3 Learning Goal Communication Competence

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> This is the crux of the matter. The question is not whether people have the skills, but whether they deploy them appropriately.
>
> John Skelton 2011: 213

Abstract: In the following, the basics of (promoting) communicative competence will be elaborated, from which the connecting perspectives to specific topics, problems and concepts on didactics, practice and evaluation of medical interviewing can be pointed out, which will be taken up again and dealt with in detail in further chapters of the textbook.

First (§ 3.1), we will use a concept of 'communicative competence' in a multidimensional competence model, which allows us to reconstruct an interaction of *professional* and *everyday competences* between doctor and patient. Despite the *asymmetry* of the interaction roles, both partners in the conversation must cooperate in many ways from different participation perspectives in their conversation work in order to be able to achieve a common goal of the conversation, which in the ideal case of a *helpful relationship* consists in the intended success of the therapy. In order to achieve this goal, doctors must have *specific (partial) competences* (of listening, understanding, questioning, informing, etc.) from different perspectives of action, which they bring to bear from their professional perspective in a situation-specific way (§ 3.2). In the practice of communication, a *competent guidance of conversation* is challenged by more or less frequently occurring *conflicts of maxims*, for the solution of which doctors must develop a specific *fitting competence* in a (self-)critical attitude.

In a general *fitting model* (§ 3.3), medical fitting competence is described as a *self-reflective* meta-competence with which the general communicative competences for taking medical histories, providing information and making decisions must be precisely adapted to changing (social, individual, situational, disease-specific, etc.) conditions and demands on communication. In order not to jeopardise the relationship with the patient, an *empathic* competence is often required in the balancing act for what is just "reasonable", which is characterised by a well-dosed mixture of confrontational versus tangential conversation. The interplay of different types of *communicative* and clinical competence in "ideal" medical action already points to the normative foundations of doctor-patient communication on which the promotion of com-

municative competence must build (§ 3.4). In the formulation of *maxims* and *learning objectives* for doctor-patient communication, we first refer to specific "previous achievements of classics", whose topicality can also be used for a *manualisation of doctor-patient communication*. The use of such a manual in communicative practice requires from the medical side, in turn, the *fitting competence* described above, which allows for a *flexible* reaction to changing (social, situational, disease-specific, etc.) conditions and challenges of guiding medical conversations. The flexible application of our Cologne Manual on Medical Communication (C-MMC) will be further elaborated later under the aspect of the "art" of guiding medical conversations (§ 17-23).

At the same time, as a preview of our further didactic concepts, our *Cologne Evaluation of Medical Communication* (C-EMC) is presented, with which we want to establish the *unity of teaching and examination* in the sense that only what has previously been taught and practised should be examined.

3.1 Competence model of doctor-patient communication

A sustainable concept for the promotion of communicative competence can hardly be developed “at the drawing board”. Only an empirical analysis of the current state of doctor-patient communication, as methodically outlined in the preceding transcript analysis (§ 2.3), will open up possibilities for intervention measures with concrete objectives for improving doctor-patient communication, the effects of which will in turn have to be demonstrated in empirical evaluation studies (§ 40-43). Of course, these empirical studies cannot be guided "without theory" but must take into account the "logic" of a "good" conversation (§ 3.3, 40.2). Here the normative question of the "good" conversation arises analogously to the question of the "good" doctor (§ 6), who should ultimately guide a "good" conversation and therefore have the corresponding *communicative competences,* which he or she must have acquired beforehand in his or her training.[1]

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1 Different terms, concepts and approaches (to promote) communicative competence will be discussed continuously (and especially theory: § 4-9, didactics: 13-17, evaluation: 40-43). In the following, we will essentially distinguish between *clinical competence* (in the narrower sense of *medical* competence) and *communication* competence (in the broad sense). The dif-

3.1.1 Multidimensional competence model

The ambitious objective of contributing to the *promotion of communicative competence* in the clinic and practice with this textbook is intended to be more than the mere promotion of a *rhetorical* competence. Even if rhetorical competence is helpful in almost all professional and life situations, medical competence cannot be reduced to this. Rather, the complex interplay of professional knowledge and action must be taken into account, which, as communicative action, is based on our everyday competence, but has experienced a special institution-specific development within the framework of the medical "care system". In this context, the key competences that have been developed within the framework of a general competence model (in OECD projects) will first be differentiated in order to then establish a transfer for the relationship and communication between doctor and patient.

Medical competences should also be considered within the framework of a general competence model, within which they can take on an institution-specific form. Following a series of OECD projects in which the traditional *concept of performance* was replaced by a *concept of competence*, Weinert (2002) gave a definition in this context (Box 3.1), in which the various dimensions of competence are summarised succinctly:

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ferent traditions of the concept of competence in (language) philosophy, (socio-psycho-)linguistics, pedagogy, medicine and psychotherapy can only be referred to here by way of example: Habermas 1971, 1981, Badura 1972, Lenzen 1973, Hymes 1973, Miller 1990, Dickson et al. 1991, Koerfer 1994/2013, Harden et al. 1999, Weinert 2001, 2002, OECD 2002, 2005, Rychen, Salganik 2000, 2003, Deppermann 2004, Becker-Mrotzek, Brünner 2004, Hartung 2004, Duffy et al. 2004, Rider, Keefer 2006, Becker-Mrotzek 2008, Rychen 2008, Albanese et al. 2008, 2010, Vogel, Alpers 2009, Harris et al. 2010, Kiessling et al. 2010, Laughlin et al. 2012, Wouda, van de Wiel 2012, Lurie 2012, Lingard 2012, Hodges, Lingard 2012, Grimmer 2014, Härtl et al. 2015, Frank et al. 2015, Hannawa, Spitzberg 2015, Jünger et al. 2016, Thistlethwaite 2016, Monti et al. 2020, Kiessling, Fabry 2021, Moreno et al. 2022, Venktaramana et al. 2022. Cf. on specific communication and competence concepts § 1, 7, 9. Special reference should be made to Salmon, Young 2011 as well as to Skelton 2011, who each emphasize the aspect of *creativity* over pure *skills*, to which we return separately (§ 17). The results of our own empirical studies on *key competences in medicine* are also presented separately (§ 6).

Box 3.1	Multidimensional concept of competence

The OECD has (...) suggested on several occasions that the ambiguous concept of performance should generally be replaced by the concept of competence (...). In this context, competences are understood as the cognitive abilities and skills available to and learnable by individuals in order to solve specific problems, as well as the associated motivational, volitional and social readiness and skills to be able to use the problem solutions successfully and responsibly in variable situations.

Weinert 2002: 27f.

Such a multidimensional concept of competence has been used within the framework of OECD projects to differentiate *key competences* that are to have universal validity. This objective is pursued with the programmatic claim to transcend the mere teaching of *skills* or *techniques* in the direction of competent thinking and acting, which in changing contexts with (self-)critical *reflections* can certainly contribute to the *emancipation* and *participation* of individuals in social (also conflictual) interactions of (possibly heterogeneous) groups (Rychen, Salganik 2000, 2003, OECD 2002, 2005, Rychen 2008). In this context, specific (*communicative*, *cooperative, social*, *intercultural, ethical,* etc.) competencies, for example, are placed in a competency framework in which, in addition to *reflexivity*, the *autonomy, flexibility*, *creativity* and *responsibility* of the acting subjects, even in specific conflict situations, are particularly important.

It is *one* thing to demand the teaching and development of key competences, but it is *another* to achieve this objective in the practice of individuals and groups. *Empirical* studies must clarify the extent to which such key competencies are promoted or inhibited in certain institutional constellations of action (e.g. in the classroom, in court or during consultations and rounds, etc.) are promoted or inhibited. In this context, the different participation roles between the (types of) actors ("agents" as well as "clients") are to be differentiated, who can use different institutional scopes of action differently (Koerfer 1994/2013). Such a research perspective will be outlined below for the medical consultation (in the practice and on rounds) and will be further developed in the course of

the textbook under theoretical, didactic, empirical and evaluative aspects.[2]

3.1.2 Dialogical communication and helping relationship

A transfer of such a general competence model, as conceived in the OECD projects, to the design of the relationship and communication between doctor and patient cannot be limited to the action perspective of one of the two action partners alone. Rather, both participation perspectives must be taken into account reciprocally, in which the interaction of doctor- and patient-side competences must be examined. Despite all the differences between the two partners in the dialogue, they are constitutively dependent on the *participation* of the other partner and must coordinate their activities *alternately*. In doing so, they must both *communicate competently* in their own way, *cooperate flexibly* in the exchange of information and decision-making, and take joint *responsibility* without losing their personal *autonomy*, etc.

The complex interplay of *professional competencies* of doctors and *everyday competencies* of patients will be summarised and explained in advance in a diagram (Fig. 3.1) and then further elaborated and differentiated in this chapter (§ 3.3-8) and then in the textbook on the basis of empirical examples of conversations. In order to give an overview in brief, we will first emphasise (in 12 theses) essential aspects of the structure and function of the *joint conversation work* and *helping relationship* between doctor and patient, which we will then return to in detail in further theoretical, didactic and empirical chapters, which will be referred to accordingly in advance.

1. Inner and outer communication circles

When analysing and evaluating doctor-patient communication, the focus can be placed on "inner" or "outer" circles of the dialogue, taking into account their specific *interdependencies.* For example, edu-

2 In the following, a transfer of a multidimensional competence model to doctor-patient communication will be outlined, taking into account the participation perspectives of both conversation partners. The results of empirical studies on *key medical competences* will be presented separately (§ 6).

cational, motivational and decision-making talks may not be effective if patients - for whatever reason - do not behave outside the consultation (*non-adherence*) in a way that was jointly *decided* and *agreed upon* by the two partners in the conversation (§ 10.4). If a new, revised agreement is not reached, in which, for example, a therapy plan is *corrected* or *renegotiated* in such a *flexible way* (Fig. 3.1) that the requirements of *evidence-based* medicine can be brought into line with the patient's preferences in *life* (§ 10.3), this can lead to a serious test for the further *relationship* between the two partners.

2. Helpful conversations in a helpful relationship

At the centre of the *dialogue* between doctor and patient is the establishment and development of a sustainable relationship, which has been described as a "helping alliance" (Luborsky 1988) or "therapeutic alliance" (Saketopoulou 1999, Street et al. 2009, Wöller, Kruse 2010) from a psychotherapeutic as well as (in the narrow sense) from a *medical* perspective. In a helping relationship, not least the patient's competences and resources should be strengthened (*empowerment*), which also means that "medical help" must be provided as "help for self-help" (v. Uexküll 2003: 1346) (§ 3.1.7). The *helping relationship* thus becomes the *lynchpin* of the joint *conversation work,* which will have to be differentiated in the conversation analysis as *dialogical communication* (§ 7) according to specific *communicative action patterns* (of asking questions, telling stories, making decisions, etc.) (8-10, 18-23). In the joint conversation work, the two conversation partners each bring in their specific *competences*, which they must alternately relate to each other from a *professional* and *everyday world* perspective. Ideally, the dialogues between doctor and patient in a helping relationship soon develop into *helping conversations* in which the interlocutors jointly explore various therapeutic paths which they then decide on, follow or try out (§ 8) in order to achieve improvement or even mere alleviation of the patient's complaints, which is provisionally summarised here (Fig. 3.1) under the collective term *outcome* (as a "placeholder").

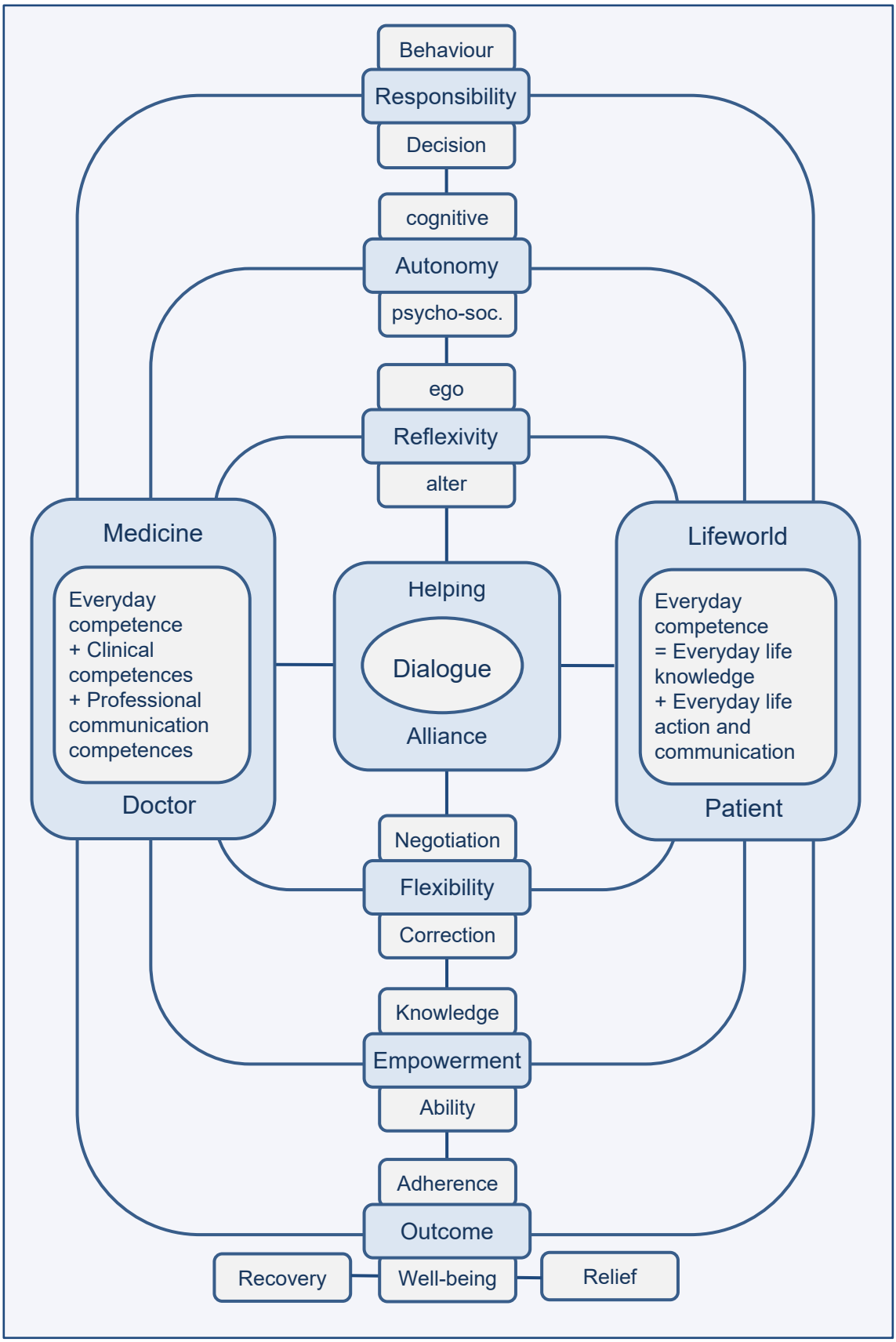

Fig. 3.1: Interdependence model of professional and everyday communication skills

3. Outcome

In the *discussion of outcomes,* a distinction is made between *indirect* and *direct* therapeutic approaches (Street et al. 2009, Street 2013, Laidsaar-Powell et al. 2014) (§ 8), which in any case must be anticipated, discussed, reflected upon and decided upon as *solutions to problems* before they can be *tested* or *implemented* outside of the consultation. This "outer" circle of doctor-patient conversations, which concerns the (non-)*adherent* behaviour of the patient, for example, will be differentiated in detail later (§ 8, 10). Likewise, *communicative* action will then have to be supplemented by *instrumental* action (surgery, medication, etc.) (§ 8), which manifests itself outside of the conversation, but which must always be communicated between doctor and patient, for example in the *prescription conversation (§* 26) or in the *explanation* before an *operation* (§ 10, 22, 39).

4. Participation, autonomy and responsibility

The joint communication work between doctor and patient aims more or less at *long-term effects* to be achieved after medical education and shared decision-making (SDM), for which both partners then assume joint *responsibility* while preserving their personal *autonomy* (§ 10). Here, conflicts can arise between *evidence-based* medicine and the patients' *lifeworld* preferences, which puts the helping relationship to a serious test. Acceptance of responsibility usually implies a willingness on the part of the patient to change *attitudes* and *behaviour* (§ 21), for which a certain degree of *self-responsibility* must be assumed. In the problem case of *non-adherence,* joint communication between doctor and patient is again the "inner" place for jointly *negotiated solutions to problems,* which in turn have to be tried out or realised outside the conversation, in order to be made an issue again in the next consultation and ratified in the "final" decision-making, for which both partners take responsibility in their own way "until further notice", etc.

5. Non-adherence as a communication problem

A particularly painful and costly problem is the lack of "therapy compliance" on the part of patients (Albus, Matthes 2014, Matthes, Koerfer, Albus 2015, Hauser et al. 2015, 2017, Hauser, Matthes

2017, Albus 2022) (§ 8, 10, 26). Here, the perspective of long-term successful cooperation and goal setting often recurrently requires short-term conversation work, in which, if necessary, "insufficient" or even "erroneous" *patient attitudes* (e.g. "subjective illness beliefs", "control beliefs", etc.) (§ 21) must be made the subject of discussion, which become "effective" "outside" the conversation (taking medication, diet, sport, etc.). Possible *solutions to problems*, which may also affect the patient's "lifestyle", require a high degree of *flexibility* from both partners in order to reconcile the requirements of evidence-based medicine with *preferences* relevant to the patient's lifestyle (§ 10.3). To mediate competently here in case of conflict is a special challenge for the professional action of doctors, who at the same time have everyday competences that they should use as well as exceed.

6. Medical dual competences

Like other institutional representatives (in school, university, court, administration, etc.) (Koerfer 1994/2013), doctors have a *double competence*, namely, in addition to their professional competence, they also have everyday competence (Fig. 3.1). Since nothing is "foreign" to them in terms of everyday life and professional experience, they should be able to weigh up the medical requirements with the alternatives that are (un)reasonable in terms of life together with the patient. This double competence should enable them to anticipate conflicts between the *life-world* of patients and *medicine* (in the sense of Mishler 1984) (§ 10.1) and to initiate *solutions to problems* in *comprehending* (e.g. of technical language) (§ 10.5, 27) and *understanding* (e.g. of *preferences* relevant to the *life-world in* decision-making) (§ 10.3) in good time.

