24 Ward Round Communication

Armin Koerfer, Laura L. Kilarski, Christian Albus

> The ward round, the highlight of each day, had always been the biggest disappointment at the same time.
>
> Thomas Bernhard, *The Breath*

Abstract: Patients who come to hospital are usually seriously ill. The inpatient hospital stay alone represents a caesura in the patient's previous life, which confronts him or her with special challenges, in the face of which his or her previous everyday routines of coping threaten to fail (§ 24.1). In this emergency situation, which is often experienced in this way, the patient needs special communicative attention from the hospital staff. Their communicative competences are required in a bundle of functions ranging from admission interviews to discharge interviews (§ 24.2). Compared to these specific competence requirements, professional communication practices in everyday hospital life often prove to be considerably deficient. This is due to institutional conditions (pressure to act, time constraints) and especially to the paradoxes of triadic communication, in which hospital staff often communicate over the heads of the patients (§ 24.3). The deficits can be demonstrated in quantitative and qualitative conversation analyses of ward rounds (§ 24.4-5). Alternatives to traditional ward round communication have been tested in a reform model (§ 24.6-7). The exemplary analysis and evaluation of this alternative ward round communication (§ 24.8) leads to model conversations which, with demonstrable improvements, can serve as a model for further reform developments.

24.1 The hospital from the patient’s perspective

First of all, the hospital staff must contribute to coping with the specific disease situation, which is often subjectively experienced as threatening, as soon as the patient is admitted and integrated into the ward. Referral or admission to hospital represents a radical change for the patient in several respects, which is often experienced as "being torn out of life" that can no longer be continued as "usual". Outpatient treatment, which only selectively prevents the patients from their habits, is obviously no longer possible, but inpatient treatment is unavoidable, which is experienced with diverse, often "mixed feelings".

24.1.1 Between fear and hope

With inpatient admission, a caesura is also reached in the patient's self-perception that far exceeds the horizon of experience of a mere external change of different places of living: an illness that makes a stay in hospital necessary is often experienced in a special way as a "mortification". The patient is no longer dependent on an individual helper such as the family doctor on a case-by-case basis, but on institutionally organised help that has to be claimed "around the clock" in shift work. In this context, the multitude of helpers is not always only experienced as reassuring, but from the practical perspective of experienced clinicians such as Morgan and Engel (1969/1977) (Box 24.1), it can contribute to confusion precisely because the patient often misses a direct reference person as an individually available contact person.

Box 24.1 In whose care is the patient actually?

In hospital, patients come into contact with a bewildering number of people. The nursing staff changes three times a day. The doctors, students and student nurses change departments. Specialists, dieticians and laboratory assistants come and go. Anxiety, dejection, irritability, anger and other moods sometimes reflect the patient's inability to recognise whose care he is actually in.

Morgan, Engel 1977: 16

However, the guarantee of and at the same time dependence on organised permanent help is only one side of the patient experience in hospital. The other, often existential side of the experience is that the "best help" can fail when, for example, medical art reaches its limits.

In addition to the hope of a cure or at least improvement of the condition, there may be objectifiable "dangers to life and limb" for the patient, which may develop differently depending on the type, severity, course and not least treatment options of the disease. Admission or even emergency admission to hospital usually has "serious" to "dramatic" reasons, and further treatment (e.g. surgery) often involves risks or has an uncertain outcome. The associated loss of safety and control triggers a variety of fears in patients, such as pain or even death.

On the one hand, the fears relate to the (more or less favourable) course of the disease itself, but on the other hand they are due to a (more or less "objectifiable") mistrust of the art of medical treatment.

The spectrum of the manifold fears of patients in hospital can be seen, for example, in *case reports* (Box 24.2) of a female patient who has already had relevant previous experiences and therefore fears and repeatedly delays further hospital treatment.

Box 24.2 Fear in hospital (case report)

For weeks, Inge Walter has not been able to sleep through the night. Time and again she wakes up with pain in both hands. Her fingers feel numb, she can no longer grip the water bottle on the bedside table: the 68-year-old suffers from carpal tunnel syndrome on both sides. Two surgical interventions would be necessary. But Inge Walter does not want to go to hospital. Immediately, memories of earlier operations surface, combined with agonising feelings of being at the mercy of others and defenceless. Even though she is assured that the operation is a routine procedure. "Does that mean that nothing can happen?" she asks herself. No, of course not, she knows that. That is why it remains the same: she is afraid.

Hempel 2010: A1740

While in individual cases, as in the case of this patient, special previous experiences may have been formative, according to the results of representative *surveys* (Box 24.3) of German citizens, it must also be assumed that there are generally widespread reservations and fears. These may relate to hospitalisation in general, but also to very specific problems from various areas (incorrect treatment, infections, pain, etc.) which, according to the respondents' perceptions, are associated with inpatient treatment.

Box 24.3 Fear in hospital (type, frequency and significance)

More than half of all Germans (54 percent) are afraid of a hospital stay, about one in ten is even very afraid of it. This is the result of a Forsa survey (...) At the top of the list is the fear of treatment errors (65 percent) and unsuccessful therapies (61 percent). 55 percent of the respondents are worried about contracting dangerous germs, 53 percent fear suffering pain. In hospital, fear is one of the most significant phenomena: fear shakes patients considerably in their sense of self and can affect their physical and mental health.

Hempel 2010: A1740

However, these fears before and during hospitalisation and their negative consequences for health are only one perspective of patients' experiences. The other remains fundamentally connected with the hope for which the hospital was visited in the first place. Here, however, (overly) high expectations are often cherished, which are then of course often disappointed. Thus, the hospital staff as a whole must adjust to an ambivalence of the patients' feelings, which can fluctuate between fear and hope. Accordingly, the hospital as an institution can experience very different attributions and evaluations.

24.1.2 Institution of refuge and terror

This ambivalence in patients may constantly develop in one direction or the other depending on their findings and condition, which must also be constantly perceived and therapeutically dealt with by the clinic staff. In this context, both individual and typical behavioural and experiential patterns of patients must be taken into account, as was vividly described by Morgan and Engel (1969/1977) (Box 24.4) from their many years of clinical experience. According to them, the institution “hospital” can be experienced by patients in the extremes as a "place of refuge" or as a "strange, frightening place".

Box 24.4 Ambivalences of the patient experience

By no means all patients experience the hospital in the same way. Some see it as a place of refuge where they will be helped and their discomfort alleviated. For others, it is a strange, frightening place where they must suffer pain or even die. However, above all, hospitalisation - especially the first one - requires a significant adjustment. Patients are separated from their homes and families, which can be both an ordeal and a relief. Patients must largely give up their personal independence and freedom of action but are freed from many obligations. They are often confined to bed. The daily routine is changed, the food is unfamiliar. Unpleasant and painful interventions are imminent. Frightening things are seen and heard. On the other hand, patients are cared for and served, and they hope that their suffering will be relieved, and their problems solved (...) The nurses, doctors and students must make a concerted effort to help

> the patient adjust to hospital life. They can do it if they are able to give the patient as much security as possible.
>
> Morgan, Engel 1977: 16

As Morgan and Engel make clear in this context, the fears that continue to emanate from the hospital for many patients cannot be entirely removed. This is in the "nature of things" because it is, after all, a "sick" house in terms of its institutional function.

But the stay there can be made much easier for the patients, especially by providing "as much security as possible". This formulation alone ("as much as possible") suggests a maxim for action according to which the "common endeavour" in question (see above) can only ever represent a gradual approximation to the *ideal of medical action* (§ 3, 7, 17). Here, hospital staff face the challenge of mitigating the individual perception of the hospital as a place of "horror" and strengthening it as a place of "refuge". As will be shown in detail, the success of this task depends to a large extent on effective communication with the individual patient, understanding how to take up and deal with their comprehensible ambivalences between fear and hope.

24.2 Key functions of ward round communication

Overall, the patient's current situation in hospital is essentially determined by the change that has become necessary from the familiar living environment of everyday life to an institution that is foreign to him or her (§ 5, 10, Mishler 1984, Koerfer 1994, Koerfer et al. 2005). In this unfamiliar, crisis-like situation, the self-evident and certainties of everyday life can turn into incomprehension and uncertainty to such an extent that one's own self-confidence is impaired. However, when self-assurances threaten to break down and tried and tested coping routines fail, specific cognitive, emotive and communicative services are required with which the loss of possibilities for meaning and action can be overcome or at least mitigated, and the coherence of self-experience can be more or less restored (Antonovsky 1987). This requires special professional help, which is to be provided selectively and specifically in individual cases and as a rule as a permanent service, in order to stabilise

the patient or to prevent regressive relapses or worse (e.g. suicidal tendencies, § 29).

24.2.1 Supportive interventions

The hospital situation, which many patients experience as threatening, demands a supportive communication function from the entire ward team and also from the doctor in order to strengthen the adjustment performance, which concerns the disturbed self-esteem of the patient. In view of the ambivalences described above, it should be noted that patients can often only accept help from others in very different ways. As we have seen, their self-experience can be significantly shaped by feelings of powerlessness, helplessness and dependence (Box 24.2).

According to Morgan and Engel (1969/1977), very individual and at the same time typical behaviour patterns (from dependent to pseudo-independent) of patients must be assumed here. As Morgan and Engel explain from their own clinical experience, considerable resistance is often to be expected, for example with "pseudo-independent" patients who try to cover up their fear or helplessness with aggressive behaviour (Box 24.5). Accordingly, according to Morgan and Engel, the doctor should be able to withdraw to a large extent and initially leave control of the conversation to the patient.

Box 24.5 Helpful conversation with aggressive patients

Some patients mask their fear or helplessness with aggressive behaviour. These patients cope with their deep-seated fear of inactivity by being perpetually active and trying to be in control all the time. It frightens them to be sick, bedridden and subject to the routine of hospital operations. They find nursing staff threatening rather than helpful (...) These patients show behaviour typical of them. They are always restless and active, even when seriously ill. They play down or deny their symptoms and dismiss serious complaints as trivial (...) Such a patient can become angry at any time during the case history, especially if he realises that he is losing control in the conversation (...) If (the doctor) understands that such behaviour is based on fear and an attempt to control the situation, then he is prepared for an outburst of anger, does not reprimand the patient for this, but helps him to regain the feeling that he is in control of the situation. The topic that led to the outburst is dropped for the time being and the conversation is left to the patient (...) If the patient still

> hesitates, (the doctor) drops this topic and turns to another one that is less stressful for the patient or supports his self-esteem. For example, he asks him about a time when the patient was healthy and successful. Perhaps the patient will then spontaneously return to the issue that caused his anger.
>
> Morgan, Engel 1977: 67

All in all, medical offers of help should always be made cautiously and the dosage should be tailored to the patient's needs. This accuracy of fit of verbal interventions refers to the general problem of dosage in medicine (§ 3, 7), which in this sense is always individual medicine. If possible, the individual communicative attention towards the patient should be supportive in such a way that their remaining autonomy is not unnecessarily restricted but largely promoted. As we have already worked out in detail in the discussion of the relationship models (*paternalism - service - cooperation*) and their hybrid forms (§ 10.4), the relationship model suitable for this individual patient must be renegotiated with the patient himself again and again and (depending on the type, severity, course and duration of the illness) updated if necessary when the patient's treatment situation or attitude changes.

In general, the problems in communicating with the patient increase with the duration of treatment, especially if there is no end in sight. Especially in the case of longer hospital stays, the general problem of hospitalisation must be taken into account, which in extreme cases can cause the patient to decompensate. Likewise, an already existing depression or even suicidal danger as a comorbidity (§ 29) can be intensified by a stressful hospital stay, which must be recognised in time by the doctor in direct contact with the patient and counteracted with them in supportive conversations. If necessary, a psychosomatic consultation (Fig. 24.1) should be sought for additional support in severe cases, in which a surgeon or internist, for example, feels that his or her professional experience or available time have been exceeded. Such a consultation can also provide specific crisis interventions.

However, the demands on the doctor's communication competence are by no means exhausted in this "prevention of the worst". The supportive function is to be fulfilled as a continuous performance in so far as a helping relationship ("helping alliance", Luborsky 1988) is to be established with the patient in the long term, also in the daily work on the ward, which is a very first prerequisite for therapeutic success (§ 3, 8). Finally, the motivation and cooperation of the patient is also dependent

on this quality of the relationship, whose individual (sceptical or optimistic, passive or active) attitude can have a significant effect on the course of treatment.

24.2.2 Phase-specific functions

The intended treatment success is determined overall by effective communication with the patient, which must fulfil a variety of phase-specific functions beyond the permanently supportive relationship: The clinical conversation work with the patient extends in detail to the

- confirmation of the reasons, motives and expectations at the time of admission and inpatient admission
- detailed biopsychosocial anamnesis (§ 9, 19)
- cautious communication of diagnosis and thorough information before and after further examination and treatment measures (pre-post) (§ 8, 10)
- shared decision-making (§ 10, 22)
- consensual implementation and control of further diagnostic and therapeutic measures and appropriate education
- motivating and initiating further treatment before the patient is discharged

Although the sequence here suggests a certain ideal-typical sequence of functions (Fig. 24.1), these are to be performed repeatedly if necessary and in *circular communication processes* (§ 8), in which planning and discussion of examination and therapy measures as well as debriefing of their results etc. may alternate.[1]

[1] In a linear model, Merriman, Freeth (2022) distinguish four phases: „Phase 1, focusing attention; Phase 2, sufficient gathering of information, opinions and suggestions and formulating a management plan; Phase 3, articulating and checking the management plan; Phase 4, agreement, and closure“ (2022: 414ff.).

