23 Drawing Conclusions

Summarising and Giving Perspectives

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> Closing clinical consultations has not been the subject of much analytic attention, particularly in comparison to other phases of the medical consultation.
>
> White 2015: 170

Abstract: An essential function of ending the conversation is to build a *bridge* between the current and the following consultation, until which a helping relationship should continue to have an effect and be sufficiently sustainable. The more the patient is involved in the final phase of the consultation, the better this bridging function can be fulfilled. Ideally, the patient's interests are taken into account in all aspects that are to be differentiated in the 6th conversation step of the manual (Fig. 23.1).

In practice, however, less detailed closing phases are to be expected, which do not necessarily have to be deficient. In the case of long-term relationships and care histories, the end of the conversation can often be brief and to the point, because the participants can communicate with a few key words in their routine dealings on the basis of shared prior knowledge. But here, too, as especially in initial conversations, several steps and attempts at understanding are often necessary so that it becomes sufficiently clear which objectives are to be pursued for the next conversation, until which the *helping relationship* must be bridged satisfactorily for the patient.

Altogether, three types of conversational developments are to be distinguished in the final phase: (1) Conversation *terminations*, (2) *rounding off* conversation, (3) Conversation *expansions*. These types of conversation termination and their sub-types will be differentiated in the following on the basis of the corresponding manual steps and concretised in detail using examples from the final phase of conversations. Finally, suggestions will be made for documentation after the end of the conversation, so that a continuous continuation of the conversation is guaranteed, in which possible gaps in the medical history are to be closed, which then also includes the balancing of previous diagnostic and therapeutic measures that were initiated in the current conversation.

23.1 Manual step 6: Drawing conclusions

In the practice of real conversations, often not all aspects that we have differentiated in the 6th step of the manual are taken into account (Fig. 23.1). While abbreviated procedures for ending the conversation can be tolerated in follow-up conversations, care should be taken, especially in initial conversations, to ensure that as many aspects as possible are sufficiently taken into account that can contribute to the patient's safety until the follow-up conversation. This includes not only the final scheduling of diagnostic and therapeutic measures, but also questions about further concerns and the satisfaction of the patient, who must bridge the time until the next visit to the doctor with the interim result of this conversation.

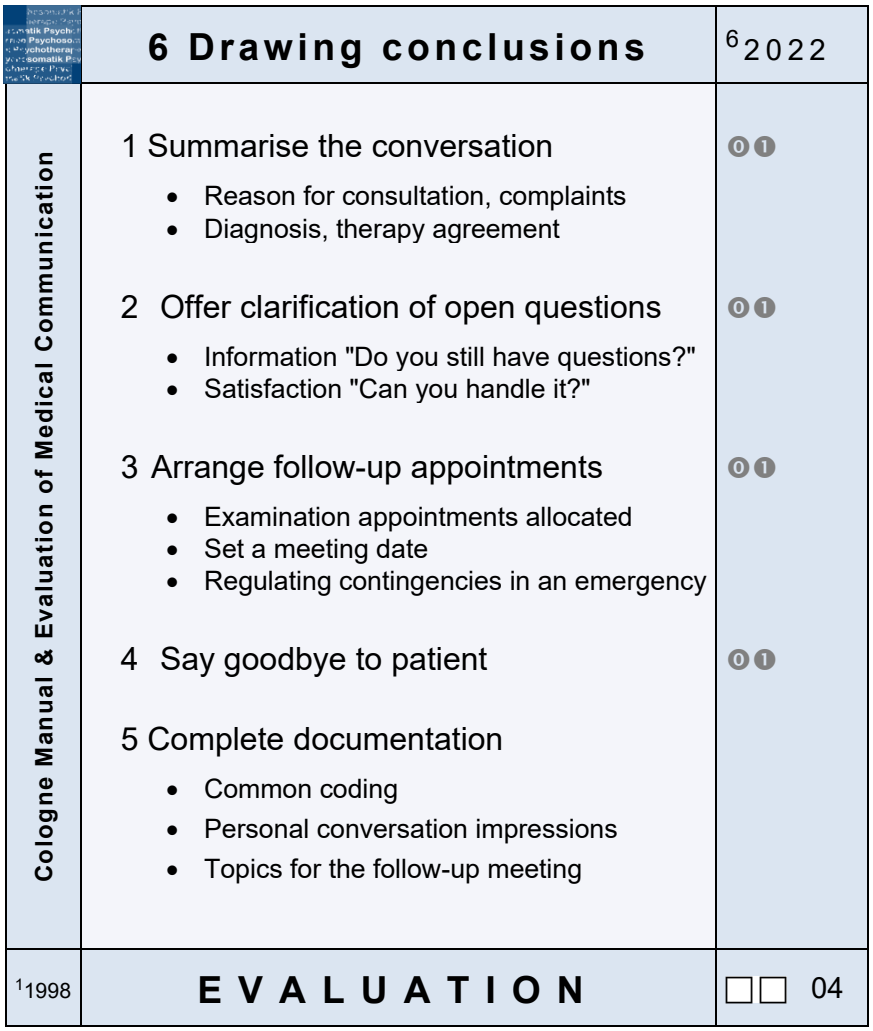

Fig. 23.1: Excerpt (Manual/Evaluation): Step/Function 6: "Drawing conclusions" (Cf. the complete Manual at the end of the chapter, Fig. 23.2)

As has already been made clear (in the motto), the termination phase of conversations has only been insufficiently studied in comparison to other conversation phases, even from the perspective of experts (West 2006, White 2015). This shortcoming can hardly be overcome here with the few selected aspects and examples that are intended to serve as didactic orientation in conversation termination. The relevance of the *bridging function* of the termination phase can be overlooked, in which the effectiveness of a *helping relationship* is to be secured until the next doctor's visit (§ 3, 8). In practice, more or less successful cases can be distinguished, which would have to be further differentiated in a functional conversation analysis, in which entire interaction histories of follow-up conversations would ultimately have to be taken into account. To this end, the examination of selected examples of conversations can only ever be a beginning for a broader *comparative conversation* analysis, as outlined elsewhere in the handbook (§ 2, 10, 17, 19, 40).

For didactic purposes of orientation in teaching and further training, we group the aspects in Step 6 of the manual according to three types of conversation development, whereby further subtypes can be distinguished:

(1) **Conversation terminations**: Conversations can be terminated more or less abruptly, which often happens *implicitly* through an immediate transition to the examination, which can be *moderate* to *abrupt.* In addition, the end of the conversation can also be accomplished by an *explicit* closing formulation by the doctor after a sufficient saturation of topics and conversation has been achieved. In this case, in a further subtype, the patients can take the *initiative* for ending the conversation.

(2) **Rounding off conversations**: Conversations can be rounded off by drawing a more or less detailed *summary* in the sense of our manual (Fig. 23.1). In the *ideal case* of the complete final phase of a conversation, (a) the previous findings, decisions and perspectives for action are summarised, then clarifications (b) of open questions and (c) of the patient's satisfaction are made possible and (d) the further conversation and examination appointments are agreed upon and, if necessary, (e) emergency arrangements are made before finally (f) the patient is "officially" said goodbye.

(3) **Expansions of conversation**: Despite the doctor's initiatives to end the conversation, patients may resume old topics or introduce new ones. As subtypes, one can distinguish smaller *supplements to new starts* of conversations, in which completely new concerns of patients can come up, which may well "go beyond" the previous scope of topics. In extreme cases, a follow-up conversation with new patient complaints and concerns may already develop from the currently concluded conversation, leading to its own conversation and relationship dynamics.

These (sub-)types will be concretised in the following by means of examples. In the evaluation, we also focus in the 6th step on conversation termination of our conversation manual on *observable* conversation behaviour, for which a total of 4 out of 50 points can be awarded according to C-EMC (Cologne Evaluation of Medical Communication) (Fig. 23.1+23.2). Finally, some suggestions are made for the documentation of conversations (§ 23.6), which should also be taken into account in teaching and training under this documentary aspect, because they help to structure the follow-up conversations.

23.2 Terminations of conversations

We start with breaks in the conversation, where either the end of the conversation is explicitly pronounced by the doctor without a transition, or a transition to the examination is established moderately to abruptly. In these cases, the transitions can be experienced more or less as deficient from the patient's perspective if the previously discussed topics have not yet reached sufficient saturation. In another subtype, the final initiative may also be explicitly verbalised by the patients themselves, who seek to release their doctors from further "obligation to talk" in a kind of "self-censorship".

23.2.1 Explicit medical closing formulations

Conversations are often concluded "briefly and succinctly", without any summarising transitions being given by the doctor. In contrast to initial conversations, in repeated follow-up conversations the two conversation

partners can often already refer to longer histories of interaction and care, which apparently allow a more or less abrupt closing formulation by the doctor in routine treatment. In the following example (E 23.1), the doctor can conclude the conversation relatively abruptly with an explicit closing formulation without the patient being particularly irritated.

