6 Key Medical Competences

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> A 'good' doctor is defined not just by what he does but by the way he or she does it.
>
> Harden et al. 1999a: 11

Abstract: With the paradigm shift towards a biospsychosocial medicine on the one hand (§ 4) and the social change as well as the changed mortality spectrum on the other hand (§ 5), a new profile of requirements for the *doctor of the future* has emerged, which traditional medical education can no longer meet (Murrhardter Kreis 1995, Sachverständigenrat 2009, BMBF 2017). The demands for reforms in education and training refer to the teaching of *key competences* with which the future doctor can meet both the *constant* (continuity) and the *change* (discontinuity) in his or her professional field both *routinely* and *flexibly*. As we

have seen, *evidence-based guidelines* (§ 5) can at best be an orientation and decision-making aid, but they cannot release doctors from their professional responsibility but require of them precisely a creative application of evidence-based guidelines and recommendations of experts of the subject-specific profession to "their" individual patients.

In the introduction (§ 6.1), the question is raised about the model of the "good" doctor who should ultimately be able to conduct a good conversation. In a second step (§ 6.2), the competence profiles of a good doctor are to be differentiated as they are reflected in the self-image of the representatives of the profession. For this purpose, the results of own empirical studies, obtained by means of interviews, will be reported. On this basis, professional models of medical action will be discussed, in which various key medical competences can be placed in a relationship with a specific weighting, in which they come into their own in the ideal case of interaction with the patient. Beyond the special requirements in patient contact, the medical role as a "communicator" must also be perceived (§ 6.3), in which communication within the team and with the public is important. Finally (§ 6.4), the special challenges to (self-)reflection competence are to be described, with which, in the sense of continuous further learning, not only the training of (subject-)specific competences of physicians is to be promoted, but also the general formation of the physician's personality, which can succeed especially in group learning.

6.1 The model of the good doctor

Precisely because the scientific understanding of medicine has changed and the conditions of medical action (society, morbidity spectrum, professionalism) have developed (§ 4, 5), the professional self-image of the doctor's role (as *rescuer*, *friend*, *helper*, *service provider*, *expert, etc.*) has increasingly come under (self-)criticism.[1] A pronounced debate about the "good" doctor is about the clarification of key professional competencies that should suffice for an image of the doctor of the future (Dö-

[1] Cf. Ringsted et al. 2006, Frank et al. 2015, NKLM 2.0. 2021. We have already dealt with these different roles of doctors (§ 4.4). We therefore refer to the detailed role descriptions by v. Uexküll and Wesiack (1991) in their "Theory of Human Medicine", in which they distinguish between the roles of magician, priest doctor, pedagogue (Socratic dialogue), friend, helmsman or gardener, expert (homo faber), (knowledgeable) partner.

rner 2001, Troschke 2004, Simon (ed.) 2005, Schubert et al. 2005, Kiessling et al. 2010, Witt (ed.) 2010, Steiner-Hofbauer et al. 2017, Schnelle, Jones 2022, 2023). The fact that the doctor's reputation has been "talked about" in this way can be taken as a symptom that the profession needs to reassure itself of its medical mission statements.

The question of the "good" doctor is currently booming, precisely because what was taken for granted until now, which initially still existed in a post-Hippocratic medical ethics, is being put to the test, which is certainly permissible and can be useful. However, one-dimensional or even monocausal answers to the question of the "good" doctor are as inadequate, as is the "good" conversation that he or she should ultimately be able to conduct. This connection between the characteristics of professional speakers and conversations in the medical field of action must be further clarified in the following, which we will try to do here selectively and in the course of the textbook in regular interim observations in the evaluation of more or less "good" conversations, as they are conducted by more or less "good" doctors.

6.1.1 Good doctors have good conversations

If one takes, for example, the currently rightly highly traded *communicative competence* of the doctor as a *key competence*, it quickly becomes clear that it can neither be taught in training and further education in isolation nor applied unspecifically in practice. It is true that at first the relevant context can still be formulated quite simply: A "good" doctor should first and foremost be able to have a "good" conversation with his or her patient, which, however, only seems to shift the definitional and evidential value. But what is a "good" doctor-patient conversation? And more specifically, what is a *good conversation* with "internal medicine" or "surgical" patients? Or even more specifically: What is a *good* conversation with "cardiological", "gastroenterological", "urological", "orthopaedic", "psychiatric" patients, etc. – assuming that "good" doctors can always classify their patients so "well"?

What is a "good" conversation with "multimorbid" patients, who can easily be misjudged even by "good" doctors, because multiple illnesses exceed their professional competences and they can hardly fall back on corresponding guidelines for multimorbidity, as this was already complained about in advance (§ 5) with the Council of Experts? What is a "good" conversation with *older* patients (§ 37), who are not only fre-

quently suffering from multiple illnesses, but also often limited in their hearing, speech and understanding of the world? Finally, how should so-called "difficult" patients (§ 34) be dealt with, who seem to jeopardise a "good" conversation from the outset?

6.1.2 Degrees of freedom of medical action

Such questions about the "good" doctor, who must be able to conduct a more or less "good" conversation even in "difficult" cases, are not merely posed rhetorically here, but are intended to "run along" throughout this textbook, chapter by chapter, in the theory, didactics, empiricism and evaluation of medical conversation, whereby answers are given step by step that should lead to a plausible overall understanding of what characterises the "good" doctor and the "good" conversation. Here, from a methodological point of view, it is important to note:

Although *speaker* and *conversation* should be seen as a *unit,* if only because one cannot in principle separate the acting persons from their actions, analytically structural and functional distinctions can be made, which may initially be formulated in a *thing-structure-event language* before they are in principle cancelled out again in a *person-action language* (Schnädelbach 1982, Koerfer 1994/2013). A strictly *system-theoretical* view of communication, as claimed at the earliest since and with Luhmann (1964, 1984), fails to recognise that communication failures are, under all structural conditions, due to individual actions performed by *subjects of action* who could also have acted differently (Koerfer 1994/2013), if one assumes corresponding degrees of freedom of action, i.e. disregarding extreme cases (of *rituality*, *coercion*, *violence*) where, by definition, there is no choice of action.

To relate the problem to our medical field of action: Here, for example, *interrogative* interview types are distinguished from *narrative* interview types and structurally described, but in individual cases it is the doctor conducting the interview who - whether under the systemic conditions of time pressure or not - conducts an "interrogation interview" (§ 19), in that he or she (sic) on the one hand asks a battery of suggestive information questions or in turn continuously interrupts the patient and on the other hand lacks all forms of active listening and empathic feedback. Conversely, the "good" doctor, because he or she is "attentive" and "empathic", can distinguish him or herself by consistently using

"varied" interventions of the corresponding type (e.g. "empathic feedback") (§ 20) in "his" or “her” conversations.

Providing this empirical evidence will be precisely the task of quantitative and qualitative conversation analyses, as they are carried out throughout this textbook or presented as reports on the results. In addition, a competence profile of the "good" doctor can be created below, which can at least be considered a "good" prerequisite for "good" medical conversation.

6.2 Key medical competences

Thus, without unnecessarily personalising the question of the "good" doctor in the following, (types of) (weighted) "characteristics" of the "good" doctor are to be identified, which reveal a *competence profile* that allows an individual orientation of the practising doctor towards the ideal type, who potentially has the necessary overall resources. In our own study (Herzig, Koerfer 2005, Herzig et al. 2006) we evaluated a survey of "professorial" representatives of the profession, each of whom was presented (in the early 2000´s) with the question in the *Deutsche Medizinische Wochenschrift*: "When is a doctor a good doctor?" We briefly describe the content analysis procedure, the results of which will then be discussed.