7. Clinical and communicative competences

The *professional* communicative competences of doctors represent specialisations of *everyday competences.* In everyday life we are also able to *listen* competently, to *inform* and to *ask questions* and to *answer* (also *empathically*), but these competences experience an *institution-specific* development in the medical consultation and ward round, which is not least determined by *clinical* competences (in the

broad sense) (Fig. 3.1) (§ 3.3).[3] For example, detailed questions about patients' eating behaviour are asked because of the general clinical relevance, but also to clarify a suspected eating disorder if the clinician is familiar with this clinical picture anyway. In both cases, *communicative competence* should prevent him or her from asking an information question in a *suggestive* form ("Appetite is normal?"), but this still happens often enough in practice (as in this extensively documented example in § 21). Furthermore, due to their clinical knowledge and routine knowledge (in dealing with defence processes), doctors usually know how to use their professionally developed *empathic* competence to avoid "overstretching the bounds of what is reasonable" in conversation practice. Rather, they change from a *confrontational* to a cautious, *tangential way* of guiding the conversation (§ 3.3, 17, 20, 32) in order not to endanger the relationship with the patient by doing the "unreasonable". Often the limits of the *resilience* of the relationship, which has developed in the meantime, are then tested again later.

8. Asymmetry of the helpful relationship

Doctors and patients encounter each other in the development of the "helpful relationship" (Luborsky 1988, Street et al. 2009) with the *reciprocal knowledge* of their *asymmetrical* participation roles as *helpers* and those in *need of help,* who in this sense enter into an alliance of purpose for a period of time, from which they can both benefit in specific ways. For all the differences in the nature of the possible *benefit* ("health" of the patient versus "professional satisfaction" of the doctor), the form of the "long and intimate association" between doctor and patient has been characterised several times by Balint (1964/1988: 186, 335-7) as a "mutual investment society". The types of investment may differ, but at the end of the ideal development both "investors" can hope for "their" intended "profit".

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3 In the following, we distinguish between (in the broadest sense) *clinical* and *communicative competences*, which together are to be considered *professional* competences. In order to avoid a possible misunderstanding: It is precisely one of the concerns of this handbook to identify *communicative* competences as specific *clinical* competences in the medical profession as a whole.

9. Dialogical symmetry

For all the *reciprocity of the knowledge of the asymmetry of* the relationship between the helper and the person in need of help, the joint assumption of *responsibility* is just as unavailable as the preservation of mutual *autonomy* (v. Uexküll 1993, 2003) (§ 10). In order to ensure the *equal* (not the same) participation of doctor and patient, a *dialogical symmetry* is required, according to which there are approximately symmetrical opportunities for access to topics and forms of communication that are considered relevant from the respective participation perspective (§ 7, 10, 17). For example, the patient's rights of presentation, questioning or argumentation should not only be respected, but the corresponding communication competences should be continuously and sustainably strengthened in the conversation (empowerment) (Fig. 3.1). Accordingly, the analysis and evaluation of doctor-patient communication should not be based on a "naive" concept of symmetry, according to which all participants *tell* and *listen*, *ask* and *answer*, *assert* and *contradict,* etc. in equal measure. The fact that in doctor-patient communication one partner *narrates competently* and the other *listens competently* is a *functional* asymmetry. A *dysfunctional asymmetry* will have to be distinguished from this, in which (in the sense of Habermas 1971, 1981) at least one of the partners shifts from *communicative* action to *strategic* action, which will be repeatedly made an issue both in theory (§ 7, 17) and in practice (18-23, 24-25).

10. Complexity of the "power question" in helpful conversation

By no means should the problem of symmetry be reduced to the analysis of quantities, although they can also have an impact on the quality of conversations (§ 40), for example when *interruptions* or *questions* (of a certain type) *dominate* (§ 19, 21). The "question of power" in conversation can also be very complex or even paradoxical. This can be plausibilised in advance with the psychoanalytic conversation, which is an informative type of conversation due to its extreme characteristics and which invites *comparative* conversation analyses (Koerfer, Neumann 1982) (§ 40). For the understanding of psychoanalytic therapy, it would be "absurd" to attribute the "power" in the conversation to the patient alone, just because he or she is recognisably clearly dominant in the speech portion. As is well

known, this kind of "dominance of conversation" derives from the principle of "free association" handed down with Freud, which, according to Morgan and Engel (1969/1977), should also find a moderate application in the medical consultation and ward round (§ 9, 17, 19, 25). Here we are dealing with the apparent "paradox" that one partner (already according to Freud 1913: 194) "lets" the other partner "tell", who then precisely in the ideal case makes intensive and extensive use of it - in the interest of both interlocutors, one of whom knows the meaning of the *association rule* in advance from a professional perspective and the other learns to use it from the action perspective (Koerfer, Neumann 1982). It is through the interaction of everyday *narrative competence* and professional *listening competence* that the relationship can develop into a *helpful one* in the first place.

11. Interrogative versus narrative conversation

The patient's willingness to speak "freely" and at the same time "outspokenly" does not come about by itself, but often has to be motivated and animated through conversation. Thus, it is part of the doctor's *communication competence* to promote and challenge the patient's *narrative competence* through *active listening,* especially when taking anamnesis, because in the *narrative* pattern of action, completely different (types of) information can be obtained than would be possible through the mere *question-answer pattern.* This difference between *interrogative* and *narrative* interview styles, in which patients can participate more or less actively at different levels of competence, will be described in more detail below (§ 3.1.4) on the basis of the *dialogue roles* of speaker and listener and then elaborated in detail both in the theory of *biographical-narrative anamnesis taking* (§ 9) and in empirical interview analyses (esp. § 19, 20).

12. Rationality and reflexivity

The postulated *dialogical symmetry* assumes - despite all possible cognitive and psychological impairments due to illness or age (§ 3.1.7, 37) - in principle *equally rational* interlocutors (§ 10.6) who do not have to "talk down" to each other but can meet "at eye level". At the same time, both conversation partners initially also have an eve-

ryday *reflective competence* in which they can also critically observe and assess themselves (*ego*) and the other partner (*alter).* In this sense, patient (dis)satisfaction is to be understood as a manifestation of the reflection of self-experienced conversations in the consultation and ward round (§ 40). The fact that doctors, after a long period of training and further education, (should) have a specific *professional competence in reflection*, which, according to v. Uexküll, Wesiack (1991), should also be designated as a medical *meta-competence* (§ 3.3, 13, 17), is usually also appreciated by the patients, even if they usually only "tacitly" benefit from it. From a doctor's point of view, continuous self-reflection on one's own practice of talking and acting is a necessary prerequisite for the critical correction of "deficiencies" and "mistakes" and thus for an optimisation of professional action as a whole.

A number of these aspects on the complex interplay of *professional* and *everyday* competences between doctor and patient are directly taken up again in this chapter (§ 3.1.3-8), others are developed in later theoretical and didactic chapters and exemplified in the practical chapters with empirical examples. In case of further interest and need for information, the distinctive reference structure should serve as before for easier orientation.

3.1.3 Relationship models and communication patterns

Although the analogies between a psychoanalytic therapy session and a doctor's consultation soon reach their limits, there is nevertheless an essential correspondence between the two types of conversation. Just as in psychoanalysis, in the medical consultation "nothing else goes on but an exchange of words" (Freud 1917/1917: 9).[4] However, this *exchange of words* can be shaped quite differently for quite different purposes,

[4] Freud's well-known dictum was of course originally tailored to psychoanalysis (Flader, Schröter 1982, Koerfer, Neumann 1982, Scarvaglieri 2013 Peräkylä, Buchholz 2021). Nevertheless, it also applies analogously to the medical consultation, in which initially only words are exchanged before action can usually take place outside the conversation (§ 8). We will repeatedly discuss the differences and similarities between the two types of conversation, such as the moderate application of the principle of *free association in the medical consultation* as well (§ 9, 17, 19, 24).

with different communicative participation roles and relationship patterns between doctor and patient. Even though a relationship, however helpful, may be intended, this can be realised differently in the communication between doctor and patient. The type of communication and the type of relationship are mutually dependent. Once the relationship and communication patterns have been established, they can hardly be changed due to the well-rehearsed expectations of both interlocutors.

If doctors want to stick to the traditional, *paternalistic* relationship model, they do not need to change anything in the usual *doctor-centred* conversation. They can make extensive use of their medical questioning competence when taking the medical history and, as the competent expert, enforce their right to order or prescribe without "ifs and buts" by *strategic* action (see above) (*instruction*, *threat,* etc.) against the patient, from whom only *obedience* is demanded anyway (§ 10). It is no coincidence that a change has taken place towards this extreme model of *authoritarian paternalism* (§ 10, 25), which not least took into account the "facts" that the lack of obedience, which was captured by the older concept of *compliance* (§ 10.1), not only results in a prolongation of subjective suffering, for example if medication is not taken or is taken incorrectly, but also causes high costs.

However, the discussion about the appropriate design of the relationship and communication between doctor and patient is by no means over. Thus, following Beach (2013), the developmental stages of a doctor-patient relationship will be discussed later (§ 7.5) in a historical perspective:

1. Doctor-centred
2. Patient-centred
3. Relationship-centred
4. Interaction-centred
5. Dialogue-centred

These developments were not coincidentally promoted by the *paradigm shift* from *biomedicine* to *biopsychosocial* medicine, as founded by Engel (1977/79) and continued, for example, by v. Uexküll, Wesiack (1991) (§ 4). This paradigm shift coincided with a general *structural and functional change in medicine* (§ 5), which necessitated new *key* medical *competencies* (§ 6), which in turn could only be taught through a *reform of* medical studies (§ 13, 14). Paul Lüth's early book title was already programmatic for the development: "Von der stummen zur sprechenden

Medizin" [From silent to speaking medicine] (1986). With this emphasis on "speaking medicine", communication training also increasingly moved to the centre of an *integrative* curriculum (§ 13, 14), involving a variety of subjects that contribute to the promotion of communicative competences in an interdisciplinary manner.

"It takes two to tango"

The developments in reform cannot be adequately captured by a mere reversal from purely *doctor-centred* to purely *patient-centred* medicine (see above). However, it is clear that the "new" *contents of conversation,* such as those determined by the *themes of a biopsychosocial medicine* (§ 4, 19), cannot be obtained in the *"old" forms of conversation,* as they may have been commonplace in traditional, *interrogative* anamnesis taking or *order medicine.* Despite the new participatory roles of patients in *biographical-narrative* anamnesis taking (§ 9) and *participatory* decision-making (§ 10), the extent of their *active involvement* is by no means already fixed. Rather, the participation rights and obligations of *both* conversation partners are to be put into perspective from their respective perspectives as helpers and those in need of help.

The relationship in the conversation between doctor and patient has often been expressed from both a medical and psychotherapeutic perspective with the image of the two dancing partners ("It takes two to tango") (v. Uexküll 1987, Smith, Hoppe 1991, Hinze 1992, Koerfer et al. 1994, Charles et al. 1997, Buchholz, Reich 2014, Buchholz, Kächele 2016). If the dance is to succeed, the two dancers must harmonise sufficiently and coordinate their movements sufficiently. In this metaphor of dance, the commonality and dependence of action is highlighted, whereby the dancers can also take turns in the role of the "leading" dance partner, who determines the dance style, tempo, rhythm, etc. vis-à-vis the "guided" partner - regardless of any differences in the individually available competences.

Symmetry and Autonomy

The differences between doctor and patient are obvious, namely for *competences in the sense of skills* as well as *responsibilities of the agents* (Koerfer 1994/2013). This unequal distribution is predetermined by the sick role of the patient and the complementary helper role of the doctor.

The fact that one partner complains about his or her symptoms and the other empathically listens or inquires with interest is to be recognised as *functional* asymmetry. This is to be distinguished from a *dysfunctional* asymmetry in which a doctor (in the sense of Habermas 1971, 1985) (§ 7, 10) essentially shifts from *communicative* action to *strategic* action and seeks to assert his or her interests vis-à-vis the patient primarily through forms of communication such as *ordering, interrogating, trivialising, appeasing, extolling,* etc.

Here, communication can range between the extremes of an *authoritarian* to *libertarian* approach, in which the patient is treated either as an "immature child" or as a "customer king". In the one case, the patient is "taken to task" according to the *paternalism model* as if by an authoritarian father and forced to *obey by instructions*, in the other case according to the consumptive *service model* as if *courted* and *served by a product provider* - with all the risks of a "complaisance medicine" that offers what is in demand.

That the *loss of autonomy* of the patient, who in the traditional, strongly *authoritarian* paternalism model can even be kept immature with good intentions (protection from further burdens), could be reversed by merely reversing the asymmetry according to the pure service model is an illusion against which v. Uexküll (1993: 62) rightly warned: "No 'responsible patient' without a 'responsible doctor'". The practice of the doctor-patient relationship cannot be absorbed in the simple alternative according to which the "power in conversation" lies either entirely with the doctor or solely with the patient.

Rather, doctor and patient should meet as dialogue partners - unequal in roles yet equal in rights - whose actions are intertwined in the *reciprocity* of perspectives that one partner cannot succeed without the cooperation of the other. While the doctor is the expert of his or her art of healing, the patient is the expert of him or herself and his or her complaints. Thus, both partners are alternately dependent on each other in both expert roles (§ 10). In the *cooperation model* of a *dialogical relational medicine,* the question of power does not arise as long as both dialogue partners mutually leave their personal autonomy and create approximately *symmetrical opportunities for dialogue* (§ 7, 10, 17), both for the *relevance* of communication topics and purposes as well as for the means of communication considered relevant by both participants. In the sense of a "genuine" conversation, which according to Martin Buber (1954/1986: 296) cannot be "predisposed" (§ 7.5), the "dialogical principle" should also be brought to bear as far as possible between

doctor and patient, even if the institutional conditions of conversation often enough prove to be an obstacle.

3.1.4 Dialogue roles of speaker and listener

If the *dialogical principle is* also applied accordingly in medicine, the "fight for the word" should become superfluous. Because of the dynamics of *oral* communication, there may be "interruptions" in speaking, but these can be tolerated if they do not "get out of hand" (§ 19, 40). In case of conflict, the following also applies here: "The wiser gives way" - and in case of doubt this should be the doctor because of his or her professional dialogue role. Nevertheless, doctors must also be able to "come into their own" precisely because of their social role, but they should, as far as possible, leave their prerogative *to the patient,* whose illness-related distress can express itself precisely in his or her individual *need to communicate* about the events relevant to him or her (*patient's events).* The doctor's *patient-centred* approach then consists of letting the patient "do the talking" and thus arriving at an initial picture of the patient, his or her personality, his or her illness and his or her concerns. Here, the well-known *paradox* arises again, which seems to consist in "letting" the patient speak, which again raises the "power question" of who should, can or may "leave" what and for what purpose to whom in the conversation, etc. - which should be "left" as a *paradox* here. [5]

Application of the dialogical principle

If sufficient space has been given to the patient's need for information, the change can also be made to a more *doctor-centred* conversation, in which doctors satisfy their remaining need for information on the events relevant to them (*doctor*'s *events*) with a detailed exploration on their part (§ 21), although they must be able to allow a return to a patient-centred conversation at any time if necessary. However, the term and

5 For the discussion of this paradox, the special type of psychoanalytic conversation has already been mentioned (§ 3.1.2) (Koerfer, Neumann 1982), which is characterised by the fact that the patient apparently "exercises power" through his or her large share of speech, which the analyst, however, seems to "grant" her or him. Cf. also § 9 on Narrative Medicine.

concept of patient-centred conversation need some explanation in order to prevent possible misunderstandings that could arise from the apparent paradox that the conversation should be *patient-centred* and yet the guidance of the conversation is incumbent on the doctor, who cannot be released from this responsibility. However, the *dialogical principle* should also be interpreted again and again for the doctor's guidance of the conversation in practice (§ 7.5) in such a way that no contradiction should arise between *guidance* and *conversation*.

If a *patient-centred* conversation is to be assumed here first,[6] this does not mean, however, that doctors could merely "let the patient talk" and otherwise more or less attentively "lend him or her their ear". Rather, the doctor must actively meet the patient as a listener when speaking. Because: Without a listener, there is no speaker.

This *listener-centred* perspective is now increasingly being asserted against the traditional *speaker-centred* perspective in *philosophy* (Fiumara 1990/2013) as well as in *communication studies* (Schmitz 1998, 2000). Once the listener's co-responsibility for the speaker's utterances is conceded, traditional perspectives undergo such a transformation that attributing even the opening of the conversation to the listener no longer has to appear paradoxical. The change in the customary perspectives has also been pointedly expressed by Schmitz (Box 3.2):

Box 3.2	Speaker-listener roles

It follows from these considerations that the activity of the speaker, which according to common understanding is the decisive factor for the opening of a conversation, in turn presupposes the activity of at least one listener (...) For this reason, it makes little sense to adhere to the common, unreasoned view that we speak *in order to be heard*. Rather, we speak - and this applies phylogenetically, ontogenetically and in a generalised sense to any kind of verbal and non-verbal communication - *because we are heard*.

Schmitz 2000: 319

6 Beach (2013) again refers to the historical development from *doctor-centred* via *patient-centred* medicine to *relationship-centred* and finally *interaction-centred* or *dialogue-centred* medicine, which will be further differentiated later (§ 7.5).

It is irrelevant to what extent the speaker-listener relationship is structured more by *around-to motives* or *because-motives* or in the complex interplay of the two types of motives, but the interaction between speaking and listening is beyond question. In the medical consultation, moreover, the speaker-listener relationship takes on an *institutional* character because both interlocutors encounter each other with appropriately established "expectations" that they will "cherish" in advance. Accordingly, patients also seek medical consultations with the common expectation that they will find an attentive listener who will "listen" to their complaints, grievances and concerns - in the multiple sense that "listening" can have.

Resonance und Relevance

Thus, the actors jointly assume that the doctor will not only "lend her or his ear" to the patient but will also "provide assistance and help" conversationally. However, both partners know in advance about the expectations of the professional listener vis-à-vis a speaker who will and must "lament their suffering" etc. before he or she can be "listened to", so that a layering of "expectations of expectations" arises here that can no longer be adequately grasped from the mere *speaker-centred* perspective.