E 23.1		"Let's call it a day. . you'll be in touch again"
01	D	(...)
02	P	(...) because, as I said, when I'm a pensioner, we do so many things... and it's just the opposite.
03	D	a huge disappointment .
04	P	yes . a real . real disappointment! I have to say, he's doing his job, but he's already doing everything, no . but then there's always the drinking and then [...] like an old man of 70 .
05	D	Mrs S . let's call it a day . yes? . you'll be in touch again .
06	P	yes . i'll get back to you . right . it doesn't help . [I have to get through this.

The patient seems to be able to accept the abrupt conclusion well, because in the course of the conversation so far she had had her say about her complaints and concerns in detail. Most recently, she had complained about her retirement life with her husband, which the doctor had acknowledged in several *empathic* feedbacks (§ 20.6). The harmony between the interlocutors was last expressed again in the *empathic* communication when, after the doctor had named her emotion (03D: "a huge disappointment"), the patient indicated through the almost literal restatement (04P: "a real disappointment") that she obviously felt well understood by the doctor. In any case, the topic of the "disappointing" retirement life again experiences a relevance upgrade by the doctor, which stimulates the patient to prolong her tale of woe, which is reproduced here in abbreviated form (04P). The doctor can now intervene at this point in the conversation with a "final word" because this story of suffering is already sufficiently known to both partners from this and the preceding conversations. The doctor and the patient are both aware of the resulting burden, which at the advanced stage of the conversation does not require any further detailing in order to achieve further clarification or even a change in their life situation.

For her part, the patient, despite all her resignation, draws a practical conclusion on her way out ("it doesn't help, I have to get through this"), which the doctor can leave uncommented. The topic of the current stress, which was intensified by a visit of the (partly foreign-speaking) relatives from "America", had already been discussed in detail. Since nothing was to be changed in the medication either (on the patient's known heart and blood pressure problems), the doctor can, according to the final formulation, limit himself to his role as a helper who makes himself available if necessary ("You'll be in touch again"). This doctor's offer is also accepted by the patient through explicit affirmation ("yes, I'll get back to you, right"), so that the bridging function in the helping relationship is perceived by both sides until the next consultation.

23.2.2 Closure through patient initiatives

When topics or entire conversations have reached a sufficient "saturation", they can also be ended on the patient's own initiative. In the following conversation, in which a number of topics had been discussed in detail (physiotherapy after surgery, cholesterol values, restrictions in physical exercise, etc.), the physical restrictions are once again brought up as a topic, whereby the patient finds it difficult in everyday life not to let anything "show". After the doctor has expressed his understanding several times in *empathetic* feedback, the patient ends the topic on her own initiative (E 23.2), with a reason that is tantamount to critical *self-censorship* (06P: "but I don't want to keep you"). By saying thank you and goodbye to each other ("bye"), the end of the conversation is formally completed.

E 23.2		"but I don't want to keep you"
01	D	that . where you just say that again . that not letting it show.
02	P	hm . that's the worst ...
03	D	that . yes .
04	P	yes . that requires tremendous strength ....
05	D	yes ...
06	P	but I don't want to keep you ... thank you very much .
07	D	yes bye .
08	P	goodbye .

Apparently, patients themselves often enough recognise in a critical self-assessment the relevant final point in a sufficient saturation of topics and conversations, which they then decide to end on *their own initiative* - whatever is meant and understood by those involved as relief. In the following example, too, a certain saturation has occurred after a whole series of topics have been discussed ("ringing in the ears", "burdens" with the husband, "blood values" of the patient suffering from leukemia, "values" with "low" blood pressure, "vice" of smoking, etc.). Finally, the topic of "ringing in the ears" comes up again (E 23.3), before the patient then marks the conclusion on her own.

E 23.3		"... and then get back to you"
01	D	yes . I can write down the [drops] again . yes . we could do it .
02	P	I mean, if I take a few ... uh ... like this ... and what do we do with them [points to ears] ... go to the ear doctor? .
03	D	in uh ... we can, we have to look at that again, and ... it could be that uh ... the whole burden that you have with your husband at the moment.
04	P	that it is stronger because of it.
05	D	that it is stronger because of it.
06	P	I'll wait a little longer [stands up] . and then get back to you.
07	D	yes .

After the many previous topics, the doctor and the patient quickly adopt a joint perspective on the topic of "ringing in the ears", which the patient brings up again, whereby the patient can already anticipate the doctor's contribution in a *joint sentence production* (04P: "that it is stronger because of that"). After the practical conclusion ("I'll wait a little longer"), the patient also independently announces the use of the doctor's role as a helper if necessary ("and then get back to you"), whereby the doctor only emphatically agrees ("yes"). All in all, the patient not only verbally marks the end of the conversation several times, but also de facto stands up at the same time.

Here, too, the conversation may have reached a sufficient point of saturation from the patient's critical self-observation perspective, which leads to a voluntary self-restraint in the use of the doctor's services, without this claim having to be completely abandoned. Rather, it is kept alive in the "prophylactic" announcement of a repeated "re-registration"

if necessary ("I'll get back to you") - which, despite the self-evident nature of a trusting doctor-patient relationship, is renewed again and again at the end of the conversation as a ritual with a bridging function.

23.2.3 Direct transition to the examination

While terminations can be carried out more or less explicitly through the doctor's or the patient's initiatives, the doctor's transitions to the examination represent implicit terminations of the conversation. Even if the transitions from the conversation to the examination are carried out directly and without a final phase, they can be more or less moderate or abrupt, so that two subtypes can be roughly distinguished in this dimension.

Abrupt transition

For the subtype of an *abrupt* transition, the problematic example (E 23.4), which had already been described as deficient under the aspect of *empathic* communication (§ 20.4), should be mentioned again. For a better understanding, the information from the previous conversation history should be added, according to which the patient had already mentioned the "other trouble in the family" beforehand, without immediately getting to the point, which is why she now has to make another attempt on this topic.

E 23.4		" ... then I will examine you now"
01	A	(...) so you say yourself that there is stress behind it ... or are there other things that cause you problems? I mean other difficult things.
02	P	well I had other/other trouble in the family within .
03	A	hm .
04	P	which is actually still ongoing, which was only there recently, where a lot of things got mixed up... but ... that's also the only thing then .
05	A	hm . yes Mrs S . I think I will examine you now .
06	P	hm .

After the first unsuccessful attempt at the beginning of the conversation, the patient now tries again to introduce the topic that is obviously relevant to her ("trouble in the family") at a designated point in the conversation where the doctor had opened up a suitable topic opportunity (01D: "stress (...) problems (...) other difficult things?"). The patient readily takes up this conversation offer, which the doctor offers with a wide range of topics, and again places her specific topic offer explicitly and unmistakably (02P: "other trouble in the family (...) where a lot of things also got mixed up"). Although the doctor is here appropriately under pressure to react to the current patient offer under the aspect of *conditional relevance* (§ 9.4), he makes a radical change of topic with a relevance downgrade.

Instead of taking up the topic of the "trouble in the family" through simple forms of *active listening* and deepening it through *relevance upgrading* (§ 17, 19), the doctor sets a communication stopper (*truncator*) ("hm . yes Mrs S") and immediately leads over to the examination ("I think, then I will examine you now"). This not only shuts down the patient's topic, but also her associated emotion, which may not be recalled in a follow-up conversation. Patients are also learning subjects who can recognise in good time in the ongoing interaction with the doctor what is thematically "in" in a conversation and what is not, because the doctor obviously shows no interest.

Moderate transition

While in such cases the topic and at the same time the end of the conversation is abrupt because the doctor switches from *patient's events* (such as "trouble in the family") to doctor's *events* ("examination") (§ 19.7), the change of topic may appear less abrupt from the patient*'s* perspective if the doctor is already moving within a thematic chain of doctor*'s events,* for example in the case of the typical doctor*'s* questions in the system anamnesis, which he goes through "from head to toe" (§ 21.6). A corresponding transition from the relatively saturated system anamnesis to the examination can then be perceived as less abrupt in many cases, because the patient has not been able to "get to the point" in an initiative way for some time anyway, but answers doctor's detailed questions much more reactively to complete the anamnesis. Following a series of doctor's *events,* the transition to the examination then appears to be *moderate* if the patient's interest in the topic is obviously not cur-

tailed. In the following example (E 23.5), for example, the doctor moves directly from his last detailed explorations to the examination without first making an intermediate summary.

E 23.5		"yes . then I would like to examine you for a moment"
01	D	great .
02	P	hm .
03	D	and appetite, digestion, bowel movements, is everything okay? .
04	P	hm .
05	D	great .
06	P	hm .
07	D	yes . then I would like to examine you for a moment .
08	P	hm .