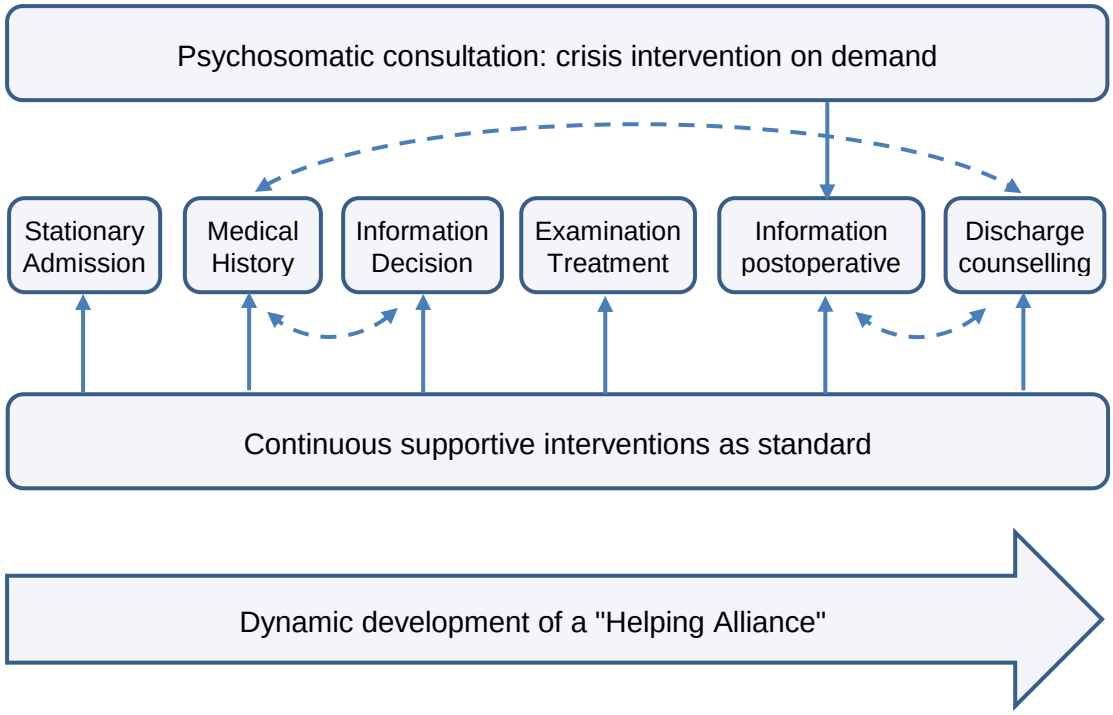

Fig. 24.1: Ideal-typical process model of ward round communication

The circular resumption of phase-specific functions becomes necessary when, for example, new situations with new findings and treatment alternatives arise and the patient's attitudes, fears and hopes change accordingly. The fact that a good biopsychosocial anamnesis can always be extended after a large number of ongoing ward rounds will be shown later by way of example using a specific consultation shortly before a patient is discharged, in which the focus is on a patient's illness behaviour and coping after discharge from hospital (§ 24.6-7). In all these cases from admission to discharge, the daily ward round is essential as the centrepiece of ward work, to which the patient often attaches very high expectations, however realistic or even justified these may be, because certain functions were not or only insufficiently performed.

Patients' expectations of the ward round can easily be disappointed. The writer Thomas Bernhard, for example, formulated his individual expectations and disappointments very impressively in his autobiographical story "The Breath" from his own perspective of experience as a patient:

Box 24.6 ‚The doctors never spoke to me'

The ward round, the highlight of each day, had at the same time always been the biggest disappointment (...) I had had a constant desire to talk to my doctors, but without exception they never spoke to me.

Thomas Bernhard, *Der Atem (The Breath*)

If the *speechlessness* experienced in this way during the ward round is already complained about by a patient who certainly knew how to use the *word* and yet was not able to *make* himself *heard* sufficiently during the ward round, one can already assess the communicative hardships of patients who may be less practised in using the word.

Compared to everyday life in the ward, it may be authentic but unrealistic to have "an incessant desire to speak to his doctors". Likewise, it may be a rhetorical exaggeration on the part of a writer that his doctors "but without exception never spoke to him". Nevertheless, the *speechlessness* experienced so dramatically can be documented in empirical studies based on direct observations of ward rounds, which will be reported on below.

24.3 The ward round as multi-person communication

The dilemma of the ward round has been characterised in linguistic and clinical conversation research as "prevented" or "failing" dialogue (Bliesener 1982, Fehlenberg et al. 1996, 2003). This is not only about the conflict between “real world” and medicine (§ 10.2), which should only be mitigated in favour of the patient, but about elementary deficits in the collection of psychosocial data from the perspective of a *biopsychosocial* approach to care (§ 4), for which the traditional biomedical collection of anamnesis falls short.

24.3.1 Research on ward rounds

The deficits and disturbances in doctors' communication with patients were described early on in research on ward rounds and have been further differentiated in the last four decades (Köhle, Raspe 1982, Fehlen-

berg 1983, 1987, Ott 1996, Langewitz et al. 1998, 2002, Koerfer et al. 2005, Lalouschek 1995, 2005, Menz et al. 2008, O'Hare 2008, Nowak 2010, Weber 2011, Fischer et al. 2016, Walton et al. 2016, 2019, 2020, Buck 2022, Merriman, Freeth 2022, Morris et al. 2022). Possibilities for improvement have been pointed out in detail and demonstrated in evaluation studies (e.g. Putnam et al. 1988, Langewitz et al. 1998, Hellmich et al. 2010). Nevertheless, according to the results of even recent research, the prevailing conversation practice in hospital wards seems to have hardly improved, so that the main desiderata (in practice and education) persist (e.g. Ott 1996, Häuser, Schwebius 1999, Weber et al. 2001, Langewitz et al. 1998, 2002, Koerfer et al. 2005, Weber et al. 2007, 2009, Papsdorf et al. 2009, Weber 2011, Weber, Langewitz 2011, Nikendei et al. 2016, Baldt 2022, Buck 2022, Khalaf, Khan 2022).

According to Weber's (2011) research, there has even been stagnation in international research specifically on *ward round communication* up to this point (but cf. the more recent reviews by Walton et al. 2016, Morris et al. 2022). Of course, stagnation only applies relative to the general progress in research on doctor-patient communication, which, however, has shifted the focus to the (general) doctor's consultation (primary care) or specialist practice (cf. on the state of research also § 2, 25). This discrepancy will be used here as an opportunity to briefly take stock of the main results of *quantitative* and *qualitative* research on ward rounds (§ 24.4-5), before we then present (§ 24.6-7) the Ulm reform model conceptually and with the help of examples of conversations.

24.3.2 Medical communication privilege

The cognitive interest of ward round communication research as a whole must take into account the specific situation, which is traditionally a multi-person communication between doctor, patient and nursing staff. This is a special constellation of relationships that can be characterised as a specific type of *trialogical communication* (Dieckmann 1981, Koerfer 1994) or *triadic interaction* (Weber et al. 2007, Weber 2011, Weber, Langewitz 2011, Buck 2022, Baldt 2022). Traditionally, the doctor is in the communication centre, from where he or she chooses to seek more or less dialogical communication with a potential partner, while the others often have to remain in the role of "silent" listeners until they are specifically addressed by the doctor (Fig. 24.2). In the traditional

constellation, the doctor has a *privileged right of initiative with* which he or she always decides on the new dialogue roles (of listener and speaker).

In this context, the asymmetry of dialogue role assignment can become highly complex: The typical constellation of the ward round can be complicated by further participation roles (head physician, assistant physician, etc.), whereby a complex hierarchy of competences (knowledge, competences, responsibilities, etc.) can be assumed (Fig. 24.2). For example, in the usually weekly chief physician rounds, other physicians or the nursing staff can be asked to give a "report" instead of the patient, which is then given coram publico, as it were, in the sense of trialogical communication.

From the point of view of the intentionality of communication, different types of speakers and listeners must be distinguished: In trialogical communication, all those present can more or less be (made) listeners. For example, a de facto listener such as the patient should also be able to listen as a secondary listener, even if the head doctor (CA) has not primarily addressed him, but the ward doctor (SA) or the nurse (PF). Sometimes, however, the patient as a listening third party is systematically excluded from interprofessional communication, as we will see in empirical examples.

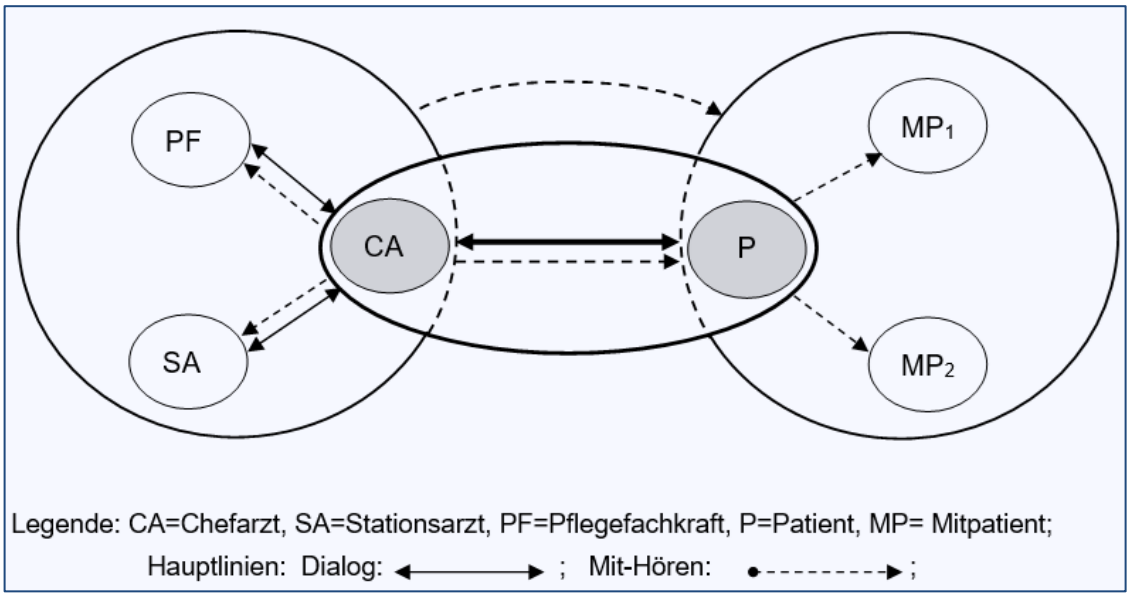

Fig. 24.2: Triadic communication constellation: Example of a ward round by the chief physician. English legend: (CA) chief physician, (SA) resident physician, (PF) nurse, (MP) fellow patient. Main lines: Dialog: ; indirect listening:

The (factually tolerated) inclusion of other fellow patients in the listening audience is likely to be particularly sensitive (in the standard case of the multi-bed room), which is a special aspect of trialogical communication. In this way, fellow patients can become co-hearers of both interprofessional communication (e.g. doctor-nurse) and doctor-patient communication - with a not inconsiderable consequence: many a ward round may have remained incomplete due to the patient's embarrassment in front of an extended audience, without this (type of) communication barrier being recognised or taken into account. From the perspective of experienced clinicians, this dilemma can only be solved by a change of situation:

Box 24.7 Concealment because of listening fellow patients

Much of the information that the patient withholds in the first interview, he or she will tell in the second or third interview when he or she has gained trust in the doctor. Sometimes a patient also withholds information because other patients in the room are listening. In a later conversation in private, the patient will spontaneously fill in the missing information.

Morgan, Engel 1977: 69

The reverse conclusion can be drawn from this: As a rule, the ward round is no longer perceived as a "dialogue" between doctor and patient (§ 18.3). This, however, would be a prerequisite for the *intimacy* (§ 2.4.2) that should be inherent in a *trusting* doctor-patient relationship.

Regarding the type of knowledge, a distinction must be made between professional knowledge and specific empirical knowledge in daily contact with patients. It is no coincidence that the restructuring of traditional ward rounds is considering a stronger participation of nurses (see below), in order to be able to systematically use their knowledge advantage qua greater proximity to the patient in everyday ward life for the ward rounds as well.

However, research into patient-centred, i.e. dialogue-based ward round communication continues to focus on the participation opportunities of patients who, in traditional rounds, are primarily confronted with *interprofessional* communication (chief physician, consultant, resident physician, nursing staff), in relation to which they often risk being left behind with their concerns: this applies all the more the more professional "side communication" turns into the actual "main communica-

tion". In this kind of triadic communication, the patient becomes an excluded third party who is talked about in his presence without being talked to personally. Moreover, because the patient often lies in bed, around which the team talks standing up (instead of sitting down, if possible) (§ 18.6), communication takes place in a concrete and figurative sense "over the patient's head".

24.3.3 Paradoxes of triadic communication

This creates a *paradox that is* apparently more or less accepted by all sides, because it can certainly be used suboptimally: The patient becomes the audience of his professional case discussion, from which he can or should "benefit" more or less depending on his personal conditions (age, education, ability to concentrate). The paradox is tacitly maintained and continued in clinical teaching (like a "hidden curriculum") because in this kind of trialogical communication the *illusion of* a dialogue with the patient can be maintained: Although hardly a word must have been exchanged with him on the matter, the patient present was an "eye and ear witness" to his own case discussion, so that he can be *considered* involved and informed.

The paradox of triadic ward round communication can occur in different variants: The subject participation of the patient present can in each case be counterfactually asserted with an as-if attitude, no matter what the patient has heard, understood or accepted. The processes of hearing, understanding and accepting can themselves become the object of manipulation without removing the suggestion of subject participation. Thus, the team members can gradually dose the flow of information according to their liking, for example by semantic or acoustic means, or prevent it altogether if the indirect communication is judged to be counterproductive for the patient who is listening in.

If the interprofessional side communication is "not intended for the ears of the patient", it can be communicated past the patient by using medical jargon ("aplasmocytosis") or the unwanted listener can be excluded from the communication completely by lowering the voice (collegial "whispering"). For this type of *strategic* communication in the ward round, many empirical variants have been differentiated in qualitative ward round research (see below).

The specific institutional framework conditions and linguistic-communicative characteristics of the traditional ward round have been

researched in the last three decades in a variety of theoretical and empirical, qualitative and quantitative approaches, which should be integrated in multi-method studies (e.g. Köhle, Raspe 1982, Fehlenberg 1987, Fehlenberg et al. 2003, Koerfer et al. 1996, 2005, 2010). Although research cannot be reduced to a simple dichotomy of quantitative versus qualitative methods, approaches with more *quantitative* and more *qualitative* questions and foci should be distinguished here, the integration of which we will return to separately (§ 40-43) in the evaluation problem of training and further training interventions in medical interviewing.

24.4 Quantitative ward round research

In more quantitative research, deficits in traditional ward round communication can already be shown through the critical comparison of data, for example, on overall ward round duration and and, in particular, how communication is directed., These comparisons reveal that participation opportunities for the patient, doctor, and nursing staff are often controlled in a doctor-centred manner, in the sense of the trialogical communication model (Fig. 24.2). By means of relatively simple measures, it can be shown how quantities can turn into qualities or: how "countable" things can indeed "count".

24.4.1 Duration of conversation and direction of interaction

First of all, duration of conversation and direction of interaction are relatively simple measures of (lack of) communicative attention towards the patient (Fig. 24.3a,c). Under these aspects of communicative attention, conditions seem to have changed little beyond designated reform wards (§ 24.6). While in early studies (Westphale, Köhle 1982) the duration of ward rounds per patient on traditional wards was still given as 3.5 minutes (Fig. 24.3a), Häuser and Schwebius (1999) also report just under two minutes per patient on general internal medicine wards.

