2 Interdisciplinary Research on Medical and Therapeutic Communication
A Critical Review

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> Much of the work that we have done in health communication has been interdisciplinary.
> Parrott, Kreuter 2011: 4

Abstract: The preceding statement by Parrott and Kreuter on the state of *interdisciplinarity* in health communication research is not as self-evident as the authors initially suggest in the introduction to the "Handbook of Health Communication" in 2011. Just two decades earlier, Stewart and Roter had lamented a lack of interdisciplinarity in their research summary:

> Until very recently, researchers have worked in single disciplines rather than on interdisciplinary teams (Stewart, Roter 1989: 252).

The different perspectives may be historically based, but also depend on the respective claim to interdisciplinary research. Parrot and Kreuter also make the qualification directly after their positive statement:

> One dilemma facing academics from different disciplines who are in pursuit of health communication is a lack of awareness of what other disciplines are doing (Parrott, Kreuter: 2011: 4).

Rather than ignorance, which may be due to a narrow-minded view through one's own glasses, mutual awareness of the theories, methods and results of different disciplines is certainly the very first prerequisite for interdisciplinary research. Despite all the initial difficulties, this has undoubtedly come a long way in the meantime, which is reflected, among other things, in established *standards* for theoretical and empirical, quantitative and qualitative analytical approaches, which we will return to separately under the aspect of evaluation (§ 40-43).

Here, we will first (§ 2.1) provide a brief overview of *key turning points* in medicine and interdisciplinary research and of the subject matter, development, and topics of psychotherapeutic, clinical and social science research (§ 2.2), for which we provide a *critical review* that is both *historical* (§ 2.2.3) and *topic-specific* (§ 2.2.4).

The review continues (in § 2.3) on a specific topic: After presenting the discussion on definitions of the term *competence* as they are commonly used in *pedagogy*, *psychology*, *linguistics* and *medicine*, Chapter 2.3 will develop and justify a *definition* of *communication competence* in medicine in several steps, which will also contribute to a competence-based *taxonomy of learning goals* within the framework of the *Cologne Communication Curriculum* (§ 2.3.1-12).

Since the practical part (IV) of the handbook focuses exclusively on *empirical anchor examples*, the empirical *method* of video- and transcript-based *conversation analysis* will be described (§ 2.4). This method of *empirical* conversation analysis is exemplified in advance using an example (§ 2.4.4), which is followed by a presentation of the essential *transcription rules* (§ 2.4.5), which will subsequently apply to the handbook as a whole.

In a fifth step (§ 2.5), the approach of a *functional* conversation analysis will be outlined, which we will also follow in this handbook in order to be able to work out the specific *patterns* of action and goals ("endpoints") in medicine, which will be illustrated using learning concepts from the *Cologne Communication Curriculum*.

Finally (§ 2.6), problems and perspectives of *evaluation* are highlighted, ranging from the use of a basic *evaluative vocabulary* of conversation analysis to knowledge-guiding *theories* and *models* to established "gold standards" for evaluation, the further development of which will be an ongoing focus of this handbook.

2.1. Paradigm shift in social research

The interdisciplinary development of the research subject of doctor-patient communication is very complex, intertwined in many ways and branched out into very different disciplines. A main line of distinction can be drawn between the following traditions, in which specific variants can be differentiated:

- *Clinical* conversation research, which can be divided into *psychotherapeutic* and *medical* conversation research (in the narrower sense).
- *Social science* conversation research (in the broader sense), in which disciplines as diverse as the philosophy of language, sociology, linguistics, psychology, anthropology, etc. are involved, each with their own specific knowledge interests and research methods.

As we will see in more detail, theoretical and empirical, qualitative and quantitative approaches as well as diverse mixed forms can be distinguished in both research traditions. The *integration* of these approaches is called for as an essential *paradigm shift* (§ 7, 9, 40-43), because a continuation of their dichotomous distinction has proven to be less than fruitful.

All the disciplines involved have undergone enormous developments in recent years, which in the case of the *empirical* variants of conversation research can be attributed not least to the possibilities of using technical recording and documentation methods (§ 2.4). A number of disciplines have more or less individually or jointly undergone "their" specific "paradigm shifts" and have entered into specific interdisciplinary collaborations with other disciplines, which we can only mention in passing here.

2.1.1 Turning points in medicine

Before we outline the development of interdisciplinary research in more detail, particularly from the perspective of *clinical* conversation re search, we will first highlight the key *turning points* in medicine that can be used to explain "their" specific perspective of interdisciplinarity:

- Biopsychosocial turn (§ 4, 5)
- Communicative turn (§ 1, 6, 7, 8)
- Narrative turn (§ 9, 19)
- Participatory turn (§ 10, 22)
- Empirical-evaluative turn (§ 2.5, 3.3, 5.4, 40-43)

As we will return to these turning points in medicine repeatedly throughout the handbook, we will only provide a brief overview here with references to individual chapters in which the development and scope of these turning points are explained in more detail.

In the introduction chapter (§ 1), we already outlined the *communicative turn* in medicine, in which George Engel in particular emphasised the relevance of the *communicative* approach to the patient (keyword "dialogical" or "talking medicine") (Koerfer et al. 1994, 1996, 2005, Olesen 2004, Koerfer, Albus 2015, 2018). As will be explained in detail (see below and § 4, 5), it is no coincidence that the communicative turn coincides with the "paradigm shift" from *biomedicine* to *biopsychosocial* medicine (Engel 1977/79, 1981, 1997, v. Uexküll, Wesiack 2011, Giorgi et al. 2020, Tramonti et al. 2021, Smith 2021, Lugg 2022, Roberts 2023, Bolton 2023, Egle et al. 2024).[1]

With this paradigm shift, the thematic reduction of the traditional, essentially *biomedically* focused anamnesis must be replaced by a *biopsychosocial* anamnesis (§ 9), in which biotic, psychological and social *issues* and their links are developed from the concrete, lifeworld perspective of the patient's experience in dialogue with the doctor. Such a biographically relevant reconstruction of a history of illness and suffering will also not succeed in the traditional, *interrogative* interview technique, in which patients can merely fill in pre-formatted "slots" by giving answers to the doctor's questions. Rather, the *communicative* turn must be given a concrete form as a *narrative* turn (§ 9), according to which patients enjoy a special communication privilege in that they can tell their patient *stories* in their *own words* from their patient perspectives.

This communication privilege is not merely a formal right to speak for narrative self-presentation, but is to be defined substantially in the

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[1] References not listed at the end of this chapter can be found in other topic-specific chapters and in the complete bibliography (with over 2500 references) of the handbook. This bibliography also includes all references listed in the following tabular literature overview ("Traditions and Topics") (Table 2.1) (§ 2.2.3).

sense of a "participatory" turn in medicine in such a way that patients can not only articulate their personal rights and interests as *subjects*, but can *actively exercise them*, which should ultimately lead to *shared decision making* (SDM) in cooperation with the doctor (§ 2.2.3, 10, 22, 33).

Finally, all these developments in medicine are not merely about postulates and maxims of an *ideal-typical* medical practice, but must be subjected to a practical test in the spirit of *evidence-based* medicine (§ 5). Such a practical test should not be limited to *the instrumental* actions of physicians ("surgical intervention"), but should be extended to *communicative* actions ("medical conversation") (§ 6, 7) in such a way that an *evaluation* (§ 2.5, 3.3, 40-43) on the empirical basis *of authentic* conversations is possible.

2.1.2 Interdisciplinary turning points

Before we go into this *empirical-evaluative turn* in *interdisciplinary* conversation research in more detail, it should be added that the turning points in medicine did not take place in the "closed" space of the individual discipline, but coincided with other turning points in the social sciences, such as the "linguistic turn" or "pragmatic turn", which were relevant for language philosophy and linguistics (Apel 1990, Koerfer 1994/2013), or the "narrative turn", which was equally relevant for linguistics, sociology, medicine or psychology (§ 9, 19. 20).[2]

These general turning points in the social sciences have been used productively in medical conversation research for their own specific turning points. For example, the adoption of the *communicative* (*linguistic-pragmatic*) turn has also shown that the analysis of doctor-patient communication cannot be objectively reduced to the mere "exchange of words", as Freud (1916/17: 9f) rightly emphasized in his time, but that doctor and patient perform *speech acts* with their words (Austin 1962/72) (§ 7.3), in that the interaction partners express suggestions, requests, objections, consents, etc. in a sequentially organized dialogue.

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[2]　See below, § 2.2.4: topic focus 9 and handbook § 9, 19, 20. Cf. Labov, Waletzky 1967/1973, Bruner 1987, Kleinman 1988, Koerfer et al. 1994, Mishler 1995, Straub (ed.) 1998, Greenhalg, Hurwitz (1998), Koerfer et al. 2000, 2005, 2010, Charon 2006, Goyal 2013, Baroni 2014, Köhle, Koerfer 2017, Habermas 2019, Habermas, Fesel 2022, Kirmayer et al. 2023, Koval 2024, Palla et al. 2024, Fioretti 2025.

These utterances do not take place without context, but are embedded in an *institutional* framework in which the two interaction partners perceive their specific roles as doctor and patient, as already described by Parsons (1951/70) and Freidson (1970/79). For example, it is not about a friend's request to close the window, but about a patient's request to write a prescription, which the doctor can refuse not because of unfriendliness or self-interest, but for medical reasons, so that in the *functional-pragmatic* conversation analysis (§ 2.5) the *institutional* binding of speech acts must be taken into account (Koerfer 1994/2013), which we will discuss separately (§ 7).

2.2   Research development and state of research

Before medicine began to deal with its essential medium of communication as a subject of research, the tradition of psychotherapy (conversation) research was already more advanced. However, both research traditions meet in the "empirical-evaluative" turn, which was soon made possible by the use of modern recording and documentation procedures. Without even coming close to doing justice to the further development here, a few *milestones* on the way to *empirical clinical* conversation research based on *authentic* conversations can be highlighted.

2.2.1 Psychotherapeutic traditions

Since communication is not only essential in (psychoanalytical) psychotherapy, but also has a unique selling point in its specifically analytical and therapeutic mode of action, the early preoccupation with communication as a subject of research was obvious. Here, the research arc spans from Freud via Jaspers and v. Weizsäcker to Balint and v. Uexküll, thus establishing the interface with medicine at the latest.

In this tradition, *case reports* were initially the main source of research - with all the shortcomings inherent in reports on communication. However detailed and critical they may be, reports on communication are not communication itself (Labov 1971, Koerfer 1981, 1985) (§ 2.3). The *methodological dilemma* of accessing the "original" cannot be overcome in principle for many reasons (*observer paradox* etc.), but it

can be alleviated if research approaches the "original" as "unadulterated" as possible and controls "distortions" and "losses" as far as possible.

As early as the 1930s, Carl Rogers (1942/85) and his colleagues used the media of (audio) recording and transcription of therapy conversations, which were still new at the time and in this context (§ 40.2), in order to be able to determine and describe the differences between *directive* and *non-directive* conversations.

In German-speaking countries, the Ulm corpus project on (psychoanalytic) therapy interviews initiated by Horst Kächele and colleagues has been a resource for many "empirical" studies in the sense that they were carried out using audio recordings and transcripts (Kächele et al. 1973, 2006, Thomä, Kächele 1989: vol. 2; English Edition 2012). This made it possible to subject the relevant studies to *intersubjective* scrutiny. This type of data access was soon also used for interdisciplinary research (Flader, Grodzicki 1982, Koerfer, Neumann 1982, Schröter 1982), in which representatives of various disciplines (psychoanalysis, linguistics, sociology) were involved (Kächele 2016).

This "empirical" tradition of clinical psychotherapy conversation research has since undergone numerous variations with established, *transcript-based standards*.[3] In these research projects, *interdisciplinarity* has been established not only through cooperation, but also in "personal union", as it were, in that these colleagues have combined their therapy (research) competences with linguistic, conversation-analytical and narratological competences, from which we repeatedly seek to benefit here.

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[3] See below, § 2.2.4: topic focus 2 and this Chapter: § 2.4. Cf. Rogers 1942/1985, Pittenger et al. 1960, Sheflen 1964, Labov, Fanshel 1977, Koerfer, Neumann 1982, Kächele et al. 1988/2012, Buchholz (ed.) 1995, Buchholz, Streeck 1994, Buchholz 1996, 2005, Streeck 2004, Boothe 1994, 2011, Peräkylä et al. (eds.) 2008, Pawelczyk 2011, Scarvaglieri 2013, Buchholz 2014, Buchholz, Reich 2014, Buchholz, Kächele 2013, 2016, 2017, Peräkylä 2019, Guxholli et al. 2021, Montiegel, Robinson (2021), Dimitrijević, Buchholz (eds.) 2021, Buchholz 2022, Buchholz et al. 2022, Scarvaglieri et al. (eds.) 2022, Barnes, Woods 2024, Ekberg et al. 2024, Parry 2024.

2.2.2 Medical and social science research

At the same time, a tradition of *medical* conversation research (in the narrower sense) emerged which, although it only came into interaction with the tradition of psychotherapy conversation research at a later stage, took a comparable *empirical-evaluative* turn (see above).

The main problems of doctor-patient communication were first noticed by the pioneers of medical conversation research themselves, who experienced contradictions and resistance in their own daily practice. As researchers, doctors often took a critical look at conversations that they or their colleagues had conducted themselves as doctors. Later, other social science disciplines were added, so that an *interdisciplinary* field of research was able to develop here too.

Despite all the differences, including personal attitudes to their subject matter, *medical professionals* (M) on the one hand and *social scientists* (S) (linguists, sociologists, psychologists, etc.) on the other hand work on the sides of the same medals (Fig. 2.1), which will be explained further below as a preliminary picture.