Such an abrupt transition from conversation to investigation could also be observed in many previous examples, which can only be referred to here by way of example (§ 19.6, 19.8). Since in these cases our empirical data collection also ended for the further analysis of the conversation, we can only speculate about the possible continuation of the conversation during and after the investigation. In any case, a *break in the flow of conversation* can be observed, which in the last example is less severely interrupted than in the previous example, where a typical *patient event* ("trouble in the family") remained unaddressed because it was replaced by a typical *doctor event* ("examination") - with all the risks that ignorance entails by interrupting an emotional topic of conversation. In principle, however, it cannot be ruled out that in cases of a direct transition from the conversation to the examination, a resumption and continuation of conversations that were merely "interrupted" in the meantime can occur, which could then ideally be concluded completely in a similar way as will be described below with the type of *conversation rounding off*.

23.3 Rounding off conversations

In the ideal case of ending the conversation, the steps of the manual are completely fulfilled, but in practice this remains the exception. Especially in follow-up conversations, abbreviated procedures are often chosen,

which can nevertheless be perceived from the patient's perspective as a satisfactory *rounding off of the conversation,* in which a *helping bridging function* until the next visit to the doctor is perceived to a greater or lesser extent.

23.3.1 Bridging function of helping

In the interviews available to us, "complete" interviews in the sense of taking all aspects of the manual into account were rather rare (Fig. 23.1). In many conversations, especially in follow-up conversations, which were characterised by routines of further treatment, the clarification of *open questions* and *patient satisfaction* were missing (§ 23.3.3-4). Often, the farewell took place "appropriately" outside the consulting room, because the doctor accompanied the patient outside to the "reception" to make appointments or write prescriptions, or the intermediate step of the examination took place in a separate treatment room, where the communication was possibly continued and concluded with a farewell.

Summaries of the consultation were sometimes made in between in the ongoing conversation as interim summaries, while at the end a balance of the results was drawn and the further objectives were put into perspective (§ 23.2.2). Particularly in initial interviews, the results will often have to remain rather vague, since the findings are still at the beginning and must first be expanded and deepened through further interviews and examinations. Nevertheless, the doctor must formulate possible steps in relation to the patient's expectations of his role as a helper, which can at least serve a bridging function until the next consultation, even if immediate help cannot yet be provided here and now.

At this intermediate stage in initial consultations, the doctor often sums up the conversation with a metaphorical comment according to which he or she has first "formed a picture" of the patient or the illness. Analogously, the continuation for a follow-up consultation is then put into perspective in such a way that the doctor first has to "complete the picture" before the problems at hand can be specifically treated further.

In the following example of an initial consultation (E 23.6), in which a number of complaints and suspected diagnoses have already been discussed, also by previous practitioners, the doctor sums up the knowledge and interim results gained so far with such a "picture" perspective, with the restriction that he would like to "study all the physi-

cal examinations again" (03D). After an interim solution of helping, the doctor then makes the proposal for another appointment, to which the patient has to adjust for the time being in a *wait-and-see perspective*.

E 23.6		"that you can help yourself at the moment"
01	D	hm . i would like to suggest the following . i have actually already been able to form a certain picture .
02	P	yes .
03	D	but I would like to say again that I would like to study all the physical examinations again.
04	P	yes .
05	D	and I now suggest that you first of all do this pain therapy immediately.
06	P	yes .
07	D	that you can help yourself at the moment .
08	P	yes .
09	D	but I would suggest that we make another appointment.
10	P	yes of course .
11	D	yes? .

As the many listener responses ("yes") show, the patient is quite reasonable about the reasons given ("studying the file") and is generally prepared to wait for the next visit to the doctor for further clarification before she can be helped further. The doctor can obviously anticipate that the vague summary ("I have actually already been able to form a certain picture") and the expected bridging perspective may be unsatisfactory for the patient. In any case, he simultaneously proposes a kind of interim solution ("pain therapy"), which is to be carried out "initially" and "immediately" in order to offer the patient some "help" "at the moment", which is then also realised immediately after the conversation in a treatment room. This establishes a short- and long-term *relationship of helping,* in which the patient, trusting in the future result of the doctor's "study of the file", has to wait until the next visit to the doctor.

While in this case "momentary" help for pain relief was still possible, in most initial consultations patients have to adopt a *wait-and-see perspective* until the follow-up consultation, by which time laboratory results can be expected, for example, on the basis of which decisions on further help can be made. As will become clear in further examples, the corresponding objectives for future action are then summarised in the

final phase of current conversations, which are intended to serve the bridging function of helping until the next appointment.

23.3.2 Summarising

Summaries can refer *retrospectively* to past actions and *prospectively* to future actions, whereby a distinction must be made between *communicative* and *instrumental* actions (§ 7, 8). If, for example, the objectives for follow-up consultations are summarised, instrumental actions are also discussed, which are then also carried out between the consultations and without direct medical involvement, such as taking blood samples before laboratory examinations (§ 8.2). In this context, possible results are already anticipated in the consultation, which are to be used as a basis for future decision-making, e.g. when a decision has to be made between continuing or changing the current medication, which can already be formulated as a topic in advance in the current course of the consultation, etc.

As a prototypical example with a *summary,* in which an already completed decision-making process is summarised towards the end of the conversation and the further meaning and purpose of future action is put into perspective for the follow-up conversation, the termination sequence (E 23.7), the development of which had previously been traced under the aspect of "agreeing on a course of action" (§ 22.4.2), should be considered again. In the course of the conversation, the doctor and the patient had already agreed to check whether the patient's "skin changes" were due to the side effects of medication, for which further laboratory results had to be awaited. After this interim assessment, the doctor had also extended the anamnesis to include other complaints of the patient ("problems with the back") and discussed his family and professional situation, before returning to the patient's current reason for the consultation at the end of the conversation (E 23.7) and then giving a perspective on the joint action until the follow-up conversation.

E 23.7		"appointment for 20 minutes so that we can get to know each other better"
01	D	then we'll do the following, we'll just have a short talk today ... please continue to take the medication, I'll check it next week in the blood test .

02	P	all right .
03	D	yes, and then you can make an appointment for 20 minutes or so please.
04	P	yes, it's no problem.
05	D	that we get to know each other a little better.
06	P	no problem doctor .
07	D	agree? .
08	P	agree .
09	D	fine, I'll make you the appointment in front .
10	P	let’s do it . [both walk out]

In this final sequence, the past and future actions of the two interlocutors are once again summarised. Beyond the decision-making process, in which the current medication is to be continued for the time being, subject to the results of the examination (02P: "all right"), an appointment is to be made for a longer conversation "so that we can get to know each other better" (05D). Because the first interview, which was mainly about the main concern of the "skin changes", was obviously too short with regard to the further collection of anamnesis, the omissions should be compensated for in the follow-up interview.

For the purpose of this further objective of an initial consultation, longer appointments are normally reserved in this GP practice (§ 25.6), which in this case was not possible ad hoc and should be made up for accordingly. This objective is alternately agreed upon several times by both parties (04-10) before they both leave the consulting room to make further appointments. In order to bridge the gap until the next consultation, the patient can take with him the intermediate result that the doctor offered his assistance under both aspects, namely on the one hand in clarifying the concrete problem that had been the current reason for the consultation ("skin changes") and on the other hand for the long-term assumption of the role as "future" family doctor, whom the patient had to choose anew because of his change of location.

23.3.3 Clarification of open questions

The clarification of open questions occurs less frequently than would be desirable in terms of relevance in the practice of general practitioners and specialists. Yet the "classics" of research and didactics on doctor-

patient communication have already identified the question of open issues as a *maxim* for conducting the conversation towards the end (Box 23.1), for which they even give a concrete recommendation for formulation.

Box 23.1	Question about open topics

At the end of the interview, whether the history is complete or not, the doctor gives the patient another opportunity to bring up something that may have been bothering the patient for a long time. He simply asks, "Is there anything else you would like to talk about?"

Morgan, Engel 1977: 58

Although the question about open issues could easily be asked in this form towards the end of the conversation, it is often omitted. Apparently, the question about open questions is avoided because the feared risks are to be avoided. These risks are often summarised by members in training groups as the fact that conversations could "get out of hand" thematically. Such fears had already been mentioned in relation to *empathic* communication, in which patients' emotions were to be warded off as "uncontrollable" (§ 20.2). With this defence, a possible success through a correspondingly restrictive conduct of the conversation is simultaneously assumed, through which certain topics could be avoided "in the long run".