Likewise, v. Uexküll (1993) has already reformulated the traditional, *speaker-centred* perspective from a *medical* and *semiotic* perspective in a *feedback model of interpersonal relationship* (Box 3.3). Based on a general model of the relationship of living systems to the environment, v. Uexküll emphasises our chances of survival as dependent on the reciprocal services of our fellow human beings, on whose "suitable counterrole" we are also necessarily dependent in conversation.

Box 3.3	"Speaking needs listening"

Figuratively, one can imagine a relationship as a thread which, if it is to hold, must be spun by both sides. The importance of these threads for our health becomes understandable when we realise that every performance of our body requires a counter-performance of its environment. In order to breathe, we need the counter-performance of the surrounding air. In order to walk, our feet need the counterpart of the floor, to lie down, our back needs the counterpart of the support, etc. If the counterpart is missing, we are handicapped or paralysed. It is the same with our

> relationships with our fellow human beings. Here, every role needs the appropriate counter-role. Speaking needs listening, giving needs taking, questions need answers if the relationship is not to break up.
>
> v. Uexküll 1993: 60

As in life, it is also true for medicine as a "speaking" medicine that those acting are dependent on *resonance*, which the doctor in particular has to ensure from his or her professional perspective: The specific *counter-role of the doctor* can be described under the aspect of *guiding a conversation* with meta-communicative expressions from our everyday language: If the thread of the relationship is to be "spun" and not "torn", the doctor must first of all "get the patient to speak" from his or her side, then "pull him or her into a conversation" and finally "keep him or her in the conversation" so that he or she does not "fall silent" again or even "drop out" of the conversation altogether. All in all, the doctor must guide the conversation as a "dialogue" (§ 7.5, 18), in which the patient can "bring up" everything that is *significant* or *important* to her or him, and in which at the same time everything that the doctor needs to know or wants to know because it is relevant to him or her should "come to his or her ears".

For both interlocutors, the *relevance problem* arises in an entangled action perspective: since neither actor knows at the beginning what is relevant for the other, this is also particularly true for the doctor-patient conversation: Although the relevance problem between doctor and patient is not fundamentally different from that in everyday communication (Schütz 1955/1971, Kallmeyer 1978, Koerfer 1994/2013, Koerfer et al. 2000, 2004) (§ 7.5, 17.4), because of the special *interdependence* of the professional and lay roles it requires reflexive and flexible *negotiation of solutions to problems* for which both partners can take joint responsibility.

This is precisely where the institutional communication conditions with different social participation roles of doctor and patient come into play, with which they alternately contribute their specific professional and everyday competences from both perspectives of action.

3.1.5 Reciprocity of perspectives for action

The complex interaction between the action perspectives of doctor and patient, who first have to find their dialogue roles as speaker and listener and then regularly change, can already be illustrated by *positive* and *negative maxims* by Morgan and Engel (1969/1977) (Box 3.4). As a professional listener, the doctor is dependent on the corresponding information from the patient, who in turn must first be "motivated" in his or her willingness to communicate or must not be "inhibited" in his or her "spontaneity".

Box 3.4 Positive and negative conversation maxims

He [the doctor] must encourage the patient to speak freely, because only the patient can tell him what he has experienced (...) He avoids questions that the patient can answer with a "yes" or "no" as far as possible, because otherwise the patient stops reporting spontaneously and only waits in silence for the next question.

Morgan, Engel 1969/1977: 41 and 49

The application of such *positive* and *negative* maxims, which have already been differentiated elsewhere as *commandments* ("Do ...") and *prohibitions* ("Avoid ...") (Koerfer et al. 1994, 1996, 2005), will be deepened in this handbook in the form of a *communication manual* (§ 3.4, 13, 17) with practical *anchor examples* (§ 18-23). As will be illustrated there with empirical examples, it is precisely the interplay between the patient's *narrative competence* and the doctor's *listening competence* that is important, for example, in taking an anamnesis, and the doctor must first "awaken" the patient's willingness to tell the story by *active listening* (§ 9, 19).

In the sense of Morgan and Engel, the doctor must first *motivate* ("encourage") the patient to tell, in order to then keep a narrative that has begun going, without prematurely interrupting the patient's flow of narrative and thought by asking questions (of a certain type) (§ 9, 20, 21) - with the effect so pointedly formulated by Balint:

> *If one asks questions, one receives answers to them, but nothing more* (Balint 1964/1988: 186, italics in original).

Here, a rough distinction can be made between *interrogative* patterns of action (questions - answers - silence - questions, etc.) and *narrative* patterns of action (telling - active listening - telling on, etc.) (Fig. 3.2-3), which are to be further differentiated for the empirical purposes of analysis and evaluation later (§ 9, 17, 19, 40), when patient narratives are placed in the context of *biographical* narrative history taking.

As we will see from empirical cases, there are extreme variants of the *interrogative* pattern, with which a kind of "interrogation conversation" develops (§ 19). The patients answer the doctor's questions succinctly and then wait "silently" for the next question - a *vicious circle* with a compulsion for both interlocutors that they soon can no longer escape (Fig. 3.4-5). In contrast, with the narrative action pattern, the doctor receives information "freely delivered" in the sense of Balint through actively supported narratives according to form and content, which cannot be gained through mere answers to questions. Patient stories are *stories of illness and suffering* that can predominantly only be *told* by the patient, but not by the doctor through mere questions.

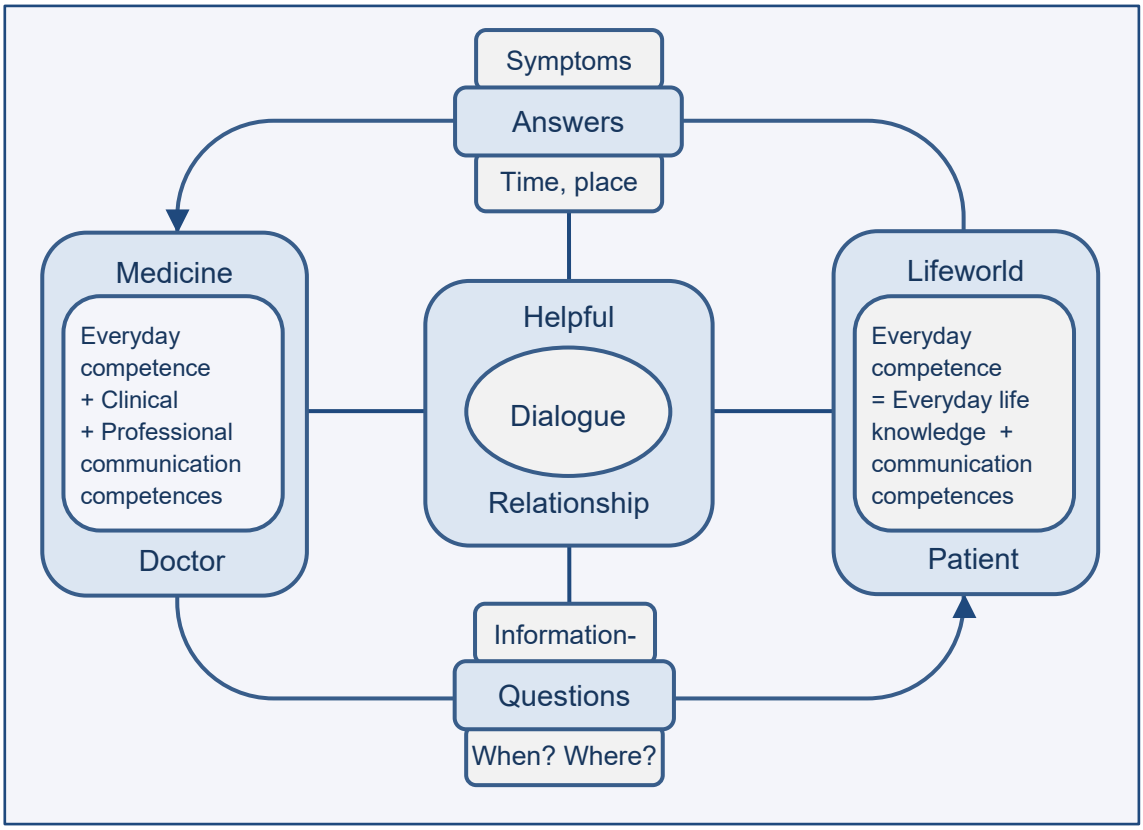

Fig. 3.2: Interrogative communication pattern

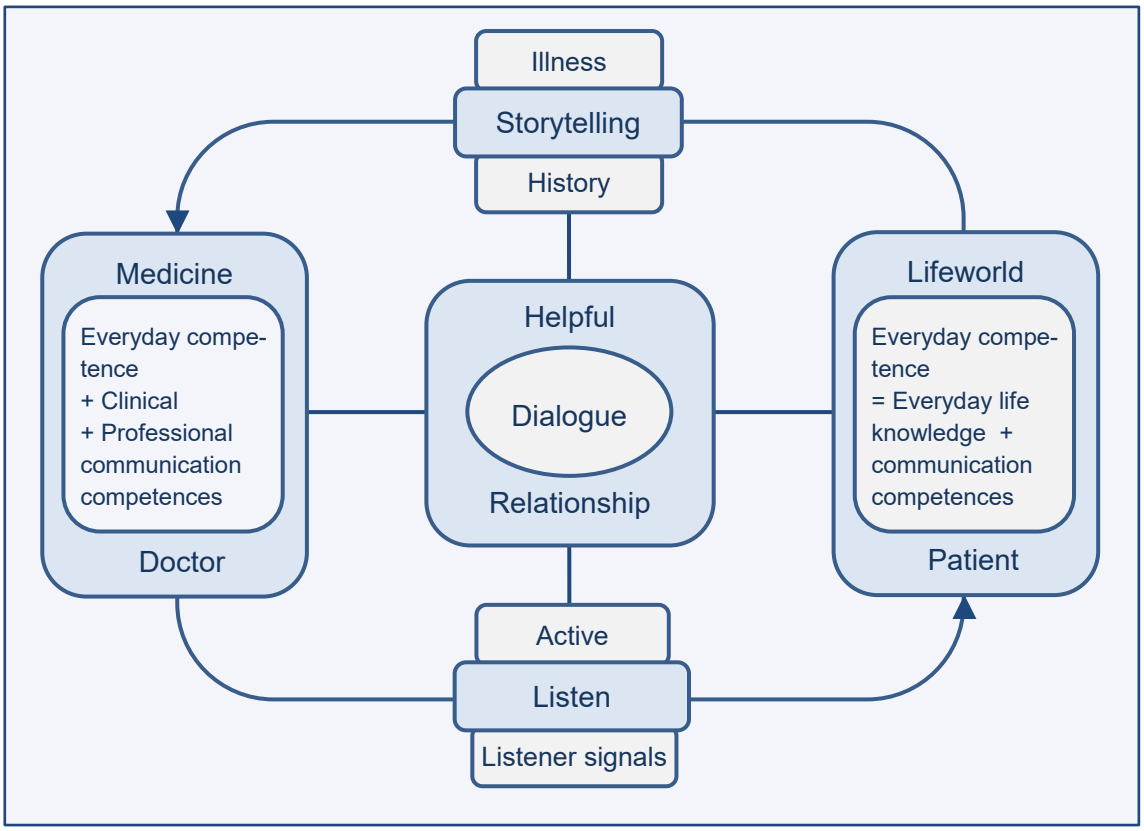

Fig. 3.3: Narrative communication pattern

This means that detailed questions are not frowned upon, but are indispensable if the doctor has to clarify the time, locality or intensity of, for example, certain symptoms during *complaint exploration* (§ 21), but priorities should be set according to which the patient should first "speak up" in order to "in his or her words" introduce his or her concern in the lifeworld context of his or her experienced "history of illness".

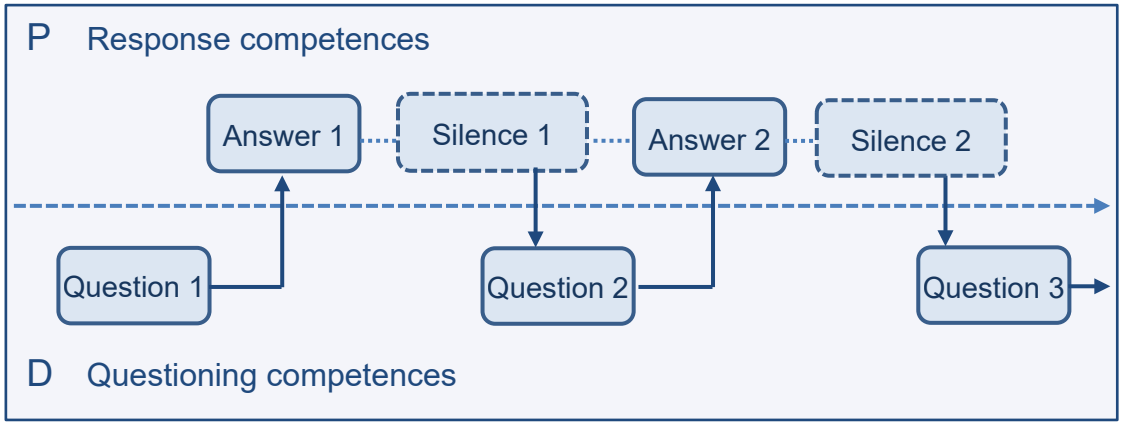

Fig. 3.4: Interrogative action pattern in the course of conversation

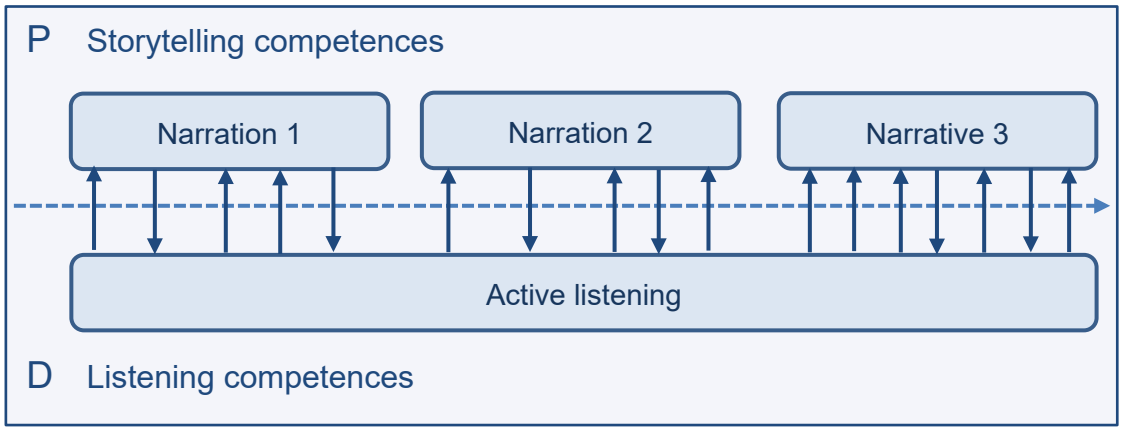

Fig. 3.5: Narrative action pattern in the course of conversation

Under the aspect of *verbal conditioning,* the prevention or promotion of "free", i.e. *associative* and *narrative,* patient speech will be examined in empirical cases (§ 9, 17, 20, 21), in which the actors (can) make more or less use of their *professional* as well as *everyday* competences, depending on the interlocutor, who must *act* accordingly.

Ideally, there is a *joint* (re-)*construction of the patient's story* (Brody 1994), in which *both actors* are equally involved with their *professional* and *life-world* competences (§ 9, 19). This specific form of cooperative *narrative* (Koerfer et al. 2000, Koerfer, Köhle 2007, Köhle, Koerfer 2017) is an *institution-specific* form of narrative because both actors contribute their different competences for diagnostic and at the same time therapeutic purposes, which according to Gadamer (1993) (§ 7, 9) should characterise a good conversation between doctor and patient anyway.

Although or precisely because the *professional* and *life-world* competences of the actors correspond well in a successful case of cooperation, the difference to everyday communication is unmistakable: In doctor-patient communication, the priority must be taken into account that medical action relates to the well-being of the patient (and not vice versa). The principles of "prevention of harm" (*primum nil nocere*) and even "healing" (*bonum facere*) determine the specific institutional meaning and purpose of medical action, from which the patient should benefit first and foremost. If this results in a certain therapeutic success in *(treatment) action*, which always presupposes joint *conversation work,* this success can of course also rightly be reflected secondarily in a doctor's *professional satisfaction*. In this sense, the doctor can also pursue "egoistic" *motives* secondarily, although his or her *main motive* of help-

ing the patient should be characterised by "altruism" overall. In this respect, there are again asymmetries between the actors, but these should be well balanced in a helping relationship.

3.1.6 The Problem of (A)Symmetry

In contrast to the medical assistant, the *motives* of the patient in need of help may remain "egoistic", because it is solely about his or her health. The *patient's privilege of being the centre* of all efforts as the sick person remains characteristic of the relationship design: Unlike in everyday communication, the medical consultation and ward round, despite all cooperation, is about the (re)construction of stories of suffering and recovery by patients, not by doctors: at best, they are allowed to tell stories about themselves and other patients (and then only anonymously) if it is about illustrations for the benefit of the current patient and a narrative on the doctor's side is used in the sense of *model learning.*

In short: In doctor-patient communication, the interaction roles between the actors are relatively clearly distributed: The fact that one interlocutor *narrates competently* and the other partner *listens competently* again points to a *functional asymmetry* that will have to be distinguished from *dysfunctional* asymmetries, in which at least one of the interlocutors shifts from *communicative* action to *strategic* action in the sense of Habermas (1971, 1981) (§ 7, 9, 10, 17, 24). Here it is a matter of establishing a *dialogical* symmetry in a *biopsychosocial* medicine (§ 4), which in any case not only grants the patient *active cooperation* in the conversation but demands it.

The type of *functional asymmetry* between doctor and patient is also not at issue when later a shift from the *paternalistic* to the *participatory* model of relationship is advocated, which is accompanied by a change from the traditional, *doctor-centred* to the so-called *patient-centred* style of conversation (§ 7-10, 17-23). This change is mainly about the already outlined differences in tendency between primarily *interrogative* and primarily *narrative* styles of conversation, which definitely differ in the use of different *conversation techniques,* which are even to be taught in the form of a *conversation manual* (§ 17-23). Here it is important to change the trend in education and training in order to complement the questioning competences that have always existed from a medical point of view in the direction of developing listening competences of doctors,

who should increasingly use verbal and non-verbal *techniques* of *active listening* (§ 19).