In the English-speaking world, for example, early research by Barbara Korsch was groundbreaking, in which critical observations were made from the perspective of pediatrics as to how doctors more or less silenced parents through their communicative behaviour, for example when informing them, or at least systematically prevented their active participation (Korsch et al. 1968, Korsch, Negrete 1972, Uexküll 1987, Koerfer et al. 1994, Koerfer et al. 2010, Koerfer, Albus 2015, Köhle, Koerfer 2017). For example, the merely demonstrated listening behaviour of the parents, who only expressed listening signals (*hm, yes, okay,* etc.) mechanically, as if they had understood, although their feedback behaviour seemed "without sense and reason", was striking. They were obviously already "lost" in terms of content without their doctors noticing this and correcting their own conversational behaviour accordingly.

Such studies have already sensitised researchers to the "large" effects of the "small" communication units, such as the listener signals (*hm, yes*), which was of course also an established subject of research in other sciences (Duncan 1974, Ehlich 1979, Koerfer 1979), which increasingly became the focus of clinical conversation research (Flader, Koerfer 1983). With the use of video recordings, the observation spectrum of *nonverbal* communication (body posture, eye contact, etc.) ex-

panded considerably, which is dealt with separately (§ 12, 18) due to its specific significance for doctor-patient communication.[4]

With the *empirical turn* in research, which began in the 1970s at the latest and was characterised by the fact that it was at least based on audio recordings, systematic studies could begin, which soon impressed with their extensive data. Byrne and Long (1976), for example, carried out their studies of (types of) verbal interventions and interview styles of types of conversations (C) on the basis of more than 1000 individual conversations (c).

The empirical approach of clinical conversation research soon met with (in the broadest sense) *social science* disciplines (S) (Fig. 2.1), in which conversations (of different types) (C) were examined on the basis of empirical data (exemplary conversations) (c).

The initial focus here was essentially on the differences between *everyday* and *institutional* communication as well as (types of) communication in various institutions, such as schools, universities, courts, tax offices, employment offices, etc.[5] From this *comparative* perspective, an interdisciplinary interest in the analysis of doctor-patient conversations as examples of a special type of *institutional* communication also developed.[6] This also involved the particularly controversial aspect of *(a)symmetry* between doctor or therapist and patient, which was the subject of a sometimes very controversial discussion,[7] which continues to this day and will be discussed separately (§ 7-8, 10).

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[4] See below, § 2.2.4: topic focus 6 and handbook § 12, 18, 25. Cf. Scherer, Wallbott 1979, Argyle 1983, Streeck 2004, Lausberg 2011, Matsumoto et al. 2013, Hall, Knapp (eds.) 2013, D'Agostino, Bylund 2014, Schmid, Cousin 2014, Hall et al. 2019, Lausberg 2019, Burgoon et al. 2021, Lausberg 2022, 2024, Gil Deza 2024, Gordon, Druckman 2025

[5] See below, topic focus 3 and handbook § 5-7. Cf. Ehlich, Rehbein 1977, Hoffmann 1983, Koerfer 1994/2013, Birkner, Meer (eds.) 2011 Ehlich, Rehbein 1977, Hoffmann 1983, Koerfer 1994/2013, Birkner, Meer (eds.) 2011, Ehlich 2020, 2022.

[6] See below, topic focus 3 and handbook § 5-10. Cf. Fisher 1984, Fisher, Todd 1983, Ehlich et al. (eds.) 1990, Redder, Wiese (eds.) 1994, Löning 1985, Menz 1991, Lalouschek 1995, Have ten 1991/2013, Peters 2008, 2015, Scarvaglieri 2013, 2020.

[7] See below, topic focus 3 and handbook § 7-8, 10. Cf. Siegrist 1982, Fehlenberg 1987, Maynard 1991, Have ten 1991/2013, Koerfer 1994, Roberts 2000/2013, Koerfer et al. 2005, Brock, Meer 2004, Menz, Al-Roubaie 2008, Peters 2008, 2010, Pilnick, Dingwall 2011, Heritage 2013, Groß 2015, Weiste et al. 2016, Scarvaglieri 2013, 2020.

Fig. 2.1   Medical and social science research: sides of the same medals

p p p p p p p
LW

l
s
y
s   S   c c C c c   M   m
l   m
s   m
y   m
m
m
m

(N)VC
i d i d i d
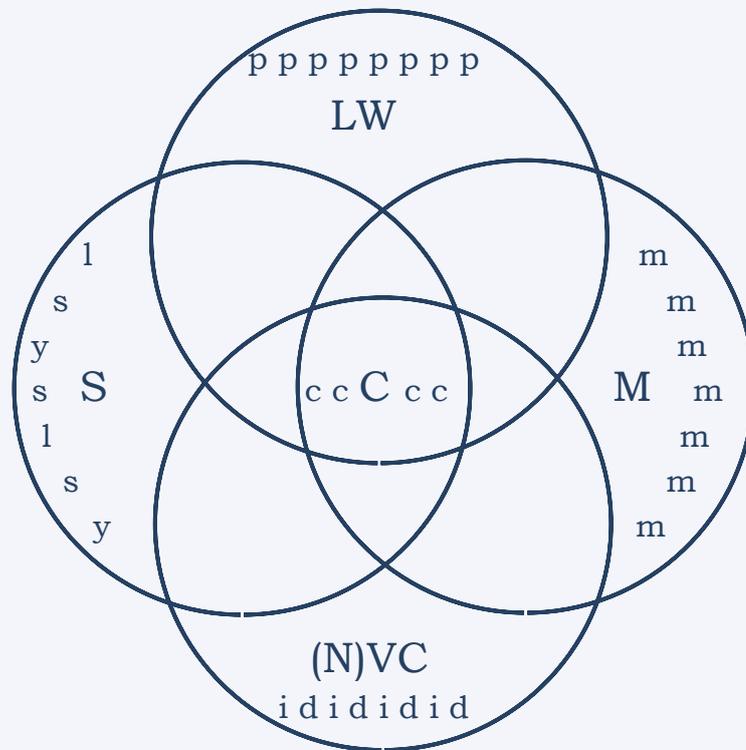
Legend:
Capital letters: Systems, types   Small letters: Individuals, examples
C   Conversation type   c   Conversation
LW   Lifeworld   p   Patient
M   Medicine   m   Medical professional
NVC   (Non)verbal communication   i   Idiolect / d dialect
S   Social science   l   Linguist
                                           s   Sociologist
                                           y   Psychologist

The interdisciplinary research interest was reflected in a series of collective volumes, which often included contributions from scholars from different disciplines, to which we will return in many chapters.[8] For the

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German-speaking countries, Köhle and Raspe (eds.) (1982) are a good example, where early studies were conducted under the title "Das Gespräch während der Visite" (*The Conversation During the Ward Round*). This volume brings together theoretical and empirical studies by medical professionals (m), linguists (l), sociologists (s), psychologists (y), etc., the results of which we will discuss in detail later in our research on *ward round communication* (§ 24).

Another outstanding work in terms of methodology was the monograph "The Discourse of Medicine" by Elliot G. Mishler (1984), who, with reference to the communication theory of Jürgen Habermas (§ 7.3), described the conflicts of understanding and communication between doctor and patient as a clash between *the lifeworld* (L) and *medicine* (M) as a system (Fig. 2.1) We will also return to this approach separately (§ 2.3, 10.2) in order to be able to determine the specifically institutionally conditioned conflicts between doctors and patients, which are based on different systems of relevance and therefore run the risk of systematically talking past each other.

Overall, the theoretical and empirical analysis of conversations must take into account that, despite the *institutional nature* of communication, the *individuality* of patients (p) always leads to individual conversations (c), in which medical action must take into account the individual ties of the patient in his or her specific lifeworld. Despite all the *social* ties of verbal and non-verbal *communication* (N-VC), which is mediated via layers, roles, language codes etc. and is both part of and a medium for the lifeworld we all share, medical understanding must ultimately be based on the *idiolects* (i) (often dialects) of patients (Mishler 1984, Flader 1993, Bindernagel et al. 2010). Many examples from the practical section (IV) of the handbook are characterised by dialect, with patients using unconventional language (§ 18-25), to which doctors must respond appropriately.

Doctors must take into account that their patients *speak their own language* when they complain about their suffering in order to find medical help. In order to understand all the verbal nuances of communication, physicians need to have special *listening competences*, which we will deal with throughout this handbook (and especially in § 9, 11, 19, 20, 27).

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glieri et al. (eds.) 2022, Baumeister et al. (eds.) 2023, Mezzich et al. (eds.) 2023, Kitchen et al. (eds.) 2024.

2.2.3 Changes in relationship and communication models

After the initial focus of interdisciplinary research on basic situations (*ward rounds, primary care*) (§ 24, 25), increasingly specialised fields of competence in medical practice (*psychosomatics, oncology, transplantation medicine, palliative medicine,* etc.) were differentiated in the further development, a number of which will be explained in detail later (§ 24-39). First, the traditional and thematic developments in interdisciplinary discussion research will be outlined and summarised in a *synoptic presentation* with exemplary literature references (Fig. 2.2, cf. § 2.2.4.).

We cannot and do not wish to provide a *historical and systematic* review here, but have instead made a selection that corresponds to the development and sequence of topics in the Handbook. Before providing an overview of the literature, which is structured according to specific topics (topic focus 1-15) (§ 2.2.4), we would like to give a *historical* overview of the development of *relationship and communication models,* which have undergone change over the course of more than five decades (Fig. 2.2).

Six stages in the development of medicine

The *interdisciplinary* collaboration between medical professionals, psychotherapists, sociologists, linguists, etc., described above has provided theoretical and practical insights into the structures and functions of medical and therapeutic communication. These insights have also led to new models for shaping relationships and communication with patients in healthcare practice, which are briefly outlined below.

If, in the interests of the necessary reduction, one neglects the various reform movements, some of which are parallel or even contradictory, as well as overlaps and transitions, then the various model developments can be summarised in tabular form with a timeline (Fig. 2.2).

In a rough order and classification, which is also based on the year of publication of the relevant publications, *six stages of development* can be differentiated over a longer period of time spanning several decades. Clinical experience and theoretical developments went hand in hand with the empirical research results described. However, the reform movement in *education* always lagged behind *theoretical* developments, and this *discrepancy,* which will be described in more detail (see § 2.2.4: topic focus 8, 13, and § 3, 13, 14), continues to this day.

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Phase	Stages in the development of medicine (theories, models)			Time	Exemplary literature (theories, models, didactics)
1	Doctor-centred model: Authoritarian ethics	Disease-centred Autonomy & Decision D ⟶ P Interrogation	Bio-Medicine		Traditional medicine (practised before and also after v. Weizsäcker 1940, 1946, Balint 1964, Morgan, Engel 1969, Engel 1977, 1981, 1988, 1997 and others).
2	Patient-centred	First stage: P ⟶ D	Bio-psycho-social Medicine		Balint 1964, Byrne, Long 1976, Engel 1977, 1981, 1988, White 1988, Levenstein et al. 1989, von Uexküll, Wesiack 1991, Koerfer et al. 1994, Charles et al. 1997, 1999, Elwyn et al. 1999, Mead, Bower 2000, Koerfer, Albus 2015, 2018, Bruch et al. 2024, Elwyn et al. 2025, Aboushawareb et al. 2025
	Business: Libertarian ethics	P ⟶ D Dialogical asymmetry			
	SDM: Discourse ethics	P ⟷ D Dialogical symmetry			
3	Relation-ship-centred model	Disease & illness Asymmetrical roles & equal autonomy Narration & SDM (D ⟷ P) & Discourse Ethics	Bio-psycho-social Medicine		Tresolini et al. 1994, Mead, Bower 2000, MC Beach et al. 2006, Rider, Keefer 2006, Suchman 2006, Kenny et al. 2010, Zhou et al. 2023
4	Interactional care model				WA Beach, Dixon 2001, Robinson 2003, WA Beach 2013
5	Partnership & Dialogue-based model				Pellegrino, Thomasma 1981, Uexküll 1987, 1993, Herzka 1990, Koerfer et al. 1994, v. Kampits 1996, Engel 1997, Anderson 1999, Roter 2000, Olesen 2004, Koerfer et al. 2008a, 2008b, Koerfer, Albus 2015, 2018, Collins, Street 2009, Walseth, Schei 2011, Richard, Lussier 2007, 2014, Chin-Yee et al. 2019
6	Partnership & Narrative-based model				Brody 1994, Koerfer et al. 1994, Greenhalgh, Hurwitz 1998, Koerfer et al. 2000, 2008, 2009, 2010, Charon 2001, 2006, Mishler 2005, Goyal 2013, Köhle, Koerfer 2017, Milota et al. 2019, Galvagni 2022, Kirmayer et al. 2023, Palla et al. 2024

Fig. 2.2: Stages in the development of medicine -
Modified on Koerfer, Albus (eds.) (2018: 329) (cf. § 3, 9, 10, 13, 17-23).

From doctor-centred to patient-centred medicine: Education deficits

The first movement was a shift away from traditional, paternalistic, doctor-centred medicine and towards patient-centred medicine, in which the patient became the focus of attention, requiring a different type of relationship and communication. [9]

In English-speaking countries, the initiators were primarily pioneers such as George Engel (e.g., 1977, 1997), who founded biopsychosocial medicine (§ 4), and Michael Balint (e.g., 1964) who initiated the *reform* movement later named after him, known as *Balint group work*, which continues to this day (see § 2.2.2 topic focus 14, and § 6). In German-speaking countries, it was primarily the work of Thure von Uexküll and Wolfgang Wesiack (e.g., 1991, 2011) that contributed to the establishment of *biopsychosocial* medicine and initiated reform movements at German universities (Ulm, Berlin, Cologne, Heidelberg, etc.), which, however, were implemented at different tempo.