In contrast to open, empathic communication, which not only passively allows topics but actively promotes patients' initiatives, the assumed alternative should be briefly paraphrased once again: If, as a doctor, you want to suppress certain topics anyway, you use an interrogative interview style that only allows asked topics from the outset (§ 19.6). However, it must then be expected that the topics that have been successfully suppressed for a long time, which also include corresponding *attitudes* and *emotions* of the patients (*doubts, disappointments, anger,* etc.), can later "break through" in other ways than conversationally, be it through *non-adherence* of patients or their *change of doctor* (§ 10, 19, 26). In contrast, a *narrative interview style,* as described above and supported by many examples (§ 9, 19), can bring to light topics that are relevant to the patients and that cannot be easily asked.

In addition, the *question* about *open questions* can take on an exceptional function, because this type of question opens up a wide range of

topics from which the patient can choose according to his or her individual *preferences*. In practice, the feared risks of a "sprawling" conversation often turn out to be unfounded, because after a sufficiently saturated conversation, the patients often enough do not use the opportunity to talk and discuss at all, or only to make minimal additions.

In the following example (E 23.8), the development of the conversation had already been traced beforehand, the subject matter of which was primarily determined by the "fear of cancer". Although the doctor "cannot recommend" the examination requested by the patient, both had agreed on this, which is now summed up again before the doctor asks for further *open questions*, which he formulates here in a modified form (11D) that roughly corresponds to the above recommendation by Morgan and Engel (Box 23.1).

E 23.8		"do you have anything else to talk about"
01	D	I would say the following: we can . we can do the examination, yes . I don't recommend it, yes . I even think that it is not really necessary . but it is important to me that you are reassured . above all, it is important to me that you have the feeling that you are really one hundred percent, yes .
02	P	been checked through, yes.
03	D	and . when we have the result, yes . and we have the point, then I would like to continue the conversation.
04	P	yes we could .
05	D	yes? .
06	P	yes sure .
07	D	that we'll see how it is then .... yes, what do you think of that? .
08	P	yes okay, agreed, why not .
09	D	yes? should we stay like this? .
10	P	sure .
11	D	great . do you have anything else to . talk about? .
12	P	oh no, but the girl can take my blood pressure, then I don't need to bother you. but here . [points to her foot] . that's how it starts . and then it goes up to here . and I often get the lump here too, it's suddenly there . and I can't get it off . and I don't know what from . although I mainly wear flat shoes (...) .

This further topic offered by the patient is then taken up by the doctor with an *empathic* relevance upgrade ("does that worry you?") before he then announces an examination ("we'll take another special look at

that") and both leave the consulting room, so that we have no further data on the progress (examination result, appointments, etc.). In any case, the doctor's question after a question that was still open ("do you have anything else to talk about?") only prolonged the pure conversation time by about one minute. The fact that questions after *questions* that remain open can also make more communication space necessary will be shown by further examples, where at the end of the conversation there can be larger *supplements* or even *restarts* of conversation (§ 23.4). Possible extensions of the conversation must also be expected with the related question about *patient satisfaction*, which can take on the function of a stimulation of the topic in the final phase at the end of the conversation in a comparable way, in order to check and secure the sustainability of the help offered at least until the next consultation.

23.3.4 Questions about patient satisfaction

Those who ask questions about patient satisfaction certainly run the risk of being confronted with patient dissatisfaction. However, open communication will be more effective and efficient in the long run than the possible alternative of repeatedly dismissing dissatisfied patients from the consultation who have not sufficiently had their say with their disappointments and frustrations. Often enough, the doubts, objections and resistance of patients later find their way into the conversation without being asked or they are reflected in non-adherence.

We recall the example of the patient who was dissatisfied with the mere referral to the radiologist and only demanded help with her current pain in the final phase of decision-making (§ 22.4.3). She was also sceptical about the new measure suggested by the doctor ("injection") (E 23.9), as in her last experience it had not been sufficiently effective before.

E 23.9		"so . please take off your coat"
04	P	no! . now . but how/what do I do now with the pain? . I can't stand it any more .
05	D	today? .
06	P	[nods] .
07	D	we need to give another injection right away, targeted . I know that you were doing better after two or three infusions last week

		or two weeks ago.
08	P	yes . and I got an injection rather last week . I think on Monday morning or something . I had a day or two of rest . I thought, great, it's going to work . and then I was here on Wednesday . it also got better over a few hours ... and on Friday nothing, no reaction at all, not at all .
09	D	so . please take off your coat .

If the doctor then simply ignores and ignores the patient's concerns by only giving a verbal instruction ("please take off your coat") in preparation for his instrumental action ("injection"), it is probably only a matter of time before the patient expresses her continuing dissatisfaction more explicitly in a subsequent session - which could of course only be empirically verified by the long-term observations mentioned at the beginning.

Also in the three following examples on the question of patient satisfaction, it can only be about satisfaction in the "here and now" of the current consultation, in which in each case a decision, however provisional, must be made for (further) treatment, which in the case of different clinical pictures relate to short- to long-term perspectives. The first example (E 23.9) is about physiotherapy (after an accident), which is to be continued under certain conditions ("taxi").

E 23.10		"is that enough for you today, or do you still want . "
01	D	yes .and now to/for physiotherapy . that also goes easily, yes? .
02	P	yes . that's possible . that's possible . yes .
03	D	when the taxi comes, yes? .
04	P	the strength training, which is also part of it, that gives me pleasure even .
05	D	Mrs F. yes . is that enough for you today . or do you still want ....
06	P	no, no . no, no . that's good .
07	D	the values are basically the same as they were in the past, there is an increase ... sometimes I think, when you say that . You fall into a hole, yes . so these situations, that are also huge efforts for the body .
08	P	yes . yes .

The doctor's question about the patient's satisfaction leads to a short digression, which de facto hardly takes any time here. However, the end

of the conversation, which had already been mentioned before (§ 23.2.1), only comes about after just under two minutes because the doctor invites the patient to discuss a topic (07D: "You're falling into a hole"), which the patient then legitimately engages in for a longer time. Nevertheless, it was the patient herself who finally brought about the end of the conversation on her own initiative in a kind of self-censorship (E 23.2: 06P: "I don't want to keep you any longer").

In the second example (E 23.11), the doctor and the patient agree, after a long discussion, to postpone knee surgery as long as possible. Towards the end of the discussion, the doctor once again ascertains the patient's preference before asking to what extent the patient will be able to "cope" with the expected pain.

E 23.11		"can you cope with that?"
01	D	so you'd also rather . we keep dragging this out? .
02	P	with the operation . definitely .
03	D	and with the pain that's there now . can you cope with that? .
04	P	I can cope with that, but it's ... eh . eh . and ask Dr. Schulz if I have an easy job . it's not an easy job (...)

Consent is limited here by work-related stresses, which will soon be eliminated, however, as the patient will soon retire at an advanced age. On the subject of retirement, there is another short dialogue between the doctor ("then you can live with the complaints") and the patient ("I can live with it"), before the conversation is finally ended with a clear signal of agreement from the patient ("all right"). After the doctor's question, the "remaining time" until the end of the conversation was about one minute, which served not only to clarify the patient's current satisfaction, but also the patient's further career and life perspectives, which had already been discussed in previous conversations and could now be further concretised for the given reason.

The following conversation is also about waiting for a possible operation. The doctor informs the patient that he does not currently have to "fear" that "you will have difficulties walking", before summing up: "The intervertebral disc situation is good". However, since it is to be expected that the complaints, which had already been discussed at length, will continue, the doctor asks the patient about his satisfaction (E 23.12), which is answered in the affirmative by the patient.

E 23.12		"is that enough for you?"
01	D	is that enough for you? .
02	P	yes . in itself .
03	D	yes? .
04	P	I ... I'll do what I want to do now ... and if it doesn't work any more, we'll try an injection or something...
05	D	yes . any time . yes . that's possible and .
06	P	yes . there is no reason to do anything different now, no . and I am happy as long as I can still walk . [both leave the consulting room]

Although the patient answers the doctor's question in the affirmative ("yes"), his residual scepticism is unmistakable ("in itself ...") and is also heard, understood and answered accordingly by the doctor ("yes?"). However, the patient then emphasises the "here and now" of the decision-making process, in which he already anticipates further help in the event of a problem, for which he both asks for and receives his doctor's consent. Since he expresses his personal satisfaction ("I am happy") under a certain condition ("as long as I can walk"), both interlocutors can end the conversation in this common perspective by getting up and leaving the consulting room without further ado.

The last two cases are essentially a type of decision-making in which both partners finally agree on a preferred option of "watchful waiting" (§ 10.3). In this process, the patients' possible coping problems in everyday life may not yet be fully anticipated by the patients themselves. Patient satisfaction is certainly often an *unstable* issue that remains a permanent problem in consultations, whether manifest or merely latent. In the latent case, not even asking about patient satisfaction because one does not want to "wake sleeping dogs" can certainly not be a permanent solution for an informative communication that wants to contribute to the self-education of patients.