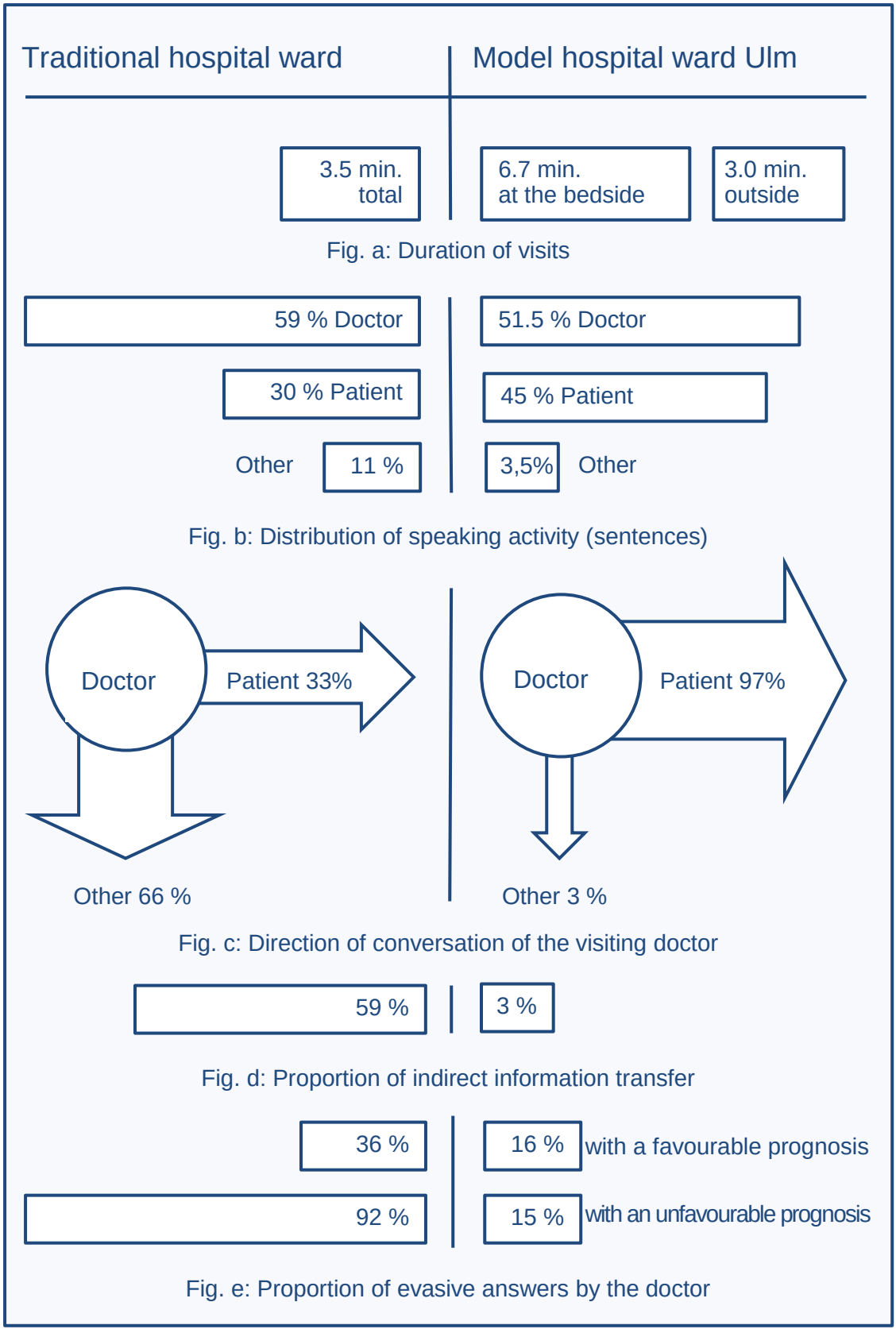

Fig. 24.3: (a-e): Dialogue structures of the ward round
(after Westphale, Köhle 1982, Fehlenberg et al. 2003)

In such mini-rounds, the patient will have even less time to speak than in the already short ward rounds of 3.5 minutes, in which the patient has to make do with about 30% of the conversation (Fig. 24.3b). 80% of this share of the conversation consists of answers to questions from the doctor, who in turn asks 82% of the questions, i.e. the participation role of the doctor is essentially *proactive,* that of the patient essentially *reactive*.

24.4.2 Asymmetric participation

This tendency towards *passivity* is reinforced by the patients' experience that their already rather modest initiatives to obtain information are often answered indirectly or evasively, namely 36% in the case of a favourable prognosis and even 92% in the case of an unfavourable prognosis (Fig. 24.3d-e). Accordingly, patients in traditional ward rounds are increasingly dependent on the exchange of information in interprofessional communication. The quantitative weight of this is manifested by the fact that 66% of the comments made by the doctor in charge of the ward round are not addressed to the patient but to other team members (doctors, nurses) (Fig. 24.3c).

In this case we are dealing with a particularly doctor-centred trialogical communication, which is predominantly conducted "over the head of the patient". Paradoxically, the patient may "profit" from this communication as a non-addressed but "third listener" or, in the absence of an alternative, may even have to "profit" from it.

An "unmistakable sign" of the passivisation of the patient as a non-intended third party is then speaking about him/her in the third person ("he", "she", "his", "her" etc. instead of "you", "your" etc.). As we will see from empirical examples from qualitative ward round research (see below), the communication barriers for the patient are so high due to this type of doctor-centred conversation that he can hardly intervene in the interprofessional conversation.

According to research by Weber et al. (2001), the patients' participation in conversation was also limited to only 29%. In terms of the proportions of topics, profession-specific action (62.4%) and factual exchanges (32.9%) dominated over "emotional work" (4.5%). In particular, a comparatively high proportion of non-professional interventions (20.3%), which include communicative strategies of *blocking* and *evasion*, were found in relation to expressions of feelings.

24.5 Qualitative ward round analyses

Communication strategies such as *blocking* and *evasion*, with which entry into an *open dialogue* with the patient is prevented, have become the subject of qualitative, conversation-analytical studies in particular (e.g. Bliesener 1980, 1982, Nothdurft 1982, Siegrist 1982, Quasthoff-Hartmann 1982, Bliesener, Köhle 1986, Ott 1996, Menz et al. 2008, Novak 2010). Here, the sometimes subtle linguistic-communicative means have been examined with which doctors more or less consciously, but in any case routinely, erect barriers against the patient's participation in dialogue - for whatever institutional or individual reasons or motives (lack of time, defence against emotions, etc.).[2]

Although strategic as well as communicative action can be inherent in everyday as well as institutional situations, in principle our actions are based on a *model of ideal communication* (§ 7), according to which we may expect at least minimal rules of understanding and communication even in institutions, as we are used to in our everyday lives (§ 7, 9, Koerfer, Neumann 1982, Koerfer 1994). Here, as there, we expect answers to our questions or justifications to our reproaches and complaints, etc. Even if our expectations may not be as unrealistic as those of Th. Bernhard, who wanted to "talk to his doctors without interruption" (see above), we nevertheless assume the validity of a normal form also in the institution of the hospital, which we may demand from the everyday perspective as patients.[3]

24.5.1 Structural communication barriers

Thus, Nothdurft (1982) also analyses the structural *impermeability of* hospital rounds primarily under dimensions and characteristics under

---

2 Cf. on the motives and reasons also the evaluation problem (§ 3, 9, 40), on the special framework conditions of institutional communication can always only be dealt with in passing here (Ehlich, Rehbein 1986, Koerfer 1994/2013, Ehlich 2921, 2022).

3 Even if not always as courageously as the actress Hildegard Knef, who as a real patient rejected the doctor's opening question ("How did we sleep today?") with a protest against the wording ("we").

which elementary rules of everyday communication are violated in the round.

- The *unobservability* of the ward round often results from the fact that the team communication bypasses the patient. This can be the case, for example, with the "side communication", which may be the "main communication", in which the clinic staff talk among themselves and even lower their voices, precisely so that the patient cannot become an involuntary listener and witness.
- The *opacity is* due in particular to the technical terminology ("hypotension", "ischaemia"), the jargon ("irreversible", "insufficient", "indicated", "dissolve water", "tumour not responding", cf. below) and the complex or abbreviated language ("CT", "PSA value") of the clinic staff.
- Finally, patients suffer from the *unpredictability of* a possible entry into communication, in which they, as potential speakers, miss or miss the take-over points ("When can/should I say something here?") that are relevant for them in dialogue.

The following example (E 24.1) (from Nothdurft 1982) also demonstrates several aspects of the *impermeability* of ward round communication for a patient whose barriers to taking over the speech and active participation in a professional "side communication" between the doctor (D) and the MA (M) are unmistakably high.

E 24.1		"We cannot dismiss her"	Comment
01	M	She came in because of a suspected ischaemic myocardial reaction...	Inscrutable
02	D	With absolute arrhythmia. If she moves and stands up a bit, yes then we don't need so much [unintelligible].	
03	M	[talks in parallel to D] The last ECG was done on the 11th, when the welfare worker was positive.	Unwatchable
04	D	What positive?	
05	M	[quietly] assesses things, so that she finds accommodation somewhere, then	Unpredictable
06	D	No, we can't discharge her. She still has these huge wounds on her knee joint.	

Here, a "social case" that has to be "accommodated somewhere" is obviously compared with medical facts that ultimately speak against discharge ("giant wounds"). The potential discharge discussion is conducted as a purely interprofessional team communication without subject participation of the patient. Because of the technical hurdles (e.g. "ischaemic myocardial reaction", "absolute arrhythmia"), the sequence of the conversation remains not only *inscrutable* for the patient, but also *unobservable* in so far as the doctor and the MA make their secondary communication (also for the transcriber) incomprehensibly quiet at times, whereby they speak about the patient exclusively in the third person ("she"). The two professional interlocutors coordinate their speech organisation so closely (sometimes simultaneously) that the possibility of the patient taking over the conversation remains *unforeseeable*, if she even knew how to intervene in the dialogue in a meaningful way.

24.5.2 Asymmetrical verbal actions

According to Siegrist (1982), these types of communication strategies prevent patients from entering into conversation at all, and the possibly previously successful conversation initiatives are withdrawn from them again or transformed with the use of so-called *asymmetrical* verbal actions by doctors. Siegrist distinguishes between four types of reaction to asymmetrical verbal acts:

- Failure to observe,
- Change of addressee or topic,
- Relationship comment and
- Communication of functional uncertainty.

For the time being, a few short sequences of conversations will suffice as anchor examples to illustrate the communicative deficits and disruptions of traditional ward rounds. In the following example (E 24.2) from Siegrist (1982), the change of topic is accompanied by a change of addressee, so that the patient is denied any further opportunity to participate in favour of purely interprofessional communication:

E 24.2		"Is the blood good"	Comment
01	P	Is the blood good?	
02	D	I beg your pardon?	
03	P	The blood?	
04	D	[to the nurse] Yes, we can't avoid having an X-ray of the stomach on Monday.	Change of addressees and topics

For the following example (E 24.3) from Raspe (1983), the contextual information should be added that this is a patient with leukaemia a few days before his death, in whom a retinal haemorrhage has led to severe visual disturbances, but which the patient tries in vain to make an issue of, which the doctor radically changes:

E 24.3		"I can't see anything anymore"	Comment
01	P	I do not see	
02	D	Hm?	
03	P	I can't see. I can't see anything any more!	
04	D	Hm ... and how's the breathing otherwise?	Change of subject

In further conversation-analytical research, the focus of observation has been increasingly sharpened and several other communication strategies for preventing dialogue with the patient have been described, some of which extend over several conversation sequences and are often realised very subtly in linguistic terms (e.g. Bliesener 1980, 1982, Quasthoff-Hartmann 1982, Bliesener, Köhle 1986, Fehlenberg 1983, 1987, Fehlenberg et al. 2003). For example, Bliesener (1982) distinguishes a total of 12 rejection strategies towards patient initiatives (e.g. *blocking*, *overrunning, stalling, immobilising, turning, shifting,* etc.). Insofar as these rejection strategies are not always successful at the first attempt, interaction loops with counter-strategies of the patients (e.g. *boycotting* through minimal reactions) arise.

These counter-strategies, for their part, no longer serve to enforce the original initiatives, but only to compensate for personal slights. Repeatedly going through such interaction loops with rejection strategies on the doctor's side and reaction strategies on the patient's side can in

turn lead to greater friction losses in communication between doctor and patient, whose joint track record then falls considerably short of the possibilities of a dialogue that is open from the start.

24.6 Patient-centred ward rounds

A changeover to an *open dialogue* with the patient has been tested since the early 1970s on a model ward in the Centre for Internal Medicine at Ulm University Hospital (Köhle et al. 1977, Westphale, Köhle 1982, Fehlenberg et al. 2003, Köhle, Siol 2003, Koerfer et al. 2005). The model trial on patient-centred ward rounds included both treatment conceptual and organisational-structural changes as well as, above all, changes in communication with the patient.

24.6.1 The Ulm Reform Model

Overall, the innovative approach of the Ulm ward was committed to an integrative biopsychosocial concept of understanding and treatment (cf. § 2.2). The patient-centred approach had both personal and institutional-organisational prerequisites: The doctors involved were simultaneously undergoing further training in internal medicine and psychoanalysis, and supervision opportunities and one-year further training courses were also offered for the nursing staff (Köhle et al. 1977).

In order to be able to anchor the biopsychosocial view of the patient as a subject in practical ward work, the organisational structures as well as forms and contents of communication also had to be changed. From the research situation described above as well as our own critical experiences in traditional ward work, a number of consequences were drawn for which a conception of the "ward round as dialogue" is constitutive. In summary (according to Köhle et al. 1977, Fehlenberg et al. 1996, 2003, Köhle, Siol 2003), the following main objectives can be differentiated for the new, integrative ward round concept:

- ***Conversation room***
  Patients should be given more room to *talk about* their complaints and concerns during the ward round. In order to minimise the often disturbing exchange of information in interprofessional com-

munication between the team members during the ward rounds, the necessary discussions are, as far as possible, moved out of the ward rounds and into separate pre- and post-discharge meetings.

- ***Dialogue***
  The ward round should mainly take place as a dialogue *between* the doctor conducting the ward round and the patient. While the doctor conducts the conversation with the patient as much as possible "at eye level" (chair at the bedside), the other team members are involved at a greater distance, mainly as observers.

- ***Equal opportunities***
  For communicative forms of participation (question-answer, claim-dispute, propose-object, etc.) as well as topic initiatives, there should be extensive *equality of opportunity* for both dialogue partners. Here, *dysfunctional* asymmetries must be reduced in favour of an approximately *symmetrical* communication (Westphale, Köhle 1982, Koerfer, Obliers, Köhle 2005).

- ***Consultation therapy***
  The ward rounds should be integrated into the overall treatment plan and at the same time be conducted as a *therapeutic* dialogue. In the sense of the "consultation therapy" developed by Balint and Norell (1970/1975), psychotherapeutic interventions can also be used here. Depending on the indication, more *emotionally supportive* or more *interpretative to confrontational* forms of intervention are chosen.

Ward round communication at the Ulm model ward has been evaluated in detail in extensive accompanying research (Raspe, Köhle 1982, Bliesener, Köhle 1986, Fehlenberg 1987, Fehlenberg et al. 1996, 2003, Köhle, Siol 2003). In the following, exemplary cases from the internal psychosomatic ward rounds will first be presented and analysed and then essentially the comparative study results on the quantitative interview parameters already presented (in § 24.3) (Fig. 24.3a-e) will be summarised in a final evaluation (§ 24.8).

24.6.2 Biopsychosocial anamnesis: "that I won't grow old"

The following transcript example is an excerpt from an approximately 10-minute ward round that took place in the Ulm reform ward (Fehlenberg et al. 2003). The patient is a 58-year-old farmer who was resuscitated after a severe anterior wall myocardial infarction and treated in the intensive care unit, where he suffered a reinfarction and pneumonia occurred as a further complication. After 19 days, the patient could be transferred to the internal psychosomatic ward, where the subsequent ward round took place.