6.2.1 The good doctor from the perspective of the profession

The object-related cognitive interest of our pilot study was the reconstruction of meaning constituents for the "good doctor" in the mirror of the medical professional representatives (n=83), whose judgements in answering the question about the good doctor were subjected to a content analysis. A number of methodological aspects of content analysis were to be taken into account, whose cognitive possibilities should precisely not follow a misunderstood dichotomy of quantitative and qualitative procedures in empirical social research (Ritsert 1972, Lamnek 1995/2010, Mayring 1997). What is to be "countable" must rather be qualitatively determined beforehand and again in between and, if necessary, corrected several times.

The content analysis of the responses followed the principles of a circular, object-related reconstruction method in the sense of *grounded*

theory (Glaser, Strauss 1967, Strauss 1994). The categories of the analysis were thus not obtained in advance, abstractly and independent of the subject matter, but successively, concretely and in the test on the data material. To illustrate the coding procedure, the formation of units and categories, the coding of W. Stremmel's answer is given here as an example (Tab. 6.1), which was converted into 5 categories.

The categories were developed tailor-made on the text material. In circular, open coding, category designs are tested, corrected or discarded (and vice versa) on prospective text units until a saturation of probation is reached. Categories were coded by several coders (some independently) in multiple passes through the material and recoded according to group consensus. When forming categories, it should not be seen as a methodological weakness, but rather as a methodological strength of a content analysis if, in view of the large amount of data, not the same but similar things are to be summarised under one category.

In the process, however, differences must be levelled out that remain in the mere pairwise comparison of text elements. This is the price to be paid for the comparability of large text occurrences whose commonalities can only be captured by neglecting certain differences.

No.	Interviewee	No.	Text units	Categories	n
53	Stremmel	53.1	A good doctor has great medical knowledge	Specialists-competence	5
		53.2	and is curious to learn new things and keep up to date with the latest knowledge.	Learning readiness	
		53.3	Even more important, however, is the ability to adapt this knowledge individually to one's patient	Patients-orientation	
		53.4	and their psychological and life situation.	Empathy	
		53.5	Therefore, the Samaritan attitude as a helping doctor has the highest priority.	Helpers	

Tab. 6.1: Unit and category formation (from Herzig et al. 2006)

Some examples are listed for the category "empathy", which is realised by the interviewees with quite different paraphrases. In the three exam-

ples given (Tab. 6.2), only one example (No. 50.5) directly contains the expression "empathy", which functions as a name for the entire category, in which other expressions (such as "putting oneself in someone's position", "understanding" etc. or, as in example 20.1: "emotional competence") are also included as paraphrases.

No.	Interviewee	No.	Text units	Categories	n
20	Usadel	20.1	When (professional and) emotional competence are congruent	Empathy	3
50	Mash	50.5	A good doctor has (...) empathy for his patients	Empathy	
51	Neundörfer	51.3	and to understand the sick person in his or her particular situation.	Empathy	

Tab. 6.2: Formation of categories for "empathy" (from Herzig et al. 2006)

The circular coding and recoding process described stabilised in the end at 9 categories with which the spectrum of competences for the "good doctor" unfolded by the interviewees (n=83) could be captured almost completely (≥ 95%) and sufficiently differentiated, so that only 12 (=5%) of a total of 261 text units remained in a residual category (such as: "must be a role model", "from physician (as a scientist) to doctor (as a practitioner)", "despite current economic and bureaucratic adversities"). For each of the 9 content-analytical categories, prototypical examples are listed here in an overview (Tab. 6.3) as quotations, paraphrases or keywords.

No.	Category	Exemplary prototypes
1	Professional competence	*Scientific medical competence* "A doctor should have a high and up-to-date level of expertise", "criteria of evidence-based medicine", "profound knowledge of diseases based on science".
2	Action competence	*Craft, skill, ability* "A good doctor must act properly, not hastily, but in a timely and consistent manner". "A doctor should (...) have manual dexterity", "be well versed in his craft".
3	Empathy	*Empathy, emotional competence, empathy* "A good doctor has [...] empathy for his patients",

		"understands his patients with empathy", "understand the sick person", "show great empathy for patients".
4	Patients orientation	*For the good of the patient, individuality* "When the patient is always at the centre of his medical action". "(if the doctor) adapts this (outstanding competence) to the patient's wishes at all times", "salus aegroti summa lex", "accompany to the end for the patient's benefit", "when the patient is the focus".
5	Authenticity	*Openness, honesty, truth* "If he or she honestly informs the patients (...) about possible courses of action". "How would I want to be treated myself", "(...) and honestly".
6	Helper role	*Helping Partner, Samaritan* *"Therefore, the Samaritan attitude as a helping doctor has the highest priority", "is a helping and respectful partner to his patients (...)", "likes to help other people".*
7	Reflexivity	*Knowing one's own limits, limits of medicine, critical faculties, wisdom* *"insight into the limits of medicine", "humane sense of proportion in therapeutic decisions", "observing the limits of one's own will and ability", "when he repeatedly questions himself and his performance".*
8	Willingness to learn	*Up-to-date knowledge, lifelong learning, continuous training* *"A good doctor (...) is curious to learn new things and to keep up to date with the latest knowledge", "if his knowledge stays up to date", "willingness for continuous training", "lifelong readiness for new things".*
9	Cooperativeness	*Being able to listen, informing, joint decision-making, patient as partner, ability to work in a team* *"Ability (...) to communicate with the patient as a partner", "when he or she informs patients (compassionately and honestly) about possible courses of action in order to arrive at jointly supported decisions on this basis without absolving themselves of responsibility", "A good doctor must be able to listen well - to his or her patient, to his or her colleagues", "Exchange with others".*

Tab. 6.3: Categories and prototypical specimens

The analysis and interpretation based on the frequency of occurrence of the categories suggest a dominance structure, the tendencies of which would have to be examined in further, comparative studies (Herzig et al. 2006). First of all, according to the quantitative evaluations, the 4 categories of *professional competence*, *action competence, empathy* and *patient orientation* prove to be essential, accounting for about 2/3 of the entire spectrum, with *professional competence* and *empathy* dominating in each case (> 20%) (Fig. 6.1). The categories "cooperativeness", "willingness to learn", "reflexivity", "authenticity" and "role of the doctor as helper" are added to the image of the doctor with considerably lower frequencies.

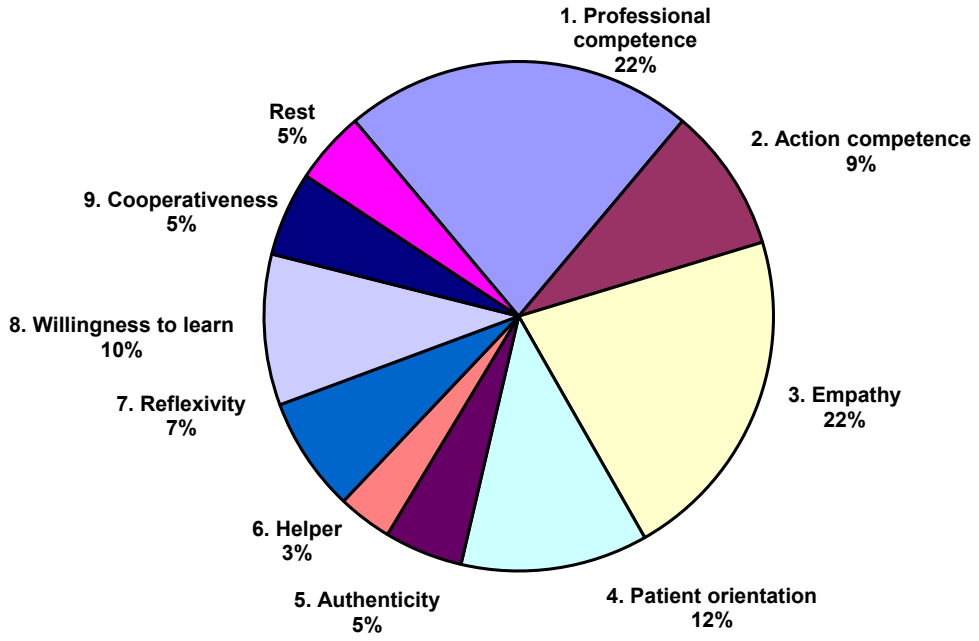

Fig. 6.1: Categories 1-9 (mod. on Herzig et al. 2006, Herzig, Koerfer 2018)

These first results of our study must be placed under a methodological reservation insofar as a specific bias is to be expected here: After all, we are dealing with professional judgements of professors of medicinal disciplines who, moreover, were to answer the question: "When is a doctor a good doctor?" for a scientific journal (*Deutsche Medizinische Wochenschrift*). Here, therefore, a rather *academic* image of a doctor could be expected from the outset, which, although drawn by a very relevant professional group (professors) who, because of their dual research and teaching function, perform a high multiplier function (*role model)* for prospective and practising doctors, cannot represent the entire spec-

trum of what is supposed to be considered a "good doctor" in the medical professions as a whole.