When changes did occur, they were introduced at different speeds in theory and practice that could hardly keep up with theory. The dual and parallel paradigm shift, which entailed a departure from traditional, *paternalistic* medicine and a shift towards new, initially strongly *patient-centred* relationship and communication models, took place in various waves and phases. [10] Accordingly, the resulting shift towards "talking medicine" revealed gaps in the education system, which was not

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[9] The term *Patient-Centered Care* (PCC) is often used as a generic term, but it is also used critically when the distinction between different models needs to be emphasised and justified (see below), cf. Byrne, Long 1974, Weiner 1986, White et al. 1988, Mead, Bower 2000, Langenbach, Koerfer 2006, Beach 2013, Kumar, Chattu 2018, Milota et al. 2019, Feldthusen et al. 2022, Grover et al. 2022. See below for criticism of exaggerated concepts of patient-centred medicine.

[10] Delays can also be explained by the reception of the relevant literature, which was accessible to varying degrees in the reform debate: The paradigm shift was introduced in theory early on in the English-speaking countries with the works of Balint (1964), Balint, Balint (eds.) (1962), Balint, Norell (eds.) (1973) and Morgan, Engel 1969, Engel (1977) (1997), and continued in German-speaking countries primarily with the work of v. Uexküll, Wesiack (1991), (1996), (2011) (English Edition: v. Uexküll 1995, v. Uexküll, Wesiack 1997).

equipped to promote the necessary *communication competences* in medical education (Box. 2.1).

Box 2.1	Communicative shift and deficits in medical education
Medicine is currently undergoing a communicative shift (...) As the paradigm shift from biomedical to biopsychosocial care led to recognition of the importance of the doctor-patient consultation for medical history taking, diagnosis, and therapy, deficits in medical training became apparent, and the problem of how to promote the communicative competence of doctors.	

Koerfer et al. 1994: 53

In the meantime, entire fields of research have developed that deal with basic research as well as empirical conversation analysis and educational reforms at universities (focus topics 3-15) (§ 2.2.4, 2.3.9, 3, 13, 14). However, the *deficits* in education have not yet been remedied, as current studies on *communication curricula* show (Bachmann et al. 2022, Venktaramena et al. 2022) (cf. § 2.3.5, § 13, 14).

In the theoretical chapters of the handbook (§ 4, 5, 6, 10) and in the didactic chapters (§ 3, 13, 14), the wave movements in the transformation of relationship and communication models are further differentiated. Chapter 10 in particular discusses the various participation models (SDM, etc.) that emerged after the shift away from traditional paternalism and towards *patient-centred medicine*, which, however, soon became differentiated with further models.

From patient-centred to dialogue-centred medicine

Here, the pendulum swung from the *paternalistic*, *authoritarian* model to extreme directions in which patient autonomy dominated, accompanied by a loss of autonomy for the physician. In these extreme models, a *libertarian ethics* prevailed, according to which the patient - under the motto: "The customer is king" - could make decisions about his treatment almost single-handedly, without the physician, who at best could only provide him with adequate information. Later, moderate models based on *discourse ethics* prevailed, according to which decisions are made by *mutual agreement* in a *symmetrical* partnership through dialogue (Koerfer, Albus 2015, 2018, handbook: § 10, 22).

In the discussion about the *optimal model*, however, criticism was not directed at a *patient-centred model* in principle, but rather at extreme manifestations such as the *service/business* model, in which the

patient alone should be able to benefit from the libertarian ethics, which could lead to extreme variants (according to the motto: "anything goes").

The associated *asymmetry* in the relationship, which can lead to the disempowerment of the physician, should be abolished in a *dialogical model*, which was formulated early on by Pellegrino, Thomas (1981, 1988) and later justified in many variations from different perspectives, in which the *dialogical principle* in the sense of Buber (1954/1986) is also applied to the doctor-patient relationship and communication to be evaluated within the framework of *discourse ethics* (cf. v. Uexküll 1987, 1993, Gadamer 1993, Koerfer et al. 1994, 2008, Kampits 1996, Ritsert 1992/2004, Kettner, Kraska 2009, Koerfer, Albus 2015, 2018) (§ 7, 10 of the handbook). According to this view, the two conversation partners, doctor and patient, meet in their own way as experts who engage in dialogue in the interests of both parties, which was summarised by Olesen (2004) in a short editorial as an essential interim conclusion of the discussion (Box 2.2).

Box 2.2   Dialogue-centred medicine

In conclusion, the way forward lies in accepting that a good consultation is a meeting between two different experts: the patient and the doctor. These experts should realise that they each have a unique expertise, and from this position they should build common ground for their interaction. This demands that the doctor preserves his/her professional integrity and that the two parties respect each other's positions and are, indeed, willing to interact. The tool they should use in this process is dialogue, i.e. an exchange of thoughts and ideas and a discussion staged to come to agreement on a topic (...) The time may thus have come to stop focusing on the concept of patient-centred medicine and to go for developing a concept of balanced, dialogue-centred medicine.

Olesen 2004: 194

With this model of *dialogue-centred* medicine, the social roles of patient and physician (already described by Parsons 1951/1970), whereby the patient seeks out the physician in the role of professional helper due to their need for assistance, remain unchanged, as does a significant asymmetry in communication. This asymmetry *is constitutive* for doctor-patient communication: neither can the social roles of doctor and patient be fundamentally questioned, nor can their respective expert roles

be exchanged, which in any case are to be determined in an optimal model[11] in a complementary manner (see below, and § 10).

Despite all *social asymmetry*, however, a far-reaching *dialogue symmetry* must be maintained, which in turn should not lead to the myth of an ideal consultation with interlocutors who are equal in every respect (§ 7). From an *ideal speech situation* in the strict sense of Habermas (1971, 1981; English: 1984, 1987), a transfer to the "ideal consultation hour" can only be established to a limited extent (§ 7, 10), which, however, can be distinguished as a good consultation hour from less good to extremely bad examples by analysing the conversation (§ 19-22, 24-25).

As we will see in the discussion of (a)symmetry (§ 10), the expert role of the patient essentially relates to the individual lifeworld, while the doctor relates to medicine (as a system). This distinction between lifeworld and system was introduced by Mishler in 1984 (with reference to early work by Habermas) (cf. above) and serves to critically analyse *discrepancies* and *conflicts* in medical communication and to overcome them (see below § 2.3). Both dialogue partners also have knowledge of the lifeworld, which we all have equally. From this, Mishler (1984) derives an obligation for the doctor to provide a *translation* between medicine and the lifeworld in dialogue with the patient, in both directions. This is possible because the doctor has a *communicative dual competence*, as it were, which must be differentiated within the framework of a definition of the doctor's professional competence (§ 2.3).

Since the *social asymmetry* between doctor and patient is constitutive, there are also *dialogue asymmetries* that correspond to the *institutional* division of roles. Although the patient should have the first and last word in all relevant decisions, in order to be able to make qualified use of it in the end, dialogue-based interaction between the two part-

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[11]   As already assumed above in terms of the necessary reduction, we can only provide a rough overview of the history of the development of medicine over a period of more than five decades (cf. Fig. 2.2 above). At this point, we will only refer to the model of so-called *interactional care*, which is primarily associated with the work of WA Beach (Beach, Dixon 2001, Beach, Mandelbaum 2005, Beach 2013), to whose description of the history of medicine we also refer. We can only refer here to further developments of a specifically *person-centred* medicine that is still relevant today, using exemplary literature: Finset 2011, Cowie 2011, Bayne et al. 2013, English 2016, Kumar, Chattu 2018, McCormack et al. (eds.) 2021, Bahrs 2022.

ners in the medical consultation (taking a medical history, providing information, etc.) is required beforehand.

In this respect, despite all justified criticism of the asymmetry that often prevails in practice, no naïve concept of dialogue-based symmetry should be used. It would again be a myth to naively assume an *ideal speech situation* (in the strict sense of Habermas 1971, 1981) in doctor-patient communication, in which both interlocutors would have symmetrical opportunities for dialogue, which they could choose completely freely (speaker-listener roles, turn taking, speech acts, topics, etc.) (§ 7). Rather, when analysing, evaluating and teaching medical communication, a distinction must be made between functional and dysfunctional asymmetries.

The dialogical principle: Functional and dysfunctional asymmetries

Conversations between doctor and patient are by no means about a kind of "halving of power and control" in the strict sense of half participation in the conversation in general and also in certain types of communication forms and functions (such as listening signals, assertions, questions and answers, etc.). The fact that one partner in the conversation talks in his role as patient and the other partner actively listens in his role as doctor is a specific asymmetry in this institutional type of conversation.

From the perspective of both dialogue partners, it is not expected, nor would it make sense, for both partners to talk and listen, ask and answer, inform and inquire, assert and deny, suggest and agree, etc. to the same extent. In contrast, the application of the "dialogic principle" (Buber 1954/1986) to doctor-patient communication means that dialogic symmetry is guaranteed in the sense that there is approximately equal opportunity for both interlocutors to set the relevance of their interests, topics and purposes and to choose the necessary means of communication (Koerfer et al. 1994, 2008, Koerfer, Albus 2015, 2018) (§ 7, 10).

However, the reciprocal acceptance and application of the dialogical principle must be doubted if empirical analyses of conversations show that certain forms of communication on the part of doctors (such as interruptions, ignoring, marginalisation, trivialisation, inquisitorial counter-questions, rebukes, instructions, etc.) are used in the sense of a strategic use of language.) in the sense of a strategic use of language (Habermas 1971, 1981, Apel 1990, Koerfer 1994/2013) increase and ul-

timately dominate the entire conversation, so that the symmetry (of communication opportunities) that is possible in principle turns into a de facto dysfunctional asymmetry.

Even if no ideal speech situation (in the strict sense of Habermas 1971, 1981) (§ 7) can be assumed for the doctor-patient dialogue, empirical conversation analyses should nevertheless be carried out within the framework of a generally valid discourse ethics (Koerfer et al. 1994, 2008, Koerfer, Albus 2015, 2018) (see § 2.5, and § 3, 10, 40). Just as one can speak of the "good doctor" (§ 2.3, 6), one can also speak meaningfully of the good conversation, which is orientated towards an ideal consultation. Empirical analyses of conversations also only make sense if they are counterfactually guided by norms, so that the *deficits* can be detected in the *evaluation* in the first place (§ 2.5, 40).[12] It is precisely here that typical "mixtures" can be identified that make the relevant difference between *interrogative* and *narrative* medicine in empirical conversation analyses, which is still to be described in detail (§ 9, 19-20, 24-25) and will only be briefly outlined here.[13]

From interrogative to narrative medicine

The change from extreme variants of patient-centred medicine to dialogue-based medicine was accompanied by the development of *narrative medicine*, which can be understood either as an independent development or as a specific variant of *dialogue-based* medicine. [14]

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[12] A critical analysis of conversation must want to examine *power* and *dominance* as well as *deception* and *manipulation,* as this analytical perspective is also laid out in Habermas, who, for all his theoretical leanings, certainly has empirical analytical perspectives. The mere description occasionally postulated in conversation analysis is in any case a self-deception, as becomes clear in the methodological chapters (§ 2.5 and 40) and in the practical chapters of the Handbook (§ 17-23).

[13] It should already be anticipated here that qualitative and quantitative methods of analysis should be combined, for example by referring narrative analyses to previously quantified data, according to which, for example, a doctor withdraws to a fifth of the conversation overall and opens up a large part of the speech to the patient, which the patient can use for longer narratives in one go (> 100 words).

[14] Since the term "narrative medicine" has now become established in the literature, it will also be used here for the sake of brevity. The term "narrative-based medicine" would be more accurate. Following research in psy-

While doctor-centred medicine was dominated by the question-answer pattern, which can lead to a kind of inquisition in excessive variants of interrogation (§ 19), a narrative pattern prevails in dialogue-centred medicine, in which the patient takes on the active role of the narrator and the doctor actively listens and initially holds back with his typical anamnesis questions.

Even with the more recent development of narrative-based medicine, the distribution of social roles (doctor, patient) and interaction roles (speaker, listener, turn taking, speech acts, topics, etc.) is clearly structured, so that it would be a possible misunderstanding if both dialogue partners were to tell each other stories.[15] Telling a medical history is the privilege of the patient, who finds a professional listener in the doctor. This storytelling extends not only to the medical history, but also to the decision-making process, for which the doctor must hear and understand the appropriate life story and values in order to be able to negotiate the right options for the patient.

Open-ended developments and participation models

What this negotiation process should look like in individual practice cases is certainly often disputed (Koerfer, Albus 2015, 2018) (§ 10). The fact that these negotiation processes cannot be organised according to a uniform pattern of action is shown by the ongoing discussion about the necessary differentiation of models, which initially began with distinctions between three or four models (Emanuel, Emanuel 1992) and is now often already in double figures if many variants are allowed.

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chotherapy, in which patient narratives have had a special quality of knowledge and experience since Freud, the narrative concept has increasingly established itself as a model of communication and participation, first in medical anamnesis and then in decision-making, even if the practice often looks different. A separate chapter 9 outlines the historical and systematic perspectives, which are then explored in conversational analysis examples from practice (chapters 19-22, 24, 25).

[15] This does not mean that a singular medical history might not make sense in some cases if the evidence of abstract risks is lost. As Chapter 9 makes clear, narratives have original, powerful functions of conveying experience that can hardly be achieved with reports and statistics.

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In the practice of dialogue-based decision-making, it will rarely be possible to assume one universally valid ideal model (Koerfer, Albus 2015, 2018) (§ 10, 22). As in everyday life, the same applies in medical care practice:

- *One shoe doesn't fit all.*

With this plausible proposition, a number of models are ultimately differentiated in order to be able to select a suitable model for different types of decision-making situations (Lussier, Richard 2008, Epstein, Gramling 2013, Keller, Sarkar, Schillinger 2014). Overall, a broad spectrum of models and their variants can be assumed, with fluid transitions. In order to capture this plurality typologically, numerous distinctions have been made in research on decision-making, e.g. four models (Emanuel, Emanuel 1992, Peters 2015) or six models (Kettner, Kraska 2009) or nine models (Sandman, Munthe 2010, Sandman et al. 2012). Without any claim to completeness or selectivity, the following models can be distinguished in a loose list, the validity of which is quite plausibly justified in research on decision-making: [16]

- Paternalism model
- Interpretation model
- Deliberation model
- Information model
- Business model ("service")
- Prevention model
- Agent model
- Contract model
- Cooperation model ("shared decision making") (SDM)
- Partnership model
  etc.