Conversation process 1: Biomedical topics

As can be seen from the conversation, the patient is known to the doctor conducting the ward round, who has to adjust to his "tendency to deny illness" because of their common previous experience. In the first part of the conversation, omitted here (cf. Fehlenberg et al. 2003: 451ff.), after the greeting and the patient's self-initiated and anticipatory communication of his condition ("I'm fine"), it is first about the clarification of the complaints in the arm, which the doctor sums up as follows after the physical examination: "the vein has been quite annoyed by the catheter. And that there is still a bit of a bruise in there and that is perhaps pressing on the nerve". After the end of this predominantly biomedically oriented phase of the conversation, the topic changes, initiated by the doctor: As she had heard from the nurse in advance, the patient wanted an appointment with the priest, but for organisational reasons this had not yet come about, which the patient was very disappointed about.

Course of conversation 2: Biopsychosocial topics

After bringing up the patient's wish for a conversation with the priest, the doctor skilfully takes up this obvious need for conversation and makes it their own matter between doctor and patient. The following transcript has been adopted here in the second part with the transcrip-

tion conventions (after Fehlenberg et al. 2003: 452f.).[4] We have provided the transcript here with a commentary column, the key points of which will be further elaborated in a brief analysis afterwards.

E 24.4		"that I won't grow old"	Comment
01	D	ah yes.	
02	P	and no one is still interested (3 words unintelligible).	
03	D	mhm.	
04	P	I think that if you are in intensive care for 14 days or 3 weeks and then wake up like this, (...) it wouldn't be a pity if a priest said a good word.	Psychosocial patient concerns
05	D	that's what you need, isn't it? You always say when you first come in that you're doing so well, but when you asked me the other day what was going on with your heart and what had happened and was going to happen, I thought that you were already (.) worried or how things were going.	Supportive and empathic interventions
06	P	I mean, it's just, I'm fully aware that my health is not what it was, and that,	Illness insight
07	D	mhm.	
08	P	that not much can come of it. That I have to reckon with the fact that I won't grow old. [3 seconds pause]	
09	D	yes?	Illness insight?
10	P	that's my opinion.	
11	D	mhm.	
12	P	it depends on the situation.	
13	D	mhm, yes, at least, I think they already talked to you in the intensive care unit, (.) that, yes/that	Resumption, clarification
14	P	yes/	
15	D	you have to expect it./Yes.	
16	P	yes/	Confirmation

[4] In class, the whole conversation should be available. The first part of the conversation is analysed in Fehlenberg et al. (2003), so we can focus on the second part here.

17	D	mhm.	Reconfirmation
18	P	also the (...) I don't know the name of the doctor (1 word unintelligible) right now.	
19	D	the B., the one with the beard?	
20	P	yes .	
21	D	mhm. Doctor/ B.	
22	P	he said to my wife, when I come out and your husband has a fork in his hand, he's not well (patient laughs) because apparently I'm not supposed to work (.) much or not hard at all.	Ambivalence in quotation form: "shall seem"
23	D	mhm.	Paradox
24	P	that must be clear to me, apparently.	Formulation
25	D	How is it for you, the outlook?	Expansion of the
26	P	ja/I have been very active so far.	biopsychosoc.
27	D	mhm.	Medical history
28	P	there is a changeover, but (.) (1 word unintelligible)	
29	D	tell me, you had no complaints at all before?	Detail exploration
30	P	no.	
31	D	did you work full time?	Insisting
32	P	yes.	Intervention
33	D	yes? (.) Or/have S'	
34	P	was sixty/	
35	D	do you sometimes have to take it easy?	Interpretative and
36	P	no.	insisting
37	D	not at all?	Interventions
38	P	I was sixty percent war-damaged, and I was often very tired in the evenings.	
39	D	mhm, (.) yes.	
40	P	however, I was, uh, in treatment before.	
41	D	yes, why actually, if you had no complaints?	Insistent intervention
42	P	I always have rheumatic pain	
43	D	[...][shorter omission about taking medication]	
44	P	[...]	
45	D	and you never noticed anything, (.) never had any complaints, worked full time?	Insistent intervention
46	P	yes, I, I say to my wife, I (ha I have today) a working spirit again. (laughing) (2 sec. pause)	
47	D	again?	Active listening
48	P	yes.	

49	D	so you weren't able to work as well for a while after all?	
50	P	yes, sometimes one was already more tired, (innit) with the weather influences and such.	
51	D	how's that? Have you actually handed over yet? That's always a very important time for farmers, when they have a	Exploratory extension of the bps history
52	P	no./	
53	D	do you have a son?	
54	P	yes. Yes.	
55	D	and have not yet handed over?	Insistent intervention
56	P	no, but (..) (I will certainly do that) when I'm well enough to manage it again.	
57	D	is that what you're going to do now?	interpretative
58	P	yes, yes, (..) That's worthless. If the other people do the work (he laughs briefly) and I just show (...). that's not possible.	and confrontational interventions
59	D	is that difficult for you?	
60	P	yes, it is difficult [...].	

In the following, only selected aspects of a highly complex ward round can be considered here, in which the doctor seeks to complete the *biopsychosocial* anamnesis (§ 4, 9) and at the same time to pursue *therapeutic* goals (§ 8) that concern the patient's current processing of the illness and future illness behaviour after discharge.

24.6.3 Interaction and theme development: "very active so far"

The development of the conversation is to be traced under certain interactive and thematic aspects, in which quantitative and qualitative analytical perspectives are to be applied in combination, as will be further justified and elaborated later in the evaluation of conversations (§ 40).

Ambivalence of the insights of the disease

First of all, the specific ambivalences of the patient are expressed in a variety of linguistic forms, whose insight into the illness still proves to be provisional and unstable, as suggested by his hesitant, vague and

distancing formulations. Although the patient specifically marks his own opinion several times (10P: "that's my opinion), it is relativised several times, for example through vague restrictions (12P: " it depends on the situation") or through distancing forms of quotation. With these, the pre-treatment doctor is acknowledged as the quoting authority (18ff: "The doctor said ... because apparently I shouldn't work much any more"), but the claim to validity of content associated with this is at the same time called into question again with the specific formulation twice ("apparently"), so that in summary a strangely paradoxical self-statement emerges (24P: "that must be clear to me, apparently").

In combination with the modal verb ("must"), the patient is still very cautious about the appearance of a need to change behaviour ("should/must ... apparently"). Compared to the self-contradictory statement ("it must be clear to me, apparently"), a formulation without modalities ("it is clear to me") would certainly be more an expression of conviction on the part of the patient. However, we had already encountered the alternative between a merely *obedient* or *persuaded* patient on the one hand and a *convinced* patient on the other in the chapter on shared decision-making (§ 10).

Types of verbal interventions

As can be reconstructed from the doctor's reactions, in the specific case the patient's ambivalences were also perceived as such by the doctor, i.e. his more or less manifest/latent cues were also heard (e.g. Salmon et al. 2004, Koerfer et al. 2005, 2010). To be able to recognise and process the relevant patient attitudes (beliefs, faith, hopes, fears, etc.) for diagnostic and therapeutic purposes, the practitioner uses a range of appropriate (types of) verbal interventions, as differentiated in detail in other parts of our manual (§ 17, 19-21). This includes both simple interventions such as *active listening* (47: by repeating words with the question intonation "Again?") and a series of complex interventions which are both *supportive* or *emphatic (*05) and *explorative* or *interpretative* (35ff.). The doctor also uses these in an *insistent* form (37: "not at all?"), with which she obviously pursues her doubts about the authenticity of the conspicuously monosyllabic, strictly affirmative ("yes") or negative patient answers ("no") in a critical sequence (29)-(38), in which, from the doctor's point of view, the denial of his need for protection obviously manifests itself.

Role and identity conflicts

Through the insistent interventions, the patient's illness-related impairments are "brought up" (38: "was often very tired in the evening", cf. 50), which must be taken into account not only in the past, but also in the future. In order to test the real life applicability of an illness behaviour, the rationality of which must be negotiated jointly between doctor and patient (§ 4), the doctor explores and evaluates together with the patient his future living and working conditions in his profession as a farmer. The patient's role and identity problems can then be fully "brought up" on the subject of the upcoming handover of the farm to his sons, when the patient expresses a possible but untenable compromise self-ironically and distancing himself by laughing (58: "If the other people do the work (laughs briefly) and I just show off"), before immediately rejecting this narcissistic fantasy (of a show-off) (and the emotions associated with it) ("That's not possible").

This discrepancy in the patient's current self-experience, whose professional abandonment still threatens to be tantamount to self-abandonment, is precisely anticipated by the doctor with her immediately following intervention (59: "Is this difficult for you?"), as can easily be seen from the patient's reaction (60: "yes, it is difficult"), who clearly marks the question content in the affirmative by repeating it (cf. on the accuracy of fit of interventions (§ 3, 17)). With this sequence of conversations, the therapeutic material is finally gained, which both conversation partners continue to work on in the remaining time of the ward round with the clarification of a closer career and life perspective of the patient, who finally shows himself convinced of the necessity and possibility of soon handing over his farm to his sons for the good of all.

Turn-taking organisation and distribution of speaking rights

Under the evaluative aspect that good conversations can still be improved, reference should first be made to a few weaknesses in the conduct of the conversation, in which the doctor interrupts the patient early on at a relevant thematic development point instead of letting him continue to talk (28: "there is a change, but/", cf. also 34: "was sixty/"). Perhaps these early interruptions are, as so often, due to the time pressure in the ward round setting, which also does not exceed the relative-

ly short duration (with physical examination) of 10 minutes here. Otherwise, this 10-minute ward round is conducted in the classic form of a *two-way conversation* (§ 18.3), in which communication with third parties present (two nurses, another doctor) is limited to minimal sequences, which, in addition to the general greeting and farewell, include clarifying the name of the priest (a total of 46 words). In the dialogue itself, the patient has his say with a total of 60% (Tab. 24.1), which is a very good value compared to the average values of both traditional (30%) and reformed (45%) ward round communication (above Fig. 24.3b). The patient can use his relatively high share of the conversation for a series of longer speeches, in which he can speak "in his own words" on specific topics.

To determine the longer speech contributions, a conversational procedure is considered in which, according to Duncan (1974), a "speaker-auditor-interaction during speaking turns" is possible. Certain listener activities (such as "hm", "yes") are understood as feedback ("auditor back-channel") with which the current listener can provide information to the current speaker and the latter can nevertheless continue in his speech "as if uninterrupted" (§ 19, 17, 40). For example, the patient can "talk in one piece" with his utterances (06)-(12) without being "interrupted" in a relevant sense by the doctor's listener feedback (07), (09), (11).

Conversation share (words)			
Doctor	Patient	∑	Other
509 (40%)	746 (60%)	1255 (100%)	46

Tab. 24.1: Share of conversation

We have repeatedly used this procedure to detect longer speech contributions to be able to map the specific dialogue role structure of speaker and listener in doctor-patient communication (Koerfer et al. 2000, 2010, Koerfer, Köhle 2009) (§ 17, 19, 40). Applying this procedure to the present ward round conversation, we arrive at a speaker-specific speech or topic domain in each case that has to do with the interactive expert roles of the speakers (Fig. 24.3, tab. 24.1-2). In this context, 5 of the 7 longest speech contributions (>50 words) are realised by the patient alone. While the doctor's domain arises in the longer explanatory con-

tribution on the *biomedical* topic (omitted here) ("bruise on the arm due to the catheter") and in the *psychosocial* topic transition (05), the patient makes his 5 longer speech contributions on the *psychosocial* topic (omitted here) of his many years of church work and his (thus justified) wish to visit a pastor as well as on his state of health (06ff.) and his (associated) change of perspective regarding retirement.

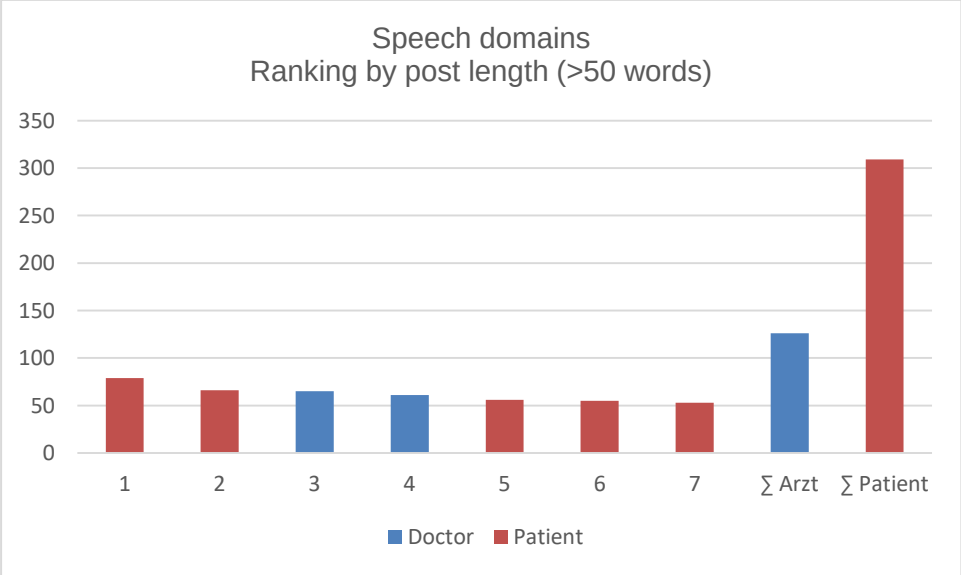

Fig. 24.4: Speech domains

Theme organisation and theme domains

Interestingly, the complementary *initiating function* according to which the biomedical topic is initiated by the patient and the psychosocial topics by the doctor - an expression of a highly complex interaction structure in which topic initiation and topic development turn out to be *joint* constructive achievements of both interaction partners.

The specific interactions in the joint construction of narratives (Brody 1994) are repeatedly discussed in this handbook (§ 9, 19, 24.7, 25). It should be pointed out here that the longer patient contributions identified in this conversation are also very first candidates for a narrative self-interpretation of the patient (Tab. 24.2) (§ 40), in which the patient begins to reflect on his roles as a sick person and finally, in this context, as a church parishioner, husband, father and farmer (in retirement).

		Theme domains Theme-specific placement							
		Arm	Church/Pastor		Illness/Resting/Coping				∑
Speaker	A	61				65			126
	P		79	53	66		56	56	309
		4	1	7	2	3	5	6	
		Ranking 1-7 (speech length > 50 words)							

Tab. 24.2: Subject domains

24.6.4 Therapeutic dialogue in ward rounds

If one draws an overall balance for this ward round, then both conversation partners have formally and in terms of content recognizably "come into their own" and have been able to use this right to build up a *common reality* in the sense of v. Uexküll, Wesiack (1991, 2011) (§ 4.4). *Formally,* the doctor was able to withdraw from 40% of the conversation and yet, or precisely because of this, was able to draw the patient into a conversation in which he was able to "have his say" in detail as an expert on himself.