6.2.2 GP competence profiles

In order to broaden the spectrum of the medical profession, we asked the same question ("When is a doctor a good doctor?") to practising physicians (general practioners, or GPs, n=51) in the direction of a comparative study (Herzig, Koerfer 2005), with partly congruent, partly divergent results (Fig. 6.2). These differences can be interpreted as different

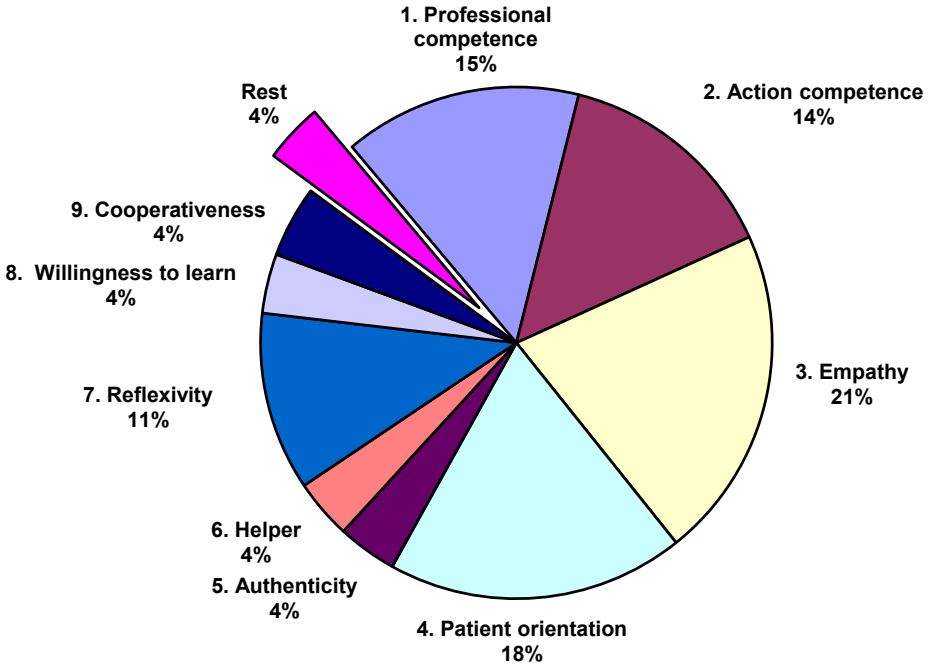

Fig. 6.2: Categories 1-9 (GPs) (mod. on Herzig, Koerfer 2005, Herzig, Koerfer 2018)

weightings in the "theory-practice" relationship, in which the GPs would like to see *action competence* and *patient orientation* strengthened on the one hand, and emphasise *reflexivity* more on the other. In order to systematically pursue such (preliminary) tendencies further, above all the data basis would have to be expanded and differentiated, also to enable *comparative* studies between different groups. Here, possible differences between general practitioners and specialists as well as specialists (internists, surgeons, etc.) among themselves (e.g. Simon (ed.) 2005), doctors and other health care professions as well as doctors and medical students and finally, in general, between professional representatives

and laypersons (patients) would have to be determined in order to obtain a differentiated overall picture of the "good doctor".

6.2.3 Professional models of medical practice

The preceding content analyses of the statements of professorial and GP professional representatives on the question: "When is a doctor a good doctor?" resulted in an initial more or less ideal self-image of the medical profession, which was structured by a relative weighting of categorically attributed characteristics or competences of the doctor. Beyond these relative weightings of the total of nine categories in the sense of a ranking, a three-dimensional order can be obtained if one follows a model of professionalism development developed in the Anglo-Saxon world, which has become known under the title "The Scottish doctor" and has been further developed in many ways (Harden et al. 1999a, 1999b, Simpson et al. 2002, Ellaway et al. 2007). In this "three-circle-model", a distinction is made between three types of competences (Fig. 6.3), whereby "competences" are used synonymously with "intelligences":

Box 6.1 Three-circle-model

(1) The inner circle represents what the doctor is able to do, e.g. the physical examination of a patient. This can be thought of as 'doing the right thing'. It can be equated with technical intelligence (...).
(2) The middle circle represents the way the doctor approaches the tasks in the inner circle, e.g. with scientific understanding, ethically, and with appropriate decision taking and analytic strategies. This can be thought of as 'doing the thing right' and includes the academic, emotional, analytic and creative intelligences.
(3) The outer circle represents the development of the personal attributes of the individual - 'the right person doing it'. It equates with the personal intelligences.

Harden et al. 1999b: 547

In analogy and modification to this Scottish profession model (Fig. 6.3), the nine categories found in our study can be divided into three centripetally structured areas, which are then occupied in total (per circle) with approximately equal frequencies of mention (Fig. 6.4).