In the theory as well as in the didactics of guiding conversations, it will be explained in detail that the competences to be taught can by no means be reduced to *skills* (§ 13, 17). In the presentation and justification of our conversation manual (§ 17) and the empirical foundation with anchor examples (§ 18-23), it will become clear that in the *creative* "art" of guiding medical conversations, the thoroughly useful *conversation techniques* in conversation practice must always be combined with specific (*self-reflective*, *psycho-social, empathic, ethical,* etc.) competences in order to be able to adequately support patients in developing *their* specific competences in dealing with their health problems.

Medical competences are thus essentially directed towards (strengthening) *patient-side* competences (*empowerment*), which is not least a necessary prerequisite for *autonomous* and (self-)*responsible* decisions and actions that affect the health and life of the patients themselves.

3.1.7 Cooperation and conflict

For the purpose of decision-making (§ 10), doctor and patient initially enter into an "asymmetrical" relationship, as has been described as a "Helping Alliance" (Luborsky 1988) or "Therapeutic Alliance" (Saketopoulou 1999, Street et al. 2009) (§ 8.2). Ideally, the relationship develops in the direction of participation and finally emancipation of the patient, who can use *medical help* according to v. Uexküll (2003) as *help for self-help* (Box 3.5), whereby *autonomy* may only be limited in special cases of illness-related decision-making incapacity.

Box 3.5	Help for self-help and autonomy

The insight that a person's individual reality is a prerequisite for his or her ability to act, for his or her autonomy, means that *medical help must be help for self-help,* that casually formulated the illness belongs to the sick person, but not to the doctor, and that the sick person must decide for himself or herself about existential questions that affect him or her.
The doctor can only be an advisor in such decisions. He may only take decisions away from the sick person if he is incapable of making decisions or if he has to protect a sick person from himself. Both require a

> very critical examination of the question of whether and if so, where the autonomy of the sick person is limited by his or her illness.

v. Uexküll 2003: 1346, emphasis in original

Although the participation roles of *helper* and *person in need of help* are clearly distributed, both interlocutors can ideally meet as in a *win-win situation*, in which they *negotiate the best solutions* to the patient's *problems* in a *symmetrical* interaction ("on an equal footing") as *autonomous* subjects (§ 10). Thus, in the *participation model* of the doctor-patient relationship with v. Uexküll (1993), a mutual preservation of *autonomy is* postulated for both interlocutors, who can benefit equally from a *dialogical* communication (§ 7).

However, the intended success can only be achieved if both partners in the conversation are sufficiently *ready* and *willing to* cooperate with their different *professional* and *lifeworld* competences up to the point of *shared decision-making* (SDM), which they can each take *responsibility* for individually and at the same time jointly. In the sense of Mishler (1984), *conflicts* can arise between the life-world "voice" of the patient and the "voice" of medicine (as a system) (§ 10.1).

However, doctors could competently help to defuse these conflicts, since they have a *double competence*, as is the case for all professional actors (teachers, doctors, judges, etc.) in institutional communication (Koerfer 1994/2013). On the one hand, doctors also have their *professional* competences as a result of their *medical training*; on the other hand, as members of the general *living world,* they still have *everyday competences* that they should not discard when they put on the gown. Due to their *dual competences,* they should be *ready* and *willing* to anticipate conflicts between the living world and medicine and to initiate *solutions to problems* in cooperation with the patient.

In doing so, they must take into account general problems of understanding and comprehension, where a knowledge gap must be overcome reciprocally in *dialogical* communication (§ 7), as well as helping to overcome specific conflicts in *clarification* and *decision-making* (§ 10), which should already begin with the appropriate mediation between *specialised communication* and *everyday communication* (§ 27).

In unfavourable cases, these conflicts between the life world and medicine can also lead to a separation of the relationship between doctor and patient if no balance can be created and one voice begins to disproportionately *dominate* the other. As a rule, the medical voice of

the doctor must still be assumed to be dominant, although in the opposite case he or she must defend him or herself against a patient's request for a "medicine of convenience", for example, if he or she wants to hold on to medical autonomy for his or her part in the sense of v. Uexküll (1993). This danger of loss of autonomy exists if the patient seeks to change from the shared decision-making (SDM) model to the purely *consumptive service model* (§ 10, 22), which the doctor may have to reject already because of his obligation to *evidence-based* medicine (§ 10.3).

Here, medical action as *rational* action comes up against its - if you will - systemic limits, where subjective action is no longer determined by will and ability alone but must be oriented towards higher "institutional" instances (the profession, the legislator, etc.). After that, what is "desired" or "feasible" from whatever participation perspective must be limited for other good reasons.

However, the development of a *helpful* relationship can also be disturbed under *motivational* or *volitional* aspects (in the sense of Weinert, Box 3.1) or fail completely. For successful cooperation, the doctor's *willingness to help* is just as necessary as the patient's *motivation* and *willingness* to be helped.

Arousing this willingness in a patient who has difficulty accepting help is an essential part of a doctor's *professional* competence. Often patients have to be *motivated* for a conversation at all before their subjective *attitudes* and *beliefs* can be "brought up" (§ 21), in order to finally achieve a change in behaviour, for example in the sense of *adherence* to medication (§ 10, 26). Here, doctors often experience themselves (as expressed in training courses) as "motivational artists" who try to convey the necessity for a certain health behaviour to their patients with the "tongues of angels".

In this context, the *professional* competence of doctors is particularly challenged in the case of "difficult" patients (§ 34), when they initially do not want to or cannot accept the doctor's *willingness to help* for whatever reason (conflict of values, insecurity, doubt, denial, etc.). With a specific *empathic* competence (§ 3.3, 17, 20), these problems in verbal and non-verbal communication must first be *perceived* by the doctor, i.e. *understood* and *reflected upon* at the same time, before he or she can react to them *appropriately* and initiate *solutions to problems.*

3.1.8 Reflexion and fitting as meta-competences

In the practice of conversation, the *reflection* of a patient's defence experienced in this way often also leads to a change from a more *confrontational* to a more *tangential* guidance of conversation, with which the (complaints of the) patients are still taken seriously, but the personal impositions are offered in a "dosed" manner (§ 3.3, 17, 32). Here again *(a)symmetry* comes into play between an everyday and professional reflective competence. Both partners in the conversation will initially notice that the conversation is "faltering" or that something is "going wrong", but the doctor will have to exceed this perception with his or her professional reflective competence in order to be able to "steer" the conversation in the sense of an appropriate guidance of the conversation into channels in which a further escalation of the conflict ("hardening of the fronts") can initially be avoided or even mitigated.

Medical *reflexion competence*, which v. Uexküll and Wesiack (1991) refer to as medical *meta-competence* (§ 3.3), includes the "art" of choosing the *appropriate* continuation of a conversation in which the patient is sufficiently challenged without endangering the relationship itself, in the critical observation of self and others (ego and alter) (Fig. 3.1). This requires a special *fitting competence* (§ 3.3) in communicative action, which doctors should also have as a meta-competence in order to be able to "control" their specific communication competences situation-specifically, so that, depending on the conversation situation, an empathic feedback is chosen as an appropriate continuation of the conversation as an alternative to further, insistent demand. However, making the appropriate choice from the diverse repertoire of verbal and non-verbal interventions "in every case" (§ 3.3, 17) requires many years of learning processes in training and professional practice, which cannot be replaced by *textbook knowledge,* no matter how good it may be.

These learning processes can lead to very *individual learning curves* (§ 40), which can be characterised by steady learning progress, but also by regressions, for example when critical self-reflections initially lead to irritations, which can also inhibit spontaneous conversational behaviour. Altogether, four types of competence development can be distinguished, which we will come back to later in the evaluation (§ 40-43):

- ***Textbook knowledge*** (1st order concept and rule knowledge: students according to lecture, seminar, text reading etc.)
- ***Practice knowledge*** (1st order knowledge plus trial knowledge in trial handling: students handling simulated and real patients).
- ***Professional knowledge*** (1st order knowledge plus 1st order routine knowledge according to real practice: practitioners: doctors, therapists, nurses, etc.)
- ***Expert knowledge*** (2nd order routine knowledge and/or 2nd order specialised scientific knowledge: lecturer, researcher, supervisor, etc.)

As mentioned above (§ 1.3), the path of a "novice" through specific progress in competence development to "mastery" can be quite lengthy, for example in the development of specific *empathic* competences (3.3, 17, 20). Here, doctors have to find the necessary "sensitivity" for what is currently *reasonable* for the patient in the *here* and *now* of a conversation (Koerfer 1994/2013: 276ff), which is just "suitable" without "overtaxing" the patient or even "endangering" the relationship with him or her. This "tact" can ultimately only be developed in the practice of conversation, when the experience of conversation is gained as to how patients may (over)react to a doctor's verbal intervention.

Despite this limitation, the reading of a textbook can of course still be helpful if the theory and didactics of guiding conversations are at the same time supplemented by empirical examples on which the problem of *fit* can be successfully practiced insofar as the continuation alternatives can be continuously *reflected upon* vicariously for the acting doctor (§ 1, 13). With this kind of *simulation,* a kind of "practice knowledge" emerges that is situated between "textbook knowledge" and "professional knowledge" (as "routine knowledge"). It is, as it were, a *trial action* in the subjunctive: "How would I act as a doctor if I had to act here and now instead of the real doctor in this conversation?" (§ 1.4, 13.5). In the critical comparison of one's own intervention proposal with the real continuation of the conversation, one's own reflective competence is challenged again.

With the didactic-methodological reservation that "dry runs" can certainly have advantages and disadvantages, the two *meta-competences* of *reflexion* and *fitting* are to be made the subject of discussion in this handbook, first by way of introduction (§ 3.2) and then on an ongoing-

basis by way of example, and subsequently set in relation to specific communication competences. [7]

3.2 Competent communication guidance

As will be explained, the *art of guiding a medical consultation* (§ 17) is not exhausted in the rhetorically optimal formulation of an information question, for example, which should not be asked in a suggestive manner (§ 21.2) but requires a specific *fitting competence*. Doctors must have this fitting competence as a self-reflexive meta-competence in order to be able to take into account both the (specialist) medical "state of affairs" and the individual course of the conversation with this individual patient and his or her personal stories of suffering, interests, concerns and preferences, which in turn must be done "in the language of the patient" - even or especially when the patient belongs to a different generation and/or culture, etc.

3.2.1 Specific communication competences

Overall, doctors' communication competences are to be taught as profession-specific competences with which doctors make use of their everyday *communicative* competences, such as *listening*, *questioning*, *answering* and *communicating,* which they at the same time *specialise for* their *professional purposes* (*taking medical histories*, *giving diagnoses, making decisions*, etc.). In a first overview, *communicative competence* can be divided into the plurality of many sub-competences (Box 3.6), which doctors should possess in their professional guidance of conversations.

[7] Since the *fitting competence* can itself become the object of the *reflexive competence,* the latter would have to be labelled as a *meta-meta-competence.* Unless otherwise specified in certain contexts, this distinction should be disregarded for the sake of simplicity, so that we will then speak of *fitting* and *reflexive competences* (as meta-competences) without distinction.

Box 3.6	Specific competences of professional conversation

In the guidance of medical conversations, specific (partial) competences of the doctor can be distinguished (here as an example), which together interact in his *communicative competence:*

- Listening competence
- Comprehension competence
- Questioning competence
- Formulation competence (e.g. "comprehensibility")
- Empathic competence
- Intercultural competence

These *specific competences* in guiding medical conversations must be further differentiated and combined in the application (*performance*), whereby they must be placed in a suitable prerequisite-consequence relationship: Asking the *right questions* at the *right time* requires *competent listening*, which, however, is not an end in itself, especially if it conflicts with the competence of understanding: If the elementary *understanding* of individual patient statements (e.g. description of a complaint) or even the thematic "thread" of the conversation as a whole is at risk to get lost, it makes sense to "terminate" the willingness to continue listening and to interrupt the patient's narrative flow "in good time", before misunderstandings irreparably accumulate. Interruptions are therefore not frowned upon per se, but rather their communicative *misplacement* at a point in the conversation where the doctor should "let it go".

In order to "keep a conversation going" with listening competences at all, at least minimal listener feedback (such as *hm*, *yes*, *aha*, etc.) is required "in between" even when the patient should already be in the flow of speech. Otherwise, the patient (like almost every speaker) would fall silent if the listener response failed to materialise. The omission of listener feedback, but also questions and follow-up questions, can also be interpreted as disinterest in the medical consultation or ward round and can lead to *conversational disturbances* just as much as the excessive interruption by medical question batteries, which can lead to a kind of "interrogation conversation" (§ 19) due to an inappropriately used *question competence.*

Such an interrogation conversation would be far removed from a dialogue in the sense of a "genuine conversation" (Buber 1954/1986) (§ 7). In such a case, the *questioning competence* would have "dominated" the

listening competence in an inappropriate way - a negative balance to which we will return later with Balint's (1964/1988) critique of the "usual anamnesis" (§ 9.5).

3.2.2 Conversation maxims and maxim conflicts

The outlined balancing act between *listening* and *asking questions,* especially at the beginning of the conversation, but also between *asking questions* and *clarifying* etc. in a later phase of the conversation, in which a medical decision may already be pending (§ 10), makes it clear to what extent doctors are exposed to certain conflicts of maxims when guiding conversations, to continue their conversations in cooperation with the patient in one direction or the other (Koerfer et at. 1994, 2008, 2010). A first set of conversational maxims (Box 3.7) illustrates how these can compete with each other in conversational practice.

Box 3.7 Conversational maxims and conflicts of maxims

In the guidance of medical conversations, the following maxims can be distinguished (here as examples), which can be formulated (negatively) as *prohibitions* ("Avoid X") and (positively) as *commandments* ("Do Y), whereby some of these maxims can conflict in the concrete practice of conversation:

- Start with open questions!
- Listen attentively!
- Let the patient tell!
- Avoid interruptions!
- Ensure understanding and comprehension!
- Give empathic feedback!
- Close information gaps by asking detailed questions!
- Avoid leading questions!
- Avoid multiple questions!
- Speak the language of the patient!

Some interview maxims can be followed unconditionally, so to speak. For example, multiple questions should be avoided as a matter of principle, because patients would be cognitively overwhelmed by "batteries of questions in a row", if only because they would often not know which questions they should answer first or then in what order. Likewise,

there are rarely reasons *not to* speak the patient's language. In problematic cases where the use of technical terms seems appropriate ("insulin", "stent", "defibrillator", etc.) (§ 27), the doctor's specific *formulation competence* is required to provide the necessary translations and explanations.

With other maxims, however, the conflicts already mentioned can soon arise in the practice of conversation, for example, if the patient who is telling the story quickly loses the thread, expresses him or herself unclearly, contradicts him or herself, etc. and the doctor, even in the case of ideal comprehension competence, can hardly follow the *content/topic,* so that with this "diagnosis of conversation" a (re)questioning *interruption* would be "indicated" to secure comprehension. Clarifying interruptions are also useful if the patient - for whatever reason (forgetfulness, belittlement, denial) - leaves systematic gaps in information that the doctor urgently needs to close in order to understand the course of life and illness, etc.

Thus, the patient's *right to tell the story* may conflict with the doctor's *duty to ask questions* in order to obtain information, which, however, always requires a case-by-case examination that requires a specific *weighing of interests* in this specific conversation with this individual patient with his or her personal characteristics. The result of such a "conversation diagnosis" by the doctor, oriented to the individual case, can be to "accept" an interruption in this specific case in favour of securing understanding or obtaining information, i.e. to decide on a conflict of maxims in a certain direction, in which "clarity and securing understanding" should be important.

In order to be able to make a sustainable decision about the further course of the conversation in such *change-relevant conversation* situations, in which conflicts of maxims between conversation alternatives have to be resolved, a special *fitting competence* is required, which will first be described below in its function and then identified as a medical *meta-competence* for critical-reflexive *self-observation.*

3.2.3 Conflicts of maxims and fitting competence

For the resolution of recurring conflicts of maxims, a specific *fitting competence* must be developed with which doctors have to flexibly adapt to the often spontaneously changing challenges in conversation (§ 3.3, 17). Especially in such *situations of suspense,* where there is a real al-

ternative of *listening* versus *interrupting,* for example, in order to ask a question of understanding, doctors must use their *fitting competence* to decide the current *conflicts of maxims* according to the ranking *relevance maxim* in a context-sensitive way, as is to be done by the doctor continuously and ad hoc during a conversation under certain here-and-now alternative questions (Box 3.8).

Box 3.8 Relevance maxim: What has priority "here and now"?

When guiding a medical consultation, doctors must have the *competence to make decisions* about *conflicts of maxims* in alternative continuations of the consultation according to the higher-ranking maxim of *relevance,* e.g. under the question of what has *priority* "here and now", i.e. what is to be done or omitted with the next step of the consultation or what is to be put on hold and left for later:

- Is listening further to the patient's complaint description here and now *more relevant* than asking for details?
- Is maintaining the patient's narrative flow here and now *more relevant* than clarifying a possible misunderstanding?
- Is the further execution of the patient's subjective ideas of illness here and now *more relevant* than the necessary correction of the wrong?
- Is the further education of the patient here and now *more relevant* than the outstanding prescription issue?

At such *change-relevant* points in the conversation, where a decision has to be made to continue the conversation in one direction or the other, a communicative *cost-benefit calculation* has to be made, which doctors are also used to doing in other medical actions, when they have to make a *relevance assessment* in order to be able to justify a choice between certain treatment options for themselves and their patients. From the point of view of relevance assessment in decision-making, there are a number of analogies between the guidance of conversations and "other" medical actions.

Even in medical action in the narrower sense, there are often *ambivalent* decision-making situations because, for example, *conservative* or *surgical* treatment measures "balance each other out", i.e. are found to be (almost) equally "suitable" in a given case, which we return to under the aspect of equivalence ("equipoise") (§ 10) in medical decision-making. Just as the decision between medical treatment measures re-

quires the consideration of their respective benefits and risks for this patient, doctors must *weigh up goods* in their guidance of the conversation under a maxim of relevance in order to be able to decide on possible conflicts, for example, between the patient's *right to narrate* and the doctor's *duty to ask questions* in order to ensure understanding and obtain information.