The giving of the floor led to a rudimentary narrative self-representation of the patient "in his own words", in the selection of which the doctor, as "cue-giver", had a considerable share with her partly proactive, partly insistently confrontational interventions (e.g. 25: "how is it for you, the outlook?", 37: "not at all?", 41: "why actually?", 51: "actually already (court) handed over?"). The associated *midwifery function* of medical interventions, which *help to verbalise* the patient's knowledge and experience, has already been discussed in detail (§ 9.5).

In terms of content, the dialogue between the doctor and the patient led to the clarification of the physical complaints and the need to talk to the priest and to the further completion of the biopsychosocial anamnesis, the findings of which could at the same time be used for therapeutic purposes in the sense of the "consultation therapy" (Balint, Norell 1970/1975) claimed above (§ 25.6.1). For the biographically developed

life and conflict situation of the seriously ill patient, who is facing drastic changes relevant to his life, a self-reflective attitude could be promoted and a possible coping approach for the time after the hospital stay could be worked out. At the same time, this would provide a perspective for the still outstanding discharge interview (Langewitz 2017), which could be deepened in the subsequent further treatment (rehabilitation, etc.).

However, the further-reaching therapeutic claim should not be "outsourced" from the ward round, but should be perceived in daily contact with the patient, if possible in a "dialogue", in which the other team members should largely hold back as described.

Another example of a ward round from the Ulm reform ward will be used to show the possibilities of biopsychosocial conversation as a dialogue under the aspect of cooperative narration between doctor and patient, in which the jointly constructed achievements of patient stories are worked out.

24.7 Cooperative storytelling in the ward round

The following ward round also originates from the Ulm model ward. It illustrates even more strongly an approach to biographical-narrative anamnesis as it was presented in advance and illustrated with empirical examples, especially from the family doctor's practice (§ 9, 19). The following consultant round, in which a number of other persons (physicians, nursing) participate only in the background, initially follows a traditional path of biomedically oriented conversation, before a change to the biopsychosocial ward round model occurs due to a topic initiative of the consultant conducting the conversation.

However, the ward round can only be described here in abbreviated form, as can the history of a preceding ward round to which both interaction partners refer in the current ward round, the presentation and analysis of which we draw on previous work (Koerfer et al. 2005). For all the conceptual advances of the ward round, attention should first be drawn to the shortcoming in the *location* of the conversation (§ 18.6), in which the doctor conducting the conversation (instead of sitting) talks to his patient standing up, as it were "from above". Thus, the patient, who is lying particularly flat in bed, has to look up at his doctor and talk, which is not exactly conducive to promoting the most symmetrical communication possible.

24.7.1 History and examination: "doesn’t hurt at all"

The patient was admitted as an inpatient because of a pulmonary embolism and a leg vein thrombosis. Most recently, he had complained of a depressive mood and expressed suicidal ideation. After being greeted by the team, the consultant takes charge of the conversation, which first begins by clarifying the patient's general condition (P: "it's all right") and his current complaints, who declares that he is pain-free (P: "I'm not in any pain now"). The doctor then carries out two physical examinations, each with introductory words, by first listening to the lungs and then examining the left leg, which now no longer causes any discomfort compared to the previous examination (P: "it doesn't hurt at all"). Following this physical examination of the leg, further *details* are explored in the sense of *completing* the anamnesis (§ 21), which, with a direct question from the doctor (D: "Do you wear rubber stockings?"), refer to previous treatments or measures affecting the leg (veins).

By answering the doctor's detailed questions, the patient can at the same time bring in the rationality of the order at the time ("support stockings"), which took place in the same clinic ("When I was here with my heart"), as well as of his own illness behaviour (adherence), which is checked again by the doctor with a question of reassurance ("And if you work too?"), which is answered in the affirmative by the patient.

24.7.2 Biographical-narrative anamnesis: "don't go crazy".

With this medical reassurance of the patient's adherent behaviour towards the illness, the ward round could just as well be ended in a more or less discharging manner. The doctor could introduce this end of the ward round by appealing to the patient (in the sense of *opening up closing*) (§ 23) to continue the reasonable behaviour shown so far ('Just keep it up ...'). Otherwise, the doctor could draw a positive overall conclusion by emphasising the mutually agreed improvement as the provisional conclusion of a good course of treatment and say goodbye to the patient until further notice.

As much as such a conclusion of the conversation would be objectively justified based on the previous findings, it would not be able to satisfy the patient's *subjective* concerns. As becomes clear in the further course of the conversation, the patient's need for clarification is directed

less towards his current physical condition in the here and now of his stay in hospital, but rather towards his life afterwards, the continuation of which in the way he was accustomed to so far seems questionable.

Stimulation function of the doctor in his midwifery role

However, this individual patient concern only comes into play through a different kind of continuation of the conversation, in which the doctor goes beyond the mere improvement of the patient's physical condition. The doctor carries out this qualitative change in the conversation in several steps, in which he carefully and successively carries out a transformation from the previously purely biomedical to the biopsychosocial anamnesis. The transformation succeeds in each case without a recognisable break, in that the doctor directly follows the topics offered by the patient, which he expands at the same time. It is a continuous development of themes in which old themes (*given*) are linked with new themes (*new*). The topics do not arise by themselves, but are unfolded interactively by both conversation partners in the sense that *one word gives the other*. In this process, both partners interact with each other as cue-givers who pass the material for the dialogue construction of the life narrative to each other, however, with the asymmetry that can already be observed at the beginning of the conversation, that the patient would probably remain in the passive participation role if he were not stimulated by the doctor to further unfold the topics. This *stimulation function of* the doctor in his role as *midwife*, which is repeatedly described in the handbook and illustrated with examples (§ 9, 17, 19, 25), is also to be shown in this ward round example.

Current professional life: "What do you do for work?"

After the patient has markedly affirmed the doctor's reassurance (39D: "and when you work, too?") (40P: "when I work, too, yes"), the doctor initiates a change from the biomedical to the biopsychosocial anamnesis by making the patient's professional life the subject of a simple question for detailed exploration. Whereas up to now work was only marginally discussed under the biomedical aspect (wearing support stockings), the profession is now made the central topic of the ward round directly af-

terwards (41D: "what do you do for work?") and through further listening activities by the doctor according to content and individual significance.

E 24.5		"What do you do for work?"
33	D	yes .
34	P	and then they ordered me to wear rubber stockings during that time .
35	D	hm .
36	P	I wear this all the time .
37	D	hm .
38	P	so also on Sundays and always . innit. so during the day . not at night . at night I have it off .
39	D	and when you work too? .
40	P	when I work too . yes .
41	D	what do you do for work? .
42	P	I have a construction business .
43	D	a construction business? .
44	P	yes . with the children .

As in the preceding sequence, the patient must first be "lured out of his reserve" in this sequence and stimulated by appropriate interventions by the doctor to further elaborate on the topic in each case: First, the doctor uses a simple technique of *active listening* (§ 19), namely word repetition with question intonation (43D: "a construction business?"), through which the listener's interest is particularly marked in the sense of a *relevance upgrade* (§ 17.4, 20.4). The patient in turn reacts with an information supplement (44P: "yes . with the children") ("yes ..."), which would not have come about without the doctor's intervention (43D), or at least not in this way.

Autonomy questioned: "You don't do it alone anymore"

The doctor's further intervention (45D: "You don't do that alone any more ...") is more complex, in terms of form, content and function. Obviously, the doctor's intervention hits a "vital nerve" of the patient, who reacts vehemently and in one piece, without the need for further stimulation.

E 24.6		"you don't do it alone anymore"
45	D	you don't do that alone any more . your son does that already . or what-
46	P	Yes . they do it . yes . that can certainly be the case . but up to now the father has always been the one in front, y'know. because the father is such a . how should I put it . so crazy, y'know . you can't do it without work, y'know.

Central to this second intervention is the thematic key symbol that the doctor introduces here (45D: "no longer do it alone"), with which the problem of *autonomy,* which is psychodynamically significant for the patient, is precisely retrieved, namely in the threatening context of a time perspective ("no longer") and real alternative ("your son is already doing that"). In this context, the patient is cognitively and emotionally confronted with a possible loss of autonomy, whereby he obviously feels audibly and visibly challenged to make a statement.

His *affirmative-adversative* reaction structure ("yes ... but", Koerfer 1979), which is characteristic for the further course of the conversation, refers to the ambivalence conflict of the patient, who verbally moves between agreement (46P: "yes, they are already doing that") and rejection of a possible presupposition ("but until now the father has always been the one in front"). Both with the specific time perspective ("until now") and with the specific metaphor ("the person in front"), the patient, who here presents himself in the third person of a social role ("the father"), apparently at the same time carries out image work that is experienced as necessary, with which he seeks to "save face" in self-presentation. This self-representation is addressed in several ways, namely (1) to himself as a person who suffers a threatening loss of image as well as warding it off, and (2) to his social environment (family), to which he must return in perspective, and last but not least (3) as an appeal to the doctor and the team members in the current conversation of the here and now of the ward round, which is obviously about his future career perspective, which at the same time essentially shapes his life perspective ("it doesn't work without work"), as becomes increasingly clear in the further course of the conversation.

Age and reason: "Then don't go crazy".

The patient's conflict of ambivalence already manifested itself in another concession in the self-representation, in that he again admits in the third person ("the father") and at the same time hesitantly in the formulation (*hesitation phenomena)* doubts about the rationality of his own behaviour (46P: "because the father is such a . how should I put it . so crazy, y'know . without work it doesn't work, y'know"). In contrast to this self-image as a patient's offer to the doctor, to whom the patient presents himself as a "crazy person" when it comes to work, alternative (explorative, interpretative, confrontative, educational, etc.) possibilities of intervention now open up for the doctor. However, a decision on their suitability cannot be made without further clarification of the patient's real social living conditions, if the inherent life models of "reason" associated with possible interventions, which simply negate the patient's admitted "being crazy", are not simply to be imposed on him or her in the abstract.

Therefore, the doctor's subsequent information question (47D: "How old are you now?") has a different function here than simply clarifying the calendar age. Rather, the information question takes on an exploratory function, which consists of clarifying the social retirement age, this being a precondition for a further intervention strategy that is significant in everyday life. In cases in which the patient has reached or exceeded retirement age, there would be alternative continuations of the conversation in which, for example, the "entry into well-deserved retirement" could be made the topic including the familiar idiomatic expressions.

However, insofar as the doctor's probing question leads to other "objective" findings about the patient's "life data", other thematic continuation alternatives arise, which the doctor brings into play by exploring the 61-year-old patient's subjective ideas. By confronting the patient with the corresponding normativity of social expectations (49D: "well, then you're still working"), the doctor presents him with certain "objective" norms for subjective validity testing, as it were. The patient is thus once again challenged to a (self-)explanation of his attitudes and expectations towards his present and future way of life.

E 24.7		"then you shouldn't go crazy"
47	D	how old are you now .
48	P	61 .
49	D	61 . well . then you're still working .
50	P	well, it's clear that you're still working. You're supposed to work, innit [=isn't it?] . but if someone says a doctor said that if someone is working, then he should also take care of himself . then you shouldn't go crazy and still go to work . (I would) .
51	D	how old are your sons, your children? .
52	P	yes, one is 37/38 and the other 43 .

Again, the patient reacts with the ambivalence of a verbal double structure (50P). Its *affirmative* part is expressed in a marked agreement ("it's clear that you're still working"), while the *adversative* part ("but if someone says ... then you shouldn't go crazy") consists of the reproduction of a counter-argument of a citation authority (of a pre-treatment doctor). Before the consultant can take up this ambivalence conflict ("who shouldn't play crazy, is obviously playing crazy") and give it back to the patient for further processing, he in turn clarifies the necessary knowledge prerequisites for preparing further interventions, which firstly include age (51D: "how old are your sons?") and then the status and function of the patient's children, i.e. information about the real living conditions is obtained, which only allows realistic conclusions to be drawn (possibilities of detachment and relief through children - cf. below) for dealing with the conflict of ambivalence.

Living autonomy: "I was already independent at the age of 16".

The mere thematization of the children's "independence" by the doctor (53D) obviously "provokes" the patient to prove that the patient's independence is even greater and, above all, earlier than that of the children, which means a re-thematization of the already virulent "autonomy problem" that the doctor had already touched on in a questioning manner (45D: "you don't do that alone any more . your son already does that . or what"). The critical comparison (me in the past - the children today) is now contrasted by the patient in such a way that it indirectly leads to a devaluation of the children who were only able to achieve

their independence in advanced adulthood (54P: "today already big") with their (father's) help and preparatory work. With this kind of downward comparison, the patient makes a revaluation of his self, who has mastered everything earlier and without outside help, so that *autonomy* seems to be increased to *self-sufficiency.*

E 24.8		"I was already independent at the age of 16".
53	D	then they are already completely independent or .
54	P	yes, I was already independent at the age of 16, when I came out of my apprenticeship, and they are already big today.

It remains to be seen to what extent a specific *generational conflict* is already expressed here, as it was often formulated from the perspective of the (post-)war generation according to the motto: 'We had to build everything ourselves with our own hands, while everything fell into your laps'. - This could also be an element of a latent *life narrative* of this patient, to which the vocabulary from the previous ward round would also fit, in which a jargon typical for the patient ('toiling away' and 'plaguing') was used, which we will come back to.

Latent resignation: "It works without me too".

The patient's ambivalence, already expressed in the preceding sequences of this current ward round, now becomes fully manifest in the following passage, after the doctor makes the possibility of the patient's professional relief through his children ("... already ... without you") during the current illness ("now, when you are ill") an explicit topic.

E 24.9		"I can already see that it works without me . "
55	D	they already run the business without you now when you are sick .
56	P	yes, I realise that it works without me .
57	D	yes .
58	P	I can already see that it works without me .

The marked, double reaction (56/58P: repetition with identical wording after the doctor's *signal to listen*: "I already realise that it works without me") already shows the relevance of the statement for the patient, who has to concede a loss of autonomy with this concession of a professional replacement by his sons. As an external observer, one can "hear" as well as "see" in "sound and image" that this concession can only be made by the patient "with a heavy heart".

Personal life motto: "I am only healthy if I can work".

This serious concession is obviously also perceived or understood by the doctor, which is why he tries to clarify the patient's emotions at this point - also in the sense of a self-understanding of the patient, who must solve his current ambivalence conflict (autonomy vs. need for help = dependence) in the near future. Without building up a suggestive pressure of expectations at this "delicate" developmental point of the conversation, the doctor's intervention here provides a *real alternative to choose from* ("do you like it or not so much"), which the patient is free to decide.

E 24.10		"I am only healthy . if I can work"
59	D	do you like it or not so much?
60	P	me:? .
61	D	yes .
62	P	so frankly . I'm only healthy . if I can work . lots and lots and lots [clenches both fists vigorously, which he holds up in the air while lying down] .
63	D	yes .
64	P	then I am happy in the evening.