The variety of models is difficult to classify comparatively and to evaluate critically for practice, especially since there are also superordinate relationships and mixed forms. We have attempted (in § 10) to depict the different variants in a power shift/control model (Fig. 2.3), in which selected literature from five decades is taken into account and previous theoretical considerations (§ 7-10) and empirical analyses of conversations (§ 17-25) can be summarized.

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[16] In Chapter 10 of the Handbook, we have listed literature covering a period of five decades. A selection can be found in this Chapter 2 under § 2.2.4: Thematic focus 8 and 15.

A: Power and control

Doctor's power and control
Doctor centred medicine
Doctor's agenda
Fact collecting

Feelings
Expectations
Patient's agenda
Patient-centred medicine
Patient's power and control

B: Knowledge, preference, acting

Use of doctor's knowledge,
preference and acting
Interrogation
Instruction
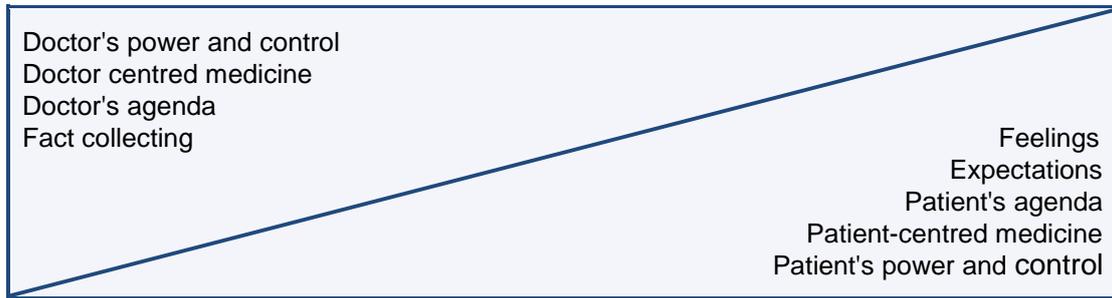
Narration
Negotiation
Use of patient's
knowledge, preference, acting

C: Verbal Gradation

Doctor makes decision and instructs the patient	Doctor makes decision and announces it	Doctor sells his decision to the patient	Doctor presents tentative decision subject to change	Doctor presents problem, seeks sug-gestion & makes de-cision	Doctor defines limits and requests the patient to make decision	Doctor permits patient to make his/her decision
1	2	3	4	5	6	7

D: Medical ethics framework

I	II		III
Paternalism	Shared decision making		Service
←– →			
Authoritarian ethics	Discourse ethics		Libertarian ethics
Information one way	D & P Shared information		D Offer-advertisement
D Decision	D & P Shared decision		P Decision
D Autonomy D Responsibility P External control by D	D & P Autonomy: Symmetry D & P Shared Responsibility D & P Shared control		P Autonomy (D) P Responsibility (D) P Self-control

Fig. 2.3: A-D: Power/control-shift models
cf. Byrne, Long 1976, Pendleton 1983, Koerfer et al. 1994, Elwyn et al. 1999,
Charles et al. 1997, 1999, Roter 2000, Tate 2004, Koerfer et al. 2005, 2008,
Koerfer, Albus 2015, 2018

A reduction of the variety of models can initially be achieved by a graduating representation, in which fluid transitions between different types of conversational styles and forms of participation in decision-making can be considered at different levels. The first two levels of representation (Fig. 2.3: A, B) show how power and control can be (unequally) distributed in the doctor-patient dialogue and how certain communication patterns (interrogation vs. narration; instruction vs. negotiation) can dominate. In the theoretical chapters (§ 9, 10), we differentiated three prototypes (paternalism, SDM, service) according to medical ethical models and the dominance of action patterns, which formed the basis for the empirical analyses of the conversations (§ 19-22, 24, 25).

Even though the work of Byrne and Long (1976) appeared long before the SDM concept, their verbal graduations and those of Pendleton (1983) still appear to be appropriate (Fig. 2.3: Level C: 1-7) in order to obtain practicable, comparative descriptions of models and fluid transitions in decision-making practice.

In terms of positioning and functional definition, it remains to be seen whether the SDM model is located more or less in the middle between the extreme poles (level D) and/or whether the middle position can also be functionally regarded as the "golden mean" in all practical cases, which can still be justified within a discourse-ethical framework.

The various possibilities of patient participation in medical decision-making continue to be discussed as competing models of relationships and decision-making. If a single model cannot suffice for all practical cases, this also applies to the SDM model (shared decision making), the content of which was already being discussed before it was given its traditional name.

In an extensive discussion about decision models, the SDM model has also been repeatedly revised, modified or critically scrutinised in terms of definitional features or effectiveness or efficiency (e.g. Charles 1999, Waldron et al. 2020, Elwyn, Vermunt 2020, Thomas et al. 2020, Elwyn 2021, Scalia et al. 2022, Galasiński et al. 2023, Resnicow et al. 2023, Elwyn et al. (eds.) 2025, Elwyn et al. 2025). In these discussions, the focus is both on differentiating the preferred SDM model in practice and on differentiating it from alternative participation models in medicine in order to take into account the plurality of decision-making in practice.

However, there is a risk of over-differentiation here, which must at least be countered with a didactic reduction if teaching is to succeed in

providing orientating reflections on practical examples (§ 22, 24-25) that serve to develop key competences (§ 2.3).

Plurality of models and research-based learning

If the diversity of decision-making practice is to be adequately taken into account in the discussion about the plurality of participation models, this has consequences for training. Even if the SDM model continues to have the greatest preference in teaching,[17] teaching should remain open to a critical, comparative discussion in order to be able to determine the optimal model for typical and specific decision-making situations. Where questions remain controversial in research, they should not be concealed in teaching, but rather addressed in order to be able to react reflexively to problems and conflicts in later professional practice. The critical question posed by Epstein, Gramling (2013) and then by Thomas et al. (2020) from the perspective of the philosophy of dialogue:

> What is "shared" in shared decision-making? (Thomas et al. 2020)

should be posed immediately as a learning impulse in class and on the basis of empirical examples (§ 22, 24, 25), so that the answers to this question can be obtained on the basis of comparative dialogue analyses. In specific practical cases - despite the warning against the danger of over-differentiation - certain types of decision-making situations must continue to be differentiated, in which, for example, the severity of the illness or medical uncertainties must be taken into account (Whitney 2003, 2004, 2008) (§ 10), so that the participation relationships between doctor and patient can shift in a justified manner - also through qualified consent and delegation of the patient to the doctor ("Doctor, please decide for me!"), if the relationship of trust is otherwise sufficiently sustainable. [18]

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[17] See § 2.2.4: topic focus 8, 13, 15, and handbook § 10. Reference should be made here to more recent literature (Teaching SDM): Tidhar, Benbassat 2021, Leblang et al. 2022, Xiao, et al. 2024, Aboushawareb et al. 2025. Elwyn et al. 2025 provide a brief historical overview of the development and criticism of SDM in their introduction, cf. Elwyn et al. (eds.) 2025.

[18] Here, a patient might also exercise their right not to be confronted with an excess of information, etc., which they consider to be unnecessarily burdensome. In our empirical analyses of conversations, the problems of meta-communication become clear, which also concern the mutual negotiation of expectations.

A number of empirical examples from the practical section of the book (IV) have already been used as learning opportunities in training and continuing education, including an example from a palliative consultation ("okay when it comes to an end") (§ 8, 22). The consultation is about self-determination of quality of life at the end of life, where individual decisions must also be made in the context of pain treatment. The doctor recalls the consensus that has already been reached, which he puts up for discussion again: "I remember our agreement ... I just want to talk about it again ..."). This example makes it clear how difficult it is for patient and doctor to reassure each other in repetitive dialogue spirals that a consensus that has already been reached can also be mutually and permanently supported as a shared perspective for action.

After all, the first decision that comes to mind, which may also be consent given out of confusion, does not have to remain the final, stable decision, the validity of which depends not least on the type and scope of information provided by the physician. This is often a balancing act between information deficits and information overload, both of which can lead to the dreaded "confused consent" of patients (§ 10), which can only be ruled out by repeatedly reassuring their understanding through dialogue.

Overall, the theoretical, didactic and empirical chapters of the handbook are intended to make concrete contributions to the scientific foundation of communication curricula, in which learners develop a *reflective meta-competence* in addition to specific competences in research-based learning processes (§ 13) in order to be able to continuously monitor and, if necessary, correct their future communication practice with patients, taking into account the current state of scientific development. These desiderata should be addressed in the following chapter on communicative competence (§ 2.3) as well as in didactic chapters on communication training (§ 13) within our Cologne communication curriculum (§ 14).

2.2.4 Traditions and topics

Over the past five decades, extensive theoretical and empirical studies on doctor-patient communication have described considerable structural, functional and content-related deficits in communicative interaction with patients and have shown in detail the possibilities for improvement

(§ 40-43). In the process, the interdisciplinary research outlined above has developed, in which medical and linguistic, sociological and philosophical traditions of language, anthropology and medical ethics, each with their own specific methods, have been linked in a variety of ways.

Interim Summary

As already mentioned, the arc of this interdisciplinary research begins with Freud's early work (1912/13) on psychoanalytic treatment techniques, which continues to have an impact on current psychotherapy (conversation) research (Lakoff 1977, 1980, 1983, Thomä, Kächele 1989/English Edition 2012, Koerfer, Neumann 1982, Kächele et al. 2006, Kächele 2010, 2016). Therefore, parallel to psychotherapy research, the now characteristic approach of *narrative* medicine (Greenhalgh, Hurwitz 1998, Koerfer et al. 1994, 2000, 2005, Charon 2006, Goyal 2013, Köhle, Koerfer 2017, Gülich 2017, Birkner 2017, Charon 2022, Kirmayer et al. 2023, Palla et al. 2024), which is particularly concerned with a *biographical-narrative* anamnesis (§ 9, 19), as has always been a matter of course for (psychoanalytic) therapy (Schafer 1995, Boothe 2011), has been able to develop through cross-connections.

Social and health policy developments (§ 5), which are accompanied by a transfer from the responsible citizen to the *responsible patient*, have strengthened tendencies towards *participatory* medicine (§ 10, 22), in which the patient should have the first and last word. As already explained under the perspective of *turning points* in medicine (§ 2.1), this patient's word should not only be used for narrative self-expression through patient stories, but also for active participation in medical decision-making (§ 10), in which the patient - with certain restrictions within the framework of *evidence-based* medicine (§ 5) - should be able to "assert his or her own mind".

Under these premises of *narrative* and *participatory* medicine, new standards for *dialogue-centered medicine* have been set, which are now being followed up in modern, empirically oriented, video- and transcript-based *conversation analyses* (§ 18-25), *manualisations* (§ 17-23) and *evaluation* studies on doctor-patient communication (§ 2.4-5, 40-43).

Critical-narrative review

The literature review begun above will be continued in tabular form (Table 2.1) based on a selection of relevant literature on specific research traditions, topics, and methodological aspects, which we will also return to in individual chapters of the handbook (see right-hand column) with further literature. A number of these works are referred to and commented on in this chapter (see § 2.3-2.5 below). In addition to assigning the references to the respective topic focus (1-15), keywords are provided and notes and brief comments are made.

The references that are particularly relevant to our book have already been mentioned above and will be taken up again later in this chapter (§ 2.3). Further references follow in other theoretical, didactic, and empirical chapters (especially § 3, 10, 17-25).

We refer to this chapter 2 as a whole and to the following topic-specific overview as a critical-narrative review under both aspects:

- The review is *critical* because we seek to differentiate and evaluate the outlined traditional developments and reforms in medicine (theories, models, education, and evaluation) in a comparative approach according to their advantages and disadvantages.

- The review is *narrative* because we have made a selection based on criteria from our previous research and reforms in the Cologne communication curriculum, which we can only compare with other curriculum reforms to a limited extent through references.

Overall, our overviews are guided by the historical and thematic structure of our living handbook, which cannot be systematic and complete, but must necessarily be selective. The selection was therefore based on our knowledge interests as manifested in the structures and content of the handbook. [19]

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[19] Since the selected literature often covers several topics, some references are mentioned more than once.

2. Interdisciplinary Research on Medical and Therapeutic Communication

Topic focus (overview: 1-15)[20]

1. Psychotherapy: Theories and techniques
2. Psychotherapy: Empirical Conversation Research
3. Institutional and Asymmetrical Communication
4. Medical Anthropology and Biopsychosocial Medicine
5. Communication Competence
6. Nonverbal Communication
7. Medical Care: Conversation Research
8. Communication and Relationship Models
9. Narrative Medicine
10. Active Listening and Empathy
11. Information and Understanding
12. Specific Competences and Fields of Practice
13. Education and Evaluation
14. Specific Balint Group Work
15. Medical Ethics: Reasoning and Acting

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[20] All references (including reviews) not listed at the end of this chapter can be found in the relevant chapters or in the comprehensive bibliography (with approx. 3000 references) of the handbook. In addition to assigning the references to the respective topic focus (1-15), keywords are provided and notes and brief comments are made.