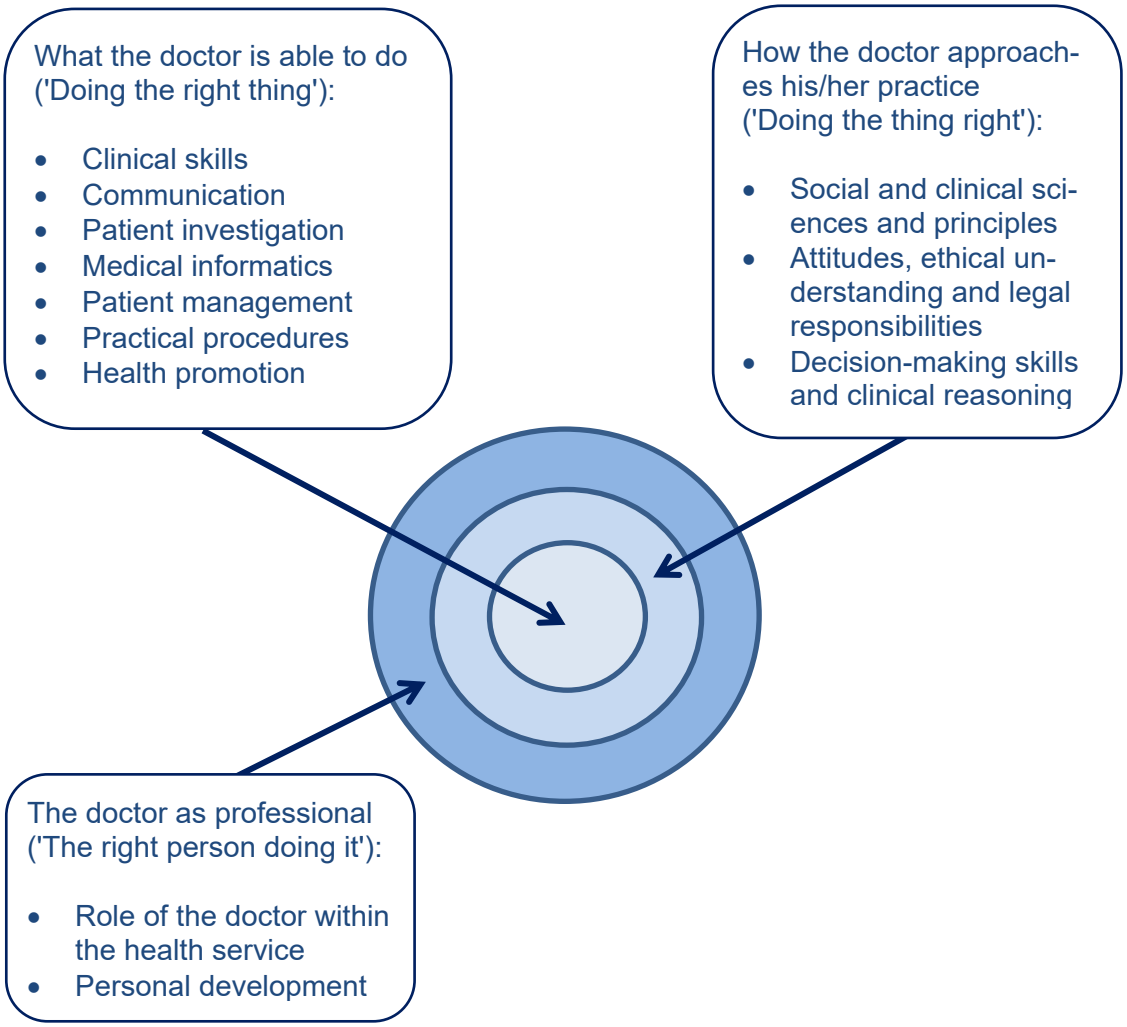

Fig. 6.3: Profession model (Harden et al. 1999a, b, Simpson et al. 2002)

Both professional models are analytical distinctions of (areas of) medical competences that can only be effective by interaction in practice. The commonalities between the two professional models consist in the threefold division of the areas of competence, which are, however, specified with different classifications: While in the "Scottish" professional model only the professional roles and personal developments of the doctor are "external" prerequisites for the "right" person to act ("outer circle"), the "Cologne" model differentiates a series of further qualifications that the "good" doctor must combine as a person in order to be able to bring the core competences of medical action to bear in direct interaction with the patient:

In order to be able to appropriately perceive his or her *professional* and *action competences* ("inner circle") towards the patient with the necessary *patient orientation* and *empathy ("*middle circle"), the acting person must have acquired a series of individual qualifications ("outer circle"), which he or she must continuously prove in the interaction with his or her action partners. These include a constant *willingness to learn*, *reflexivity*, *cooperativeness*, *authenticity* and, last but not least, the *willingness to help,* which remains a primary virtue even in a post-Hippocratic medical ethic.

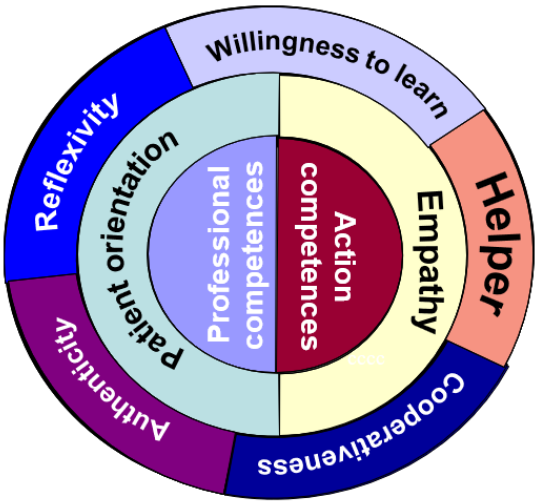

Fig. 6.4: Medical profession model (on Herzig et al. 2006, Herzig, Koerfer 2018)

In the comparison of both models, no preference should be claimed here, but merely a possible variant should be put up for discussion, which requires further analytical as well as empirical examination. The analogy and modification of the Scottish model ("The Scottish doctor") was due to the empirical findings of our Cologne study on the question of the "good" doctor, whose quantitative evaluation suggested a certain weighted accentuation, which will be further elaborated in the following using two areas of competence as examples.

Regardless of the problems of a relative weighting and allocation, we will regularly return in this textbook to all the areas of competence of medical action which we had differentiated on the basis of the content analyses on the question of the "good" doctor (Fig. 6.1-2), and at this point we would like to highlight only two central competences in advance:

These are, on the one hand, *communication competence,* which is summarised with the doctor's role function as a "communicator" not only in communication with the patient, but also in team and public relations work (Ringsted et al. 2006, NKLM 2021), and, on the other hand, the doctor's *reflection competence,* which, with v. Uexküll, Wesiack (1991), is to be understood as the *meta-competence* of a *meta-doctor* (§ 3.3), who becomes his or her own critical observer of his or her medical action, be it instrumental or communicative action.

6.3 The doctor as communicator

The communicative competence of the doctor is a *key competence* insofar as it is involved in almost all fields of medical practice. To begin with, the "omnipresence" of communicative competence can be pointedly addressed by asking a question in reverse: When does medical action happen "speechlessly" at all? Without going into the undoubtedly possible but rare exceptions (emergency medicine, radiology, etc.), a prototypical case should be named here: Even in the case of "purely" surgical action during an operation, which is essentially based on the doctor's *instrumental* competence (§ 8), it is now well studied (Uhmann 2010) how communicative coordination in the team is an essential prerequisite for successful action during surgery.

However, before such *instrumental* "interventions" (examination, operation) can take place at all, medical action was essentially *communicative* action beforehand in the anamnesis and clarification discussion, as it should also be *after* every instrumental action, when the patient is informed about the results and findings and is involved in the further decision-making process through dialogue. Before this alternation of communicative and instrumental phases of action is concretised in detail in an ideal-typical flow chart of medical action (§ 8), *communicative competence* should be described here as a *key competence* in the communication-intensive medical profession.[2]

6.3.1 The communication-intensive medical profession

Whatever the individual focus in whatever institutional environment of medical practice, the "omnipresence" of communication in clinics and

2 For various terms and concepts of *communicative competence* in different academic traditions, please refer to the literature cited above (§ 3).

practices is beyond question: the medical profession is and remains one of the most communication-intensive professions, comparable to that of teachers, pastors, journalists, etc.

According to the "Scottish" professional model, communicative competences are also more or less explicitly involved in all other competence areas. In the professional model according to Harden et al. (1999a, b) and Simpson et al. (2002), a special domain for communication is described at length and in detail, on which other domains build, which will only be reproduced here in excerpts (Box 6.2).

Box 6.2 Good Communication

Good communication underpins all aspects of the practice of medicine. All new graduates must be able to demonstrate effective communication skills in all areas and in all media, e.g. orally, in writing, electronically, by telephone etc.

- *General principles of good communication*
  This could include: being able to listen and use other appropriate communication techniques including an appreciation of non-verbal communication/body language (one's own and the interviewee's), gathering and giving information with good record and correspondence skills, mediating, negotiating and dealing with complaints, making oral presentations and writing reports/papers, telephone usage.
- *Communicating with patients/relatives*
  This could include: answering questions and giving explanations and/or instructions, strategies for dealing with 'difficult' consultation including aggression, breaking bad news and admitting lack of knowledge or mistakes, making requests, e.g. post-mortem, organ donation, obtaining informed consent, confidentiality.

Simpson et al. 2002: 139f

This variously differentiated communication with the patient is certainly the *core area* of medical action, which we will also deal with centrally here and which must be further differentiated and concretised with empirical anchor examples on the basis of our discussion manual (§ 18-23). However, the complex concept of *communicative competence* (§ 3) is already revealed in advance in our content analyses of interviews with professional representatives, who predominantly describe aspects of patient-oriented communication (Tab. 6.3), in which, for example, the "in-

dividual" patient should be "at the centre" in order to be able to act in his or her "best interests".