Although it is a genuine alternative in terms of form, content and function, the patient is put under a particular pressure to move, which he finds difficult to escape. The first thing that stands out is the patient's emphatically astonished question back (60P: emphatic: "me:" with question intonation). The patient is or acts surprised here, perhaps only to find time for his answer, which he begins after the doctor's listening signal ("yes"). After a special mark, with which the patient explicitly asserts his sincerity as a person and the truthfulness of his subsequent

statement in advance (62P: "so frankly"), he then formulates his personal life motto ("I am only healthy . if I can work . lots and lots and lots"). In this life motto, the subjective concept of health is condensed in a few words to a "short denominator", which at the same time sums up the course of the conversation so far.

24.7.3 Narrative in dialogue: From work to health

In the concluding sequence of the conversation (59-64), the *midwife function* of the doctor becomes manifest once again (§ 9.5), who puts his patient under the compulsion to (continue) narrating, which he has been doing for some time. In the process, the two interlocutors span a range of topics from work to (retirement) age and health (41-64). This narrative is not relatively "shaped at a stretch" by the patient, but in cooperation with the doctor, who, with his specific co-constructions, is substantially involved in shaping the narrative in a way that goes beyond merely *actively listening* to patients telling their stories.

Narratives are not "self-running", but are necessarily embedded in an interactive context in which they get going, stimulated by interested listeners, and must be kept going by active listening until the narrator has reached a relative gestalt conclusion after presenting the problem, evaluating it and, if necessary, solving it (§ 9.2). In general, this type of narration is seen as a major form of communication which, although developed interactively in dialogue situations, is itself essentially attributed to a *primary* speaker, even if the latter as narrator is dependent on a more or less active listener (§ 9, 19). From this point of view, a conception of cooperative or "dialogical" narration initially appears as a paradox.

This paradox can be resolved, at least for doctor-patient communication, if one understands the communicative action of the doctor as professional construction participation in patient stories in the sense of Brody (1994) ("joint construction of narrative"). The patient remains the narrator of his story, which, however, would not have come about without the doctor as co-constructor. It is possible that the narrative leads to a life-historically relevant reorientation ("new story") precisely because it is told with the specific participation of the doctor in the construction, who can thus pursue diagnostic-therapeutic purposes at the same time.

This type of cooperative narrative, which deviates from the traditional large-scale form of narrative (§ 9, 19), has been described and exemplified in detail elsewhere (Koerfer et al. 2005, Koerfer, Köhle 2007, Koerfer et al. 2010, Köhle, Koerfer 2017). Therefore, the reconstruction procedure for cooperative narration will only be briefly explained here using the present ward round example and otherwise reference will be made to analogous applications in other chapters on doctor-patient communication in primary care (§ 20.9, 25.4).

In the present case, the joint construction efforts of doctor and patient can be recognised by first considering the speaker roles in isolation from each other according to a method of text structure recognition (e.g. omission, shift and addition samples), then integrating the doctor's contributions into the patient's contributions in terms of content and subjecting the result to a coherence of meaning test (Fig. 24.5, right column reading only). Illustrated by concrete examples, this means in detail: The doctor's questioning activity (47D: "How old are you now?") is eliminated and its content (*propositional content*) is integrated into the patient's responding speech contribution (48P), so that he is allowed to answer as if "in the whole sentence": "I am now 61 years old" instead of just: "61". Analogously, the questioning activity of the doctor (53D: "Then they are already quite independent") is eliminated and its content is integrated into the affirmative answer of the patient (54P: "yes ..."). In the sense coherence test, the affirmative "yes" (after replacement by doctor's content and omission sample) can again be treated as dispensable, etc.

Finally, in a further test procedure with smaller units of communication (particles, conjunctions such as: *and*, *and then, therefore, but*, etc.), the dialogical references are correspondingly transformed logically during the integration of the doctor's and patient's utterances and this integration is subjected to a supplementary test.

In short: In a multiple sense-making process, the contents (propositional contents) of the doctor's contributions are productively attributed to the patient's contributions and the whole text construct is tested for its coherence of meaning as a narrative (fig. 24.5: only reading of the right column), in which the doctor's interventions finally merge completely, without which, however, the narrative would not have come into being.

D - P	Doctor		Patient
41-42	what do you do for work?	→	I have a construction business.
43-44	a construction business?	→	(yes) with the children .
45-46	you don't do that alone any more . your son already does that or what-.	→	(yes) they do it on their own . that can certainly be the case . but until now the father has always been the forerunner, y'know . because the father is such a . how should I put it . crazy person, y'know . you can't do it without work, y'know .
47-48	how old are you now?	→	so I'm 61 years old now.
49-50	61 . well . then you're still working .	→	And it's clear that you're still working . you're supposed to work, no . but if someone says . a doctor said that if someone procures, then he should also take care of himself . then you shouldn't go crazy and still go to work .
51-52	how old are your sons/your children? .	→	so one son is now 38 . and the other 43 .
53-54	then they are already completely independent, aren't they?	→	(yes) the children are already quite independent . so I was already . I was already independent at the age of 16 . when I came out of my apprenticeship, no . and they are already big today .
55-56	do they already run the business without you now when you are sick? .	→	so the children already run the business without me when I'm sick . so I already realise that it works without me .
59-62	do you like it or not so much? .	→	*and if you were to ask me if I like to see that or not so much*, so frankly . I'm only healthy . if I can work . lots and lots and lots [clenches fists] .
63-64	yes	→	then I am happy in the evening.

Fig. 24.5: Cooperative storytelling

Compared to the original patient utterances, the integrated contents from the doctor's utterances were specially marked (*in italics*) for easier differentiation and identification in the formal presentation and the possible omissions of smaller communication units (54P: "yes"), which are only due to the dialogue response format, were placed in round brackets, thus marking their omission in rare cases.

Since we will return to this test procedure motivated by a linguistic tradition in the evaluation of doctor-patient communication (§ 40), we will only refer at this point to a similar method by Carl Rogers (1942/85), who already at an early stage of empirical psychotherapy research sought to determine the differences between *non-directive* and *directive* conversation with an omission test (for therapist utterances) (§ 40.2.2). While the therapist's remarks seemed to be dispensable in non-directive conversation, the omission test in directive conversation resulted mainly in meaningless text fragments without any further context.

The test procedure for coherence of meaning presented here represents a refined method for identifying narratives (§ 40.2), which is particularly suitable for forms of cooperative narration. In these forms, too, the patient remains the author of his story, which the doctor has merely co-constructed with his verbal interventions as co-author. Like singing in a duet, each actor has his own part with which he contributes to the overall shaping of the narrative in dialogue. However, since it is supposed to be a "real" conversation in the sense of Buber (1954/1986: 296) (§ 7.5), the composition is not "pre-disposed“ but developed conversationally. Both partners do not know in advance how their conversation will develop, but they are mutually co-constructive in its meaningful development.

Just as the midwife is dispensable after the birth, the patient as narrator can claim the narrative entirely for himself after its conclusion. If the doctor's co-construction should have remained inconspicuous or up to unnoticed by the patient (§ 20.9), this can be all the better for narrative self-exploration, in which the doctor's foreign interpretations can apparently be well integrated into the patient's self-understanding without much resistance.

On this therapeutic path, a modified or innovative life story can be constructed together, more or less close to consciousness, which in a successful case can contribute to improvements in the practical life of patients. On the way to a *new story*, however, the "old" life story must

have been sufficiently reconstructed in order to be able to weigh up the necessities and possibilities of a reorientation on this basis.

24.7.4 Health concept and life narrative

The reconstruction of the patient's history as a medical and life history requires a corresponding biographical-narrative anamnesis (§ 9), which is oriented towards a comprehensive biopsychosocial model (§ 4). Sometimes the multitude and variety of biopsychosocial "data" is astonishing, which can be obtained through good medical conversation in the short time of only two ward rounds, so that they become part of a *common reality of* doctor and patient in the sense of v. Uexküll, Wesiack (1991, 2011) (§ 4.4).

In a summary of the biographical narrative anamnesis of the two ward rounds, of which the second ward round was reproduced and analysed in detail here, the data can be summarised in the presentation of a *life narrative* of the patient, in which his *subjective concept of health* manifests itself at the same time. In doing so, the presentation follows an evaluation line that the patient himself had expressed narratively. The procedure has already been explained in advance and exemplified by empirical examples (§ 9, 19), so that we can limit ourselves here to a brief description.

As already explained (§ 9), patients as narrators can make themselves (self-narratives) or other persons (other-narratives) the protagonists of narratives. These protagonists can be portrayed in the narrative as heroes, adventurers, comedians, lucky people, victims, failures, guilty people, etc. If one follows Gergen's (1998, 2002) typology on the *evaluative function* of narratives, then one can distinguish, for example, *progressive* from *regressive*, *tragic* from *comic* narratives.

These narratives can in turn be differentiated according to upward (*plus*) and downward (*minus)* tendencies based on critical life events on the time axis, so that the life curves of patients can be represented on the basis of their narratives as specific evaluation curves (§ 9.4) with specific characteristics (Fig. 24.6)

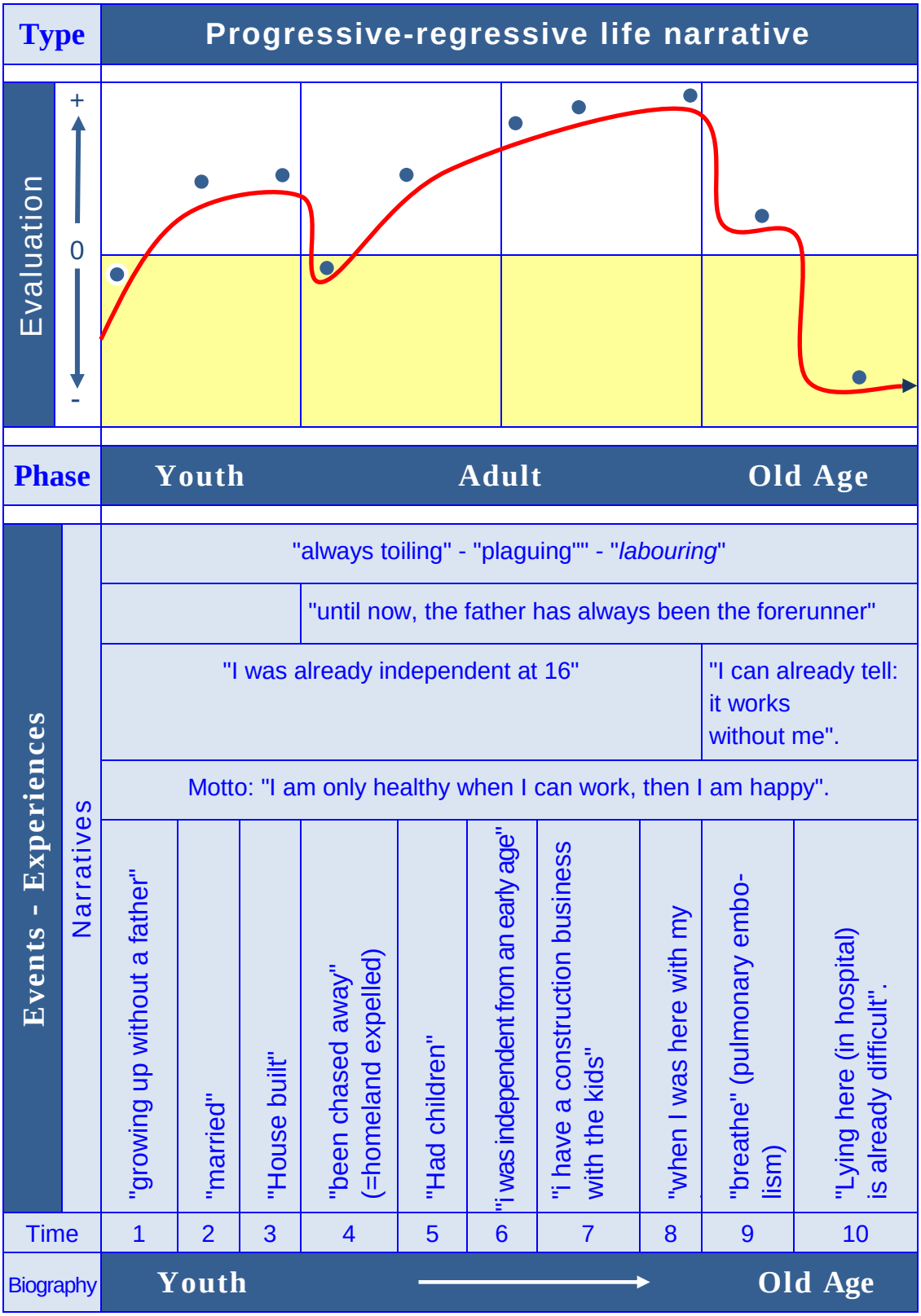

Fig. 24.6: Life narrative: 'I am only healthy/happy with work' (on Koerfer et al. 2005)

In the case of the patient from the last ward round, it is a *progressive-regressive* life narrative, which contains three biographically significant caesurae due to critical life events, which the patient was able to cope with in different ways and which are therefore reflected in the evaluation curve (Fig. 25.6) with different positive and negative slopes.

If we now take all the narrative data from this and the previous ward round together, the patient first starts *progressively* as a *hero* who, despite adverse circumstances ("growing up without a father"), builds up his own existence early on ("independent at 16", "married", "built a house") before he briefly enters the *regressive* phase of a *victim role* as a displaced person ("chased away"). After this *regressive* low point in his biography, he is then able to work his way up again *progressively* as a *hero* with a new business start-up to *independence ("*self-employed") until he is threatened by two illnesses ("heart", "breathing"), each with inpatient treatment, with another *regressive* development with an uncertain outcome.

In this current perspective of experience, the patient seems to have already lost the heroic *role* of the "father who has gone ahead so far" in his own self-perception (56P: "I already realise that it works without me"). With the threatening loss of work as the source of his "health" and his "happiness", his possibilities for shaping the self-determined life he has been used to are at risk.

The patient's last *self-evaluation* (62P: "I am only healthy when I can work, then I am happy") reveals his *subjective concept of health* (§ 21, 29). Then, via the reverse conclusion suggested by the patient himself, the assumption of a subjective evaluation scale with the poles "healthy-happy" (*plus*) - "sick-unhappy" (*minus*) becomes clear, between which all snapshots of life (above all depending on work productivity) are evaluated by the patient.

In addition to this *salutogenic* evaluation concept, other evaluative guiding concepts of *autonomy*, *hierarchy*, *mobility*, *productivity* and *normativity* come into play, with which the patient sets partly conflicting accents in the evaluation of the threatening life event of the current illness (Tab. 24.3). These ambivalence conflicts of the patient, who sees his health and happiness in life endangered by the loss of his fulfilled working life, will be summarised once again (Tab. 24.3) and commented on.

Guiding concepts	Polarity	
	Positive	Negative
Autonomy	"I was already independent at the age of 16"	"I already realise that it works without me".
Hierarchy	"Until now I was the forerunner"	*I will be the one left behind*
Mobility	"Strive and move forward make"	"Lying there all of a sudden, that's hard"
Productivity	"lots and lots of work"	"Do nothing"
Normality	"You shouldn't go crazy and still go to work"	"The father (=me) is so crazy - you can't do it without work".
Salutogenesis	"I am only healthy, if I can work, then I am happy"	*Without work I get sick and unhappy*

Tab. 24.3: Subjective guiding concepts: Verbatim quotations are in quotation marks, conclusions in italics (on Koerfer et al. 2005).