Just as elsewhere in medicine, the decision also requires an individual *case examination* in the guidance of the conversation, which must take into account the specific developmental conditions in this concrete conversation with this individual patient at this concrete state of the subject, etc. with as much *accuracy* of fit as possible. For example, a doctor will have to anticipate the specific perspective of the conversation, whether his or her "here and now" possible but strongly insistent question on this "sensitive topic" will be tolerated and answered by the patient "just barely" or whether this is already "too much of a good thing" for this patient, who has already adopted a defensive attitude several times in the course of the conversation.

As the term "*accuracy of fit"* suggests, there will certainly be more or less successful fits to differentiate in the practice of conversation in addition to the ideal case, which we will come back to in a moment (§ 3.3) and again later. The specific *fitting problems* in medical conversation will play a central role in the application of our conversation manual and will be illustrated with a variety of practical examples. Precisely because a standard solution (e.g. "Let them talk!") does not always "necessarily" fit in concrete conversation practice, the doctor's fitting *competence* is particularly challenged. This fitting competence will have to be specifically identified as a *meta-competence*, with which the doctor not only has to communicate the communicative sub-competences with each other, but also with further, specifically *clinical* competences (in the narrower sense).

3.3 Fitting model of key medical competences

When guiding a conversation, doctors must not only use their fitting competence to decide on "local" conflicts of maxims that can arise spontaneously from one conversation step to the next, for example when they have to choose between *listening* and *asking questions* or *obtaining information* and *conveying information.* In addition, doctors must be able to react *flexibly* to changing conversation conditions with changing patients as individual conversation partners, whom they must at the same time meet as professional helpers from a medical care perspective. This entails further fitting problems, which are summarised here in a basic model of medical fitting competence (Fig. 3.6), the essential components of which will be explained below.

3.3.1 Basic model of medical fitting competence

In cooperation with the interlocutor, doctors must help to develop goal-oriented conversations for professional purposes (of anamnesis, diagnosis and therapy) (§ 8) in a common direction of conversation, which should not only fit this individual patient with his or her "personal profile" (illness, gender, cultural and social origin, age, language, etc.), but at the same time comply with the "rules of the medical profession" as formulated in guidelines based on evidence-based medicine (§ 5, 10).

Overall, medical *fitting competence* must mediate between diverse social, individual, situational and institutional framework conditions. An initial presentation of the *basic model of* medical *fitting competence* (Fig. 3.6) will be explained below and then gradually modified and differentiated in the textbook and illustrated with empirical examples. What still serves here as a placeholder for the "professional repertoire of verbal and non-verbal interventions" will then (§ 17-23) also be filled empirically in detail through our manual on medical interviewing and corresponding anchor examples.

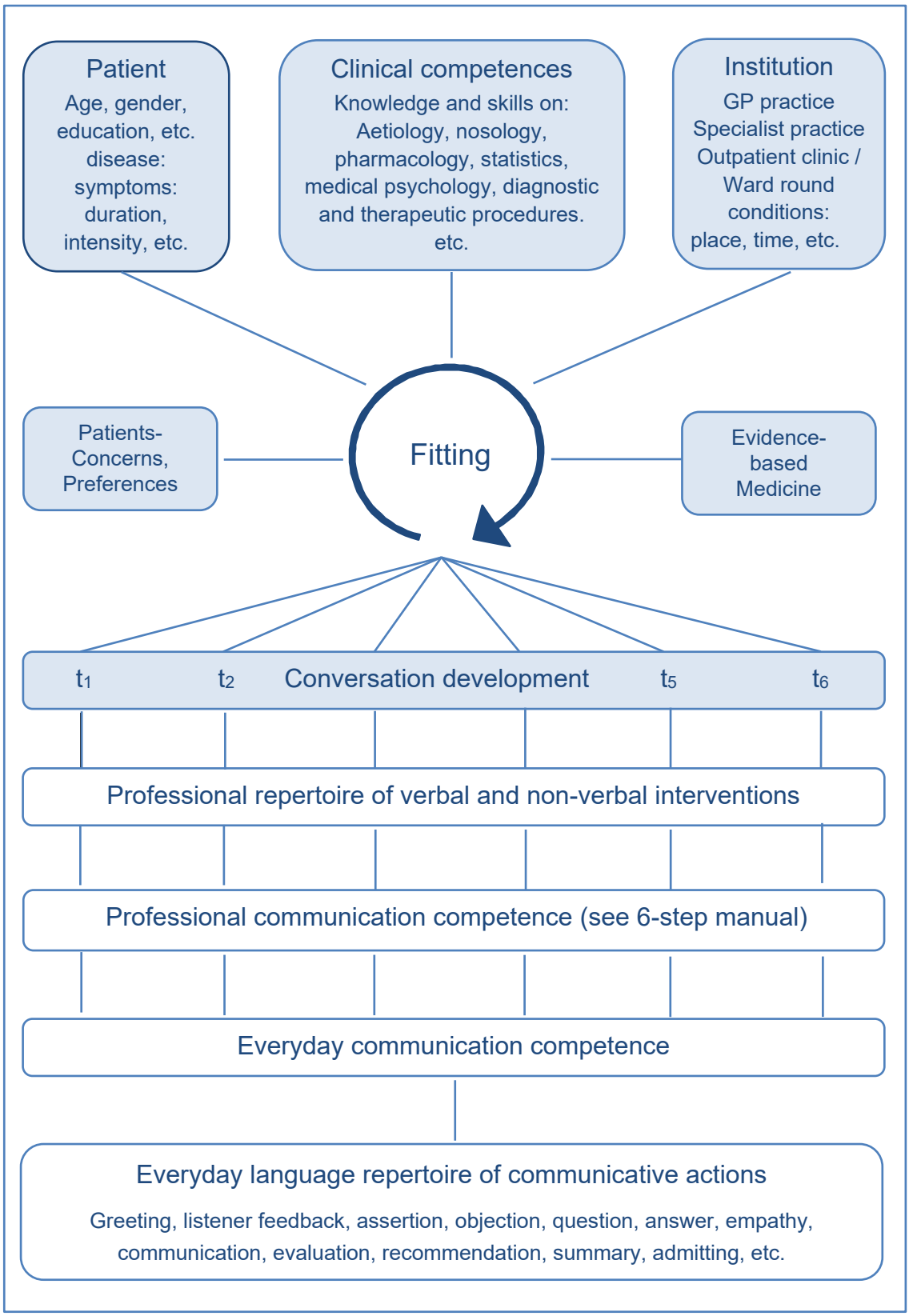

Fig. 3.6: Fitting model of key medical competencies

In the following explanations of the fitting model, we will refer to further chapters on specific topics in which specific fit problems are dealt with. At the center of the model (Fig. 3.6) is the doctor's fitting *competence*, which in a concrete, i.e. *individual* patient case must mediate between the various doctor competences on all sides and put them in a suitable relationship. Metaphorically speaking, doctors must be able to "bring together" all their *cognitive*, *instrumental* and *communicative* competences in a *case-specific manner.* This can only be done from a superordinate *meta-perspective* in which the interplay of all medical competences is reflected and appropriately coordinated in practical action in cooperation with this individual patient.

3.3.2 Self-reflexive meta-competence of a meta-doctor

In its mediating function, the medical *fitting competence* is to be understood here as the specific *meta-competence* of a *meta-doctor.* We use the concept of the *meta-doctor* in the sense of v. Uexküll and Wesiack (1991), who present their concept of the *meta-doctor* in their final consideration of the "Theory of Human Medicine" (Box 3.9), according to which medical action should be continuously placed under critical-reflexive self-observation.

Box 3.9 Critical-reflexive self-observation of the meta-doctor

To conclude our efforts towards a theory of human medicine, we want to describe the imaginary journey that a (...) doctor takes in the course of interaction with a patient. The travelogue is meant to record the reflections with which the doctor - to a certain extent as his own observer - we want to call him his *meta-doctor* - accompanies and comments on his sensations, findings, reflections, decisions and actions. The report begins with the greeting of the patient and ends at the moment when both say goodbye to each other. It is about the attempt to build a reality that is accessible to both doctor and patient (...).

von Uexküll, Wesiack 1991: 649f

We will take up the idea and concept of the *meta-doctor*, who critically reflects on his or her own medical practice "as his or her own observer", above all in the justification of our didactic approaches (§ 6.4, 13-14, 17), in which self-reflexive observation is an integral part of conversa-

tion training. There, too, it will be a matter of imparting a *fitting competence* that is to be developed in the critical-reflexive observation of self and others from the perspective of a *meta-doctor* who can "watch over the shoulder", as it were, of the "original" events between doctor and patient *as* they act (sic) (Fig. 3.7). The observation can take place directly or also "offset" via the "medial diversions" of conversation recordings (videos), in which the "cliffs of conversation" often become abundantly clear. Later (§ 6), a distinction will have to be made between observations of different orders, in which the communicative competence from the observation perspective can also be carried out "in retrospect" by several observers from a common learning group, also under the guidance of an expert (lecturer, supervisor).

What is to be promoted here in the training and further education perspective as critical *self-observation competence* of (prospective) doctors (§ 6.4, 13-17) should be permanently adopted and further developed as a *transfer* into the later conversation practice of "one's own" consultation hours and rounds. Thus, the doctor guiding the conversation should already be or her very first "critic" during the ongoing conversation, who subjects his or her communicative actions to ongoing self-monitoring and, if necessary, correction in the accompanying self-observation of a meta-doctor.

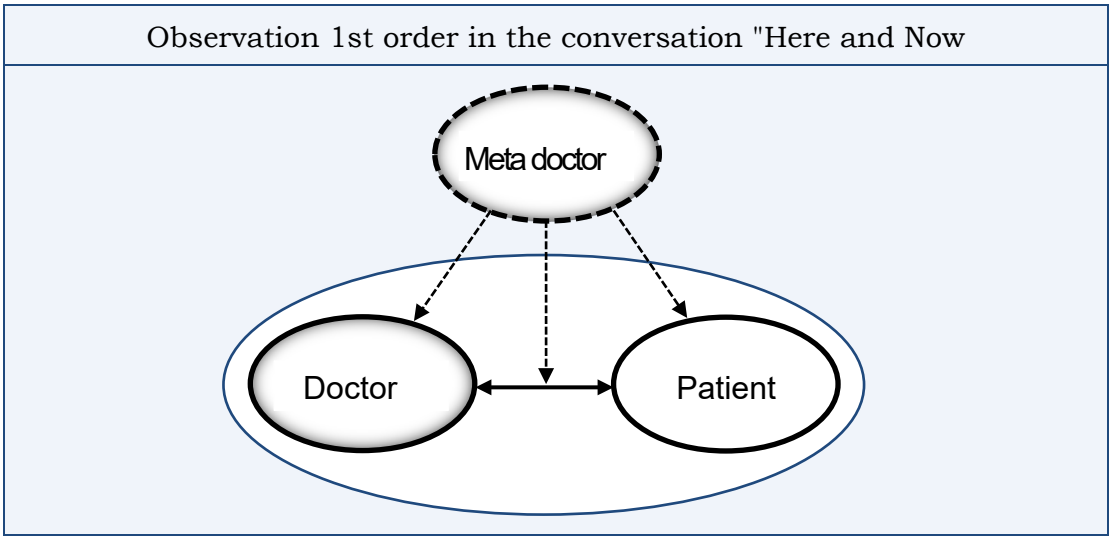

Fig. 3.7: Self-observation 1st order during the conversation

The differences between direct and indirect observations must be taken into account: What may initially be immediately "obvious" to the external (self-) or third-party observer (2nd order), for example, when watching a video, because it "jumps to the eye", may elude "one's own" direct

observation (1st order) when acting oneself. Nevertheless, through guided and spontaneous self-observation, a *change in attitude* can be initiated, with which the view of oneself and one's own actions can first be sharpened ("I interrupted again") and finally a change can be achieved ("I will continue to listen until the patient makes a clear pause"). Otherwise, the learning successes in conversation management as demonstrated in evaluation research would not be possible (§ 40-43). Since doctors in everyday conversational practice cannot escape the ongoing decision-making constraints vis-à-vis current conflicts of maxims anyway, they should be sensitised to the significance and scope of their routine actions, which are to be subjected to ongoing self-reflection in which the current relationship between the two interlocutors itself is put to the test.

3.3.3 Emotions and empathic competence

As already mentioned with the concept of the *meta-doctor* and as will be explained further, the ongoing *dialogue* always includes the ongoing dialogue *diagnosis,* with which the *development of the conversation* and at the same time the *relationship* is subjected to a critical assessment in order to be able to choose the appropriate continuation of the conversation in a well-founded way. If necessary, the current diagnosis of the conversation requires a reorientation in the further shaping of the conversation, which is always also a shaping of the relationship.

This connection between conversation and the development of the relationship, which we will be dealing with throughout the textbook, is particularly evident in the communicative handling of *emotions* and, if necessary, in specific *defensive behaviour on the part of patients*, which can put the relationship between doctor and patient to a particular test.

Thus, especially at the opening of the diagnosis in the case of severe illnesses, violent emotional reactions are to be expected, which can range from a "diagnostic shock" with freezing and silencing to manifest outbursts of fear or anger (§ 16, 38, 43). Here, the *empathic* competence of the doctor is particularly called upon (§ 20) to first stabilise the patient before his or her stresses in coping attempts can be sufficiently appreciated and acknowledged and finally his or her resources for *coping with the illness*, for example after a heart attack (Albus, Köhle 2017, Albus 2022) (§ 29), can be strengthened.

Emotional opening: Patient types

In this context, two groups of patients can be roughly distinguished according to their degree of *openness* towards (the verbalisation of) emotions. At first, the "empathetic" handling of patients who can *verbalise* their emotions (fears, anger, sadness, shame, disappointment, hope, apprehension, etc.) more or less *openly* may seem easier, because the doctor only has to *react* appropriately with his or her *empathic competence.* Thus, he or she must first merely record the emotions that are already "in question", which, however, must then be "worked on" constructively in further "emotional work" in cooperation with the patient. In this process, major difficulties and also setbacks may arise, for example, if an initially merely depressive *mood develops* into a manifestly *severe depression* in the case of a severe or even life-threatening course of the disease (§ 30), the necessary treatment of which may exceed the possibilities, for example, within the framework of basic psychosomatic care (§ 15, 24).

Compared to the more "open-minded" patients, the more "closed-minded" patients often prove to be more difficult because their emotions either cannot be "expressed" at all or only very indirectly and covertly. In the case of patients who cannot be said to "wear their hearts on their sleeves", all "signs" on various non-verbal and para-verbal (speech-accompanying) communication channels (§ 11) that may *indicate* possible emotions must first be perceived with empathic understanding competence: Nervous hand-wringing, evasive gaze, blushing, loud or soft, hectic or slowed speech, stuttering, etc. However, such "signs" are not yet "signs" in the sense of explicit, verbal communication.

Here the doctor will often first have to laboriously explore the "underlying" emotions of the patients, whom he or she must not "get too close to" for the time being if they are not to "close themselves off" completely. Such very "sensitive" and easily "offended" patients must first be met by the doctor with special empathic understanding and feedback during active listening ("ah!" "aha!", "really?", "terrible!"), before he or she gradually tries to "verbalise" the possibly underlying emotions in close cooperation with the patient (§ 20). In doing so, the presumed emotions should first be "addressed" from a *subjective* perspective of perception, which is also emphasised by the doctor ("my impression is ..."), before they can be "paraphrased" according to their tendency ("you fear that ..." or "you are worried about ..." instead of: "you are afraid of ...") and finally their "naming" and "clarification" becomes possible.

Particularly in the case of pronounced *defensive behaviour* (denial, rationalisation, etc.) on the part of patients, special empathy ("tact") is required, for whom overly "intrusive" interventions can be counterproductive (Fig. 3.8). Depending on the type of illness as well as the severity and course of the disease, however, there are different possibilities and obligations for guiding the conversation, which ultimately has to be decided by the *clinical* competence of the doctor.

From a clinical point of view, possible defensive behaviour on the part of the patient can not only be tolerated but even encouraged, as long as it does not become *maladaptive* (§ 29) (Albus, Köhle 2017, Albus et al. 2018). Defensive behaviour is maladaptive if, for example, the patient refuses the necessary treatment measures by *downplaying* or even *denying* the severity of the disease, or if his or her adherence to an indicated medication leaves much to be desired.

Confrontational versus tangential interviewing

Irrespective of this question of adaptivity versus maladaptivity of defensive behaviour, the patient must be supported and challenged in his or her *processing of the disease,* which may require repeated attempts at dialogue in the case of "difficult patients" (§ 34). In this case, the *art* of medical conversation (§ 17) consists precisely in the repeated *efforts* of ongoing conversations, which, despite all the initial "futility", can ultimately "pay off" in the successful "repetitive work" with the patient.

In the case assumed here as an example (Fig. 3.8), the doctor begins (t_1 - t_2) with *confrontational* interventions before switching to *tangential* conversation (t_3) and then returning (t_4) to *confrontational* conversation. In the further course (t_5) he or she switches again to a tangential way of talking, which he or she maintains for the time being.[8]

8 Cf. on the distinction between *confrontational* versus *tangential* interventions § 17, 20, 32, where empirical example analyses are also given. For further reading, cf: Rudolf, Henningsen 2003, Schäfert et al. 2008, Schedl et al. 2018, Stukenbrock, Deppermann, Scheidt 2021.