Although no specific category on communication was formed in our content-analytical profession model, the communicative competence of the doctor is more or less directly involved in all categories, as can already be seen from the individual statements of the profession representatives (Tab. 6.1-3). Precisely because communicative competence is ubiquitous, an independent category proved to be obsolete from a methodological point of view, as it would have been too unspecific in the context of the question about the "good" doctor. Here, the content analysis would have led to problematic multiple coding and inadmissible redundancies.

If one goes through the statements of the professional representatives on the question of the "good doctor" in detail (Tab. 6.1-3), it is obvious that, for example, the required *cooperation* with patients or colleagues is essentially based on communication (statements: "communicating with patients as partners", "being able to listen well") (§ 19). Likewise, *honesty* and *openness* (statement: "honestly inform") or *empathy* (statement: "empathy") (§ 20) can only prove themselves in communicative dealings with the interlocutor.

All in all, *cooperation*, *empathy* and *honesty* in medical action cannot be abstract values in "speechless space" but are lived and experienced as *authenticity* in communicative action with the patient, so that the person acting can be "taken at his or her word" even if it should later be primarily a matter of "wordless" action. Finally, all action is subject to a potential validity test qua communication, be it in relation to a "tacit" agreement or to a word that is specifically valid by agreement, as is particularly expressed in participatory decision-making (§ 10, 22, 26).

In all internal differentiations of direct communication with the patient, it must be added that beyond this communicative core area, the *institutional* framework of the entire patient care must also be taken into account, which points beyond the direct doctor-patient relationship and at the same time shapes it *institutionally* (§ 5). In this sense, the doctor must also act communicatively and vis-à-vis with other staff and institutional contacts in the health care system or mediate communication between them. In this way, the doctor becomes a "communicator" to all sides in the routine of the clinic or practice, from whom specific conflict solutions are expected, especially in special conflict situations.

6.3.2 Team and public relations work

Overall, the Scottish professional model (Harden 1999a, 1999b, Simpson et al. 2002) also calls for communication competences of the doctor not only in dealing with patients and their relatives, but also in contact with the immediate members in the care team as well as the colleagues involved in the treatment and those who continue to treat the patient (Flin, Youngson, Yule (eds.) 2016, Donaldson et al. (eds.) 2021, Mahmood et al 2021, Morris et al. 2022). Furthermore, the doctor's communication competences are challenged in dealing with other relatives and health care institutions (social, medical services, insurance, etc.) as well as in dealing with the media up to the public at large (Ringsted et al. 2006, BMBF 2017, Cracknell, Cooper 2018, NKLM 2.0 2021). Thus, communicative competence will also experience a special development in the medical function as a *teacher, scholar* or *expert,* who must be able to convey his or her professional knowledge to all personal or institutional types of interlocutors in a *manner* appropriate to their needs in explanatory talks or public relations work, which should be reflected, among other things, in an *understandable use of language* (§ 10, 27).

In all these functions, the doctor takes on the role of a "communicator" who has to prove his or her communicative competence in diverse (types of) conversational situations with changing communicative tasks and cooperation partners on a daily basis, not only orally but also in writing, in data documentation for patient handover in shift work to the doctor's letter for the colleague for further treatment of the patient etc.

This ubiquitous function of the doctor as a "communicator" is at the same time his or her function as a "moderator" who helps to recognise and deal with conflict situations, be it by being involved him- or herself as a party, as in doctor-patient communication or in his or her own team as a boss or employee, be it by acting as a moderator vis-à-vis "third parties" (relatives, nursing staff, colleagues, administration, experts, media, etc.).

Furthermore, scientific and ethical attitudes, principles and standards, as they are also postulated in the Scottish model (Fig. 6.3, Simpson et al. 2002: 140f), are of course not effective in "speechless space", but are mostly communicated insofar as they become manifest in communicative action itself or, in the case of their violation, require special verbal justification, be it because this is claimed by patients or their relatives or because the doctor follows a *transparency requirement* of

his or her actions anyway (§ 10). This is significant, for example, under the "delicate" aspect of "conflict communication", which extends from problems in collegial cooperation, for example at the workplace of a GP practice or clinic (Hoefert 2008), to possible medical "malpractice", which is not to be concealed, but rather to be made an issue offensively in communication with the persons concerned, etc.

Because of all these sensitive conditions of application of communicative competences, we would also like to deviate from the Scottish model and not talk about technical competences ("technical competences or intelligences"), regardless of whether it is about communication with patients, colleagues or other interlocutors in the health profession. Rather, we are talking about *creative competences* that are applied in a context-sensitive way (e.g. Salmon, Young 2011, Skelton 2011), which will be described as the "art of medical conversation" (§ 17).

6.4 Medical reflection competence

As already explained in the definition of the learning objective (§ 3), medical *reflexive competence* is a *meta-competence* under which the doctor's professional and communicative competences are to be put into the right *relationship* in concrete practice. In this context, the doctor's (self-)reflective competence must be developed in a lifelong learning process, in which the doctor's actions, both as *instrumental actions* (medication, surgery) and as *communicative actions* (anamnesis, information, decision-making), must be continuously subjected to critical examination.

In the reflexive self-observation and observation by others of the instrumental and communicative practice of action, the individual patient must be taken into account, who must be sufficiently supported in the joint development of the relationship without overtaxing him or her. In shaping the relationship, the doctor must also be able to cope with the complex processes of transference and counter-transference, which must not simply take place unnoticed behind his or her back or "break through" offensively in communication. What happens or is omitted in conversations with patients often eludes even the most critical self-observation as "blind spots", which can often only be improved in group learning.

6.4.1 The self-critical meta-doctor

In the comparative content analyses of interviews, the preliminary tendency had been identified that *reflective competence* was emphasised more strongly by GPs than by professors (§ 6.2.2). It remains to be seen whether this is due to the daily pressure to act in a GP's practice. Subjectively, this pressure to act may lead to an increased need for reflection, which GPs are apparently less able to pursue in their self-experience than clinicians at a university hospital, where a unity of research and care seems to be more self-evident and therefore needs to be formulated less strongly as a desideratum.

Regardless of such possible differences in detail, however, the reflective competence together with the willingness to learn and further training of the "good" doctor was unanimously emphasised by both survey groups. The statements of the representatives of the professions are very much in line with education and training research, which is concerned, among other things, with self-reflection on one's own medical practice. Promoting this competence is the declared aim of Balint groups, for example, which have proven their worth both in the training of medical students ("anamnesis groups" or "junior Balint groups") and in the further training of practising doctors (Rosin 1989, Köhle et al. 2001, Koerfer et al. 2004, Cataldo et al. 2005, Köhle, Janssen 2011).

Uexküll and Wesiack continue this tradition when, following their "Theory of Human Medicine" (1991), they describe in detail the role of the "meta-doctor" who, as it were, observes him- or herself critically over his or her own shoulder while acting and in doing so creates a self-reflective "travel report" about the common history of interaction with the patient, which we had already dealt with in the introduction when defining the learning objective of communicative competence (§ 3.3). Since we will repeatedly refer to this procedure of critical self-observation by the *meta-doctor*, it will be reproduced here, albeit in a strongly abbreviated form, in detail in the own words of the co-founders of biopsychosocial medicine (Box. 6.3), not without recommending reading the entire original (1991: 649-659).

Box 6.3 Critical self-reflection of medical practice

The travelogue is intended 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.
Ideally, the meta-doctor must repeatedly demand accountability from the doctor for the action-guiding theories behind his interpretations and behaviour (...) If the doctor, under the control of his meta-doctor, i.e. his critical scientific-theoretical conscience, has identified the centre of the interference field in a patient (...), then he has found an explanatory model for the "disease" or a "diagnosis" (...); the design of a realistic therapy plan can only take place with mutual agreement (...).
The instance we have called the meta-doctor can also be described as the necessary watchdog function with which every doctor must check how far his behaviour towards the patient is fair. From this point of view, the meta-doctor not only has the task of weighing different cognitive explanatory models against each other in the differential diagnostic process; he must also check in his diagnostic and therapeutic interventions how they are experienced affectively by the patient; he must give an account of their ethical dimension, which decides whether the risks associated with the interventions are reasonable for the patient, whether the burdens and dangers are in a justifiable proportion to the expected success.
This last point means that the meta-doctor has as an essential function the task of an advocate for the patient. He has to define what "success" means in the eyes of the patient and watch over the fact that the final decision about a diagnostic and/or therapeutic measure belongs to nobody else than the patient himself.