The *psychological conflict material*, which the patient has so far only been able to process with great *ambivalence*, arises from the social conflict situation that has been described for critical life situations for seriously ill patients who have to make a momentous decision "between work and retirement" (Gerhardt 1999, v. Ferber 2003). In the present case, this alternative still presents itself to the patient in certain extremes, which he evaluates above all under the guiding concepts of *normality* and *mobility* or *productivity*: on the one hand, he knows from experience of himself that he works like a "madman", on the other hand, he admits half-distantly to counteracting maxims, the rationality of which he justifies with medical citation authorities ("... a doctor said (...) then you shouldn't go crazy and still work"). At the same time, the patient fears the standstill of "doing nothing", which he can already experience and anticipate in the current hospital stay ("lying here is already difficult").

Furthermore, the patient already notices or suspects that he will finally have to cede his "hero" role as the "preceding father" (*hierarchy)* in his own family business ("construction business with the children") to his sons and thus lose his "independence" (*autonomy),* which he had acquired early and proudly emphasised several times. This autonomy was already claimed by him in his youth and de facto acquired from his life perspective, for example in the emphasised comparison with his sons, who have already entered the existing construction business and are to "inherit" from him prematurely, as it were. His current loss of significance is already noticed ("so I already realise that it also works without me") and thus admitted in front of the assembled clinic team.

In the face of the *mortification* experienced with the current illness, he initially still maintains a rigid, seemingly uncompromising salutogenic perspective. It is precisely the specifically salutogenic connection between work, health and happiness ("I am only healthy if I can work, then I am happy") that will only have moved to the forefront of the patient's *subjective health theory* (§ 21, 29) in this strict conditional logic ("only ... if ... then") with the serious illness.

Their validity is now increasingly questioned, so that the patient now experiences a painful process of a change in values, in which other priorities have to be set, which, as we know, can be difficult for many previously healthy people. Thus, the idiomatic phrase "the main thing is to be healthy", which seems to be firmly anchored in all of our everyday consciousness, can usually only move to the top of an individual hierarchy of values when subjectively serious, i.e. "life-altering" experiences of illness have been made, through which the certainty of health, which is characterised by its "hiddenness" (Gadamer 1993), has been permanently shaken.

This shattering of subjective *ideas of health* and *convictions of control* (§ 21, 29) concerns the patient's previous motto of life, which cannot simply be lived on now after the apparent illness ("I am only healthy if I can manage, then I am happy"). While the validity of this life motto may have been beyond doubt for the previous course of life, as the patient sought to credibly assure by a consistent life narrative in advance (also in a previous ward round), his "story" has recently become so "broken" in the sense of Brody (1994), however, that the patient needs specific medical help to stabilise his self: "My story is broken, can you help me fix it?". This appeal to a helping doctor undoubtedly transcends the traditional biomedical provision of help in the direction of a biopsychosocial offer of helping, in which *cure* and *care are to* be combined.

24.8 Evaluation

The quality assurance of communicative action can be controlled - as in the preceding ward round examples - both via individual case analyses and via comparative conversation analyses in a group comparison with a pre-post design, in which quantitative and qualitative methods of analysis can be combined (§ 40). In anticipation of specific evaluation methods and results, only a brief interim assessment of ward round communication will be made here.

Compared to traditional ward rounds, considerable improvements were achieved in the Ulm model ward regarding the relevant conversation parameters (cf. above fig. 24.3a-e). For example, the phenomenon of "communication over the patient's head", which was often complained about in the patient survey, was almost completely eliminated, as the doctors conducting the ward rounds directed their conversation activities almost entirely (97%) towards the patient (Fig. 24.3c). The proportion of indirect information was reduced from 59% to 3% and the proportion of evasive answers was reduced from 36% to 16% for a favourable prognosis and from 92% to 15% for an unfavourable prognosis (Fig. 24.3d-e). However, the patients were not only addressed more directly in their listening role and given appropriate answers more often when seeking information, but they were also able to perform their speaking role more actively: Thus, the patients had more to say in absolute and relative terms, as the duration of the ward round increased from 3.5 to 6.7 minutes and their share of conversation increased from 30% to 45% (Fig. 24.3a-b). In this context, reference should be made to the preceding individual case analyses, in which the patient share of conversation was 60% and 72% respectively (Tab. 24.4). Compared to other ward rounds (Fig. 24.3a-b), but also to GP-patient communication (§ 40.2), these are already "good" comparative values.

	Conversation shares (%)	
	Ward round 1 (§ 24.6)	Ward round 2 (§ 24.7)
Doctor	40	28
Patient	60	72

Tab. 24.4: Conversation shares

If these quantitative findings alone point to an increase in the patient's *opportunities for dialogue in* the ward round, supplementary studies confirmed that the improvement was also *subjectively* reflected in the patients' *experience of conversation.* This improvement also extended to other objectives of the integrative ward round concept, which concerned the *emotive* and *therapeutic* characteristics of conversation (Fehlenberg 1987, Fehlenberg et al. 1982, 1996, 2003). Although the quantitative studies were primarily concerned with demonstrating an overall improvement in the Ulm ward round practice, the findings did, however, point to considerable variations with regard to the conversational behaviour of individual doctors (ibid.). These differences also became clear in qualitative studies (Bliesener, Köhle 1986), in which the individual approaches and personal problems of the doctors in the implementation of the new ward round concept were revealed through conversation analysis.

Empirical conversation research has analysed a wealth of material for the various forms of *intransparency* and *asymmetry* in ward round communication (§ 24.4.4-5). The problems described will be exacerbated when doctors and patients from different cultures with different languages meet. The problems of intercultural and technical communication will be systematically and exemplarily explained elsewhere (§ 27, 28).

An essential consequence to be drawn from the findings of the comparative studies between traditional ward rounds and the Ulm reform concept, according to the current state of research, is that the opportunities for dialogue that open up should be used more for *narrative* forms of communication for the patient's experiential self-explorations (§ 9, 19, 25). These narrative self-explorations should no longer be merely tolerated by the doctor, but rather encouraged through *active listening* (§ 19) and empathic feedback (§ 20). As a formal criterion for successful doctor-patient communication, the dialogue role structure can already be cited, according to which longer patient contributions can be identified as candidates for patient narratives (§ 40.2.2). Here, quantitative conversation analyses can form a fruitful alliance with qualitative narrative analyses (§ 19.6-8, 40.2). However, the specific problems and methods as well as results of evaluation are dealt with separately in a thematic focus of the handbook (§ 40-43).

24.9 Further information

The volume by Köhle, Raspe (eds.) (1982), which contains theoretical and empirical contributions to the analysis and improvement of ward round communication with an interdisciplinary approach, continues to be a "classic" of ward round conversation research. As explained previously, research on ward rounds has then been further differentiated in the last four decades with different theoretical, didactic and empirical foci: Köhle, Raspe 1982, Bliesener 1982, Bliesener, Köhle 1986, Fehlenberg 1983, 1987, Ott 1996, Koerfer et al. 2005, Lalouschek 1995, 2005, Langewitz et al. 1998, 2002, Menz et al. 2008, O'Hare 2008, Novak 2010, Hellmich et al. 2010, Weber 2011, Nikendei et al. 2016, Fischer et al. 2016, Walton et al. 2016, 2019, 2020, Merriman, Freeth 2022, Baldt 2022.

Specific reviews (on research and education) are given by Walton et al. 2016, Gamp et al. 2019, Morris et al. 2022, Khalaf, Khan 2022. Theoretical and didactic aspects are considered in the contributions to the textbook on "Communication as a Success Factor in Hospitals" (Hoefert, Hellmann (eds.) 2008). Concrete examples of how ward rounds can be improved even when there is a lack of time are given by Hellmich et al. (2010). Concrete recommendations for "communication in the hospital" are given by Baller, Schaller (2017), even if the examples seem contrived and often exaggerated. Buck (2022) provides a comprehensive empirical study with many examples from communication in a palliative care unit, which she subjects to a conversation analysis.

Regarding concepts of interviewing that apply equally to (GP or specialist) practice and clinic, special reference should be made to the theoretical and empirical chapters on *biopsychosocial* medicine (§ 4), *biographical narrative history taking* (§ 9, 19) and *shared decision making* (SDM) (§ 10, 22). The specifically *cooperative narrative* is described and illustrated by way of example in other chapters of the handbook (§ 19, 20, 25). Likewise, the problems and topics on specific fields of competence dealt with in the following chapters apply equally to (GP or specialist) practice and clinic. Specific problems and methods of *evaluation* will be dealt with at the end of the handbook (§ 40-43). Those who are interested in evaluating the *life narratives* of their patients in their own professional practice, as described above in the example of ward rounds (§ 24.7), are referred to the sample in the appendix of the handbook (§ 44.4).

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

References

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

Antonovsky A (1987): The salutogenic perspective: toward a new view of health and illness. Advances 4 (1), 47-55.

Baldt B (2022): „Er weiß es noch nicht“ – Triadische Kommunikation und ihre Tücken am Beispiel eines onkologischen Visitengesprächs. Wiener Medizinische Wochenschrift, 1-8. Wien Med Wochenschr.

Balint EF, Norell JS (Hg.) (1973/1975): Fünf Minuten pro Patient. Eine Studie über die Interaktion in der ärztlichen Allgemeinmedizin. Frankfurt/M: Suhrkamp (Balint EF, Norell JS (eds.) 1973: Six Minutes for the Patient: interaction in general practice consultation).

Baller G, Schaller B (2017): Kommunikation im Krankenhaus: Erfolgreich kommunizieren mit Patienten, Arztkollegen und Klinikpersonal. Berlin: Springer.

Bernhard T (1978): Der Atem. Eine Entscheidung. 3. Aufl. Salzburg, etc.: Residenz Verlag.

Bliesener T (1980): Erzählen unerwünscht. Erzählversuche von Patienten in der Visite. In: Ehlich K (Hg.): Erzählen im Alltag. Frankfurt/M: Suhrkamp, 143-178.

Bliesener T (1982): Die Visite – ein verhinderter Dialog. Tübingen: Gunter Narr Verlag.

Bliesener T, Köhle K (1986): Die ärztliche Visite: Chance zum Gespräch. Wiesbaden: VS Verlag für Sozialwissenschaften.

Brody H (1994): „My story is broken; can you help me fix it?“ Medical ethics and the joint construction of narrative. Literature and Medicine 13 (1), 81-92.

Buber M (1954/1986): Das dialogische Prinzip. Gütersloh: Gütersloher Verlagshaus (Orig. 1954). (1981: I and thou: The dialogic principle. New York, NY: Dutton).

Buck I (2022): Pflegerische und ärztliche Interaktionen mit PatientInnen und Angehörigen auf der Palliativstation. Eine vergleichende gesprächsanalytische Untersuchung. Göttingen: Verlag für Gesprächsforschung.

Dieckmann W (1981): Probleme der linguistischen Analyse institutioneller Kommunikation: In: Dieckmann W: Politische Sprache. Politische Kommunikation. Heidelberg: Winter, 208-45.

Duncan S Jr (1974): On the structure of speaker-auditor interaction during speaking turns. Language and Society 3 (2), 161-80.

Ehlich K (2020): Linguistische Analyse und institutionelle Resilienz. In: Gruber H, Spitzmüller J, de Cilla R (Hg.): Institutionelle und organisationale Kommunikation: Theorie, Methodologie, Empirie und Kritik. Gedenkschrift für Florian Menz. Göttingen: Vandenhoeck & Ruprecht, 25-38.

Ehlich K (2022): Sprachliches Handeln und institutionelle Analysen–wieso eigentlich? In: Hohenstein C, Hornung A (Hg.): Sprache und Sprachen in Institutionen und mehrsprachigen Gesellschaften. Münster, New York: Waxmann, 21-40.

Ehlich K, Rehbein J (1986): Muster und Institution: Untersuchungen zur schulischen Kommunikation. Tübingen: Narr.

Fehlenberg D (1983): Die empirische Analyse der Visitenkommunikation: Institutionskritik und Ansätze für eine reflektierte Veränderung institutioneller Praxis. Osnabrücker Beiträge zur Sprachwissenschaft 24, 29-56.

Fehlenberg D (1987): Kommunikation zwischen Arzt und Patient. Bochum: Brockmeyer.

Fehlenberg D, Simons C, Köhle K (1982): Ansätze zur quantitativen Untersuchung ärztlicher Interventionen im Visitengespräch. In: Köhle K, Raspe H-H (Hg.): Das Gespräch während der ärztlichen Visite. Empirische Untersuchungen. München, etc.: Urban und Schwarzenberg, 232-48.

Fehlenberg D, Simons C, Köhle K (1996): Die Krankenvisite – Probleme der traditionellen Stationsvisite und Veränderungen im Rahmen eines psychosomatischen Behandlungskonzepts. In: Adler R, Herrmann JM, Köhle K, Schonecke OW, Uexküll T v, Wesiack W (Hg.): Uexküll. Psychosomatische Medizin. 5. Aufl. München, etc.: Urban & Schwarzenberg, 389-408.

Fehlenberg D, Simons C, Köhle K (2003): Die Krankenvisite – Chance für ein weiterführendes ärztliches Gespräch. In: Adler R, Herrmann JM, Köhle K, Langewitz W, Schonecke OW, Uexküll T v, Wesiack W (Hg.): Uexküll. Psychosomatische Medizin. Modelle ärztlichen Denkens und Handelns. 6. Aufl. München, etc.: Urban & Fischer, 445-56.

Ferber C v (2003): Arbeit, Gesundheit und Krankheit. In: Adler R, Herrmann JM, Köhle K, Langewitz W, Schonecke OW, Uexküll T v, Wesiack W (Hg.):

Uexküll. Psychosomatische Medizin. Modelle ärztlichen Denkens und Handelns. 6. Aufl. München, etc.: Urban & Fischer, 367-77.

Fischer MR, Wölfel T, Schmidmaier R (2016): Schnittstelle Visite. Deutsche Medizinische Wochenschrift 141 (1), 28-31.

Gadamer HG (1993): Über die Verborgenheit der Gesundheit. Aufsätze und Vorträge. Frankfurt/M: Suhrkamp.

Gamp M et al. (2019): Effect of bedside vs. non-bedside patient case presentation during ward rounds: a systematic review and meta-analysis. Journal of general internal medicine, 34, 447-457.

Gergen KJ (1998): Erzählung, moralische Identität und historisches Bewußtsein. In: Straub J (Hg.): Erzählung, Identität und historisches Bewußtsein. Frankfurt/M: Suhrkamp, 170-202.

Gergen KL (2002): Konstruierte Wirklichkeiten. Stuttgart: Kohlhammer.

Gerhardt U (1999): Herz und Handlungsrationalität. Frankfurt: Suhrkamp.