23.3.5 Appointment and emergency regulations

When negotiating objectives to be pursued at least until the next consultation, the arrangement of appointments of different types also plays a role. Doctor and patient can remain in such a way that the patient

will "get in touch" again on his own initiative as needed. However, they can also make a fixed appointment for the next consultation, before which, if necessary, other appointments without direct medical involvement are to be made in the meantime (blood sampling, blood pressure measurement, etc.), the results of which are then discussed in the next consultation. In addition, emergency arrangements should be made if necessary.

Open appointments as invitations to talks as required

In many of the preceding examples, the bridging function of helping was perceived in such a way that patients can choose the next consultation appointment entirely according to their needs. Further examples are given in which the next appointment remains open for the time being, as long as the patients do not "get back in touch" of their own accord. In this case, the patients are encouraged by the doctor to visit the doctor, usually with a formula ("You will contact me again"), which can be understood as an invitation in case of need. As already shown in a previous example (E 23.1), even or especially in the case of interrupted conversations, the *invitation to talk is made as needed* ("Let's call it a day. Yes? You'll get back to me"), which is accepted by the patient ("Yes, I'll get back to you"). In the following example (E 23.13), the choice of the next appointment is also left up to the patient, who is allowed to use the consultation depending on his or her "complaints".

E 23.13		"if complaints come, get back to me"
01	D	yes... shall we stay like this? .
02	P	yes .
03	D	or would you like some more ...
04	P	No... write that down and I'll get another pack.
05	D	good . let’s do it .
06	P	and then I hope . as I said . there's nothing here at the moment . it's an hour or so in the morning . it's usually here around the knee, then it's gone, no . when I was here last week, I . it was here too . I was still standing outside with [name] . it was warm then too .
07	D	yes .

08	P	so it was so bad, I could hardly stand, my whole leg hurt so much and it's gone now.
09	D	is gone .
10	P	so it's already done some good . no . do it like this and then ... [patient rises already].
11	D	if any complaints come, get back to me.
12	P	yes . then I'll come .

The question about possible further patient concerns first leads to a short digression in which the patient presents his changing complaints, which the doctor then takes up again thematically in the final conclusion of the conversation. Here, the invitation to talk comes from the doctor, who leaves the perception of a follow-up appointment entirely to the patient's decision-making competence. This is different with fixed appointments, which primarily fall under the doctor's competence and responsibility.

Fixed appointments as earmarked appointments

Patients are also familiar with the fact that certain appointments have to be made for an ECG or that certain time periods have to be agreed upon for a blood sample. That this results in a certain order, according to which, as in example (E 23.7) ("skin changes"), laboratory results must first be available, which are then discussed in a subsequent consultation, also corresponds to the everyday logic of patients. It often makes less sense for them to visit the doctor at a fixed appointment when they "feel free of symptoms overall", so that from their layman's point of view there is "no reason" for a consultation. In these cases, a meeting is often not attended. Patients simply stay away or sign out. In the case of corresponding experiences with certain patients, such an appointment may have to be plausibilised, as in the following example (E 23.14), in which the doctor explains the meaning and purpose of the appointment from a comparative perspective.

E 23.14		"so keep the appointment, yes?"
01	D	yes . should we leave it like this? .
02	P	yes .
03	D	but please make another appointment . and it would also be nice if you came, so keep the appointment, yes? . so that I can get to know the differences, yes? .
04	P	good . good .
05	D	yes, I mean, I'll write it down for you again .

It is possible that the admonition ("keep the appointment") and the explanation ("get to know the differences") are based on previous experiences with the patient, who might not have kept her appointments. The doctor's announcement ("I'll write it down for you again") also seems to serve to ensure that the appointment is kept. This is not only about possible forgetfulness, but also about patient motivation.

This motivation of patients can be influenced in other ways, for example if doctors regularly call in their patients. In training groups, experiences are often exchanged in dealing with patients with somatoform disorders who storm into the practice "unannounced" with severe complaints and demand "urgent" treatment. In these cases, a regular, initially also higher-frequency appointment of patients can prove its worth. The patients then come to the agreed appointments, complaining less strongly. They no longer have to give or pretend to have "weighty reasons" for visiting the doctor, but come to the practice "only" because they have finally been "called in" by the doctor. Often, the frequency of treatment can be reduced again after a short time.

Emergency regulations

Emergencies should generally be left to the emergency medical services, and patients should also be made aware of this (telephone numbers, etc.). Nevertheless, in certain cases it may be important for patients to be able to turn to the doctor they trust. In special cases, individual arrangements can be made if the doctor is willing and able to do so. There are certainly differences between general practitioners and specialists, for example, or between city and country doctors, who may be the next point of contact anyway. In the following example (E 23.15), the doctor

offers the patient, who had presented herself as an emergency because of her "particularly high blood pressure" ("for all things call 110 . yes 112"), the possibility of calling her even at the weekend.

E 23.15		"if something is wrong"
01	D	um ... I'll be here at the weekend, yes ... if there's something wrong, yes ... come by .... I'm only not here on Saturday morning.
02	P	you are not there .
03	D	but back here on Saturday at noon.
04	P	yes. okay . can I ring the bell if something is wrong? .
05	D	yes, you must . you know, I'm in the back garden, yes .
06	P	yes, yes . okay .

Such an offer for the "emergency" can rather be made by the family doctor in the countryside who is "on the spot" anyway and is also called for "house calls" not only on weekdays. Without wanting to derive a recommendation from this, only the willingness of doctors declared in training groups who had given their private telephone number for emergencies to certain patients should be mentioned. The experience was that very few patients had ever made use of this "emergency provision". However, many patients later explained that the possibility of being able to make use of this regulation "in principle" had given them a lot of security - an incentive not necessarily to copy it, but nevertheless to think about what could contribute to satisfying patients' need for security.

23.4 Conversation expansions

Attention was already drawn to the problem of wanting to "set" a "*schedule"* right at the beginning of the conversation (*agenda setting*) in the first two steps of the manual with reference to the further literature (§ 18.7, 19.4). Many conversations are characterised by a *dynamic* development of topics, to which the doctor must react with a certain *flexibility in* conducting the conversation (§ 17.2). This also includes offensive questions about possible further topics, if both conversation partners do not want to end up with a "*hidden agenda*". Often patients first solve "tickets" that are at best tangential to their main concern. Precise-

ly because the "actual" patient concerns can remain latent, the fixation on the first agenda with manifest topics often proves to be misleading.

Possibilities of correction through offensive follow-up questions can be used again at the end of the conversation with the previously described questions in the résumé, with which patients are asked about open topics and their satisfaction. However, the risk already mentioned must be taken into account that the conversations can extend considerably not only thematically but also in terms of time. In order to illustrate the problems in dealing with this risk, we will distinguish between two types of extended conversations using exemplary cases in which the physician's conduct of the conversation is challenged in different ways, namely in the case of mere *supplements,* which can generally still be integrated well into the previous framework of the conversation, and in the case of *new starts* of conversations, which already make another appointment for a conversation necessary when the available time resources have already been exceeded.

We focus here on extensions of conversations (§ 18.7, 22.4), the development of which has already been described above, so that the extensions of conversations can be placed in a larger context. In another example, which does not come from our own conversation corpus, but is taken from the literature on the topic of narrativity (Elwyn, Gwyn 2005), we want to make clear by way of example which dramatic thematic developments conversations can still take after the final phase has already been initiated.

23.4.1 Supplements

In the preceding examples, the risk had already become clear that conversations can expand following the corresponding questions about topics that remain open or patient satisfaction. While the time extensions in the examples for *rounding off conversations* are "kept within limits", barely exceeding 1 minute, the following conversation (E 23.16) goes into an "extension" of a good two minutes until the final conclusion is reached. After a consensus had been reached in a longer negotiation in the decision-making process ("no antibiotics", "only the expectorant") (§ 22.4.3), the ritual bridging function until the next appointment is already performed ("yes, I'll come in again"), before the doctor makes a further topic offer by the traditional closing question for possibly still open *questions* of the patient (05D: "would you like to ask me anything

else?"). This topic invitation is proactively taken up by the patient (E 23.16) by asking about the continuation of a previously practised treatment measure ("radiation"), which had not yet been addressed in today's consultation.

E 23.16		"is there anything else you would like to ask me"
01	D	then we only do the expectorant .
02	P	yes .
03	D	and next time I'll listen to your lung .
04	P	yes . i'll come in again .
05	D	is there anything else you would like to ask me? .
06	P	. should I continue to take radiation ? .
07	D	we'll keep going through it .