Excerpt from: v. Uexküll, Wesiack 1991: 649-659

We will return systematically to a number of the functions of the *meta-doctor* named here, in particular the *advocacy function* towards patients in shared decision-making (§ 10) as well as the critical self-evaluation of the doctor's own communication practice (§ 40-43). Here, under the question of the "good" doctor, the risk of the "perfectionist" doctor overtaxing him- or herself should be addressed in advance.

It is possible that the noble claim to the reflective competence of a "meta-doctor", as postulated by v. Uexküll, Wesiack, may not only lead to a benefit (in insights, satisfaction, etc.) but also to frustrations in the lower levels of daily care practice with patients. Thus, ideals of medical

action in general, not only of communication, can of course be suitable not only to promote the "critical scientific conscience of the meta-doctor" (see above), but also his or her "bad conscience" of not being able to meet his or her own demands in practice.

Under the aspect of psycho-hygiene, this possible "frustration" from self-excessive demands can be addressed and worked on especially in further training in Balint groups, in which the aim is not to improve patient satisfaction but also to increase doctors' professional satisfaction (Rosin 1989, Köhle et al. 2001, Koerfer et al. 2004, Cataldo et al. 2005, Köhle, Janssen 2011, Tschuschke, Flatten 2017, Yang, Wang 2022). Under the guidance of an experienced doctor (with psychoanalytic training), the solidary criticism of the many collegial "meta-doctors" can not only compensate and "give comfort", but also help to determine the "right" measure with which the "good" doctor knows how to successfully humble him- or herself without overtaxing him- or herself and the patients entrusted to him or her.

This "modesty" results from the insight that in practice one "only" has to prove oneself to be "sufficiently good" for one's patients ("to be good enough"), as was already formulated by D.W. Winnicott for attachment research, according to which mothers can also possibly suffer from an exaggerated self-ideal towards their children. Analogously, the recognition and acknowledgement of one's own limits would also be the very first prerequisites for a "good" doctor (§ 2.1), who does not necessarily have to want to be the "best".

As was already made clear in the introduction (§1) and will be detailed again at the end in the evaluation (§40-43), many hurdles are to be expected on the way to "mastery", which can lead to detours and also regressions in individual learning processes before a stable level of competence is finally reached. On this path, stages of observation and development can be distinguished in self-reflection, which can range from the change of concrete conversational behaviour in *active listening* (§19) to the intensification of *empathic* communication (§20) to the change of the *relationship model* in medical decision-making (§10, 22). The associated learning processes can best be stimulated and stabilised in group learning, as happens, for example, in Balint group work.

6.4.2 Developmental stages of self-reflection

In the tradition of Balint group work, which v. Uexküll, Wesiack (1991) follow with their construct of the (self-)critical *meta-doctor*, the critical case discussion, in which a doctor presents an example from his or her practice to the critical judgement of the group, is a core element of continuing medical education. In the meantime, modern recording media (audio, video) have provided possibilities to escape the "data distortions" of merely remembered and narrated patient cases (§ 2.3). Enriched by the authentic audio and visual material created by recordings from ongoing medical practices, Balint's old demand for *training cum research* could gain a new dimension from which both the group and individual participants benefited.[3] Individual learning progress as well as group effects could be demonstrated in an intersubjective test procedure (Köhle et al. 2001, 2010, Koerfer et al. 2004, Cataldo et al. 2005), which will be explained in detail later (§ 40).

In anticipation of the later presentation of the design and results of evaluation studies, the learning and professional situations of the self-reflective meta-doctor, who has to prove him- or herself as a "communicator" in many fields of action, of which direct patient care remains the core area, will first be outlined here as an example. What the doctor practices there as a key communicative competence can be transferred to other areas of medical action, such as communication with relatives, colleagues, media (see above), who can benefit from the self-reflexive meta-competence just as much as the patients themselves. As already briefly outlined above (§ 3.3), the (self-)reflexive role of the meta-doctor can be differentiated, for example, from the training perspective of a Balint group in a constellation of three observation and development stages (Fig. 6.5), which will be further described below:

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[3] The use of tape recorders and later modern AV media has a long tradition in education and training as well as in accompanying research on doctor-patient communication (e.g. Rogers 1942/1985, Byrne, Long 1976, Köhle, Raspe 1982, Bahrs et al. 1996, Köhle et al. 1995, 2001). In the meantime, the "method of video elicitation interviews" has established itself as a variant of the procedure (e.g. Henry et al. 2012), according to which interviews with doctors or patients, for example, are conducted on the basis of videographed doctor-patient conversations, which are thus both stimulation and subject of the interviews.