Häuser W, Schwebius P (1999): Vier Minuten pro Patient, eine Minute pro Angehörigen. Arzt-Patient-Angehörigen-Kommunikation in allgemeininternistischen Abteilungen. Psychotherapie Psychosomatik medizinische Psychologie 49, 168-70.

Hellmich B, Palme R, Ade T, Leschke M (2010): Die klinische Visite und das ärztliche Gespräch – Sinnvolle Gestaltung unter aktuellen Krankenhausbedingungen. Klinikarzt 39 (7/8), 344-8.

Hempel U (2010): Angst im Krankenhaus. Das unliebsame Gefühl. Deutsches Ärzteblatt 107 (37), B1538-40.

Hoefert HW, Hellmann W (2008): Kommunikation als Erfolgsfaktor im Krankenhaus. Heidelberg, etc.: Economica.

Khalaf Z, Khan S (2022): Education During Ward Rounds: Systematic Review. Interact J Med Res 11 (2): e40580

Koerfer A (1979): Zur konversationellen Funktion von ‚ja aber'. In: Weydt H (Hg.): Die Partikeln der deutschen Sprache. Berlin, etc.: De Gruyter, 14-29.

Koerfer A (1994/2013): Institutionelle Kommunikation. Zur Methodologie und Empirie der Handlungsanalyse. Opladen: Westdeutscher Verlag. Online 2013: Mannheim: Verlag für Gesprächsforschung.

Koerfer A, Köhle K (2007): Kooperatives Erzählen. Zur Konstruktion von Patientengeschichten in der ärztlichen Sprechstunde. In: Redder A (Hg.): Diskurse und Texte. Tübingen: Stauffenburg, 629-39.

Koerfer A, Köhle K (2009): Was ist erzählenswert? Das Relevanzproblem in einer narrativen Medizin. Psychoanalyse 13 (2), 125-38.

Koerfer A, Köhle K, Faber A, Kaerger H, Obliers R (1996): Zwischen Verhören und Zuhören. Gesprächsreflexionen und Rollenspiele zur Arzt-Patient-Kommunikation im medizinpsychologischen Studium. In: O. Bahrs, W. Fi-

scher-Rosenthal, J. Szecsenyi (Hg.): Vom Ablichten zum Im-Bilde-Sein. Ärztliche Qualitätszirkel und Video-Analysen. Würzburg: Königshausen & Neumann, 109-31.

Koerfer A, Köhle K, Obliers R (2000): Narrative in der Arzt-Patient-Kommunikation. Psychotherapie und Sozialwissenschaft 2 (2), 87-116.

Koerfer A, Köhle K, Obliers R, Thomas W, Albus C (2010): Narrative Wissensgenerierung in einer biopsychosozialen Medizin. In: Dausendschön-Gay U, Domke C, Ohlhus S (Hg.): Wissen in (Inter-)Aktion. Berlin, etc.: de Gruyter, 91-131.

Koerfer A, Neumann C (1982): Alltagsdiskurs und psychoanalytischer Diskurs. Aspekte der Sozialisierung der Patienten in einen 'ungewöhnlichen' Diskurstyp. In: Flader D, Grodzicki WD, Schröter K (Hg.): Psychoanalyse als Gespräch. Interaktionsanalytische Untersuchungen über Therapie und Supervision. Frankfurt/M: Suhrkamp, 96-137.

Koerfer A, Obliers R, Köhle K (2005): Das Visitengespräch. Chancen einer dialogischen Medizin. In: Neises M, Ditz S, Spranz-Fogasy T (Hg.): Psychosomatische Gesprächsführung in der Frauenheilkunde. Stuttgart: Wissenschaftliche Verlagsgesellschaft, 256-84.

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

Koerfer A, Obliers R, Kretschmer B, Köhle K (2010): Vom Symptom zum Narrativ – Diskursanalyse der interaktiven Konstruktion einer Patientengeschichte. Balint-Journal 11 (4), 107-11.

Köhle K, Böck D, Grauhan A (Hg.) (1977): Die internistisch-psychosomatische Krankenstation. Ein Werkstattbericht. Basel: Editiones Roche.

Köhle K, Koerfer A (2017): Das Narrativ. In: Köhle K, Herzog W, Joraschky P, Kruse J, Langewitz W, Söllner W (Hg.): Uexküll: Psychosomatische Medizin. 8. Aufl. München, etc.: Elsevier, 325-40.

Köhle K, Raspe HH (Hg.) (1982): Das Gespräch während der ärztlichen Visite. Empirische Untersuchungen. München, etc.: Urban & Schwarzenberg.

Köhle K, Siol T (2003): Zur Versorgungssituation von Patienten mit psychischen und psychosomatischen Störungen. In: Adler R, Herrmann JM, Köhle K, Langewitz W, Schonecke OW, Uexküll T v, Wesiack W (Hg.): Uexküll Psychosomatische Medizin. Modelle ärztlichen Denkens und Handelns. 6. Aufl. München, etc.: Urban & Fischer, 567-75.

Lalouschek J (1995): Ärztliche Gesprächsausbildung. Opladen: Westdeutscher Verlag.

Lalouschek J (2005): Medizinische Konzepte und ärztliche Gesprächsführung – am Beispiel der psychosomatischen Anamnese. In: Neises M, Ditz S, Spranz-Fogasy T (Hg.): Psychosomatische Gesprächsführung in der Frauenheilkunde. Stuttgart: Wissenschaftliche Verlagsgesellschaft, 48-72.

Langewitz WA (2017): Techniken der patientenzentrierten Kommunikation. In: Köhle K, Herzog W, Joraschky P, Kruse J, Langewitz W, Söllner W (Hg.) (2017): Uexküll: Psychosomatische Medizin. 8. Aufl. München, etc.: Elsevier, 293-305.

Langewitz WA, Conen D, Nübling M, Weber H (2002): Kommunikation ist wesentlich – Defizite der Betreuung im Krankenhaus aus der Sicht von Patienten und Patientinnen. Psychotherapie, Psychosomatik, Medizinische Psychologie 52, 348-54.

Langewitz WA, Denz M, Keller A, Kiss A, Rütimann S, Wössmer B (2002): Spontaneous talking time at start of consultation in outpatient clinic: cohort study. British Medical Journal 325, 682-3.

Langewitz WA, Eich P, Kiss A, Wössmer B (1998): Improving communication skills – a randomized controlled behaviorally oriented intervention study for residents in internal medicine. Psychosomatic Medicine 60 (3), 268-76.

Luborsky L (1988): Einführung in die analytische Psychotherapie. Berlin: Springer. (1984: Prinziples of Psychoanalytic Psychotherapy. New York: Basic Books).

Menz F, Lalouschek J, Gstettner A (2008): Effiziente ärztliche Gesprächsführung: Optimierung kommunikativer Kompetenz in der ambulanten medizinischen Versorgung. Ein gesprächsanalytisches Trainingskonzept (Vol. 10). Münster: LIT Verlag.

Menz F, Nowak P, Rappl A, Nezhiba S (2008): Arzt-Patient-Interaktion im deutschsprachigen Raum: Eine Online-Forschungsdatenbank (API-on©) als Basis für Metaanalysen. Gesprächsforschung 9, 129-63.

Merriman C, Freeth D (2022): Conducting a good ward round: How do leaders do it?. Journal of Evaluation in Clinical Practice, 28(3), 411-420.

Mishler EG (1984): The Discourse of Medicine. Dialectics of Medical Interviews. Norwood, New Jersey: Ablex.

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

Morris M et al. (2022): Interdisciplinary collaborative working on surgical ward rounds: reality or rhetoric? A systematic review. Journal of Interprofessional Care, 37(4), 674-688.

Nikendei C et al. (2016): Students' perceptions on an Interprofessional Ward round training–a qualitative pilot study. GMS journal for medical Education, 33(2), 1-7.

Nothdurft W (1982): Zur Undurchlässigkeit von Krankenhaus-Visiten. In: Köhle K, Raspe H-H (Hg.): Das Gespräch während der ärztlichen Visite. Empirische Untersuchungen. München, etc.: Urban und Schwarzenberg, 23-35.

Nowak P (2010): Eine Systematik der Arzt-Patienten-Interaktion. Systemtheoretische Grundlagen, qualitative Synthesemethodik und diskursanalytische Ergebnisse zum sprachlichen Handeln von Ärztinnen und Ärzten (Arbeiten zur Sprachanalyse 51). Frankfurt/M, etc.: Peter Lang.

O'Hare JA (2008): Anatomy of the ward round. European journal of internal medicine, 19 (5), 309-313.

Ott R (1996): Die Stationsvisite – quantitative und qualitative Analyse internistisch-geriatrischer Visitengespräche und Konsequenzen für den Klinikalltag. Münster: Lit Verlag.

Papsdorf I, Hannich H, Tost F (2009): Information oder Verwirrung. Eine formal-quantitative Analyse augenärztlicher Visitengespräche. Der Ophthalmologe 106 (10), 905-12.

Putnam S, Stiles W, Jacob M, James S (1988): Teaching the medical interview: An intervention study. Internal Medicine 3: 38-47.

Quasthoff-Hartmann UM (1982): Frageaktivitäten von Patienten in Visitengesprächen: Konversationstechnische und diskursstrukturelle Bedingungen. In: Köhle K, Raspe H-H (Hg.): Das Gespräch während der ärztlichen Visite. Empirische Untersuchungen. München, etc.: Urban und Schwarzenberg, 70-101.

Raspe HH (1983): Aufklärung und Information im Krankenhaus. Göttingen: Verlag für medizinische Psychologie.

Rogers CR (1942/1985): Die nicht-direktive Beratung. Frankfurt/M: Fischer (1942: Counseling and Psychotherapy. Boston: Houghton Mifflin).

Salmon P, Dowrick CF, Ring A, Humphris GM (2004): Voiced but unheard agendas: qualitative analysis of the psychological cues that patients with unexplained symptoms present to general practitioners. British Journal of General Practice 54 (500), 171-6.

Siegrist J (1982): Asymmetrische Kommunikation bei der klinischen Visite. In: Köhle K, Raspe HH (Hg.): Das Gespräch während der ärztlichen Visite. München, etc.: Urban & Schwarzenberg, 16-22.

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

Uexküll T v, Wesiack W (2011): Von der Zeichentheorie zur Grundlage einer modernen Semiotik. In: Adler RA, Herzog W, Joraschky P, Köhle K, Lange-

witz W, Söllner W (Hg.): Uexküll: Psychosomatische Medizin. 7. Aufl. München, etc.: Urban & Fischer, 10-4.

Walton V et al. (2016): Ward rounds, participants, roles and perceptions: literature review. International journal of health care quality assurance, 29(4), 364-379.

Walton V et al. (2019): How Do Interprofessional Healthcare Teams Perceive the Benefits and Challenges of Interdisciplinary Ward Rounds, Journal of Multidisciplinary Healthcare 1023-1032.

Walton V et al. (2020): Exploring interdisciplinary teamwork to support effective ward rounds. International Journal of Health Care Quality Assurance, 33(4/5), 373-387.

Weber H (2011): Das Gepräch bei der Visite. In: Adler RH, Herzog W, Joraschky P, Köhle K, Langewitz W (Hg.): Uexküll: Psychosomatische Medizin. 7. Aufl. München, etc.: Urban & Fischer, 347-58.

Weber H, Langewitz W (2011): Basler Visitenstandard – Chance für eine gelingende Interaktionstriade Patient-Arzt-Pflegefachperson. Psychotherapie Psychosomatik Medizinische Psychologie 61 (3-4), 193-5.

Weber H, Nübling M, Jestädt A (2001): Projekt VISCOM 2000. Visitenorganisation und Kommunikation. Empirische Untersuchung an einer internistischen Universitätsklinik des Kantonsspitals Basel. Basel: Unveröffentlichter Projektbericht.

Weber H, Nübling M, Langewitz (2009): Das Visitengespräch. In: Langer Th, Schnell M (Hg.) Das Arzt-Patient-/Patient-Arzt-Gespräch. München: Marseille, 77-88.

Weber H, Stöckli M, Nübling M, Langewitz WA (2007): Communication during ward rounds in internal medicine. An analysis of patient-nurse-physician interactions using RIAS. Patient Education and Counseling 67 (3), 343-8.

Westphale C, Köhle K (1982): Gesprächssituation und Informationsaustausch während der Visite auf einer internistisch-psychosomatischen Krankenstation. In: Köhle K, Raspe H-H (Hg.): Das Gespräch während der ärztlichen Visite. Empirische Untersuchungen. München, etc.: Urban & Schwarzenberg, 102-39.

Citation note

Koerfer A, Kilarski LL, Albus C (2025): Ward Round Communication. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung.

Cologne Manual & Evaluation of Medical Communication see next page.

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

1 Building a relationship	☐4	4 Exploring details	☐☐ 12
1 Framing • Enable confidentiality • Avoid disturbances		1 Inquire about complaint dimensions • Localisation and radiation • Quality, intensity *(scale 0-10)* • Dysfunction/disability • Accompanying symptoms • Time (beginning, course, duration) • Condition "In what situation ...?"	⓿❶❷❸❹
2 Greeting • Make eye contact • Verbal greetings, shaking hands • Address by name	⓿❶	2 Exploring subjective ideas • Concepts *"What do you imagine?"* • Explanations *"Do you see causes?"*	⓿❶❷❸❹
3 Introducing yourself • Introduce yourself by name • Communicate function ("ward doctor")	⓿❶	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)	⓿❶❷❸❹
4 Situating • Speak sitting down (chair to bed) • Ensure convenience • Coordinate proximity/distance	⓿❶		
5 Orientation • Structure conversation • Goals, time frame	⓿❶		
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?"*	⓿❶	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	⓿❶❷❸❹	2 Clarify expectations • Ideas, wishes, hopes *"What did you have in mind?"* • Control beliefs *"What could you change yourself?"*	⓿❶❷❸❹
3 Active listening - verbal support • Encourage speaking up • Repeating statements verbatim • Paraphrase statements • Openly ask further: *"How did that come about?"*	⓿❶❷❸❹	3 Explaining previous findings • Communicate diagnosis • Communicate problems	⓿❶❷❸❹
4 Ensure understanding • Ask "Do I understand correctly ...?" • Summarise	⓿❶	4 Examination or therapy plan • Explore decision model (SDM) • Discuss proposals and risks • Consider reactions • Strive for consensus	⓿❶❷❸❹
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	⓿❶
2 Empathise with patient's situation		2 Offer clarification of outstanding issues • Information *"Do you still have questions?"* • Satisfaction "Can you handle it? "	⓿❶
3 Respond empathically • Offer appropriate help and comfort • Acknowledge burdens, coping	⓿❶❷❸❹	3 Arrange follow-up appointments • Examination appointments • Set a meeting date	⓿❶
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..."*	⓿❶❷❸❹	4 Say goodbye to the patient	⓿❶
		5 Complete documentation • Coding & conversation impressions • Topics for follow-up talks	

⓿❶ [⓿ = not met;❶ = met] ⓿❶❷❸❹ [⓿ = not met ...❹ = fully met]

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