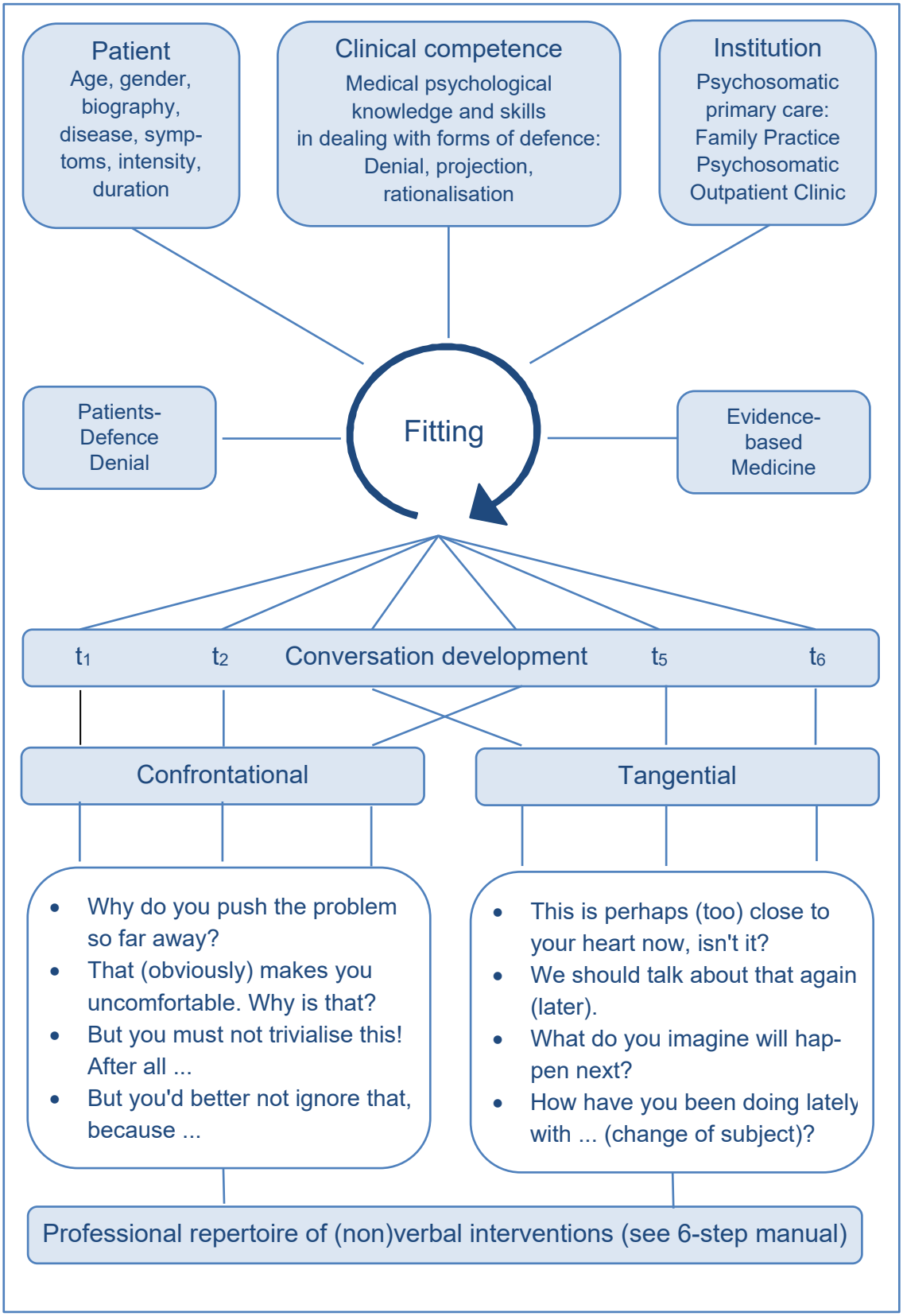

Fig. 3.8: Confrontational vs. tangential interviewing for defensive behaviour

What is presented here as a change in a single conversation can be transferred to a series of conversations with a development of conversation and relationship that is characterised by constant change and trial and error by the doctor until, for example, with a *key intervention,* which may well be *confrontational,* he or she finally achieves a breakthrough with which the conversation and the relationship take on a completely different, new quality.[9]

The spectrum of verbal interventions in confrontational versus tangential conversation ranges exemplarily (Fig. 3.8) from the *insistent demand* to clarify the patient's attitude to a "sensitive", emotional topic (more or less "intrusive") to the *radical change of topic* to be able to take away the current "sharpness" of the conversation when it threatens to become "unbearable" from the perspective of the patient's *subjective* experience of the conversation.

The change of topic often proves to be an "elegant", because particularly "economical" solution to an impending conflict, because it does not have to make it a topic and the change of topic itself is usually accepted "without resistance". However, his or her potential for conflict resolution or at least conflict minimisation can not only serve the current "satisfaction of the conversation" in the sense of "sparing" the patient (*altruism*) but can also be used for "self-sparing" by the doctor him or herself (*egoism*). In this function, the doctor can "avoid" a possible escalation of conflicts with an elegant change of topic, for example by "passing over" "disturbing" questions of the patient, which could favour an emotional conflict topic, on his or her part with the change of topic. Both functions of the change of topic will have to be worked out in detail in empirical conversation analyses, for example using the example of ward round communication (§ 24).

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9 The relevance and scope of key communicative interventions for shaping conversation and relationship has been studied in particular in psychotherapy conversation research (§ 2) (e.g. Stern et al. 2001, 2012, Ribeiro et al. 2011, 2014, Gonçalves et al. 2011, 2013, Buchholz, Kächele 2017, Buchholz 2022). Here, attention has been drawn to particular, innovative conversational moments of change ("now moments", "innovative moments", "narrative change", "meaning transformation" etc.), with which a new conversational and relational quality emerges, to which we will return separately (§ 9, 17, 19-20, 24-25).

Topic change and silence

In an interim assessment, it can be stated that the change of topic is a first source of study for self-reflective conversation and relationship diagnosis from the internal as well as external perspective of a meta-doctor (§ 3.2.2). After all, with the change of topic often not only small but large switches are made, in which conversations can develop in very different directions. Because the motives, reasons and consequences of changing topics can be quite different, it is worthwhile to observe them from the perspective of evaluating whether they are an expression of communicative *competence* or *incompetence,* which should not exclude gradual, differentiating or modifying assessments. This is made clear by the different opinions of participants in a training group (E 3.1), in which a video sequence from a consultation session became the focus of attention:

E 3.1		*Must* or *Can* or *Omit*?
01	A	I should have asked further.
02	B	Maybe you could have, but not necessarily should have.
03	C	Definitely not! Who knows where you would have ended up if you had dug deeper and what effect it might have had on the patient.
04	D	Nothing comes for free, after all!

Obviously, communication is a risky business that has its price, also or especially in medical consultations. Often there are equally good or equivalent alternatives for action - a problem that communicative action often has in common with "other" medical action. Thus, conservative and surgical measures can also be "real" alternatives, just as "*watchful waiting*" can be useful in decision-making within a certain time window (§ 10).[10] Analogously, further questions versus changing the subject are not the only alternatives that can "cause headaches" in the medical conversation, but "omissions" in the form of silence are also not a "panacea" if it turns into "awkward" silence. Such silence can also be experienced by the patient as "threatening", as if both partners, including the expert, no longer want to think of anything. The doctor's mere *listening*

10 On various forms and functions of silence, cf. the volume by Dimitrijević, Buchholz (eds.) (2021) ("Silence and silencing in psychoanalysis"), in which many empirical examples are analysed. Cf. also the empirical communication analyses on GP practice and ward rounds (especially in § 17-25).

skills come to nothing here if the persistent "lull in conversation" is experienced as unproductive and can no longer be interpreted as a pause for thought, etc. Here the change of topic is often a chance for a new beginning, to "get talking" again, etc.

As we will see in detail, there are no patent solutions in the sense of a schematic application of a manual (§ 17) for the guidance of the conversation, especially when dealing with the *defensive behaviour* of patients. The decisive factor here is the doctor's *relational competence*, with which he or she must assess the current state and resilience of the relationship and decide which "sensitive" issues are *acceptable* to the patient here and now - and what remains *unacceptable* at present.

3.3.4 Relationship competence and guiding conversations

In order to grasp the risks of the communicative handling of patients' defensive behaviour, the doctor needs a general *relational competence* with which to balance the current state of their joint relationship with regard to its further *viability*. Such a relationship balance sheet ultimately includes all joint activities, ranging from the greeting in the first encounter to possible follow-up conversations to current conversation situations. Here, both partners can have a concrete experience competence in dealing with each other, which they can at the same time use to form expectation *patterns* on how their relationship is "best" to continue. Both partners are no longer "blank slates" for each other but can meet each other as persons in whom they have developed a more or less pronounced *trust* (§ 8), which is already more or less resilient.

From the doctor's point of view, the *personal bond with* the patient can already be used for professional purposes of a relationship diagnosis, which essentially refers to *transference* and *countertransference processes* (Thomä, Kächele 1989, Wöller, Kruse 2018, Remmers 2023). In the case of advanced interaction histories, which can already range from the first taking of anamnesis to the first clarification and decision-making conversations to the determination of further examination and therapy steps (§ 8), the doctor can already refer to a concrete experiential competence in dealing with this concrete patient. He or she has got to know this patient as a sick, suffering person with these personal characteristics and peculiarities and these specific emotions (fears, anxieties, hopes, etc.), current concerns, interests and expectations with these individual likes and dislikes, which refer not least to him or her as

a doctor acting, to whom *paternalistic* or *service-providing* or *partnership* roles, etc., are offered as relationship patterns (§ 10).

The reasonableness rule

Faced with the totality of the relationship patterns proposed or rejected by the patients or even just ambivalently tested, doctors for their part have perceived their own positive as well as negative emotional reactions (sympathy, antipathy, benevolence, helplessness, disappointment), which they seek to use in ongoing conversations in a controlled way to further shape the conversation. In the process, the doctor as a meta-doctor (in the above sense) has been able to perceive various opportunities in the ongoing conversation and relationship diagnoses not only to *recognise* the limits of what is "reasonable" for this patient, but also to sound out the validity of these limits again and again with a *flexible* shaping of the conversation and, if necessary, to expand them. In this way, the expansion of the limits can be achieved precisely through a change from a rather *tangential* to a more *confrontational* form of conversation, with which the patient is encouraged to gain new insights into "sensitive" topics, which help to open up further perspectives for thought and action in his or her individual life world.

Although the differences between *everyday communication*, a doctor's *consultation* and a *psychotherapy session* will have to be worked out in more detail, a general "rule of reasonableness" applies here and there (Koerfer 1994/2013). According to this, we have to maintain certain limits of what is personally *reasonable* towards our conversation partners, which may only be extended under certain, consented conditions, for which a mandate is usually required. This mandate is usually given tacitly when the patient enters the medical consulting room, but can also be questioned, modified or re-ratified from case to case if new developments arise regarding the state of affairs and the relationship.

While it is frowned upon in everyday conversations between neighbours or in work conversations between colleagues for good reasons (not least reciprocal self-protection) to openly express "deeper" psychological motives, motives and intentions of our interlocutor or even to "interpret" his or her behaviour (in the psychoanalytical sense), these restrictions between patient and doctor/therapist tend to be overcome, even if this is not to be done with "brute force" but with all "caution".

Thus, it is precisely the sense and purpose of psychotherapy to successively expand the limits of what is *reasonable,* i.e. not "without consideration of losses", but "with consideration" for the patient and step by step in cooperation with him or her, in order to promote his or her process of self-knowledge in the sense of helping him or her to help him or herself (§ 8). This general objective also applies in a modified form to the medical consultation and ward round, even if the "helping" purpose of the conversation can only fully unfold through further instrumental actions (surgery, medication) that have already been "discussed" in the consultation.

Timing of interventions

Although perhaps at a different level of the *helpful* relationship (Luborsky 1988, Street et al. 2009) (§ 8), *defence-related* conflicts between doctor and patient also arise in the everyday practice of patient care. Even if in a moderate form, the *rule of reasonableness* applies here analogously to the psychotherapeutic conversation, in which the doctor or therapist must wait for or actively create a *degree of maturity* in the development of the conversation as well as in the patient in order to be able to place his or her (psychoanalytical) *interpretation* appropriately (Koerfer, Neumann 1982, Koerfer 1994/2013). An interpretation, no matter how accurate, would be rather counterproductive if it came at the "wrong time":

Box 3.10	Timing for interpretation

In order to listen to the way the patient hears us, restraint is also required, equal attention. This enables better and better *timing* for the interpretation. We know that the best interpretation is of no use if it is given too early - then it mainly creates resistance or even confusion.

Heenen-Wolf 2014: 95

Due to his or her possible resistance, the patient might not only not "accept" a too early interpretation, but possibly not even "take it in", because it would still overtax him or her cognitively, because emotionally, at the current stage of development. In cases of conflict, where there is a risk of too early an interpretation, the maxim of *relative relevance*

should be followed, as formulated by Albus et al. for dealing with patients with somatoform disorders:

> "Relationship building comes before interpretation"
> Albus et al. 2018: 398.

Although this maxim was formulated specifically for the communicative handling of patients with somatoform disorders, who tend to break off contact early on due to their often pronounced tendency to feel offended and skepticism (§ 32), it can be generalised as a *meta-maximum,* according to which the relationship should be given priority in case of doubt, for the everyday care practice of the doctor. Even in daily consultations and rounds, the doctor needs an ongoing diagnosis of the relationship in order to master the *balancing act* between *under-* and *overtaxing* the patient and thus to ensure the further *development* of their mutual *relationship* (§ 17). The doctor's choice between more *confrontational* or more *tangential* continuation alternatives, as contrasted above (Fig. 3.8) and described in terms of their function, is always also about creating a "sustainable" relationship with the patient him or herself.

The *sustainability* becomes particularly apparent in latent to manifest defensive behaviour because the relationship itself can be in particular danger if the patient, who is distressed by confrontations, "in his or her distress" already goes into "inner resignation" during further cooperation or even actively seeks to break off the relationship. In the final analysis, the doctor must master a conflict of maxims between *breaking off the relationship* and *breaking off the topic*, which he or she usually tries to "defuse" in the "short term" by guiding the conversation in a tangential manner, before, if necessary, taking up the "delicate" topic (§ 20, 21) again at a later, more appropriate time in the development of the conversation and relationship, which then seems sufficiently *mature for* "greater" *impositions*.

Fitting competence in defensive conflicts

Overall, in a *defence-related* conflict situation, the *fitting competence* as a meta-competence of the doctor is particularly challenged, because here the *clinical competence,* according to which, for example, the patient would "reasonably" have to urgently change his or her "self-damaging" illness behaviour (nicotine, alcohol abuse, unhealthy diet,

lack of exercise, etc.), has to be put into a suitable relationship with the relationship competence, according to which the patient must not be overburdened with a *regime* that is "unrealistic" for him or her, as he or she would otherwise terminate the relationship as too threatening. Metaphorically, this can be described in such a way that the relationship would be increasingly "overstretched" if the expectations of the patient's health behaviour were too "high".

As already explained (§ 3.1), in conflicts of maxims of this kind, as elsewhere in medicine, individual *case-by-case examinations* must be carried out, i.e. the doctor must always enter into individual negotiation processes and from case to case, i.e. from patient to patient and from moment of conversation to moment of conversation, sound out what is still "reasonable" here and now or what is already no longer "reasonable" because the defensive behaviour is already too strong.

In order to master the precisely fitting balancing act of *well-dosed* intervention, which avoids both under- and overstraining the patient, the doctor's *fitting competence* must mediate between different cognitive, psychosocial and interactive competences, which must work together in the guidance of the conversation (Box 3.11): For example, the doctor must not only be *familiar* with the relevant *forms of defence* (denial, rationalisation, etc.) in principle through knowledge competence, but must also be able to *recognise* them as such in concrete conversation with the patient and *assess* the remaining *scope for action* that is still "reasonable" before reacting communicatively in order to prevent an intensification of the defensive behaviour or even the threatened breakdown of the relationship.

Box 3.11 Clinical-communicative competences in defensive behaviour

In the mode of self-observation in guiding medical conversations, doctors must continuously carry out a relationship and conversation diagnosis in which they recognise the psychodynamic risks of certain types of conversation continuations in the interplay of their *clinical* and *professional-communicative* competences and *react appropriately* to them. For example, in the case of potential to manifest *defensive behaviour* on the part of the patient, they must

- *know* the different forms of defence (denial, projection, rationalisation, etc.) due to their specific *clinical* competence and
- *recognise* the specific forms of defence in ongoing verbal and non-verbal interactions based on their communicative *understanding*

competence and
- Based on their *relational competence, assess* the limits of what is "reasonable" and if necessary
- *act* accordingly due to their communicative *formulation competence,*
- by changing from a more *confrontational* questioning technique to a more *tangential* interviewing technique (§ 17),
- to *avoid reinforcing* the defensive behaviour of a patient (offended, hurt, overstrained, etc.) as the *objective* of the action and to stabilise the relationship.

Finally, to convey the skillful interaction of all medical competences in a problem-oriented and practical way in teaching and further training, especially in the case of defence-related conflicts, is itself a "didactic" challenge that can hardly be reduced to the transmission of merely manualised *textbook knowledge.* As will be explained, the effective interaction of the necessary individual competences can only be learned in the alternation of teaching, practice and examination with simultaneous unity, in which the self-reflective meta-competence of (prospective) doctors is to be promoted (§ 13-17). What may still go "unnoticed" in practice can emerge clearly in retrospect. In feedback procedures, for example, video recordings can be used to make "visible" what previously remained "hidden". Here, for example, additional *non-verbal* phenomena come into view (§ 12), which can also be interpreted as signs of defensive behaviour (Scheflen 1976, Streeck 2004), but which had escaped routine observation as "dismissive" body or head postures or "eloquent" silence.

The sensitive moment when a patient's willingness to talk and discuss is still present threatens to turn into a defensive attitude must be determined for both the ongoing and the subsequent diagnosis of the conversation. The "critical moment" for a change from a confrontational to a tangential way of guiding the conversation is not infrequently "missed" in the practice of conversation. Since we are all "wiser" in retrospect, it is often not surprising when doctors in the further training of a Balint group (Koerfer et al. 2004) (§ 15), for example, are able to determine exactly when the patient has "finally shut down" or "walled him or herself in" or "hedged in" or "withdrawn", etc., when they watch a video of their own conversations which seems to have escaped their observation *during* the conversation. As has been shown in evaluation studies (§ 40-43), *trained attention* to one's own conversation behaviour

and that of one's partner can bring about not only a short-term change in attitude but also a long-term change in the way one guides conversations, especially in dealing with specific emotions or forms of defence on the part of patients.