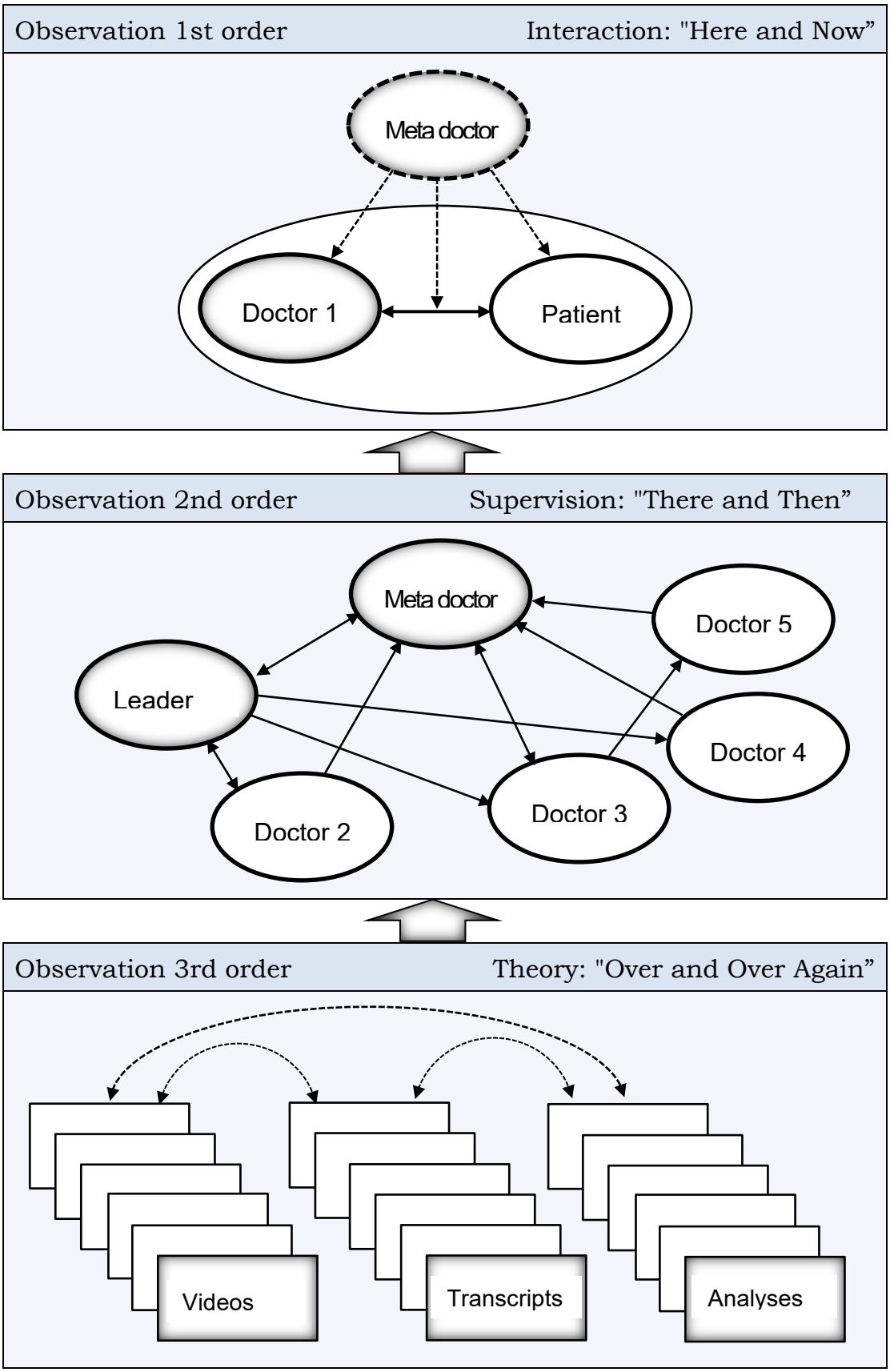

Fig. 6.5: Observation and development stages 1st-3rd order

1. Observation 1st order - interaction: "Here and Now"

The doctor has his or her conversation with a patient (as usual). In this conversation, the doctor steps out of him- or herself, as it were, and observes the interaction scene without losing conversational contact with the patient. This perception of the observation role as a meta-doctor is precisely part of the *art of conducting a medical conversation*, which may also cause problems of concentration at the beginning and later becomes the everyday routine of the "good" doctor.

In the self-reflexive observation of the interaction scene in the "here and now", the doctor perceives him- or herself, the patient and their joint communication. The first critical first-order self-observation in the dyad of doctor and patient can already lead to self-perception of "mistakes" or weaknesses ("I interrupt more often than I thought", "I am more impatient than I assumed") and initiate first spontaneous self-corrections, which can be placed again under the meta-doctor's self-observation as *trial actions,* etc.

Furthermore, doctors may not only register the embarrassment of their patient, who may blush or look away in embarrassment, but notice the connection that they themselves have interactively triggered the embarrassment with their question, because they have brought up a certain topic (eating habits, smoking, alcohol, etc.) that is obviously "sensitive" for the patient (§ 21.6). Similarly, doctors may notice in themselves certain emotional reactions (of sympathy, pity or even aggression) that the patient has triggered in them by his or her behaviour.

These emotional reactions are perceived by the meta-doctor, as it were, without, however, being acted out uncontrollably by the acting doctor in the current conversation situation. Rather, the reflexive attitude of the meta-doctor towards the countertransference of the artes allows its controlled use for diagnostic-therapeutic purposes in the "here and now" of the doctor-patient relationship.

2. *Observation 2nd order - Supervision: "There and Then"*

The reflection competence of the meta-doctor assumed in the first-order observation is usually not "pre-existing" but must often be laboriously acquired in training and further education and through self-experience in the profession. In most cases, the doctor's recurring experience in dealing with so-called *problem patients* (§ 34), who are characterised by frequent changes of doctor, lack of adherence (§ 10, 26) or repeated relapse into addictive behaviour, is the very first motivation for participation in further training. The classic complaints of doctors in case reports of Balint groups are often that they do not "get close" to their patients, that they keep getting "caught up" in the same topics, that they keep "ending up" in a "dead end", that they would "go round in circles" with their patients, that they see themselves helplessly at the mercy of "chatty" or "complaining" or "demanding" patients and that they would therefore meet them early on with impatience, changing the topic or even breaking off the consultation, etc.

These phenomena, as well as the reaction of impatience or abrupt termination, can then also be shown in the video observation (2nd order) in the distanced retrospective view of the "there and then" with empirical examples, regardless of whether they were already noticed in advance or remained closed to the direct observation of the meta-doctor. In this way, the joint observations not only of the doctor concerned but of all group members will help to show the strengths and weaknesses of the doctor's conduct of the conversation, which can show up in premature interruptions or in the lack of empathic feedback or in hasty prescriptions without the patient's explanation and consent, etc., whose non-adherence then brings "new trouble" in the next consultation, etc.

Here, both direct feedback from the group ("too many information questions", "hardly any breaks", "altogether too hectic") and the solidary exchange of experiences among the participants ("What do I do in such cases?") can lead to initial recommendations ("Give yourself the opportunity to ask questions", "Inquire about patient expectations"). Further assistance could extend to dealing with overly complaining or demanding patients with spontaneous visits to the doctor, for whom a regular appointment, but with a greater distance

and clearly defined task and consultation time may prove suitable, etc.

Dealing competently with disappointments, for example when addiction patients relapse, certainly requires greater coping resources that go beyond the normal level of expectation towards patients, whose defences (denial, etc.) should not be "broken by force", but should be dealt with gently in a *tangential* conversation (§ 3, 17, 20).

3. *Observation 3rd order - theory: "Over and Over Again" (rules, patterns)*

On this problem of defence, on the one hand, theoretical knowledge would have to be deepened with regard to special illnesses, for example, where denial is often itself part of the clinical picture (alcohol addiction, anorexia, somatoform disorders, etc.), and on the other hand, concepts and techniques of the aforementioned *tangential* conversational guidance would have to be discussed. At the same time, these can be trained in the group in role play or on simulated patients before they are practised on real patients, which in turn can be observed through the new "theory glasses" of the meta-doctor. The constant alternation of *behavioural analysis*, *theory expansion* as well as *testing* of new behavioural patterns under renewed 2nd order observation (qua video recording) leads to the discovery and deepening of rules of communication, such as those that should be known and practised in patiently dealing with problem patients ("over and over again"). In this way, the recurrence of old communication patterns can be gradually replaced by regular adoption of new communication patterns until these new patterns become part of the daily routine and as such can be reflected upon again, reinforced or corrected from the observation perspective of the meta-doctor, etc.

Changing well-rehearsed communication patterns is by no means an easy task because they go hand in hand with relationship patterns that not least affect the personality of the doctor, who may "always" cling to an *authoritarian-paternalistic* relationship design without even noticing this in the communication with his or her patients from his or her own observation perspective as a meta-doctor. Closing this perception gap is precisely the task of group work from the 2nd order observation perspective. Accordingly, the meta-doctor

in this role receives feedback on the "there and then" not only on his or her (way of) conducting the conversation, but also on his or her (way of) shaping the relationship with the patient, which after all can be stabilised again and again by the same communication patterns.

The collegial feedback takes place in the attitude of solidary criticism, from which all members ultimately benefit (§ 6.4.3), especially as each member takes on the role of the meta-doctor when the case presentation changes. In the 2nd observation perspective, the feedback was initially spontaneous through lively exchange in the group, in which "impressions", "perceptions", "ideas" are collected, which are now structured and analysed in the 3rd order observation perspective under the guidance of the group leader.

This task is usually carried out by an experienced doctor who often has psychotherapeutic or psychoanalytical training, which makes it possible to take into account the psychodynamics of the first-order interaction in the doctor-patient dyad as well as the second-order interaction in the group, which, like any (small) group, does not have to interact without conflict. Beyond the analysis of direct conversation behaviour, this third observation and learning stage also involves further analyses of transference and countertransference processes (§ 3, 20), as they have to be taken into account in every doctor-patient relationship and especially reflected on in dealing with so-called *problem patients* (non-adherence, frequent change of doctor, addictive behaviour, etc.).

Finally, in the 3rd order observation, under the guidance of the experienced group leader, a more in-depth self and group study can be initiated, in which theoretical borrowings (for example from Rogers, Balint or Engel on the concept of "active listening" as a communication pattern of "over and over again") are made or the behavioural analyses are supplemented via the diversions of accompanying scientific research (Bahrs et al. 1996, Köhle et al. 2001, 2010, Koerfer et al. 2004, 2010). In this way, further instructions can be given to the meta-doctor beyond the individual group recommendations, which are intended to contribute to the improvement of his or her medical conversation practice and relationship with the patient.