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Traditions and Topics	
Exemplary literature	

1	Psychotherapy: Theories and Techniques	Ch.
	Key words - references	
	Freud's writings on treatment techniques with "recommendations" for the doctor on psychoanalytic practice - comparative studies on congruencies and divergences between psychotherapy as conversation and everyday communication - psychotherapeutic theories and treatment techniques - association rule - narration - empathy - language and metaphors - types of intervention - transference and countertransference - now moments - change processes - therapeutic (helping, working) alliance:	9 17 19 20 21 24 25
	Freud 1912, 1913, Menninger, Holzman 1958, Argelander 1968, 1970, Sandler, Dare, Holder 1979, Lorenzer 1970, 1977, 2002, Grice 1975, Lakoff 1977, 1980, 1983, Flader, Grodzicki 1982, Luborsky 1984/1988, Thomä, Kächele 1989 (vol. 1-2)/1985-2006/English Edition 2012, Flader 1990, Anderson 1999, Ehlich 1990, Stern 1998, Lang 2000, Kächele et al. 2006, 2010, 2016, Stern et al. 2001, 2004, 2010, Boothe 2011, Bozetti et al. (eds.) 2014, Wöller, Kruse (eds.) 2018, Flückiger et al. 2018, 2022, 2024, Bucci 2020, Guxholli et al. 2021, Buchholz 2022, Remmers 2023, Antichi, Giannini 2023, Iovoli et al. 2024, Saxler et al. 2024, Salih 2025.	
	Notes - comments	
	The relevance of psychotherapeutic research for our handbook lies in particular in establishing and justifying a transfer to medical communication. The specific relevance of Freud's recommendations for physicians (*association rule, free patient speech and narratives*, etc.), which represent a violation of the usual *everyday rules of communication* (Grice 1975) (see § 2.3.9), should be applied in medicine in a moderate and differentiated manner. *Narrative* approaches in medicine and therapy are explained and justified in chapter 9, and empirical narrative examples are analysed in the practical chapters (§ 19-22, 24-25). *Comparative conversation analyses* highlight the differences between a *narrative* and *interrogative* interview style, which is more like an "inquisition" (Platt, Gordon 2004) than an *open anamnesis conversation* (Balint 1964, Engel 1997, Gadamer 1993/2006) in which the patient can formulate their concerns in their own words (§ 9, 17-22, 24-25).	

2	Psychotherapy: Empirical Conversation Research	Ch.
	Key words - references	
	Empirical studies, mostly based on recorded and transcribed conversations - conversation analysis (CA) - discourse analysis DA: association - nondirective style - types of intervention: active listening - narration - empathy - interpretation (tangential, confrontational) - language and metaphors - nonverbal communication: Rogers 1942/1985, Pittenger et al. 1960, Sheflen 1964, Labov, Fanshel 1977, Koerfer, Neumann 1982, Kächele et al. 1988/2012, Buchholz (ed.) 1995, Redder, Wiese (eds.) 1994, Luborsky 1996, Levitt et al. 2000, Streeck 2004, Kächele et al. 2006, Peräkylä et al. 2007, Peräkylä et al. 2008 (eds.), Lepper 2009, Matos et al. 2009, Boothe 2011, Voutilainen et al. 2011, Voutilainen 2012, Ribeiro et al. 2011, Pawelczyk 2011, Dahl et al. (eds.) 2012, Peräkylä 2012, Scarvaglieri 2013, 2015, Gonçalves et al. 2014, Grimmer 2014, Buchholz 2014, Marciniak et al. 2016, Buchholz, Kächele 2013, Weiste, Peräkylä 2014, Scheidt et al. 2015, Buchholz, Kächele 2016, 2017, Buchholz 2017, Schedl et al. 2018, Peräkylä 2019, Dimitrijević, Buchholz (eds.) 2021, Guxholli et al. 2021, Stukenbrock et al. 2021, Buchholz et al. 2022, Scarvaglieri et al. (eds.) 2022, Adler, Franzen 2023, Thomä, Kächele 2023, Deserno et al. 2023, Peräkylä et al. 2024.	9 11 17 19 20 24 25
	Notes - comments	
	The function and effect of a good *helping alliance* in medicine and therapy is discussed in Chapter 8, on the basis of which a transfer of *types of interventions* from psychotherapy to medicine is also established (see topic focus 10: "Active listening and empathy"). The developments of *now moments* and *change processes* are dealt with in chapters 17, 19-22, 24, and 25, where they are illustrated using empirical example analyses (primary care and ward rounds). The didactic and analytical basis for the differentiation of medical interventions is our *Cologne Manual of Medical Communication* (C-MMC) (ch. 3, 17-23). This manual, which is divided into six conversation functions and phases, can only serve as a structuring and orientation aid and should by no means lead to a schematic, but rather to a flexible and creative application practice (§ 17) that also takes into account the *psychodynamics* of doctor-patient conversations (see below, topic focus 5: "Communication Competence" and topic focus 9: "Narrative Medicine").	

3	Institutional and Asymmetrical Communication	Ch.
	Key words - references	
	Theoretical and empirical studies on medical and psychotherapeutic communication in specific institutional settings - asymmetrical communication - comparison with everyday communication - technical language - intercultural communication - comprehensibility: Siegrist 1982, Lakoff 1977, 1980, 1983, Koerfer, Neumann 1982, Fehlenberg 1983, Fisher, Todd 1983, Mishler 1984, Fisher 1984, Löning 1985, Rehbein 1986, Ehlich et al. 1990, Quasthoff 1990, ten Have 1991/2013, Menz 1991, Maynard 1991, Hinze 1992, Redder, Wiese (eds.) 1994, Menz 1991, Löning, Rehbein 1993, Koerfer 1994/2013, Lalouschek 1995, Hartog 1996, Roberts 2000/2013, Peters 2008, 2010, Kettner, Kraska 2009, Neustein 1990/2011, Pilnick, Dingwall 2011, Menz 2011, Reisigl 2011, Heritage 2013, Menz et al. 2013, Harvey, Koteyko 2013, Groß 2015, Menz 2015, Weiste et al. 2016, Scarvaglieri 2020, Hsieh 2021, Ehlich 2020, 2022, Ogbogu et al. 2022, Ilkilic 2023, Alkhames et al. 2023, Coffie 2025.	3 4 5 7 27 28
	Notes - comments	
	The *(a)symmetry* in doctor-patient communication is addressed in particular in chapters 7 and 10 and examined in all empirical chapters with sample analyses. Chapters 27 and 28 deal specifically with technical communication (*medical jargon*) and *intercultural* communication, which cause particular problems of *understanding* (cf. topic focus 11: "Information and Understanding"). Literature specifically on institutional, hierarchical, and asymmetrical *interprofessional* communication (within medical teams) is listed separately in Topic Focus 12 ("Specific competences and fields of practice").	7 10

4	Medical Anthropology and Biopsychosocial Medicine[21]	Ch.
	Key words - references	
	Phenomenological, hermeneutic, biopsychosocial, psychosomatic, semiotic, salutogenic, and systemic perspectives on medicine: (non-) pathological - disease - illness - health - well-being - quality of life, etc.:	4 5 7 10
	Jaspers 1913/1965, 1986, von Weizsäcker 1940/1973, Plügge 1962, Morgan, Engel 1969/77, Popper 1972/94, Popper, Eccles 1977/89, Engel 1977, 1981, 1992, 1997, White et al. 1988, Livenstein et al. 1989, Gadamer 1993/2006, Fuchs 2000, Borrell, Carrio et al. 2004, Alonso 2004, Schmoll, Kuhlmann 2005, von Uexküll, Wesiack 1991, von Uexküll 1991, 2001, Margalit et al. 2004, Langenbach, Koerfer 2006, Adler 2009, Fuchs 2010, Meyer-Abich 2010, von Uexküll, Wesiack 2011, Herrmann-Lingen 2012, Thieme et al. 2012, Langewitz 2013, Hontschik et al. (eds.) 2013, Smith et al. 2013, Beach 2013, Köhle 2017, Langewitz, Degen 2017, von Uexküll, Wesiack 2017, Chin-Yee et al. 2019, Georgi et al. 2020, Egger 2020. Tramonti et al. 2021, Smith 2021, Lugg 2022, Langewitz 2022, Rojatz et al. 2022, Mittelmark et al. (eds.) 2022, Albus et al. 2022, Kampits 2022, Roberts 2023, Bolton 2023, Egle et al. 2024, Bahrs 2024, Langewitz 2025, Albus, Herrmann-Lingen 2025.	
	Notes - comments	
	The *dichotomies* (mind-body, part-whole, outside-inside, cause-effect, freedom-bondage, etc.) handed down since Descartes (1641/1960) are discussed in chapter 4 in connection with the three-world theory (Popper 1972/94, Popper, Eccles 1977/89) based on further literature, especially on the *biopsychosocial* model of medicine. Using a *case study*, chapter 4 also presents the *biopsychosocial* model (Engel 1969, 1979, 1996, von Uexküll, Wesiack 1991, 2011, 2017) for a corresponding teaching module in which learners can practice integrating biopsychosocial and *communicative* medicine.	

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[21] Specific studies on reflection and justification of medical actions within the framework of medical ethics and discourse ethics are listed separately in the topic focus 15 ("Medical Ethics: Reasoning and Acting").

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5	Communication Competence	Ch.
	Key words - references	
	Theoretical different terms, concepts and approaches to (promote) communication competence[22] - different disciplines and traditions: language and speech act philosophy - (socio-psycho-)linguistics - ethnographic - pedagogy - psychology - psychotherapy - medicine - communicative turn, etc.: [23]	3 5 6 7 13 14 17
	Chomsky 1965, Lyons 1968, Habermas 1971, 1981, Badura 1972, Lenzen 1973, Hymes 1973, Mishler 1984, Scambler 1987, Miller 1990, Dickson et al. 1991, Gadamer 1993/2006, Koerfer 1994/2013, Hargie (ed.) 1997, Harden et al. 1999, Weinert 1999, 2001, OECD 2002, 2005, Rychen, Salganik 2000, Rychen, Salganik (eds.) 2001, 2003a,b, Scambler, Britten 2001, Scambler (ed.) 2001, Epstein, Hundert 2002, Trier 2003, Descy, Tessaring (eds.) 2004, Rychen 2004, Deppermann 2004, Becker-Mrotzek, Brünner 2004, Hartung 2004, Duffy et al. 2004, Rider, Keefer 2006, Herzig et al. 2006, Becker-Mrotzek 2008, Rychen 2008, Koerfer et al. 2008, Albanese et al. 2008, 2010, Klieme et al. 2008, Vogel, Alpers 2009, Harris et al. 2010, Kiessling et al. 2008, 2010, Reichertz 2010, Salmon, Young 2011, Skelton 2011, Laughlin et al. 2012, Wouda, van de Wiel 2012, Lurie 2012, Lingard 2012, Hodges, Lingard (eds.) 2012, Spitzberg 2013, Smart 2013, Bachmann et al. 2013, 2016, Grimmer 2014, Härtl et al. 2015, Frank et al. 2015, Hannawa, Spitzberg (eds.) 2015, Blacklund, Morreale 2015, Sanders 2015, Pavitt 2015, Boissy, Gilligan 2016, Windover 2016, Jünger et al. 2016, Thistlethwaite 2016, Steiner-Hofbauer et al. 2017, Koerfer, Albus (eds.) 2018, Schneider 2019, Chin-Yee et al. 2019, Röhr-Sendlmeier, Käser 2019, Monti et al. 2020, Fox et al. 2021, Kiessling, Fabry 2021, Hargie 2022, Moreno et al. 2022, Bachmann et al. 2022, Venktaramana et al. 2022, Saxena et al. 2022, Schnelle, Jones 2022, Chute et al. 2023, Schnelle, Jones 2023, Kowalczyk, Rypel 2023, Fleck et al. 2024, Hargie 2025, Fox et al. (eds.) 2025, Horila 2025, Karam, Brault (2025).	

[22] The empirical research has also focused not only on describing and analyzing (non-) verbal communication, but also on promoting the relevant competences among doctors and therapists. References to this can also be found in topic focus 13 ("Education and Evaluation"). Empirical examples of *nonverbal* communication competence are provided in chapters 12, 18, 25 (using images).

[23] Further reading specifically on interprofessional communication competences can be found in topic focus 12 ("Specific Competences and Fields of Practice"). First, reference should be made to Fox et al. 2021, Fox et al. (eds.) 2025, and in particular the contribution by Karam, Brault (2025), providing an overview of interprofessional education (IPE) (with seven sub-competences according to IPEC 2023).

	Notes - comments	
	In a book on *medical communication competence*, there is a self-commitment to explore and differentiate the extensive research on the central concept of *communication* in order to be able to detect and typify deficits and alternatives of (more or less) *good* and *bad* communication in *empirical* and *comparative* conversation analyses of real conversations (Part IV) and to be able to put the alternatives into perspective through training and education. A prerequisite for this is a clarification of the general *concept of competence* and then in particular of *communication competence* in medicine. In the discussion about valid and viable concepts of competence, we continually refer to selected literature and otherwise to the following thematic focus (6-15) as well as to the topic-specific chapters (especially § 3, 7-10. 17) of the handbook.	
	First, a few references to the literature should be given: There are a number of comprehensive books with general and specific contributions that contain many *definitions*, aspects and further literature on (communicative) competence, e.g: Rychen, Salganik (eds.) 2001, Rychen, Salganik (eds.) 2003, Descy, Tessaring (eds.) 2004, Hannawa, Spitzberg (eds.) 2015. Reference is made here by way of example to contributions on the overview of key competences (e.g. Trier 2003 and Rychen 2004 in the context of OECD studies) or to the historical development of the general concept of competence (e.g. Backlund, Morreale 2015) as well as to traditional distinctions between *competence* and *performance* (e.g. Levinson 1983/2000, Weinert 1999, 2001, Sanders 2015).	
	This controversial pair of terms (*competence-performance*) has been the subject of lengthy discussions from *linguistic, socio-linguistic* and *ethnological* perspectives (Chomsky 1965, Lyons 1968, Hymes 1972 and many others), of which Taş, Khan (2020), for example, provide a brief, critical overview. Schneider (2019), Röhr-Sendlmeier, Käser (2019) and Salman et al. (2020) should be mentioned as reviews of the general concept of competence. Vitello et al. (2021) justify their own approach to defining the general concept of competence in the context of their university curriculum (Cambridge).	
	For the specific concept of *communicative competence* (also in the context of the traditional distinctions and delimitation of syntax, semantics and pragmatics), see Levinson (1983/2000), Pavitt (2015) and again Sanders (2015). A complex model of communicative competence is used by Spitzberg (2013) to include *emotional, motivational*, etc. as well as social, *intercultural* characteristics, etc. Problems in dealing (more or less) competently with *uncertainties* in medicine are addressed by Blanch et al. 2009, Dean, Street (2015), Berger 2015, Lian et al. (2021) and Bührig, Schopf (2024).	