Since the doctor confirms this reassurance question of the patient about the continuation of radiotherapy, which he himself perhaps no longer "had in mind", without reservation, a positive overall balance can be drawn from the patient's perspective (§ 22.4.3). From the doctor's point of view, the renewed stimulation of topics can now lead to a further challenge, because asking open questions always carries the risk of extending the conversation. As the continuation of the conversation shows, the end is not yet in sight, although the decision phase seems to be sufficiently saturated. Beyond the "radiation", the patient introduces an "old" topic as a "new" topic in the "here and now" of the consultation (E 23.17), the final development of which is to be reproduced here in an abbreviated form.

E 23.17		"the mouth hasn't got any better, on the contrary..."
07	D	we'll keep going through it .
08	P	yes . so this here with the mouth hasn't got any better . on the contrary, it's got worse . that hasn't helped either, because this . look ... [shows] ... here ... it's really painful ... especially when I eat an apple or...
09	D	somehow the/ the defence situation in the body doesn't really work right away ....
	P	[...]
	D	[...]
	P	[...]

19	D	you are concerned . yes .
20	P	a bit ... yes, but no, not in the direction of lung cancer, not at all, no ...
21	D	we'll continue the checks, because it's been x-rayed. and then you'll report back next week.
22	P	and also further radiotherapy .
23	D	we'll keep on doing it, yeah? .
24	P	good .

In the omissions, a number of sub-topics are introduced in a small space, ranging from possible subjective explanations by the patient ("anemia") to common assumptions about the side effects of medication ("antibiotics", "antidepressants"), before the patient once again affirms that her concern is by no means "in the direction of lung cancer" (20P). Since this topic has already been addressed several times, both interlocutors can leave it at this obviously authentic statement by the patient.

All in all, the supplements, which were stimulated by the doctor's question about open questions (05D: "Is there anything else you would like to ask me?"), lead to a prolongation of the conversation of a good 2 minutes, before an appointment is made again ("next week") with the aim of "controls" (21D). Finally, the consensus is renewed (continuation of the "radiation"), with which an end of the conversation had already been targeted, which is now actually carried out.

Even if the sub-topics in such thematic addenda cannot always still be discussed exhaustively in the same conversation, they are conclusively raised in the consciousness of both conversation partners so that they can serve as "topic offers" in follow-up conversations (§ 23.6). Such a perspective in dealing with open topics can only be adopted if these topics have been discussed beforehand. Keeping them "under wraps" by not even asking about them with "opening" questions is often neither a sensible nor a successful strategy. As the following example shows, topics can "break through" in conversation through the patient's own initiative, even without being stimulated by the doctor's invitations.

23.4.2 Restarts

In order to highlight and illustrate the differences between mere *addenda* and *new starts* of conversations, two examples will be given in con-

clusion, which are characterised by relevant conversation developments with a new quality of conversation at the "supposed" end of the conversation. In both cases, the doctors have already made "arrangements" to end the conversation (*opening up closings*) when their patients start with new topic initiatives that are equivalent to a *new opening* of the conversation.

Another main symptom after the end of the conversation: "headache".

In the following conversation, the doctor had already initiated the conclusion of the conversation in a clearly recognisable way, when the patient just as obviously "runs afoul" of this strategy by trying to restart the conversation with a new topic. In this case (E 23.18), there can hardly be any talk of *supplements,* if only because of the scope, but also because of the new topic. The doctor previously attempted to "speed things up" towards the end with a series of detailed questions, the suggestive form of which had already been critically pointed out (§ 21.2.6), before he then moved directly on to the examination (07D), to which he was already rising.

E 23.18		"yes . well . then we will first examine you".
01	D	hm ... appetite is normal with 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 will first ... examine you . [rises]

Previously, at the beginning of the initial interview, the patient had already responded to the doctor's opening question ("What brings you to me?") with an "ambiguous" answer ("Various things"). In the course of the conversation, a number of topics are then addressed in a way that "touches on" rather than "deepens" them ("swollen feet", "weight changes", medication "because of the heart", "air complaints"). Finally, the suggestive information questions mentioned above are asked and an-

swered before the doctor rises for the announced examination. However, the patient remains seated in order to make a further offer of a topic (E 23.19), which is new in every respect, and in any case has nothing to do with the previous course of the conversation.

E 23.19		"and the head, it's not okay either"
07	D	yes ... (2) ... well, then we will first ... examine you . [rises]
08	P	and the head, that's not right either .
09	D	the head is also not okay? .
10	P	no . [laughs]
11	D	what's wrong with the head? ...
12	P	it's awful, sometimes there's nothing at all .
13	D	yes .
14	P	and then . it's just as if [...]

In the further course of the conversation, the quality, the conditions and the accompanying signs of the "headache" are discussed before the doctor then moves on to the examination again. While the previous conversation had lasted about 2.5 minutes until the patient took the initiative again, it is now almost doubled with the conversation of the other complaints. The conversation takes on a new quality not only in terms of its scope, but also in terms of this further main symptom ("headaches"), after which it is no longer a mere *addendum,* but already a *new start,* with the topic of which the patient has to assert herself against the conclusion of the conversation already initiated by the doctor.

Dramatic narrative at the end of the conversation:
"Antidepressant please".

In the second example, this new quality of conversation becomes even more apparent, manifesting itself in a dramatic narrative by the patient. The example is taken from the discourse-analytically oriented work of Elwyn and Gwyn (2005), whose transcript we reproduce here in a simplified and shortened form. The entire conversation excerpt is analysed by Elwyn and Gwyn (2005: 204-206) not under the aspect of *conversation termination*, but essentially under the aspect of *narrativity* (§ 9, 19). However, the example is suitable for teaching and training under both aspects if we want to, in Elwyn and Gwyn's words, "venture into dis-

course analysis as a form of textual microscopy" (2005: 203). We can only recommend corresponding reflections on conversation based on this kind of detailed analysis, even if the focus here is on a simplified excerpt from the aspect of conversation termination.

The entire conversation lasts just under 7 minutes, while the part documented by Gwyn and Elwyn lasts a total of 2.5 minutes, which has been shortened by half again here. The two interlocutors are already in the prescription phase, which is already about writing a prescription for a certain medicine (E 23.20), when the doctor makes another offer (05A) for an open topic or concern of the patient.

E 23.20		"is there anything else I can do for you?"
01	D	...I'm writing down a medicine for you called [medicine name]...it's little white pills (.) if you take them three times [a day (.)
02	P	mhmm .
03	D	then we will see if they help you
04	P	yes that's good *[coughs briefly]*
05	D	is there anything else I can do for you?
06	P	(.) mmh (.) well well eh is that [name]? the (.) water tablets I take?
07	D	you take them regularly?
08	P	yes every day (..) [...]
		[...]

from: Elwyn, Gwyn 2005: 204ff. (our translation)

In the omissions (out of a total of 76 words), the patient reports, among other things, about the dosage of her "water tablets" and the related problem of "urinating" on holiday (going to the toilet), for which the doctor shows understanding. Following this topic ("water tablets" - "urination"), the *dramatic medical history* (E 23.21) only emerges gradually and after the patient's request, which is formulated as a *request* (14P: "actually I would like the ... antidepressant please"). With the subsequent narration, a general *explanatory function of narratives* is performed, as it were (§ 9), which in this specific case refers to the treatment of *antidepressants.*

E 23.21		"actually I wanted to uh (...) the antidepressant please".
12	P	= eh (.) [names drug] well I still have [enough of it (.)
13	D	[mmm: mm
14	P	actually, I would like to take [drug name] the antidepressant please.
15	D	you take that?
16	P	yes .
17	D	how long have you been taking this?
18	P	(.) eh: so, five years ago my son was killed (2.0) and a short time after that (.) three months after that (.) my granddaughter three months old granddaughter three months old granddaughter, a twin, she died of meningitis (.) and then in January (.) my son-in-law eh he died of a heart problem at 22 so I refused to take anything, you know but then (.) Doctor Y insisted [.....] [omission 41 words] but I wonder (.) if it would be possible for me to take just one a day, skip one the next day, to try that and (.) you know is that okay, what do you think, right?
19	D	is that what you want?

from: Elwyn, Gwyn 2005: 204ff. (our translation)

The extended *explanation* of the treatment with antidepressants does not only include the patient's dramatic *narration* of the death of her relatives, but also the *emphasis* on her initial refusal, which she only gave up when the pre-treatment doctor "insisted on it" (18P). According to the patient's own motive story, it makes a considerable difference from her point of view whether antidepressants are requested *by the patient* or recommended and prescribed *by the doctor.*

As the doctor's first reaction already suggested, he initially seems to be surprised by the treatment with antidepressants himself (15D: "you take that?"). As this question is initially simply answered in the affirmative by the patient without further comment ("yes"), the doctor is forced into a further dialogical move towards the topic initiated by the patient. Only with the doctor's further question about the duration of the medication (17D: "how long have you been taking this?") is the patient stimulated to give her dramatic account of the death of her relatives.