In the constant alternation of reflection and testing of new communication patterns, whose practice can in turn be made the subject of further observations through renewed recording, self-reflective observation and learning processes with corresponding feedback can develop in the

group work, from which all group members can benefit. In this process, in the ideal case of learning in the sense of Bateson (1985), the participants themselves will notice their individual learning successes in their own conversational practice, which they themselves elaborate on in empirical examples (Koerfer et al. 2004, 2008) (§ 42-43).

6.4.3 Personality development in group learning

According to Balint, group work is particularly suitable for the self-reflective change of patterns of conversation, in which the collective learning processes in the group help to mutually promote the individual learning processes of the individual members. Learning in Balint groups is only a prototype of learning in groups, the advantages of which can be transferred to other learning settings. Analogously, the described (self-)reflexive procedure can be applied not only in further training with doctors, but also, with a didactic reduction, in conversation training for students (§ 13, 14).

At this point, in conclusion, it is only necessary to emphasise with Balint the meaning and purpose of group work, in which it is possible, rather than in pure self-observation, to recognise one's own "mistakes, blind spots and limitations" and, if necessary, also to deal with them or correct them. Under the ideal objective of a "limited but essential conversion of the personality" of the doctor, Balint (1964) (Box 6.4) describes how the learning group method he founded can contribute to the doctor's personality formation if the (self-)criticism takes place in a good friendly atmosphere in which all group members can profit from each other by learning not only from their own but also from the "mistakes" of others in order to compensate for their personal deficits.

Box 6.4	*Limited, but essential conversion of the personality*

Intellectual instruction, no matter how clever, has virtually no effect on this process of liberation and general relaxation. What we needed was an emotionally free and friendly atmosphere in which the realisation could be processed that our actual behaviour is often completely different from our good intentions and does not correspond much to the idea we had of it so far. Perceiving this discrepancy between our actual behaviour on the one hand and our intentions and beliefs on the other is not an easy task.

> But if the cohesion in the group is good, the faults, blind spots, and limitations of each member can be brought to light and at least partly accepted by them. The group, both collectively and individually, develops a better and better understanding of its own problems.
> The individual can bear the perception of his mistakes more easily if he feels that the group understands these mistakes and can identify with him in them, and if he sees that he is not the only one who makes mistakes. Furthermore, it does not take long for the group to discover that the technique of each member, including the psychiatric group leader, is an expression of his personality, which of course also applies to his habitual mistakes (...) As long as the mutual identification of the members is strong enough, the individual can bear burdens because he feels accepted and supported by the group. He does not feel that his mistakes and failures, as shameful as they may be, make him worthless to the group; on the contrary, he feels that by having his mistakes used as a basis for discussion, he has contributed to the group's progress.

Balint 1964/1988: 405f

The recognition of one's own personal limitations is thus a first step in the personal development of the doctor, who has to overcome possible reservations and inhibitions towards self-critical reflection in group work. Only in the solidary criticism of the group can "mistakes, blind spots and limitations" be recognised and worked on, which threaten to remain hidden from individual self-observation, precisely because the "habitual" mistakes of the individual can already be an "expression of his personality", which can easily elude the self-observation of the individual. Only through the mutual observation and criticism of mistakes do all members gradually benefit from the "discovery" of their individual "blindness" as the group progresses.

The method of learning in the group described by Balint in this way can be applied as a (self-)reflexive procedure not only in further training with doctors, but also already in the conversation training of students, either in the now established junior Balint groups or also in the problem-oriented group learning of university teaching, in which the conversation of students with real or simulated patients (SP) can be "supervised" under the guidance of the lecturer (§ 13-16, 40-43). We will present the transfer problems and possibilities of teaching conversation in student teaching in detail when we present the curriculum at our clinic (§ 13, 14). There we will show how the foundation for (self-)reflexive key competences of the meta-doctor is to be laid for future doctors as early

as possible in their studies. In principle, the procedure of critical self-observation and external observation of the meta-doctor described above applies equally to training and further training in conversation.

A first transfer can already be established through appropriate use of this textbook either in individual learning or in joint group work. By using the examples in the textbook, which are often taken from the Balint group work, to observe the doctors conducting the conversation, the role of a meta-doctor can also be simulated from the reading perspective when we invite the reader to look at/read a conversation transcript. In doing so, each reader can pause at each point in the conversation and ask him- or herself or others: "How would I continue the conversation instead of the doctor?" and evaluatively compare this fictitious proposal for a medical intervention with the real continuation of the conversation by the real doctor. We have described this simulation procedure in more detail elsewhere (Koerfer et al. 1996, 1999, 2008) and have compiled some appropriately prepared exercise examples here, which can be used individually and in group lessons.

As we continuously contrast "negative" with "positive" examples hereafter with our comparative research and teaching approach, the related problem of dealing with criticism should be addressed. When observing "negative" examples of conversation, the same solidarity in criticism should apply as is natural in the tradition of continuing medical education or student teaching. Learning from the negative model can be just as productive as from the positive model. Thus, also in this textbook, criticism of an interview style which, on closer examination, "leaves a lot to be desired" should not be confused with "colleague scolding", but should be understood as a contribution to the "error" discussion which, in the sense of Balint (see above), can contribute to the progress of knowledge.

However, those who only present themselves as master critics when they observe others should try to make themselves the "object" of the critical observation of others via video recording and transcript. Perhaps, in the first step, critical self-observation after self-recording of one's own conversation practice is enough. The role of a doctor may be difficult enough, but the role of one's own meta-doctor is no easier. In this role of the meta-doctor, openly and self-reflexively facing the critical observation of others can considerably improve one's own conduct of conversations in the role of the doctor.

6.5 Further information

The challenges to the "doctor's image of the future", on which the early analyses and perspectives of the Murrhardter Kreis (1995) were groundbreaking, were described in advance with more recent developments on the "structural and functional change of medicine" (§ 5).

On the specific question of the "good doctor", reference should again be made to the monographs by Dörner (2001) and v. Troschke (2004) as well as the volumes by Simon (ed.) 2005 and Witt (ed.) (2010), in which medical competencies are also discussed under interdisciplinary, historical, subject-specific and didactic aspects. For further literature on the "good doctor", please refer to the review by Steiner-Hofbauer, Schrank, Holzinger 2017 and the empirical studies by Schnelle, Jones 2022 and 2023.

Specifically on cooperative competences in interprofessional teamwork, cf. e.g. Flin, Youngson, Yule (eds.) 2016, Donaldson et al. (eds.) 2021, Mahmood et al 2021, Morris et al. 2022. On the training of (empathic) competences specifically in Balint groups cf. Köhle et al. 2001, Koerfer et al. 2004, Cataldo et al. 2005, Köhle, Janssen 2011, Tschuschke, Flatten 2017, Yang, Wang 2022.

The various roles of the doctor were differentiated in a historical overview with v. Uexküll and Wesiack (1991) in the chapter on "Biopsychosocial Medicine" (§ 4.4); more descriptions of physician roles and functions can be found with further literature, for example in Ringsted et al. 2006, Frank, Snell, Sherbino (eds.) (2015) (*CanMEDS 2015 Physician Competency Framework*), BMBF 2017, Cracknell, Cooper 2018, Pförtner, Pfaff (2020) and in the NKLM 2.0 2021.

Different relationship models (*paternalism, service, cooperation*) and their variants are discussed in detail with further literature in chapter 10 (Information and Decision Dialogues) and chapter 26 (Prescription talk), analyses of examples can be found in particular in chapters 22 (*Coordinating Procedures*) and chapter 24 (*Ward Round Communication*).

Didactic concepts for teaching communicative competences are presented in the relevant chapters 3, 13-16 as well as in the chapters on our *Cologne Manual on Medical Communication* (§ 18-23), in which conversation practice is to be critically analysed, especially on the basis of negative and positive examples (*best practice),* before possibilities and limits of competence enhancement are pointed out in the concluding part on evaluation (§ 40-43).

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

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