We will continually refer back to Habermas' (1971, 1981) central concept of *communicative competence* and his basic distinctions between *instrumental*, *communicative* and *strategic* action in many chapters (especially § 7, 10). This also involves *participation models* (e.g., SDM) (cf. § 2.2.3 above) for the benefit of patients within the framework of *discourse ethics*, in which *institutional* (dysfunctional) *asymmetries* in the relationship between the conversation partners must be abolished or compensated for as far as possible (cf. Koerfer et al. 1994, 2008, Kettner, Kraska 2009, Duvenhage 2024).

Further literature is referred to in specific chapters (§ 3, 7, 10), including on *non-verbal* competence (§ 12) (cf. thematic focus 6) and, following this overview of topics, in the following subchapter (§ 2.3), which deals in detail with communication competence in medicine.

Chapter 2.3 discusses general, widely used *definitions of competence* by Weinert (1999, 2001) and specifically in medicine by Epstein, Hundert (2002), before finally proposing a definition of communicative competence that is also suitable for a *taxonomy of learning objectives* in teaching.

In medical tradition as a whole, terms such as skills, competence, and performance are used inconsistently, sometimes synonymously, or, as in Miller's (1990) widely acclaimed and still relevant work, differentiated to distinguish between levels in his well-known *learning pyramid* in order to evaluate teaching and learning according to complex learning objectives. Due to its relevance in medicine, we will repeatedly refer to Miller's basic distinctions in research and teaching, which are simply reproduced here:

- KNOWS (Knowledge)
- KNOWS HOW (Competence)
- SHOWS HOW (Performance)
- DOES (Action)

For a presentation, critique, and modification, please refer § 13 (teaching), and § 40 (evaluation).

Since Miller's influential work (1990), many curriculum reforms have been initiated that also address the differentiation of competencies and corresponding learning goals.

A series of *national learning objective catalogues* in medicine (e.g., NKLM 2015, 2.0 2021) and communication curricula (e.g., Kiessling et al. 2008, Bachmann et al. 2013, 2016, 2020, Venktaramana et al. 2022) reveal the problem of how extensive, multi-digit lists of skills/ competences/ objectives (some of which have more than 100 learning objectives) can be converted into *learning objective taxonomies* that remain practicable in real teaching and learning situations (see below). While on the one hand there is a risk of *over-differentiation*, on the other hand there is a risk in traditional, rather *abstract* concepts

of competence, which pose application problems due to their abstractness and *vagueness*, e.g., in the widely used definition of competence in medicine by Epstein, Hundert 2002 (see below). In order to avoid this *dilemma* between the risks of abstractness and over-differentiation, a flexible concept of communicative competence is proposed, which allows for specifications and reductions in learning practice depending on the learning situation and learning needs (§ 2.3.3)

Further reading specifically on *interprofessional* communication competences can be found in topic focus 12 ("Specific Competences and Fields of Practice") (cf. § 2.3.8, 6, 13). First, reference should be made to Fox et al. 2021, Fox et al. (eds.) 2025, and in particular the contribution by Karam, Brault (2025), providing an overview of *interprofessional* education (IPE) with a distinction between seven sub-competences (according to IPEC 2023).

6	Nonverbal Communication	Ch.
	Key words - references	
	Theoretical and empirical studies on paralinguistic and nonverbal communication in everyday and institutional settings, medical and therapeutic settings: listening signals - pausing - turn taking - interrupting - voice (prosody, etc.) - eye contact - posture - movement (body, head, etc.) - laughing - gesturing, etc.:	12 18 - 20 25
	Scheflen 1964/1984, Kendon 1967, Duncan 1974, Ehlich 1979, Scherer, Wallbott (eds.) 1979/1984, Flader, Koerfer 1983, Argyle 1983, Heath 1984, 1986, Street, Buller 1987, Stiles, Putnam 1989, Davis, Hadics 1994, Hall et al. 1995, Bensing et al. 1995, Streeck 2004, Roter et al. 2006, Mitchum 2011, McHenry et al. 2011, Lausberg 2011, Gorawara et al. 2011, 2013, Lausberg (eds.) 2013, Hall, Knapp (eds.) 2013, Matsumo et al. (eds.) 2013, 2016, D'Agostino, Bylund 2014, Schmid Mast, Cousin 2014, Hall et al. 1919, Stukenbrock et al. 2021, Dimitrijević, Buchholz (eds.) 2021, Guyer et al. 2021, Burgoon et al. 2021, Hargie 2022, Lausberg 2022, Chute et al. 2023, Patterson et al. 2023, Lausberg 2024, Gordon, Druckman 2025.	
	Notes - comments	
	The term *nonverbal communication* encompasses a variety of phenomena. In her analyses in chapter 12 of the handbook, Lausberg prefers the term "nonverbal interaction". A systematic presentation of relevant verbal and nonverbal phenomena can be found in chapter 18 of this handbook. Patterson et al. (2023) highlight the problems associated with terms and concepts relating to nonverbal communication in their *critique* of the "Four misconceptions about nonverbal	

communication". Examples of the interplay between narratives and gaze behaviour in turn taking are analysed in particular in chapters 12, 18-20, and 25 (using still images from video sequences).

The relevance of nonverbal communication can be illustrated by the example of *eye contact* during patient narratives:

If a doctor/therapist does not already intuitively notice this, he/she can recognise from a patient's eye movements whether the patient is still looking away because he/she is concentrating on the internal narrative process, or whether he/she is coming to the end of his/her narrative when he/she looks at the doctor silently for a longer period of time and thus passes on the right to speak. Accordingly, the specific conversational maxim can be formulated as follows: "If possible, do not interrupt the patient when they look away while narrating!" Cases of turn-taking during a brief medical intervention that does not significantly interrupt the patient's flow of speech, allowing them to continue speaking "as if uninterrupted" (Duncan 1974, Flader, Koerfer 1983), are analysed in the practical section (IV) of the handbook (especially chapters 17, 19, 20).

7	Medical Care: Conversation Research	Ch.
	Empirical studies, mostly based on recorded and transcribed conversations - discourse analysis (DA) - conversation analysis (CA): active listening - narration - empathy - language and metaphors - objects and units of research: smallest units (listening signals, laughing) - sequences (questions - answers, complaint - empathic response) - overall structures, (change) processes: entire conversations - conversation series:	9 11 12 17 - 25

Korsch et al. 1968, Froelich, Bishop 1972, Korsch, Negrete 1972, Byrne, Long 1976, Köhle, Raspe 1982, Bliesener 1982, Mishler 1984, Mann 1984, Fehlenberg 1983, 1987, Bliesener, Köhle 1986, Rehbein 1986, Adler, Hemmerler 1989, Ehlich et al. (eds.) 1990, Löning P, Rehbein J (eds.) 1993, Menz 1991, Coulehan, Block 1992, Redder, Wiese (eds.) 1994, Lalouschek 1995, Elwyn, Gwyn 1998/2005, Koerfer et al. 1994, 2000, 2004, Neises et al. (eds.) 2005, Heritage, Maynard (eds.) 2006, Roter et al. 2006, Collins et al. (eds.) 2007, Gafaranga, Britten 2007, Koerfer, Köhle 2006, 2007, Peräkylä et al. 2007, Menz et al. (eds.) 2010, Neustein 1990/2011, Koerfer, Köhle 2009, Koerfer et al. 2010, Deppermann, Spranz-Fogasy 2011, Heritage 2011, Lausberg 2011, Heritage, Lindström 2012, Harvey, Adolphs 2013, Spranz-Fogasy 2014, Spranz-Fogasy 2014, Koenig, Robinson 2014, Robinson, Heritage 2014, Busch, Spranz-Fogasy (eds.) 2015, Landmark et al. 2016, Köhle, Koerfer 2017, Coussios et al. 2019,

Barnes 2019, Scarvaglieri et al. (eds.) 2022, Kondo 2022, Barnes, Woods 2024, Wu et al. 2024, Ekberg et al. 2024, Parry 2024, Jenkins et al. 2024, Abdulzahra 2025, Džanko 2025.	
Notes - comments	
This is a very limited selection of empirical studies spanning more than five decades, but important *methodological groundwork* was laid early on that can be put to good use in modern *recording-based empirical* conversation research (see § 2.3-2.5 below). In addition to their exemplary conversation analyses, Barnes, Woods 2024 (*primary healthcare*), Ekberg et al. 2024 (*outpatient secondary care*), Parry 2024 (*palliative care*), Jenkins et al. 2024 (*communication in pediatric*) also provide a review of their respective topics.	

8	Communication and Relationship Models	Ch.
Doctor-centered - patient-centered - person-centered - relationship-centered - dialogue-centered model; paternalism - service model - information model - agent model - shared decision making (SDM); negotiating - informed consent - concordance - (a-)symmetry - autonomy - responsibility - trust: Byrne, Long 1976, Levenstein 1986, Veath 1987, Levenstein et al. 1989, 1989, Maynard 1991, Emanuel, Emanuel 1992, Koerfer et al. 1994, Helmich 1994, Abholz 1994, Hellmich 1994, Quill, Brody 1996, Charles et al. 1997, 1999, Langewitz et al. 1998, Ellwyn et al. 1999, Bensing 2000, Elwyn 2001, Whitney 2003, Bensing, Roter, Hulmans 2003, Olesen 2004, Collins et al. 2005, Whitney et al. 2004, 2008, Potter, McKinley 2005, Scambler 2005, Pollock 2005, Beach, Inui 2006, Roter, Hall 2006, Koerfer et al. 2005, 2008, Stevenson, Makul, Clayman 2006, Suchman 2006, Miller et al. 2010, Deter 2010, Witt 2010, Sandman, Munthe 2010, Charles, Gafni 2011, Walseth, Schei 2011, Skirbekk et al. 2011, Cullati et al. 2011, Finset 2011, Pilnick, Dingwall 2011, Sandman et al. 2012, Clayman et al. 2012, Elwyn et al. 2012, Hekmat-panah 2013, Beach (eds.) 2013, Martin, DiMatteo (eds.) 2014, Koerfer, Albus 2015, Groß 2015, Silverman 2016, Schmacke et al. 2016, Sanders et al. 2017, Clayman et al. 2017, Hauser et al. 2017, Alheit, Herzberg 2018, Frain, Wearn 2018, Chandra et al. 2018, Kumar, Chattu 2018, Bomhof-Roordink et al. 2019, Elwyn, Vermunt 2020, McCormack et al. 2021, Resnicow et al. 2022, Grover et al. 2022, Kondo 2022, Bahrs 2022, Chmielowska et al. 2023, Zhou et al. 2023, Stivers, Tate 2023, Buß 2024, Bruch et al. 2024, Kim et al. 2024, Jiang et al. 2024, van Bostraeten et al. 2025, Morgan et al. 2025, Elwyn et al. (eds.) 2025, Elwyn et al. 2025.	4 7 10 13 17 - 22 24 25 26

	Notes - comments	
	The literature listed here focuses primarily on theoretical and conversation analysis studies of *communication* and *relationship models*, whose medical and communication science foundations are explained in the introduction (overview in § 1) and in the basic section of the book (Part II). Specific models of *participation* (paternalism, service, SDM, etc.) are discussed in chapter 10, and practical examples of more or less active, dialogical patient participation are presented in the practical chapters (Part IV). Many studies follow both an *empirical* and *theoretical* approach, such as Bern and Long in their early study (1976), in which they developed a differentiated model of doctor-patient relationships and interactive participation based on more than 1000 interviews, which can still be used today for differentiated analysis of problem presentation and use (§ 10). Since "Narrative Medicine" represents a specific communication and relationship model (§ 9), the literature on this topic is summarised below in a special topic focus (9: "Narrative Medicine").	

9	Narrative Medicine	Ch.
	Key words - references	
	Theoretical approaches and empirical studies of a specifically "narrative" medicine and psychotherapy that place patient narratives and their promotion and processing for diagnostic and therapeutic purposes at the center of research: Forms and functions of narratives (orientation, complication, evaluation, resolution, coda) - narrative self-representation - positioning - narrative types (progressive, regressive, tragic, comedic) - biographical-narrative anamnesis and personal life stories and individual stories of values in medical decision-making:	9 19 20 21 24 25
	Bliesener 1980, 1982, Bliesener, Köhle 1986, Kleinman 1988, Smith, Hoppe 1991, Ritschl 1991, Waitzkin, Britt 1993, Brody 1994, Koerfer et al. 1994, Mishler 1995, Schafer 1995, Frank 1995, Engel 1997, Meares 1998, Gergen 1998, 1999/2002, Stern 1998, Greenhalgh, Hurwitz (eds.) 1998 (German 2005), Hurwitz 2000, Grossmann 2000, Launer 2002, Hurwitz et al. 2004, Goldie 2004, Angus, McLeod 2004, Mishler 2005, Halkowski 2006, Gülich 2005, Charon 2001, 2006, Mehl-Madrona 2007, Lucius-Hoene 2002, 2008, 2009, Koerfer et al. 2000, 2005, 2010, Koerfer, Köhle 2007, 2009, Rudnysky, Charon (eds.) 2008, Matos et al. 2009, Boothe 1994, 2011, Ribeiro et al. 2011, Gülich 2012, Litschgi, Schlumpf 2012, Vickers et al. 2012, Plassmann, v. Uexküll 2013, Goyal 2013, Scheidt et al. 2015, Köhle,	

	Koerfer 2017, Gülich 2017, Birkner 2017, Charon et al. 2017, 2022, Deppermann et al. 2020, Habermas, Fesel 2022, Kirmayer et al. 2023, Habermas, Bongard 2024, Koval 2024, Palla et al. 2024, Fioretti 2025.	
	Notes - comments	
	Since the term "narrative medicine" has now become established in the literature, it will also be used here for the sake of brevity. The term "narrative-based medicine" would be more accurate. Following research in *psychotherapy*, in which patient narratives have had a special quality of knowledge and experience since Freud (§ 9), the narrative approach has increasingly established itself as a model of *person-centred* communication and *interactive participation*, first in medical *anamnesis* and then in *decision-making*, even if the practice often looks different. A separate chapter 9 outlines the historical and systematic perspectives, which are then explored in conversational analysis examples from practice (primary care, ward rounds) (§ 19-22, 24, 25). The fact that narratives are a fundamental component not only of therapeutic but also of medical communication has been recognised in medical research since at least Balint (1964), long before the term *Narrative Medicine* came into use (cf. e.g., the early works of Bliesener 1980, 1982, Bliesener, Köhle 1986, Kleinman 1988, Smith, Hoppe 1991, Ritschl 1991, Waitzkin, Britt 1993, Brody 1994, Koerfer et al. 1994, Mishler 1995, Engel 1997, Meares 1998). However, the shift from *interrogative* to *narrative* medicine began later with the paradigm shift described above toward *biopsychosocial* and, at the same time, *communicative* medicine (cf. § 2.1 above).	

