Preface

Handbook "Medical Communication Competence"

Why has there been so little progress over the years?

The benefit of good communication on patient care and outcomes is unequivocal, whereas deficiencies in communication are associated with medical errors and a negative patient experience. So why has there been so little progress over the years?

Levinson, Pizzo (2011: 1802):
Patient-physician communication: It's about time

Discrepancies between reality and relevance?

Communication skills training (CST) remains poorly represented and prioritised in medical schools despite its importance.

Venktaramana et al. (2022: 997)
A systematic scoping review of communication skills training

The critical assessments by Levinson and Pizzo (2011) at the beginning of the last decade and by Venktaramana et al. (2022) at the beginning of this decade equally point to desiderata in medical communication education (§ 1). These desiderata have not lost their relevance in the present.

Poor Medical Communication

Despite the great advances in theoretical and empirical research on doctor-patient communication (§ 1-3, 7-12, 40-43) and despite all the reform efforts initiated in the past and continued in the present (§ 1, 3-6, 13-16), the systematic deficiencies in the field of medical communication education in particular remain unmistakable.

As specific (outcome) research has shown in detail, the everyday practice of communication between doctor and patient is still often experienced by both parties as less than satisfactory. The objectifiable consequences of faulty or just insufficient or inappropriate communication for the health of patients are considerable, for example with regard to their medical understanding and coping with illness, their health behavior and ultimately their adherence to treatment, which is demonstrably poor, although it should be particularly important for them (§ 10, 26, 29). Because of patients' non-adherence, not only does their individual suffering increase, but objectively their risk of morbidity and mortality increases, associated with enormous economic costs (§ 5, 10).

Objectives and Structure of the Handbook

All in all, there are good reasons to further investigate in detail the causes of such an erroneous development, which essentially results from the disturbances and deficits of the original communication between doctors and their patients, in order to take the necessary steps towards the improvement of the predominantly poor communication practice.

We see this *Online* Handbook as a contribution on the road to improvement, which, with its easy availability, should be equally accessible to teachers and learners of medicine and other subjects. The handbook incorporates the many years of research and teaching experience from our Dept. of Psychosomatics and Psychotherapy (University of Cologne, Medical Faculty and University Hospital) on medical communication, which we have didactically prepared according to our previous learning concepts (§ 13, 14, 17-23). Our goal is the circular interaction of theory, didactics, practice and examination or evaluation of medical communication. With all the necessity of a “didactic reduction”, the still controversial questions of research should not be concealed but made a topic specifically in the sense of research-based learning (§ 13).

The contributions to research and teaching on medical communication were compiled in an interdisciplinary co-operation. We would like to take this opportunity to thank all the authors who – as physicians, psychologists, sociologists and linguists – have contributed to this interdisciplinary perspective of the handbook.

The objectives and structure of the handbook are presented in more detail in a problem-oriented introduction (§ 1), which is followed by an

overview of the state of the art of interdisciplinary communication research (§ 2) and the promotion of the learning goal ‘communication competence’ (§ 3) (Part I).

After the theoretical foundations (Part II: § 4-12) and the didactic concepts of student training and continuing professional education for doctors on medical communication (Part III: § 13-16), the empirical practical Part IV follows, which is essentially structured by our *Cologne Manual on Medical Communication* (C-MMC) (§ 17-23).

In Part V, major challenges of communication practice in specific fields of competence are described and analysed in detail (§ 24-39), subsequently, problems, methods, and results of evaluation research are discussed in Part VI. Finally, some further information is compiled in the Appendix (Part VII).

The chapter sequence chosen in this handbook (§ 1-44) suggests a structured learning experience, which, however, can also be used in a different order depending on interest, as well as in individual selection and with "side entries" into individual selected chapters. Since the handbook has become quite extensive with its 44 chapters, the thematic resumptions and cross-references between the individual chapters can be used for easier "navigation" beyond the respective introductory overviews, which are also intended to encourage more in-depth reading, as are the concluding references to further reading. The handbook is structured in such a way that it is suitable for use both for research and teaching as well as for group learning and self-learning.

English Edition

The present handbook is based on the German edition (cf. Koerfer, Albus (eds.) (2018): *Kommunikative Kompetenz in der Medizin*). The English edition is designed as a "Living Handbook" that already contains the majority of the chapters, which will be gradually followed by further chapters. The individual chapters have been revised, updated and translated.

We would like to make the following comments on the translations: German-language "classics" were quoted according to the German editions and translated here (e.g. Binswanger, Buber, Bühler, Eibl-Eibesfeldt, Freud, Gadamer, Habermas, Jaspers, Kant, Scheler, von Uexküll). English-language "classics" were often quoted after the German edition and translated here as well (e.g. Austin, Argyle, Balint, Ec-

cles, Engel, Grice, Labov, Luborsky, Popper, Rogers, Schafer, Searle, Watzlawick). In these cases, the English titles and editions are mostly added in the complete bibliography of the handbook. Otherwise, the English-language literature is cited in the original wherever possible.

Empirical Doctor-Patient Communication

For methodological reasons to be explained further (§ 2), our approach is "strictly" empirical in the specific sense that we have taken the poor as well as the good examples largely from an extensive corpus of videotaped and transcribed conversations conducted in real clinical settings. For this reason, we would like to take this opportunity to thank all the doctors and their patients who gave us a concrete insight into their communication practice. Future generations of doctors and patients can benefit from their willingness to be "observed over the shoulder" in conversation when patients later meet better trained doctors. This Online Handbook of *Medical Communication Competence* is intended to make a concrete contribution to this goal.

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References

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

Levinson W, Pizzo PA (2011): Patient-physician communication: It's about time. JAMA 305 (17): 1802-3.

Venktaramana V et al. (2022). A systematic scoping review of communication skills training in medical schools between 2000 and 2020. Medical Teacher, 44(9), 997-1006.