The doctor, who probably remains "speechless" from surprise or even shock, can in any case only listen to the longer narrative, short-

ened here, in silence without any listening signal. Only when the patient asks him about a possible change in dosage ("skip one the next day") does a topic-specific response ("is that what you want?") come, which remains reduced to precisely this patient question of dosage. In addition, this intervention is not particularly "further-reaching", since in the best case it merely asks for the patient's wish, which she had just formulated.

Without being able to know the conversation as a whole, because it is only documented in this final phase, it can probably be concluded from an *evaluative* aspect that an incomplete medical history was taken with serious omissions, if this dramatic patient history is only revealed at the end of the conversation, as if "by chance" and "incidentally" via the medical history on medication.

In this case, the doctor should have started earlier with a *biographical narrative* anamnesis (§ 9, 19) and explored events and experiences relevant to the patient's life, with which the conversation would have taken on a completely different thematic development with a different relationship dynamic. In short: What has to be explored systematically in the anamnesis interview beforehand cannot be left to the "coincidence" of a thematic development in questions about medication at the end of the interview.

All's well that ends well?

Of course, relevant conversation developments should be encouraged and used until the end. But not every way of conducting a conversation has to lead to a "good end" where the omissions in past conversations could still be compensated for. Relying on the mere "coincidence" of a relevant topic development at the end of the conversation is also not always effective because one cannot always hope for a patient initiative at the end of the conversation. Patients are also learning subjects who orient themselves to the "recognisable" end and therefore no longer dare to assert themselves against the intentions already marked by their doctors to end the conversation. The two previous conversations may be "lucky cases" in this respect, in which the patients were initially able to assert themselves against their doctors with their topic initiatives, even if their long-term success cannot be tracked (due to a lack of longitudinal documentation and studies).

Despite all the similarities, the differences between the two examples should be highlighted once again: While in the first example the patient has to assert herself counterfactually and abruptly with her topic initiative against the doctor's closing activities, the change in the second example takes place continuously in the "prescription conversation" (§ 26), in which the topic of (reasons for) taking "antidepressants" is introduced as if "incidentally". In addition, in the second example, the doctor had initially kept the end of the conversation open by issuing another topic invitation ("is there anything else I can do for you?"), which may continue to have an effect in the sense of *conditioning* (§ 9.4), so that the patient may continue to feel encouraged to continue the conversation in this way. However, instead of the supplements that are probably only expected, the doctor gets a new start to the conversation with a thematically new quality of conversation, which also challenges the shaping of the relationship with the patient in a new way.

What both conversations have in common is that they reveal serious deficiencies in the preceding anamnesis conversation in the final phase, which make these conversation restarts necessary. Since the relevant topics are only "heard" at the end, but finally, it could be judged from an *evaluative point of view* that everything "went well" at the end. However, in both cases, due to the lack of documentation, it is not possible to see how the topics "made heard" were dealt with: In the first conversation, the doctor immediately starts the examination again, even after the conversation has been restarted. The second conversation ends (unfortunately in the documentation) with the question about the motivation for changing the dosage of the antidepressants (19D), so that the events and experiences relevant to the patient's life remain correspondingly "underexposed" in the documented conversation.

The two preceding examples each show in their own way how conversations can still develop thematically with a completely new quality, even if they are already in the final stage. The patients' topics had to be pushed through, as it were, against their doctors' attempts to end the conversation, whose way of conducting the conversation reveals *strategic* action (§ 7.3, 10.2, 24), which is characterised at least by passive resistance to further opening up of topics. In both cases, the patient initiatives only brought up topics at the end, which should have been discussed long ago in a good case history. Thus, the doctors' omissions had to be compensated for by patient initiatives on topics that the doctors should have "elicited" from the outset.

Whereas in the first example the doctor "took refuge" in the examination at the announced and then actual end of the conversation, in the second example the doctor limited himself to merely formally asking the patient about a possible change in dosage, without acknowledging the dramatic patient narrative with a single *empathetic* word in between or afterwards. Whether the doctor later made up for an *empathetic acknowledgement* (§ 20.5) of the patient's psychosocial burdens is, as mentioned, beyond our knowledge, since the further course of the conversation was unfortunately not documented. In a subsequent interview with the doctor who conducted the discussion, however, his "helplessness" to react appropriately to such a dramatic patient story is revealed (Box 23.2).

Box 23.2	"to engage, but more through gestures than words".

One second I'm prescribing dyazide and estrogens, the next I'm listening in turn to her list of the deaths of her son, granddaughter and son-in-law (...) That I couldn't imagine going on living at all if I lost my son, never mind the tablet withdrawal. I suppose I felt she wanted to sound me out, so I was willing to engage with her - though more through gestures than words.

from: Elwyn, Gwyn 2005: 210 (our translation)

In teaching and further training, this open *statement* by the doctor, which has been strongly abbreviated here, could in its entirety be an occasion for further conversation reflections on how the "data" of a *biopsychosocial* anamnesis relevant to the conversation can be collected in good time, even if they could "make one speechless". Therefore, topics that may prove to be "sensitive" for both sides (§ 21.6), should not be "brought up" in the first place, could only temporarily serve self-protection, if both partners do not want to expose themselves to the risk of following a "*hidden agenda*" (§ 18.7, 19) in the long run without ever noticing it.

However, both conversations make it clear from the outset that relevant topics can hardly be "kept out" in the long term, even if they sometimes only find their way into the conversation at a late stage via detours (e.g. in the case of "medication"). Once "spoken out", the topics can no longer be "left out", even if their treatment can be postponed, for example in a *tangential* communication (§ 3, 17, 21), in order to take them up again and deepen them at a "suitable" opportunity.

In doing so, the resumption and deepening of topics may have to be postponed until follow-up conversations (§ 23.6), if the remaining speaking time in the current conversation is coming to an end. Even the greatest extensions of conversation must eventually find a conclusion that conforms to the general rules of goodbye before the interlocutors can "part" in the "here and now" in a reasonably satisfactory manner until the next meeting. Particularly in the helping professions, the farewell must be connected with a bridging function until the next meeting, until which a bond as secure as possible should continue to exist for those in need of help.

23.5 Farewell rituals for secure attachment

Conversation endings must be more or less clearly marked as goodbyes at the actual end, before the spatial separation of the interlocutors is also carried out. As has already become clear with all the differences in the previous examples, the ritual farewell is constitutive for all three types of conversation endings (*terminations*, *rounding off*, *expansions*) and their subtypes, even if their helpful bridging function can be perceived with different (non-)verbal characteristics until the next consultation hour.

The farewells in the consultation are mostly linked to the appointment arrangements, although these concluding activities can also be realised outside the consultation room if the doctor accompanies the patient specifically to the "reception" for this purpose. In these cases, the further processes elude our observation, but from the conclusions of conversations within the consultation room documented here, the bridging function of the farewell can be described once again in summary, in which the patients are finally to be "released" from the current consultation in a helping perspective.

It is well known that goodbyes can also be experienced as "painful" in other areas of life, even if it is not primarily a matter of a helping relationship. Like greetings, goodbyes are, according to Goffman, "ritual announcements that mark a change in the degree of accessibility" (1974: 118ff) (§ 18.5). Saying goodbye is not only difficult in many everyday situations, but especially in the medical consultation, where from the patient's perspective the separation from the partner as a designated helper has to be accomplished, from whom one has to be able to "let

go" in a certain way. Accordingly, professional helpers often report attempts to prolong the conversation and relationship while still in the "doorway" of their consulting room.

Precisely because "accessibility" to the doctor is often interrupted for a more or less (un)definite period of time, there is often encouragement from the doctor's side to make use of the service, which is guaranteed "at any time". As has already become clear in the preceding examples, medical "accessibility" is often guaranteed according to the "need" of the patients ("You'll get back to me"), whereby in the registration practice a (telephone) pre-registration is certainly desired.

Making oneself available to the patient in a *recognisable way,* i.e. also clearly *audible* in words, as a helping contact person, serves the bridging function of helping in the time after the farewell, in which the secure bond between doctor and patient should continue to work. This time between farewell and re-encounter can be shortened if necessary, if the patient can decide on his or her own initiative when to "get back in touch". The bridge is usually built by both sides in the farewell ritual - regardless of who takes the initiative in the *ritual mini-dialogue*, which consists of this dialogue sequence: "You will be in touch again" - "Yes, I will be in touch again". Once this ritual has been completed in whatever order and variant ("I'll get back to you" - "Yes, come back in then"), the farewell formulas common in our culture ("Goodbye" etc.) can mark the final farewell, which may also be combined with a handshake (§ 18.5), before one can then also physically "part".

In a concluding example (E 23.22), in which a "sick note" had already been discussed and decided upon in the course of the conversation, which is now issued at the end, the doctor even wishes the patient a "speedy recovery" when saying goodbye, which happens rather rarely in routine practice. Thereupon, the patient can announce a possible follow-up appointment in case of a problematic development of health, as if with a "self-invitation" ("If not, then I'll come back"), which the doctor finally encourages the patient to do as a matter of course.