3.2.5 Educational and decision-making competences

It is not only in the case of the concomitant reflection of emotional and defensive processes that *clinical* and *communicative* competences must interact productively. In the critical self-observation perspective of the meta-doctor, there are constant *correspondences* between the guidance of the conversation and the "other" medical actions. Thus, even during a good anamnesis, the doctor will already come to a tentative diagnosis, the clarification of which he or she will try to pursue in the conversation before proceeding to the physical examination, initial diagnosis or therapy, the planning of which can already be developed in the ongoing conversation and "discussed" with the patient.

Likewise, further diagnostic and therapeutic steps are taken after and in further conversations in cooperation with the patient, so that a long *joint history of interaction* (§ 8) can develop between doctor and patient, in which *communicative* action enters into an alliance with instrumental action (examination, laboratory, operation, medication, etc.), which in the ideal case can contribute to the recovery or improvement of the patient. However, the doctor and patient do not enter into this alliance of *communicative action* with *instrumental* action alone as individuals in a purely *dyadic* relationship, but there are "third" players and instances that "project" into this relationship. This also includes the professional medical knowledge itself, codified in guidelines, for example, which in turn falls under the special responsibility of the doctor to convey appropriately in conversation, whose professional-communicative double competence is particularly challenged here.

In order to grasp these challenges of medical action as a whole, attention must not only be directed to the complex *interplay* of the specific *communicative* competences (of *listening, understanding*, *questioning*, etc.) distinguished above (Box 3.6), but also to the connection with further, specific *clinical* competences which the doctor must already bring to bear communicatively in the guidance of the conversation before the first *instrumental* medical action (physical examination, medication, operation, etc.) can even take place (§ 8). These *clinical* competences in-

clude all *knowledge competences* (Fig. 3.1), such as those taught in the medical education and training system as *aetiological, nosological*, *pharmacological*, *diagnostic* knowledge, etc., which in turn must meet the current standards of *evidence-based* medicine (§ 6, 10).

These professional standards determine and at the same time limit the institutional scope of action, the limits of which doctors and patients must jointly accept in their dialogical understanding, for example in decision-making (§ 10). Put casually and with different metaphorical perspectives: Communication between doctor and patient is "overlaid" or "underpinned" by evidence-based medicine (Fig. 3.8), in that doctors, for all their *individual decision-making competences,* follow their (specialist) specific *guidelines* (§ 5, 10), in which their professional knowledge is codified.

With recourse to the *understanding* and *formulation competence* of doctors, the corresponding *everyday practical* "recoding" for the hitherto mostly "ignorant" patients then takes place in the practice of conversation, who will have to "learn to live" with their new knowledge about their illness and its treatment options in their everyday life. What is important here (in the sense of Mishler 1984) is communicative mediation in the *conflict* between the *lifeworld* and *medicine* (§ 7, 10), which presents both partners with special challenges of *understanding.*

Doctors can meet these challenges with a *dual competence* that they can use *synergistically,* so to speak: Because they have both *lifeworld* and *professional* competence in communication, they can anticipate and perceive the specific understanding problems of patients and provide the corresponding translation services that are necessary to bring patients to the "appropriate" level of knowledge for them. Here, the doctor must master the tightrope walk with general *educational competence in the appropriate dosage* for this individual patient, avoiding both *underdosing* and *overdosing* of information, which must also be conveyed with specific *formulation competence* in the patient's language (§ 7, 10, 26, 27). A prototype for the communication service to be provided by the doctor here is *risk communication* (Box 3.12), because here a particularly large number of doctor competences must be applied in a bundled manner in order to achieve, for example, an appropriate risk understanding among patients for their diseases and treatment options.

Box 3.12 Medical competences in risk communication

Risk communication brings together a particularly large number of clinical-statistical-communicative competences (Elwyn et al. 2005, Steckelberg et al. 2005, Gigerenzer 2013, Wegwarth 2013), which doctors must communicate skillfully when talking to patients:

- Specific *clinical* knowledge competences on a particular disease pattern and the associated risks in treated and untreated disease courses.
- Specific *clinical* knowledge skills on treatment options and their risks
- specific *risk competences* (statistical competences) in dealing with *relative* and *absolute* risks (for diseases, (preventive) examinations and treatment methods, etc.)
- Specific *comprehension competences* to anticipate and control possible (mis)understandings of facts and figures.
- Specific *formulation competences* to illustrate relative and absolute risks in a patient-friendly way using a mix of figures, charts, tables, fact boxes, etc.
- specific *empathic* competences, for example when certain (life-)threatening risks as well as "number confusion" lead to emotional-cognitive blockades in the patient, etc.

Well-dosed information in the language of the patient is an elementary prerequisite for the promotion of patient autonomy, which in turn is an integral part of a self-determined decision. However, this decision should not be made "unqualified" just because the medical information was incomplete or the patient "broke off" because it became "too much" in the meantime. The necessary qualification of the patient is part of the medical *information* and *decision-making competence* in so far as the doctor not only has to make the right choice from the treatment alternatives for this individual patient "in accordance with the guidelines" and explain these options to him or her, but also has to organise the decision-making process in cooperation with the patient in such a way that ideally the jointly made decision is sufficiently mature to be able to expect a certain guarantee of continuity in the long term (Koerfer et al. 2008, Koerfer, Albus 2015). The *first best* decision will not always prove to be the *ultimately valid* decision if the process of *deliberation* (§ 10), in which everything that is doubtful and worthy of consideration should be

thematically addressed, could not be developed to a consensual and mutually satisfactory end, i.e. the process of clarification and decision-making has not found sufficient "saturation".

In this process, the communicative sources for the development of relationship problems will again have to be eliminated, if, for example, patients agree to a treatment measure (medication, surgery, etc.) not out of *conviction* but out of *"confusion"* (*confused consent)* (v. Uexküll 1987: 125). With such "consent out of confusion", (mutual *trust* in) the mutual relationship between doctor and patient would possibly already be fundamentally disturbed, even if the "consequential damage" should only become manifest later, for example with non-adherence on the part of the patient.

In the case of ideal *transparency* of medical action in information and decision-making, the "responsible" patient can *benefit* in his or her own way from *professional knowledge* if he or she is *adequately informed* about the treatment options in participatory decision-making (§ 10, 26, 27). Without turning the patient into a second doctor, this is ideally a *transfer of competence,* where, for example, the doctor's risk competence leads to the patient's risk competence. The doctor helps his or her interlocutor to become a "mature" patient, because he or she is *capable of making decisions,* who in turn is sufficiently competent, for example, to develop "resilient" preferences in the case of an *equivalence* ("equipoise") of treatment alternatives that *fit* his or her *individual* reality. Only when these preferences of the patient remain recognisably stable can the two interlocutors jointly come to a "sustainable" decision that can withstand a "rational" examination from the *two* perspectives of *patient-centred* and at the same time *evidence-based* medicine in the long run.

3.3.6 Professional knowledge and action competences

As *knowledge competences,* the clinical competences of the doctor usually precede the communicative action competences, although knowledge - in everyday life as in medicine - can also be gained as experiential knowledge when acting.[11] In this respect, *knowledge* and *action*

[11] For perspectives on the sociology of knowledge and the profession, especially in institutional communication, reference is made here to Ehlich, Rehbein (1977) and Koerfer (1994/2013) as examples. When "clinical" competence is mentioned below, it is usually in the sense of medical com-

can often be seen as two sides of the same coin. Otherwise, neither in everyday life nor in medicine could a unity of *teaching* and *practising* be established.[12] Nevertheless, problems and discrepancies between knowledge and action can occur when the *fit* of different competences is *missed* in practice. The variety of possible "failures" cannot be systematically differentiated here by a *typology* of omissions, misapplications, misexecutions, etc., but can only be presented in exemplary cases summarised under the concept of *failure*.

Thus, even in the purely *instrumental* actions of doctors, "failures" can occur if, for example, the professional knowledge competences (of surgeons, orthopaedists, internists) are not or only suboptimally implemented in physical examinations, operations, medications, etc. Here, the spectrum ranges from omission or incorrect measurement (e.g. of blood pressure) to incorrect diagnosis to incorrect dosage of medication, etc.

Likewise, "failures" can occur in *communicative* action if, for example, a doctor gives inadequate information about the dosage in the *prescription conversation* (§ 26) despite his or her clinical knowledge about the medication, and the patient then subsequently gives the wrong dosage because of the lack of information. Similar mismatches between *clinical* and *communicative* competences can arise in the case of a doctor who is familiar with a certain clinical picture "as such" due to his or her medical knowledge competence, but who does not ask about the known *accompanying symptoms* during the detailed exploration (§ 21). If necessary, this omission can have serious consequences (e.g. misdiagnosis) and thus constitute an equally "serious" omission. In this case, it is a matter of inadequate, deficient implementation of professional knowledge in interview practice.

Another type of "failure" in communicative action occurs when the doctor - possibly even "against his or her better judgement" - asks an information question in an "inappropriate" form, as in the following empirical example (E 3.2), by formulating it suggestively.

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petence (in the narrower sense). It should be clear that the communicative competence of doctors should first and foremost be understood as clinical competence (in the broad sense). For further differentiation we will use the terms "communicative everyday competence", "professional communicative" and "clinical competence" (in the narrower sense).

12 Our own didactic approach to communication training (§ 13-14) attempts to use precisely this connection and to combine *communication knowledge* with *communication competences* in the unity of *teaching* and *practice.*

E 3.2		"Appetite is normal for you?"
01	D	hm. appetite is normal for you?
02	P	yo, it's normal.
03	D	nothing has changed there either?
04	P	no, nothing has changed.

A characteristic of suggestive questions is that the questioner does not keep the expected answer largely open, as in the case of so-called decision questions ("Is .. normal?") or supplementary questions or word questions ("How is ..."), but more or less clearly indicates his or her expected answer, as in the preceding example. Regardless of whether the doctor violates his or her communicative competence here or whether he or she "does not know better", i.e. does not have this specific *formulation competence* in the first place, with the "inappropriately" formulated question he or she even gets him or herself into a longer-term interactive fitting problem because he or she cannot be sure of the *authenticity* of such a "suggested" patient answer, which can be momentous for the further interaction: In this case, there might even be a serious "malpractice" in the guidance of the conversation, because the opportunity to discuss the "delicate" topic of a "non-normal" eating habit after a suggested "normality" of the appetite would be blocked for the time being - with fatal consequences, for example, in the case of an eating disorder, which patients like to deny anyway. In this case, the "faulty" conversation would form an "unholy" alliance with the patient's defensive behaviour.

This example and possible "fitting" alternative formulations as well as other examples with similar fitting problems will be dealt with in detail in the practical part and therefore here we will only refer to the perspective of a *comparative* conversation analysis (§ 2, 40), which can be reduced to this denominator: From the obvious "failures" of communication we can infer the positive to ideal cases in which the doctors' knowledge and action competences "fit" well with each other.

3.3.7 The "ideal" conversation of the competent doctor

This "appropriate" interaction of *all medical* (types of) *competences*, which we will return to separately (in § 6) with further differentiations

as *key competences* of the "good doctor", proves to be highly complex insofar as the *communicative competences* of the doctor are specialisations of *lifeworld competences* which only fulfil their function in interaction with the specific *clinical competences in* the sense shown. The competent doctor uses the forms of everyday communication (Fig. 3.6), which he or she *specialises in listening*, *questioning*, *sharing*, *evaluating*, *communicating*, *explaining*, *suggesting* etc. in the patient conversation for professional communication purposes. In doing so, he or she refers to his or her *medical* competences, which he or she brings to bear in the conversation in a *case-specific way.*

In summary, the competent doctor must have a number of *key competences at his or her disposal* which, in the ideal case of application (performance), he or she adapts to changing conversational conditions in a combined, context-sensitive and creative way (Box 3.13). In order to perform this adaptation, the competent doctor must develop a fitting competence as a self-reflective meta-competence that allows him or her to continuously monitor the conversation in the mode of critical self-observation and make any necessary corrections.

Box 3.13 Fitting of key medical competences

Overall, doctors must have a range of key competences and be able to adapt these to changing (social, cultural, individual, disease-specific, etc.) conversational conditions in practice in a *combined*, *context-sensitive* and *creative* way with their self-reflexive *fitting competence:*

- Medical fitting competence
  as a self-reflexive meta-competence
- Clinical competences for
  - Aetiology
  - Nosology
  - Pathogenesis
  - Statistics
  - Diagnostics
  - Therapy
  - etc. for internal, psychosomatic,
    orthopaedic, gynaecological, etc. diseases
- General communication competences for
  - Relationship building
  - Anamnesis
  - Provision of information (education)
  - Decision-making

- Specific communication competences
  - Listening competence
  - Comprehension competence
  - Questioning competence
  - Formulation competence
  - Empathic competence
  - Intercultural competence
  - etc.

A doctor who is "optimally" equipped with these competences is certainly an ideal-typical construction, behind which the conversation practice of real doctors will often fall short. Just like the idea of the "good" doctor, which we will explore separately with an empirical study (§ 6), the idea of the "good" conversation will also have to be assumed counterfactually in order to gain a normative basis for the evaluation of conversations and the promotion of communicative competences.

Cases of more or less successful fits will be discussed in detail in the practical part using the interview steps of our manual (§ 18-23). To illustrate the variety of ideal *fits,* the following ideal-typical formulations of the interplay of the key competences are to serve here for different phases of conversation and purposes of conversation, ranging from the taking of *anamnesis* to *clarification* and *decision-making* (§ 8-10), in which a "particularly" competent doctor is assumed who, like the "good doctor" (§ 6), has all the necessary key competences which he or she optimally applies. However, the possible "failures" in the practice of conversation must also be considered in *contrast,* because the conflicts of maxims outlined above cannot always be solved as optimally (as assumed here):

- **Letting people tell and listening:**
  Especially in the beginning, the competent doctor will "let the patient have the first word". For the purpose of taking an initial history, the doctor, as a listener, will first let the patient *tell* him or her in detail (§ 9, 19) and support him or her by active listening (§ 19) in order to learn something "unfiltered" and in the patient's "own words" about his or her concerns, complaints, subjective ideas about illness, emotions (hopes, fears, etc.), preferences, etc.

- **Understanding and comprehension questions:**
  The patient can count on good comprehension competence from the competent doctor because he or she is used to (help-)seeking (vague to unclear) patient formulations in everyday language (descriptions of complaints, pain, etc.) and can deal with them routinely. In this context, the competent doctor interrupts the patient with a question of understanding (§ 19) only "in the meantime" in order to eliminate serious ambiguities, because he or she cannot "leave it" like that qua clinical competence and must clarify it in time for *clinical* reasons (sic) before the ambiguities accumulate disproportionately.

- **Detailed questions on the acquisition of information:**
  In the same way, the competent doctor, when there is a "suitable" opportunity, which should "best" arise from the patient's descriptions and narratives, uses his or her *questioning competence* to refer to his or her *medical* competences by enquiring, on the basis of his or her specific knowledge of a certain clinical picture, for example, during the anamnesis in a non-suggestive form (sic) about possible *accompanying symptoms* and further details (§ 21) (duration, intensity, etc.) of the illness.) of the disease in order to fill information gaps left by the patient for whatever cognitive, social or psychological reasons (forgetting, shame, repression, denial).

- **Emotions and empathic feedback:**
  Based on his or her *clinical* knowledge and experience competence, the competent doctor can anticipate the specific emotions (fears, anxieties, etc.) of patients, for example before operations or serious courses of illness, and react to corresponding expressions with his or her *empathic* competence and give corresponding verbal or non-verbal empathic feedback (§ 12, 20). On the other hand, he or she can anticipate patient-sided forms of defence (denial, etc.), which he or she knows on the basis of his or her *clinical* knowledge competence, in good time with his or her relational competence and *perceive them* with his or her *understanding competence in relation* to the patient's factual verbal and non-verbal conversational behaviour (§ 12). In this case, the competent doctor will in turn, based on his or her relational competence, provide the appropriate dosage of the "reasonable"

and, based on his or her communicative *formulation competence,* continue the conversation with cautious, i.e. above all *non-confrontational,* follow-up questions in the sense of a "tangential conversation" (§ 17.3) in order not to further strengthen the patient's defensive behaviour and not to endanger the relationship itself.

- **Education, risk communication and decision-making:**
  For competent risk communication with the patient, who should be adequately *informed* about the benefits and risks of a medical intervention (surgery, medication) or its omission, doctors must have *statistical competence* appropriate to the medical "state of affairs", which is not always self-evident (§ 10, 26). Medical knowledge of disease courses and treatment options (and their more or less frequent risks) is a very first clinical competence in decision-making - also or especially because the two decision-making partners often enough have to agree on "imponderables" and "uncertainties" by communication, etc. This is where the doctor's *comprehension* and *formulation skills* come into play again, because the communicative coordination in clarification as well as specific risk communication ("pictures" and "language" instead of just "numbers") and finally decision-making must not take place in a specialised communication (§ 26, 27), but precisely in the "everyday *language"* that is available to both interlocutors in a common *everyday world* as a common means of *dialogue* communication (§ 7, 10).

As has become clear with the cases of competent medical action assumed here and will be further illustrated later with empirical examples, the communicative *everyday competence* is and always remains the starting and end point of communication between doctor and patient, whose communicative mediation with (the factual state of) evidence-based medicine, however, falls within the professional-communicative double competence of the doctor. This is where the *translation competence* comes into its own as a special *fitting competence* of the doctor, who not only has to *understand* and *speak the language* of the patient (esp. § 27), but also has to bridge the (social, cognitive, emotional) gap between the *life world* and *medicine,* which we will come back to separately (§ 7, 10).

As will be shown, the professionalisation of everyday communication in medical conversation by no means represents its *simplification* or even *abolition*, but rather its *differentiation* and *specialisation* for specific medical purposes of anamnesis, diagnosis and decision-making, the dialogical forms of communication of which remain essentially fixed in our everyday language and everyday communication.

3.4 Conversation maxims and learning objectives

The formulation of *conversation maxims* also serves to formulate *learning objectives* that can not only be taught in teaching but can also be empirically tested in special procedures (OSCE), since they extend to observable conversation behaviour of students or (prospective) doctors. In order to ensure the unity of teaching and examination, we have developed a *Cologne Evaluation of Medical Communication* (C-EMC) in analogy to our *Cologne Manual on Medical Communication* (C-MMC), with which (exactly) what was previously taught is to be examined. Since this connection between teaching and examination is to be shown separately (§ 13-16, 40-43), we will limit ourselves here to the upstream connection between research and teaching. Here we can refer back to the status of interdisciplinary communication research already discussed in detail (in § 2), which is only to be taken up again here under the aspect of formulating general objectives of medical communication, as they have already been handed down as "classic" textbook knowledge on communication.