10	Active Listening and Empathy	Ch.
	Key words - references	
	Theoretical History and definitions - theoretical and empirical studies on the forms and functions of active listening and empathic responding: Listener signals - turn taking - paraphrasing - repeating - asking openly - Encourage speaking up - NURSE (name, understand, respect, support, explore) - SPIKE (Setting up, P's perception, Invitation, Knowledge, Exploring/Empathy) - scenic understanding - non-directive interview style - types of interpretation (tangential or tentative, confrontational, if appropriate): Rogers 1942/1985, Sandler et al. 1979, Lorenzer 1977, 2002, Miller 1989, Smith, Hoppe 1991, Zinn 1993, Finke 1994, Buckman Kason 1994, Suchman et al. 1997, Anderson 1999, Baile et al. 2000, Coulehan et al. 2001, Smith 2022. Mercer, Reynolds 2002, Mercer et	13 17 19 20 24 25

al. 2004, Koerfer et al. 2004, Black 2004, Eide et al. 2004, Cocksedge 2005, Fiehler 2005, Back et al. 2005, 2007, Schäfert et al. 2008, Neumann et al. 2009, 2010, 2011, 2012, Bonvicini et al. 2009, Pedersen 2008, 2010, Pollak et al. 2007, 2011, Back et al. 2011, Gelhaus 2011, Schattner 2012, Fortin et al. 2012, Hsu et al. 2012, Heritage, Lindström 2012, Breyer (eds.) 2013, Bayne et al. 2013, Derksen et al. 2013, 2015, 2016, Weiste, Peräkylä 2014, Buchholz 2014, Buchholz, Kächele 2016, Buchholz et al. 2016, Sulzer et al. 2016, Frankel 2017, Seitz et al. 2017, Buchholz 2017, Hall, Schwartz 2019, Rodat 2020, Worthington, Bodie (eds.) 2020, McKenna et al. 2020, Andersen et al. 2020, Albuquerque 2020, Stukenbrock et al. 2021, Guidi, Traversa 2021, Hall et al. 2021, Kondo 2022, Collins 2022, Yang, Wang 2022, Lelorain et al. 2023, Zhang et al. 2023, Albuquerque 2023, Childers et al. 2023, Kishton et al. 2023, Epstein, Beach 2023, Chute et al. 2023, Beheshti et al. 2024, Gil Deza 2024, Jami et al. 2024, Arshad et al. 2024, Tustonja et al. 2024, Rocha, Albuquerque 2025.

Notes - comments

Active listening and empathic communication are the main topics of chapters 17-22, 24, 25, which also provide an *overview* of historical developments and *definitions* (e.g. empathy vs. sympathy, etc.). Some *types of verbal intervention* traditional in psychotherapy are adopted, modified and specified in medicine (§ 19-21). In a typology of medical reactions to patients' emotional expressions, a distinction is made between *relevance upgrading* and *relevance downgrading*, with which emotions are *ignored* or *marginalised*. The basis for the analysis and didactics is our *Cologne Manual on Medical Communication* (C-MMC), which differentiates the main forms and functions of *active listening* and *empathic* communication, for which the corresponding *anchor examples* are given in the empirical chapters (§ 3, 17-23).

Specific *evaluation studies* on active listening and empathy are listed under topic focus 13: "Education and Evaluation." Studies specifically on the development and *decline of empathic* competences (in students and practitioners) include the following examples: Hojat et al. 2004, Neumann et al. 2011, Neumann et al. 2012, Seitz et al. 2017. The specific relationships between *patient-centred* care and *empathy* in the *framework of a new clinical bioethics* are explored by Albuquerque 2020, Albuquerque 2023, Rocha, Albuquerque 2025.

2. Interdisciplinary Research on Medical and Therapeutic Communication

11	Information and Understanding	Ch.
	Theoretical and empirical studies on comprehension problems in medical information transfer and patient education, in particular in risk and prescription talk as well as under medical-psychological, statistical and linguistic aspects of technical language (medical jargon), multi-media and intercultural communication:	8 10 12 26 27 28 39
	Ley 1980, 1982, 1983, Raspe 1983, Mann 1984, Ley 1988, Löning 1994, Brünner 2005, Ditz 2005, Jung 2005, Hoefert, Hellmann 2008, Tarn et al. 2006, 2008, Collins, Street 2009, Bindernagel et al. 2010, Spranz-Fogasy 2010, Gigerenzer, Gray (eds.) 2011, Deppermann, Spranz-Fogasy 2011, Sabbioni 2011, Turner et al. 2011, Penka et al. 2012, Welschen et al. 2010, 2012, Menz 2013, Poel et al. 2013, Tarn et al. 2013, Gigerenzer 2013, Gaissmaier, Gigerenzer 2013, Wegwarth, Gigerenzer 2013, Wegwarth 2013, Han et al. 2014, Peters 2015, Kliche 2015, Bührig, Meyer 2015, Klüber 2015, Chow et al. 2021, Wegwarth et al. 2021, Wegwarth, Rebitschek 2021, Ilkilic 2023, Alkhames et al. 2023, Jayatilake, Oyibo 2023, Coffie 2025.	
	Notes - comments	
	The early works by Ley 1980, 1982, 1983, 1988, which are also used in this handbook (§ 10), are *excellent introductions* to the problems of *information transfer* and *understanding* between doctor and patient. The equally older works by Raspe 1983 and Mann 1984 already contain analyses of understanding on the basis of (German-language) *transcripts,* some of which we draw on here. Our own collection of examples demonstrates the diverse problems of *misunderstanding* already described by Balint (§ 1, 10) and which arise when doctor and patient talk past each other. The use of *technical language* is only one aspect among many that arise from fundamental *discrepancies* and conflicts between *medicine* as a (system) and the patient's *lifeworld* (cf. § 2.2, 2.3, 10). In these cases of non-understanding or misunderstanding, physicians are unable to use their *dual competences* (as physicians and members of the lifeworld) productively for the benefit of their patients (§ 2.3). Even the natural requirement to *avoid medical jargon* or to *translate* it appropriately into everyday language is often missed in practice (§ 10, 27). *Risk communication* also poses a particular problem in which, for example, *statistical* data must first be adequately understood by the doctors themselves before it is communicated to their patients. The informative book by Gigerenzer (2013) (English and German editions) contains many *examples* in which the risks are incorrectly assessed or communicated. For further reading, please refer to Wegwarth	

2013, Wegwarth, Gigerenzer 2013, Wegwarth et al. 2021. Further problems of understanding arise if the doctor and patient do not speak the same language or if they belong to different *cultural* groups. In order to avoid or at least reduce comprehension problems in *intercultural* communication, *professional interpreters* may be required (§ 28), who must have special competences in the art of mediation in *triadic* communication.	

12	Specific Competences and Fields of Practice	Ch.
Specific competences on particular fields of doctor-patient communication: primary care - ward rounds - prescription talk - pediatrics - chirurgy - oncology - palliative care - communication with patients with CHD, diabetes, pain, depression, somatoform disorders, anxiety disorders - transplantation patients - difficult and older patients - Further reading can be found in the chapters of Part V of the handbook (§ 24-39). Selected literature on specific fields of communication in medicine:	5 6 13 24 - 39

- *Primary care*
  Brody 1989, Elwyn et al. 1999, Beck et al. 2002, Launer 2002, Mead, Bower 2002, Bensing et al. 2003, Fritzsche et al. 2004, Murray et al. 2006, Heritage, Maynard (eds.) 2006, West 2006, Richard, Lussier 2006, Salmon et al. 2007, Heritage et al. 2007, Ratanawongsa et al. 2008, Miller et al. 2010, Pawlikowska et al. 2012, Little et al. 2015, Parker et al. 2020, Lian et al. 2021, 2021, Bahrs 2022, 2024, Barnes, Woods 2024
- *Ward rounds*
  Bliesener 1982, Köhle, Raspe 1982, Bliesener, Köhle 1986, Mann 1984, O'Hare 2008, Walton et al. 2016, 2019, 2020, Morris et al. 2022, Merriman, Freeth 2022, Andersen et al. 2023, Gross et al. 2023, Choi et al. 2024, Gössi et al. 2025.
- *Prescription*
  Makoul et al. 1995, Matthes, Albus 2014, Hauser et al. 2015, Hauser et al. 2017, Kirsch, Matthes 2021.
- *Communication with patients with anxiety disorders*
  Kroenke et al. 2007, Lindemann 2012, Archer et al. 2021.
- *Paediatrics*
  Cahill, Papageorgiou 2007, Spranz-Fogasy, Winterscheid 2013, Winterscheid 2015, Singh 2016, Winterscheid 2018, Bindernagel 2020, Jenkins et al. 2024
- *Oncology - Palliative care - End of life*
  Buckman, Kason 1994, Kissane et al. (eds.) 2011, Gamondi et al. 2013, Obliers, Köhle 2017, Kitchen et al. 2024, Parry 2024
- *Gerontology*
  Degen et al. 2021, Kojer 2022, Ivanova et al. 2023, Rodero et

	al. 2023. • *Communication with Pain Patients* Bertakis et al. 2003, Menz et al. (eds.) 2010, Borg et al. 2019, Jaworska, Ryan 2018, Hintz, Suk 2023, Zhang et al. 2023 • *Surgical settings* Levinson et al. 2000, 2013, Bollschweiler et al. 2008, Siu et al. 2016, Morris et al. 2022, Gould et al. 2023, Alqaydi et al. 2024 • *Transplantations* LaPointe Rudow et al. 2015, Vanholder et al. 2021, Kampits 2022 • *Interprofessional communication* Walton et al. 2019, Fox et al 2021, Scheel-Sailer et al. 2022, Karam, Brault 2025, Horila 2025, Fox et al. (eds.) 2025, • *Intercultural communication* Roberts et al. 2005, Menz (ed.) 2013, Ogbogu et al. 2022, Schouten et al. 2023, Ilkilic 2023, Hsieh 2022, 2024, Hsieh, Ma 2024, Crichton, Martin (eds.) [in press]	
	Notes - comments	
	With so many diverse fields of medical practice, it is not possible to provide uniform commentary. We therefore refer to individual chapters of the handbook (Part V), each of which deals with specific medical fields of activity (§ 24-39). Further reading can also be found in the relevant chapters. Once again, reference is made to the current *reviews* on specific topics: Barnes, Woods 2024 (*primary healthcare*), Ekberg et al. 2024 (*outpatient secondary care*), Parry 2024 (*palliative care*), Jenkins et al. 2024 (*communication in pediatrics*).	