E 23.22		P: "then I'll come back here" – D: "come here"
01	D	and only the thing with the employer .
02	P	hm . okay .
03	D	yes .
04	P	all right . thanks again .
05	D	hm . get well soon .

06	P	thank you .
07	D	will be fine .
08	P	if not, I'll come back here .
09	D	come here .
10	P	OK, thank you .
11	D	goodbye .
12	P	goodbye .

The doctor's *confirmation* of the *self-invitation* does not take the form of a simple *affirmation* ("yes"), but is also reinforced by the emphasis as an *encouragement* ("come here"). All in all, the possible assistance in this example is offered relatively awkwardly, but all the more credibly, and is gratefully accepted by the patient ("okay, thank you") just in case, before both interlocutors also formally say goodbye at the end of the consultation with the informal greetings ("goodbye"). In this way, a rounding off of the conversation has also been achieved in this conversation, in which the bridge is kept open for a return to medical "care" at any time.

The unrestricted right to return to the doctor's *care* is, of course, also rightly anchored in patients' experiential knowledge as a "customary right", which may also have developed "without many words" over a long history of care. The fact that the same few words are nevertheless regularly repeated ritually at the end of the conversation makes it clear that *words* can *make a difference* when it comes to meeting the patient's need for a secure bond beyond the day until the next visit to the doctor.

23.6 Documentation

The documentation following an interview is usually done according to certain specifications ("Gebührenordnung" (Fee schedule), ICD-11) and otherwise according to one's own experience and preferences. With all the variants in the detailed regulations, the following three fields of topics and action can be distinguished, in which objective duties of documentation must be fulfilled and personal preferences can be pursued.

23.6.1 Necessary data and coding

First of all, when documenting, all documents must be sorted and fixed that may become objectively relevant (legally or in terms of accounting), regardless of individual preferences.

A "patient file", whether "analogue" or "digital", must above all contain all examination results such as complaints, physical findings, laboratory values, ECG printouts etc. and the resulting diagnoses and treatments, as their documentation, apart from the obvious clinical significance, must also satisfy any liability claims.

In this context, e.g. in the case of pre-op information (§ 39), not only the formal consent must be documented, but also a brief record of the information communication (in keywords) should be prepared, which also takes into account possible ambivalences and reservations that may remain despite all consent.

The existence of an advance directive, and ideally also its place of safekeeping, should also be documented, unless a copy of a current version is in the patient's file.

In addition, all diagnoses and therapeutic procedures must be coded according to the currently valid coding codes (e.g. ICD-11).

Finally, a note on prescriptions, referrals or, during inpatient treatment, any consults should not be missing.

23.6.2 Personal conversation impressions

Personal impressions of the conversation should be noted down as close to the time of the conversation as possible, before the memories threaten to fade. First of all, this includes impressions about the presentation of the history of illness as a story of suffering of patients (§ 9, 10) who are more or less able to cope with their illness (coping, control beliefs, cf. § 22.2), such as the self-perception as a "victim", "failure" or "fighter".

The assessments of the patient's willingness and ability to cooperate more or less actively should also be recorded as personal interview impressions of patients who initially want to be cared for entirely according to a paternalistic model or who prefer participatory decision-making (§ 10). The assessment of whether the patient is aggravating vs. dissimulating or "difficult" (i.e. demanding, devaluing, dependent, etc.; cf. § 34)

is also helpful in order to better adjust to these particular communicative demands.

In this context, the highlighted documentation of "sensitive issues" (cf. § 21.6), inconsistencies, ambiguities in decision-making or information that must first be obtained from the doctor before it can be communicated to the patient also helps, or planned next steps in diagnostics and therapy, to prepare well for the next appointment.

23.6.3 Topics for follow-up talks

As in other areas of life, conversations cannot be continued ad infinitum, but must be concluded in *good time.* Under certain circumstances, the conclusion cannot always take place in the preferred form of *rounding off conversations* (§ 22.3), but must be carried out in the described form of *terminating conversations* (§ 23.2), if an objective measure is exceeded in the time limit of consultation hours, which are to be organised in the interest of all patients (§ 25.6).

It now seems obvious to start the conversation with exactly the topic with which one left off in the last conversation in order to maintain a certain continuity of topics. However, such an *opening* by the doctor with a specific topic would violate an elementary maxim according to which the patients should have the floor at the beginning. This free word is given to the patients precisely with the relevant conversation openings, which were described in advance in a typology (§ 19.2) (e.g. "What's up?"). Having the *first* and *last* word in the consultation is a patient privilege that should only be touched in emergencies and only restricted as far as absolutely necessary.

It should also not be possible to overrule the patient's first choice of topic by the "debt to be brought" of a past relevance hierarchy. What seemed relevant at the end of the last interview does not necessarily remain relevant at the beginning of the current interview. The priorities in the topic structure may have changed in the meantime. If necessary, they must be renegotiated. If the patient starts with a topic that is still open from the last consultation, this would be all the better.

If not, the art of conducting a medical conversation (§17) consists of keeping open topics open and remembering them as such until a favourable opportunity arises in the course of the conversation. In this way, a suitable position can be found in the case of related or similar topics, but also in the case of breaks in the conversation, when current

topics have reached a certain saturation and a "lull in the conversation" (*pause*) can be used to initiate a topic that was either already in the direct interest of the patient or simply "only" serves to complete the anamnesis (§ 21.6), which, as is well known, is never complete.

However, it is sometimes astonishing what systematic gaps in the medical history are revealed in medical training groups when members bring their case reports on individual patients into the group discussion as an object of critical solidarity. In some case reports, the lack of knowledge about the previous illnesses of the presented patients or their relatives or the lack of knowledge about family life ("Is the patient married?", "Does he have children?" etc.) or professional life ("Does the patient have a secure income?", "Is she threatened with unemployment?" etc.) becomes apparent. Just as medical interviewing can otherwise be characterised by individual strengths and weaknesses (§ 40), there are also individual differences with regard to the "contents" of anamnesis interviews, where "blind spots" can arise.

In order to remedy this, tabular overviews were suggested in the discussion, in which the "completeness" of certain categories of the *biopsychosocial* anamnesis can be tracked by corresponding entries, as they are also given in the interview manual (previous illnesses, previous treatments, family, profession, alcohol consumption, etc.). If topics could not be concluded to a satisfactory saturation point in a current conversation, their resumption should be noted for follow-up conversations. Of course, this also applies to gaps that still need to be filled in order to complete the medical history - but in each case under the aspect of the *fit* (§ 3, 17) of medical interventions that has been mentioned again.

In addition, there is a specific possibility of documentation in the patient-specific representation of the individual life narrative of patients (Koerfer et al. 2000, 2005, 2010, Köhle, Koerfer 2017). The methodology of creating and interpreting such life narratives had been explained and illustrated in advance of the theory, following Gergen (1998 and 2002) and using examples (§ 9.2.4, 19.7.5, 19.8.6). A further presentation of the content can be found in the appendix of this handbook (§ 44). It is based on interview data obtained in two relatively short ward rounds (Koerfer et al. 2005). Such representations can be made on one's own initiative on the computer or by hand (see "blank" sample after printout on paper in the appendix § 44) and can be continuously updated depending on the status of the interviews and anamnesis collection.

A further stage of development of the procedure could be achieved through the active participation of the patients, who could help to shape the creation of their own evaluative life curve on the basis of their own life events and personal experiences. In the joint design, possible convergences and divergences in the professional and lay perspectives of the participants on the patient's life and illness would also be expressed, which would have to be taken into account in further discussions. Thus, the joint conversation work on such a life narrative could contribute to a better understanding of the patient's illness and life history by others and by the patient.

23.7 Further information and references

Our didactically oriented contribution aimed at a functional differentiation of types of conversation endings in initial and follow-up conversations. Micro-analytical observations on detailed phenomena of communication processes could only be noted in passing. It is clear that in the many different forms and (preliminary) stages of *opening up closings*, subtle closing signals are exchanged between doctor and patient on both the verbal and non-verbal level, through which the "approaching end" is already "announced". Thus, doctor and patient often begin to "pack their bags" before the end of the conversation is "officially" announced and pronounced. Patients also sort out their "paraphernalia" (glasses, documents, handbag, etc.) in advance, while the doctor, for his part, has moved on to "document processing" (referral, prescription, etc.). While doctors in the "traditional" format began to close the consultation by turning to "paper files", doctors in the "modern" format mostly also turn away from the patient with a body turn when they turn to their computer. For such and similar detailed observations on the termination of the conversation, we refer once again to the studies by West (2006) and White (2015) and the further literature cited there.

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