3.4.1 Formulations of the classics

Since it is seldom necessary to start from a tabula rasa in research (§ 2), we can also fall back on the preliminary work of the "classics" in the (preliminary) formulation of *general objectives* of conversation guidance, who for their part can refer to a great deal of experience in the sense of clinical evidence. Since Freud's writings on treatment techniques (1912 and 1913), the preliminary work of the "classics" - to name a few - in the last century has extended to the works of Karl Jaspers, Viktor v. Weizsäcker, Carl Rogers, Michael Balint and the founders of *biopsychosocial* medicine, to whom George L. Engel in the USA and Thure v.

Uexküll in the German-speaking world belong (§ 4). Before we return to their works under special aspects of "good" doctor-patient communication, this introduction will highlight just one work in particular because it so convincingly combines the theory and didactics of medical conversation with clinical experience in communicative interaction with patients.

In an excellent textbook, which can certainly already be considered a "classic", William L. Morgan and George L. Engel (1969/1977) described the "clinical approach to the patient" first and foremost as a communicative approach (§ 1.1), which is to be sought in the taking of the anamnesis before the physical examination or laboratory medicine can be meaningfully connected. In their chapter on taking the medical history, they introduce this communicative approach to the patient in a "masterly" language, with which they know how to convince above all because they can build on many years of clinical experience in communicative dealings with their own patients in their concrete explanations. Furthermore, not least from the perspective as co-founders of biopsychosocial medicine (§ 4), they succeed in didactically implementing the clinical experiences in a theory-guided reflection in such a way that they rightly claim in the subtitle the high standard of an "instruction for students and doctors".

Already in the first part of their textbook, they formulate all the essentials of what to do or not to do in doctor-patient communication. Even in modern research on doctor-patient communication, the wheel does not have to be reinvented again and again, but the previous achievements of the "classics" can be used productively.

We have therefore taken the liberty of condensing the aphorisms on the guidance of medical conversations scattered over more than 40 pages of text by Morgan and Engel (1969/1977) as verbatim quotations in a maximum catalogue (Box 3.14), which should also provide us with an initial orientation.

More than 50 years ago, the co-founders of biopsychosocial medicine achieved an advance that can hardly be surpassed in terms of accuracy, clarity and brevity. They formulated the objectives of good interviewing, the validity of which has been preserved up to the present day in modern methodological-empirical research from sociological, linguistic and clinical perspectives (§ 2). These maxims of the classics will accompany us repeatedly through the handbook and serve as an orientation guide, especially in the practical part (§ 17-23).

Conversation maxims

1. The doctor must *encourage* the patient to *speak freely*, because only the patient can *tell* him what he has experienced.
2. The *degree of guidance* needed is different for each patient.
3. The doctor must remain *flexible* when taking the medical history and adapt to the nature of the patient.
4. Neither should he allow himself to be passively swamped by numerous insignificant details, nor should he guide the anamnesis in the manner of a cross-examination.
5. The doctor must always start a topic with *open questions*. He uses *specific questions* only to fill in gaps, to remove ambiguities or to substantiate certain facts.
6. If possible, avoid questions that the patient can answer with a simple "yes" or "no".
7. A question must be easy to *understand*. It must *not influence* the patient's answer.
8. (The doctor) takes over the patient's expressions, at least until he understands what the patient means by them.
9. (He tries to) *link each question* to what the patient has mentioned.
10. So the doctor *picks up the thread* where the patient left off.

Box 3.14:
from: Morgan, Engel (English 1969; German 1977: 31-75)
(selection and emphasis ours).

Certainly, the generally applicable *gold standard* of medical interviewing has not yet been formulated in all its details, as the preceding interim assessments in the research have revealed (§ 2), in which differentiation is to be made between consensus and dissent, or even only doubts and reservations can be expressed or enquiries can be made. There is probably consensus on the first maxim (in Box 3.14), according to which the patient is to be "encouraged" (especially at the beginning of the conversation) to "speak freely", i.e. to let him or her "tell", for the good reasons that only the patient has the relevant experiential knowledge that the doctor must necessarily share with him or her, which is precisely the

point of the anamnesis conversation. We will come back to this under the aspect of the *(a)symmetry of knowledge* (§ 7, 10) as well as under the aspect of the *telling* of medical histories, which was especially taken into account with the development of a "narrative medicine" (§ 9).

However, as further research will show, there are still controversial aspects of good interviewing that need to be clarified. This includes the distinction between *open* and *closed* questions (§ 21.2), which Morgan and Engel also use. It will become clear that a maxim according to which questions that can be answered with a simple "yes" or "no" (Box 3.14: No. 6) are to be "avoided" as far as possible, is not always so easy to handle in practice (as apparently assumed by Morgan and Engel).

Which basic principles and maxims of communication between doctor and patient (in agreement with the "classics") can be regarded as clarified in detail, should still occupy us throughout this textbook, as well as possible problem cases where, for example, the "degree of necessary guidance" (Box 3.14: No. 2) can remain disputed in individual cases. Instead of concealing these problematic cases in the theory and didactics of medical interviewing, the doubts should be discussed *openly* between teachers and students in the sense of our *didactic* approach of *research-based* learning (§ 13, 17).

3.4.2 Conversation manual and evaluation sheet

The preceding synopsis of general conversational maxims of the "classics" is intended to serve as a guide for ongoing orientation in complex fields of communication such as medical rounds and consultations. However, the general maxims of medical conversation, which the "classics" have left us as a "legacy" with a debt to continue, must be further specified both typologically and exemplarily in "empirical" learning contexts in which the communicative competences of (future) doctors are to be promoted.

As an orientation and structuring aid for the promotion of communicative competences, we have developed two complementary concepts at our clinic, the application of which is intended to ensure the unity of teaching and examination:

- The ***Cologne Manual on Medical Communication*** (C-MMC) serves both as a catalogue of learning objectives for teaching and for self-learning.

- The ***Cologne Evaluation of Medical Communication*** (C-EMC) is used to check learning objectives, for example in examinations according to the OSCE procedure with standardised patients.

The *manual* is designed in the form of a booklet that is intended to fit in the "coat pocket" of (prospective) doctors (§ 18-23). The *evaluation sheet* developed analogously is in A4 format and can be used as a rating instrument by examiners during direct observation of interviews or video recordings. A complete presentation of the evaluation sheet can be found at the end of this chapter and in other chapters of the Handbook (§ 1, 17). We choose an integrative presentation of the manual and the evaluation sheet, whereby the evaluation is limited to the observable interview behaviour (e.g. *listener signals*, *questions*) (Fig. 3.10). Since the conception and application of the manual and evaluation sheet will be presented and explained in detail in the practical part (§ 17), an overview of the contents and main functions will suffice here.[13]

3.4.3 Learning objectives and assessment

In the ideal case of a doctor guiding a conversation, six conversation steps can be distinguished in a certain sequence structure, in each of which certain communicative functions are to be perceived, which are further differentiated at the level of observable conversation behaviour, for example, to *active listening* (Fig. 3.10), which can be realised as *verbatim repetition* or as *paraphrasing*.

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[13] The *Cologne Manual & Evaluation of Medical Communication* has been developed in several editions since 1998 in the Medical Didactics Working Group under the leadership of Karl Köhle and applied in OSCE procedures and are still regularly used in teaching and further training at our Department of Psychosomatics and Psychotherapy (University of Cologne) under the leadership of Christian Albus (§ 13-14). For further presentation and application of the manual and evaluation form within our Dept., we refer to Koerfer et al. 1999, 2004, 2005, 2008, Köhle et al. 2010, Köhle 2011, for direct or comparative use outside our Dept., we refer to Petersen et al. 2005, Schweickhardt, Fritzsche 2007, Henningsen 2006, Lengerke et al. 2011, Mortsiefer et al. 2014, Schröder 2019, Abholz et al. 2020, Scarvaglieri 2020, Iakushevich, Ilg, Schnedermann 2021, Albus 2022, Herrmann-Lingen, Albus, Titscher 2022.

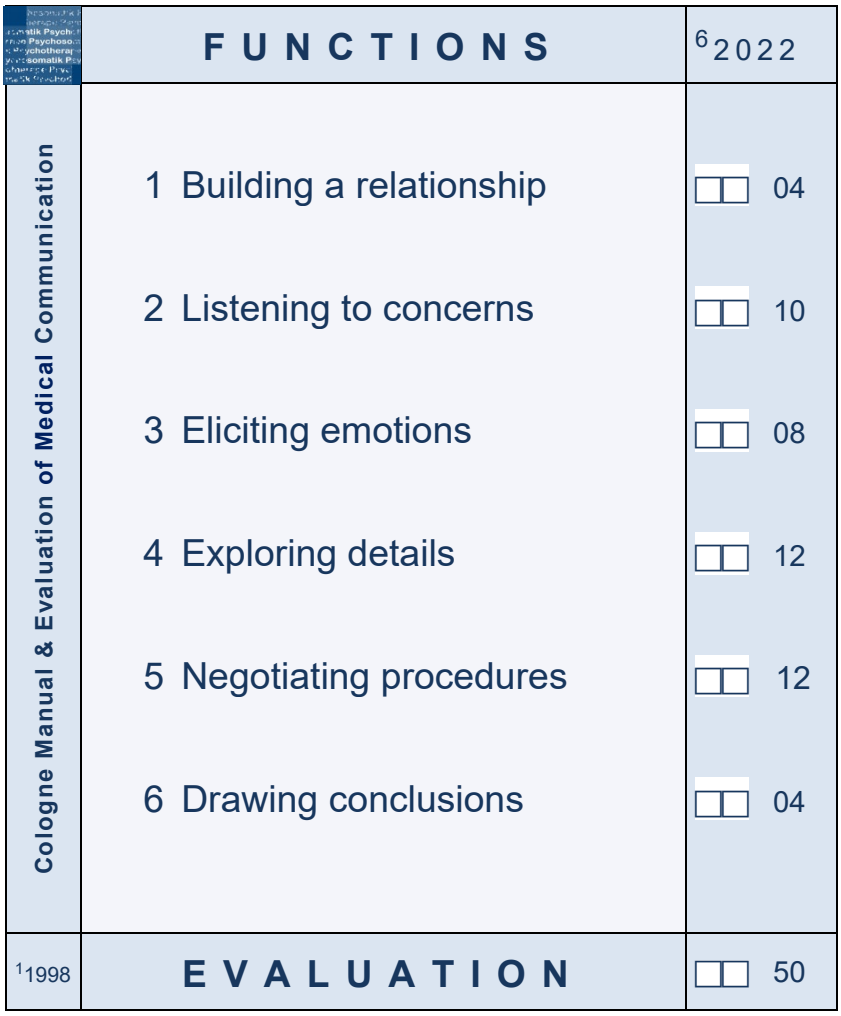

Fig. 3.9: Cologne Manual of Medical Communication (C-MMC) and Cologne Evaluation of Medical Communication (C-EMC)

In this way, a taxonomy of learning objectives emerges in which macro-, meso- and micro-learning objectives of conversational guidance can be distinguished: The six main functions are subdivided into further sub-functions, which are to be understood as action-guiding conversational maxims and, if possible, operationalised down to the action level of conversational guidance and provided with anchor examples, which can be regarded as empirical "manifestations" of the fine (micro) learning goals (Box. 3.15). As will be explained further (§ 13.2, 17.2), the hierarchy of the learning objectives can be captured in a chain of "by" *relations,* with which the super- and subordinations as well as the additive links ("and") and the alternatives ("or") can be formulated in language.

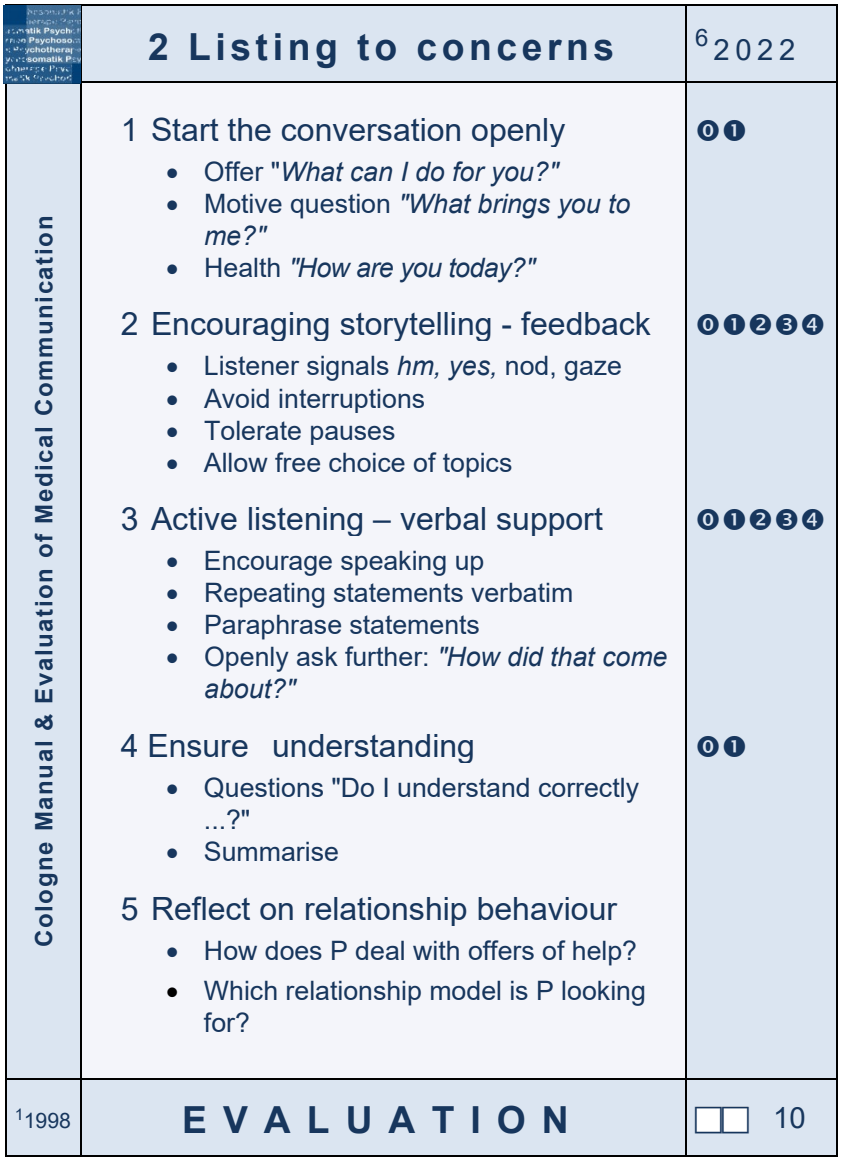

Fig. 3.10: Extract (from: C-EMC): Step/function 2: "Listening to concerns".

In teaching, empirical conversation cases from real consultations and visits should be used whenever possible for the selection of anchor examples, which, because of their authenticity, are in principle to be preferred to merely constructed examples, as this has already been justified in advance (§ 2.3). This empirical "calibration" through anchor examples will be the main task in the practical part of the Handbook (§ 18-23), in which the six main functions of interviewing are explained in detail in the corresponding chapter sequence.

Box 3.15 Learning objective taxonomy for "Listening to concerns" (excerpt)

The doctor practices a *biopsychosocial* approach to care
- by taking a *biographical-narrative anamnesis*
  - by *listening* to the patient's concerns
    - by starting the conversation openly
      - by asking about the motive for consultation
      - or by asking about the patient's well-being
      - or by offering herself as a helper ("What can I do for you?").
    - and by *promoting the patient narrative*,
      - by giving listening signals (*nodding, hm*)
      - by avoiding interruptions
      - by tolerating breaks
      - by allowing a free development of themes
      - etc.

The manual as a whole is the basis both for the didactics of conversation (§ 17) and for the evaluation of conversations, in which the doctor's conversation behaviour can be rated relative to a maximum score (of 50) according to the corresponding *Cologne Evaluation of Medical Communication* (C-EMC) (see § 1.6 or 17.5). As will be explained (§ 13, 14, 17), the congruence of the *manual* and the *evaluation sheet* follows the didactic-methodological principle of testing exactly what was previously taught ("teaching for the test"). This means that examinations can only be meaningful to the extent that they have been prepared beforehand by teaching, with which the communicative competences of (prospective) doctors are to be improved.

While the conversation manual in the classroom specifies the learning objectives with empirical anchor examples (§ 18-23), a learning objective check can be carried out with the evaluation sheet. The necessary *standardisation* in the OSCE procedure ("Objective Structured Clinical Examination") can then be achieved, for example, by using *simulation patients* (SP), which we have been training at our clinic for almost two decades and regularly use in teaching and further training, which will be reported on separately (§ 13, 14, 41).

3.5 Further information

Regarding the term and concept of promoting communication competence, reference should again be made to the *interdisciplinary research* and *literature* cited in the previous chapter (§ 2) and specifically in this chapter (§ 3). The literature cited there is taken up again and supplemented in specific chapters, for example on *dialogical medicine* (§ 7), on *biographical-narrative* anamnesis (§ 9) and on *medical decision-making* (SDM) (§ 10). In a specific chapter (§ 6), the *key medical competences* are to be discussed in the context of the question of the "good doctor", for which we have made an empirical study based on the professional assessments of university professors of medicine and general practitioners.

Our own didactic concepts for promoting communicative competence will be presented and explained in more detail later (§ 13, 14). In practical Part IV, the possibilities of applying *communication competence* are to be shown, above all, by means of examples of conversations in the GP practice and ward rounds (§ 17-25). Selected subject-specific problems in the communicative handling of certain patient groups or disease patterns are dealt with in Part V ("Specific fields of competence"). Specific problems, methods and results of evaluation are discussed in the final Part VI (§ 40-43), in which possibilities and limits of expanding communicative competences of (prospective) doctors in training are pointed out.

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Cologne Manual & Evaluation of Medical Communication see next page.

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

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

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

Fig. 20.6: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)