, my uncle, he was my aunt's husband, the one you saw there, used to have the inn on the **kogel with my aunt, now they're divorced, and it's my fault that they're divorced, because it came up through me that he's keeping it up with Franziska.
17	F	Yes, how did you come to the discovery??
18	K	It was like this. Two years ago, once ... [longer story] (...) (...) [longer omissions]
19	F	If you vomited three days later, I think you were disgusted at that time, as you looked into the room.
20	K	Yes, I will have been disgusted [she says thoughtfully] But by what?
21	F	You may have seen something naked? What were the two people in the room like?
22	K	It was too dark to see anything (...) (...) (...) [longer omissions of indirect speech, among other things].
23	R	(...) The mystery was thus solved, she had not been disgusted by the sight of them, but by a memory that that sight had awakened in her, and all considered, it could only be the memory of the night raid when she "felt the uncle's body". So I told her, after she had finished her confession:
24	F	Now I know what you thought back then, how you looked into the room. You thought: now he's doing to her what he wanted to do to me that night and the other times. You were disgusted because you remembered the sensation of waking up in the night and feeling his body.
25	K	It's possible that I was disgusted by it and that I thought that at the time.
26	F	Tell me exactly, you're a grown-up girl now and you know all sorts of things -
27	K	Yes, now of course.
28	F	Tell me exactly, what did you actually feel of his body that night?
29	R	But she doesn't give a more definite answer, she smiles sheepishly and as if convicted, like someone who has to admit that we have now got to the bottom of things, about which not much

more can be said. I can guess what the tactile sensation was that she later learned to interpret; her expression also seems to tell me that she expects me to think the right thing, but I can't penetrate her any further; anyway, I owe her thanks for being so much easier to talk to than the prudish ladies in my city practice, for whom all *naturalia* are *turpia.*
Thus the case would be settled; but (...)

Freud 1895/1952:185ff

Note from us: *Naturalia non sunt turpia* (Latin: The natural is not offensively).

For a better understanding of Katharina's entire case history, the complete conversation, the reflexive comments as well as a factual correction, which Freud only makes later for reasons of "discretion", should be taken into account. As Freud corrects in an "addendum" from 1924 to the (*authenticity* of the) case history, Katharina was not the niece but the daughter of the landlady, which makes a considerable difference in this case, as Freud (Box 21.22) himself emphasises in his comparison.

Box 21.22 Abrogation of discretion

After so many years I dare to lift the discretion observed at that time and state that Katharina was not the niece but the daughter of the landlady, the girl had thus fallen ill under the sexual temptations emanating from her own father. A distortion like the one I made in this case should definitely be avoided in a medical history. Of course, it is not as insignificant for understanding as, for example, moving the setting from one mountain to another.

Freud 1895/1952: 196

The short excerpts from the conversation documented here, which focus mainly on the beginning and then on short excerpts from the further course of the conversation, are only intended as a first suggestion for using the whole development of the conversation and Freud's analytical comments and reflections on the conversation as a "lesson" in conducting the conversation, with which we have had good experience in teaching and further training. Especially with regard to the question raised by Morgan and Engel (1977) (Box 21.1), to what extent "influencing" the patient is permissible and useful or not, the individual sequences of conversations should be reflected upon speech by speech.

The categorical distinctions that have been differentiated in advance (§ 21.2-3) on the basis of anchor examples (according to more or less open or closed word, decision or suggestive questions and interpretations) can be helpful here. In the evaluation, the success achieved by Freud, whose conversation with Katharina brought to light the "history of the illness" from which his young "patient" had been suffering for so long, must ultimately also be taken into account.

Since Freud "did not see the girl again", he can only sum up at the end: "I hope that the conversation with me has done some good to the girl whose sexual feelings were hurt so early on" (193). The fact that the brief encounter can only be a partial success, even according to Freud's critical assessment, is written on another (*psychotherapeutic*) page, which Freud (1985: 194f) briefly describes in conclusion (under the keyword "epicrisis"), thus offering further discussion material for advanced teaching and training beyond the guidance of the conversation.

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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 ...?"	⓪❶❷❸❹
2 Greeting • Make eye contact • Verbal greetings, shaking hands • Address by name	⓪❶	2 Exploring subjective ideas • Concepts *"What do you imagine?"* • Explanations *"Do you see causes?"*	⓪❶❷❸❹
3 Introducing yourself • Introduce yourself by name • Communicate function ("ward doctor")	⓪❶	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)	⓪❶❷❸❹
4 Situating • Speak sitting down (chair to bed) • Ensure convenience • Coordinate proximity/distance	⓪❶		
5 Orientation • Structure conversation • Goals, time, frame	⓪❶		
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?"*	⓪❶	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	⓪❶❷❸❹	2 Clarify expectations • Ideas, wishes, hopes *"What did you have in mind?"* • Control beliefs *"What could you change yourself?"*	⓪❶❷❸❹
3 Active listening - verbal support • Encourage speaking up • Repeating statements verbatim • Paraphrase statements • Openly ask further: *"How did that come about?"*	⓪❶❷❸❹	3 Explaining previous findings • Communicate diagnosis • Communicate problems	⓪❶❷❸❹
4 Ensure understanding • Ask "Do I understand correctly ...?" • Summarise	⓪❶	4 Examination or therapy plan • Explore decision model (SDM) • Discuss proposals and risks • Consider reactions • Strive for consensus	⓪❶❷❸❹
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	⓪❶
2 Empathise with patient's situation		2 Offer clarification of outstanding issues • Information *"Do you still have questions?"* • Satisfaction "Can you handle it? "	⓪❶
3 Respond empathically • Offer appropriate help and comfort • Acknowledge burdens, coping	⓪❶❷❸❹	3 Arrange follow-up appointments • Examination appointments • Set a meeting date	⓪❶
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..."*	⓪❶❷❸❹	4 Say goodbye to the patient	⓪❶
		5 Complete documentation • Coding & conversation impressions • Topics for follow-up talks	

⓪❶ [⓪ = not met;❶ = met] ⓪❶❷❸❹ [⓪ = not met ...❹ = fully met]

Fig. 21.3: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)