13	Education and Evaluation	Ch.
	Key words - references	
	Communication curricula - learning goals - training and continuing education - learning and action concepts: history taking (ZWECK) (German) - empathy (NURSE) - breaking bad news (BBN) - oncology (focus) (SPIKES) - shared decision making (SDM) (PEF) (German) - evaluation: OSCE - simulation - simulated patients (SP) - instruments: coding, rating, self-assessment, questionnaire, etc. - endpoints: competence, satisfaction, adherence, health outcome, etc...: Pendleton 1983, Mishler 1984, Evans et al. 1987, Putnam et al. 1988, Roter 1989, Stiles, Putnam 1989, Dickson, Hargie, Morrow 1989, Smith, Hoppe 1991, Rehbein, Mazeland 1991, Branch et al. 1991, Coulehan, Block 1992, Stiles 1992, Koerfer et al. 1994, 1996, Skeff et al. 1995, Kurtz, Silverman, Draper 1998, Langewitz et al. 1998, Koerfer et al. 1999, Köhle et al. 1995, 1997, 1998, 1999,	3 13 14 15 16 40 41 42 43

	Kaerger 1999, Baile et al. 2000, Charon 2001, Köhle et al. 2001, Smith 2002, Hojat et al. 2002, Mead, Bower 2002, Roter, Larson 2002, Roter 2003, Jünger, Köllner 2003, Duffy et al. 2004, Ford, Hall 2004, Hojat 2004, Schirmer et al. 2005, Pollak et al. 2007, Back et al. 2007, Lussier, Richard 2007, Koerfer et al. 2008, Fragstein et al. 2008, Kiessling et al. 2008, 2010, Roter et al. 2008, Haas de, Bensing 2009, Street et al. 2009, Hojat et al. 2009, Bachmann et al. 2009, Connor et al. 2009, Bylund 2010, Uitterhoeve et al. 2010, Hargie et al. 2010, Joyce et al. 2010, Langewitz et al. 2010, Duggan, Thompson 2011, Del Piccolo et al. 2011, Pollak et al. 2011, Roter 2011, Berkhof et al. 2011, Kurtz, Cooke 2011/2017, Hojat et al. 2011, Back et al. 2011, Barth, Lannen 2011, McHenry et al. 2011, Dwamena et al. 2012, Stubenrauch et al. 2012, Lelorain et al. 2012, Neumann et al. 2012, Clayman et al. 2012, Christianson et al. 2012, Elwyn et al. 2013, Finset et al. 2013, Silverman et al. 2013, Bayne et al. 2013, Vitinius et al. 2013, Bachmann 2013, Street 2013, Wouda, van de Wiel 2013, Laws et al. 2013, Moore et al. 2013, Kiessling, Langewitz 2013, Street, de Haas 2013, Baile, Blatner 2014, Peterson et al. 2014, Legare et al 2014, Laidsaar-Powell et al. 2014, Zill et al. 2014, Branch 2014, 2015, Han et al. 2014, Windover 2014, Bell, Kravitz 2014, Hauser et al. 2015, Pruskil et al. 2015, Sator, Jünger 2015, Martin et al. 2016, Maatouk-Bürmann et al. 2016, Kidd 2016, Boissy, Gilligan (eds.) 2016, Skelton 2016, Cömert et al. 2016, Phillips et al. 2016, Bachmann et al. 2016, Makoul, van Dulmen 2016, Windover 2016, Hammersen et al. 2016, Jünger et al. 2016, Wiskin, Lefroy 2016, Sulzer et al. 2016, Radziej et al. 2017, Grayson-Sneed et al. 2017, Sanders et al. 2017, Hauser et al. 2017, Brown et al. 2017, Koerfer, Albus 2018, Jünger 2018, Graupe et al. 2020, Haskard-Zolnierek et al. 2021, George 2022, Khalaf, Khan 2022, Bachmann et al. 2022, Stortenbeker et al. 2022, Chauhan et al. 2023, Lehane et al. 2023, Bos-van den Hoek 2023, Stivers, Tate 2023, Sharkiya et al. 2023, Zhou et al. 2023, Lelorain et al. 2023, Stamer et al. 2023, Sood, Riley 2024, Bruch et al. 2024, Schick et al. 2024, Zerbini et al. 2024, Lindhardt, Thysen 2024, Xiao et al. 2024, Hargie 2025, Singh et al. 2025, Sharif et al. 2025, Aboushawareb et al. 2025, Zerbini et al. 2025, Dávid et al. 2025. A systematic review of observational coding systems is provided by Hillen et al. 2025.	
	Notes - comments	
	The topic of "education and evaluation" is very complex. Some of the work is limited to the *methodology* of evaluation, while other work focuses primarily on presenting *curricula* or *teaching* concepts, or discussing specific *evaluation tools* that are often isolated and rarely integrated into a larger body of work. *Scientific foundations* are repeatedly postulated for the education and	

evaluation of *communication training* and *communication curricula*, but these have not yet been sufficiently developed, leaving many desiderata (e.g., Pendleton 1983, Inui, Cartner 1985/2013, 1989, Stiles, Putman 1989, Stiles 1992, Koerfer et al. 1994, Skeff et al. 1995, Kurtz et al. 1998, Street, de Haes 2013, Koerfer, Albus 2018, White 2020) (cf. § 2.3, 13, 40). The discussion on evaluation also addresses specific methodological problems (validity, reliability, feasibility) that still need to be resolved in order to arrive at standard solutions (e.g., Pendleton 1983, Argyle 1983, Roter 1989, Koerfer et al. 1994, 2008, Thistlethwaite 2016, Koerfer, Albus 2018, Dávid et al. 2025) (§ 40-43). Thistlethwaite (2016) describes the general problem of evaluation using the image of a *black box*, to which she poses a series of questions about the relationship between input and output that cannot yet be answered satisfactorily (cf. § 40). Here, we can only provide a brief overview of some of the problems and methods of education and evaluation and otherwise refer to the book's chapters (§ 3, 13-16, 40-43).

We have incorporated and differentiated Miller's (1990) distinction (*knows, knows how, shows how, does*) (see topic focus 5), which is often used in evaluation studies, in several chapters (§ 2.2.4, 13, 40). This basic distinction (level of assessment) was already used by Epstein and Hundert (2002: 229) to differentiate a *framework for assessment* covering all types of medical competencies: relationship building, communication, physical examination, diagnosis, ethics, etc. The *OSCEs*, which were just being established at many universities at the time, are already described by Epstein, Hundert (2002) as very heterogeneous (for Cologne Curriculum, see chapters 13 and 14).

Specific *e-learning* projects, such as those we have developed in *Cologne's communication curriculum* using video, require special evaluation methods. *Simulations* are different from *workplace learning* (e.g., during a ward round), where learning takes place through *observation* and *imitation* of "role models."

In *evaluation* studies, many aspects and methodological problems (bias, etc.) must be differentiated (learning level, situation, subject matter, objectives, measurement instruments, etc.). It makes a difference under what conditions, in what *situation*, with *whom*, and for *how long* learning takes place: *face-to-face*, *real and authentic* D-P conversations, *simulation*, *group learning*, etc.

Coding (e.g., *Roter system*) or *rating* (e.g., *Cologne Evaluation of Medical Communication*, C-EMC) of *real* conversations by *objective* observers differs from *self-assessment* (questionnaire, scale, etc.), which tends to be subjectively positive after participation in a training measure for well-known reasons (bias, etc.). Coding and rating by *ex-*

ternal observers are preferable to *self-assessments*; if the resources are available, a combination of evaluation instruments is recommended. Overall, the aim should be to achieve a *mix of methods* in which *qualitative* and *quantitative* analysis methods are not mutually exclusive but can complement each other (§ 40, 42, 43).

Specific *methodological problems* of evaluation are discussed later in this chapter (2.3-2.5). *Curricula, learning goals,* and communication *training* (students) and *continuing education* (practitioners) are presented in chapters 3, 13-16, while the associated methodological problems and *evaluation instruments* (coding, rating, etc.) are dealt with in the evaluation section (VI) (§ 40-43).

14	Specific Balint Group Work	Ch.
	Key words - references	
	Practice-oriented training and accompanying research in medical practice in the tradition of Balint, who with his call for "training cum research" significantly promoted the empirical, evaluative and (self-) reflective development of research on the doctor-patient relationship:	6 8 10
	Balint, Balint 1962/1990, Balint 1964/1988, Balint, Norell 1953/1975, Giesecke, Rappe 1982, Rosin 1989, Köhle et al. 1995, 2001, Kaerger 1999, Koerfer et al. 2004, Cataldo et al. 2005, Adams et al 2006, Lichtenstein, Lustig 2006, Kjeldmand et al. 2004, Kjeldmand, Holmström 2008, Torppa 2008, Szirt, Langewitz 2010, Koerfer et al. 2010, Köhle et al. 2010, Köhle, Janssen 2011, Tschuschke, Flatten 2017, Yang, Wang 2022.	
	Notes - comments	
	One of the central goals of Balint group work is to *improve relationships and communication* with patients. A first step in this direction is to *reflect* on one's own professional practice and "bring to light the mistakes, blind spots, and limitations of each individual member" that one makes oneself, but also that others make when dealing with patients (Balint 1964, Appendix 1: Education).	
	By sharing experiences through *case reports*, members learn both individually and collectively in the group. Under the guidance of an experienced group *leader* (see below), the learning processes take place in the mode of both *self-observation* and *external observation* (handbook, § 1 and 6).	
	Von Uexküll and Wesiack continue this tradition when, following their "Theory of Human Medicine" (1991) in a "final consideration" describe in detail the role of the "meta-doctor," who, as it were, critically observes himself over his own shoulder while acting and, in conversation with the patient, notices mistakes and weaknesses,	

which he immediately corrects or compensates for self-critically in the further course of communication. Such a *self-reflective meta-doctor* is already operating at a high level that can hardly be improved upon without further intensive education.

The *development level* of participants in Balint group work can be *lower* (naive or unconscious beginners, (un)conscious learners), as already differentiated above in topic focus 5 ("Communication Competence") (with Boissy, Gilligan 2016 and Windover 2016). In contrast, the *group leader* should generally have many years of *professional experience and psychotherapeutic* (often psychoanalytic) *education,* i.e., have achieved a particularly *high level* of development of a specific professional (self- and other-reflective) competence ("mature practice") that he/she can use in the group in the sense of *supervision* (§ 6).

In the *Cologne continuing education programme*, a tradition was developed where the physicians in the group not only presented their usual case reports, but also provided video recordings of their conversations with their patients, which were then subjected to critical reflection in the group. Many of these conversations later became the subject of conversation analysis (e.g. Koerfer et al. 1994, 1996, 1999, 2000, Köhle et al. 1995, 2001, Koerfer et al. 2004, 2005, 2008, 2010, Koerfer, Albus 2015, Köhle, Koerfer 2017, Koerfer, Albus (eds.) 2018). Many examples from these works still form the basis of the data used for the conversation analyses in this handbook (Practice Chapters 17-23).

These *conversation analyses* became part of an overall evaluation of the Balint group work, which was intended to promote the *communication competences* of the doctors over a period of one year in order to then be able to take stock of and evaluate the progress made (*pre-post design*). A *multimodal* approach to evaluation was pursued, the results of which are reported in the evaluation section of the handbook (VI) (cf. Köhle et al. 1995, Kaerger 1999, Köhle et al. 2001, Köhle et al. 2010, Szirt, Langewitz 2010, Koerfer et al. 2010, Obliers et al. 2010). As a preliminary conclusion, it should be noted that although there were individual differences among the physicians at different starting levels, they *benefited* as a group from the continuing education programme.

15	Medical Ethics: Reasoning and Acting	Ch.
	Key words - references	
16	Theories and reflections on medical ethics and discourse ethics, philosophy of medical action and human health under specific aspects: reasoning - transparency - participation - symmetry - autonomy - re-	6 7 8

	sponsibility - truthfulness - trust - quality of life - distributive justice, etc: Pellegrino, Thomasma 1981, 1988, Veatch 1987, 1989, Scambler 1987, Sass 1989, 1991, Pellegrino 1989, Kettner 1991, Coulehan, Block 1992, Gadamer 1993/2006, Mishler 1984, Wieland 1996, Kampits 1996, Vollmann 2000, Scambler (ed.) 2001, Scambler, Britten 2001, Woopen 2001, Scambler (eds.) 2001, Branch et al. 2001, 2006, 2009, 2015, Ritschl 2004, Gethmann-Siefert et al. (eds.) 2005, Stevenson, Scambler 2005, Vollmann et al. (eds.) 2009, Sandman, Munthe 2009, Kettner, Kraska 2009, Meyer-Abich 2010, Walseth, Schei 2011, Walseth et al. 2011, Siminoff 2011, Munthe et al. 2012, Brody et al. 2012, Kreß 2012, Rubinelli 2013, Hekmat-panah 2013, Labrie, Schulz 2014, Spieß 2015, Singh 2016, Chandra et al. 2018, Stanley, Sehon 2019, Albuquerque 2020, Walker, Lovat 2022, Kampits 2022, Albuquerque 2023, Duvenhage 2024, Fitzgerald 2025, Rocha, Albuquerque 2025.	22 36 38 43
	Notes - comments	
	In the tradition of *anthropological* and *biopsychosocial* medicine (focus topic 4), *medical ethics* has contributed significantly to today's understanding of the *doctor-patient relationship* and *communication*. The essentials were already formulated in basic research, even before specific medical *ethics* competencies were included in the early definitions of general medical competence (e.g., Epstein, Hundert 2001) (see topic focus 5). Anyone who today critically examines established concepts such as *shared decision making* (SDM) in relation to other relationship models should also consult *earlier works* (Parsons 1951/1970, Byrne, Long 1976, Pellegrino, Thomasma 1981, 1988, Mishler 1984, Veatch 1987, 1989, Scambler 1987, Pellegrino 1989, Gadamer 1993/2006, Scambler (ed.) 2001, Scambler, Britten 2001, Scambler (eds.) 2001, Branch et al. 2001, 2006, 2009, 2015, Ritschl 2004). Pellegrino, Thomasma (1981: 65), for example, already advocates a *partnership model* with a relevant motto, which we have also placed at the beginning of our Chapter 7 ("Dialogical communication and medicine"): *Both physician and patient 'teach' one another in dialogue.* Pellegrino, Thomasma 1981: 65 However, in practice, the question arises as to how doctors and patients structure their *dialogue* and what *lessons* they ultimately learn from it. As already explained above, in the practice of *dialogue-based* decision-making, it will rarely be possible to assume one universally valid *ideal model* (Koerfer, Albus 2015). Rather, a diverse spectrum of models and their variants can be expected, with *fluid transitions* in the dialogue practice in which the decisions have to be negotiated. These problem and conflict situations must be analysed from a *role-*	

theoretical or *system-critical* or *communication science* perspective and reflected on accordingly in teaching. For the associated *fitting* problem, doctors, who are also otherwise familiar with individual dosages, should develop *appropriate* communicative competence (Koerfer et al. 2008, Koerfer, Albus 2015), with which they can react sensitively and flexibly to different and changing patient needs in a "customised" manner (§ 10, 22). One may criticise the diversity of models (and sub-models) as an *over-differentiation* or consider it a necessity in order to do justice to the diversity of decision-making in practice. However, *informed consent*, which is universally desired in decision-making, should not lead to *over-information*, which can lead to confusion on the part of the patient, especially under time pressure, so that in the end no dialogue partner is helped by *confused consent*. Cases of confusing communication were already reported by Balint (1964) and are also analysed in detail in our discussion analyses on decision-making (§ 22).

Doctors and patients can also come into conflict because postulates that are well-founded in terms of *professional ethics* cannot be harmonised with *individual* patient needs and values, so that problems arise on different levels: Medicine as a *system* vs. *lifeworld*, *neutrality* vs. *preference*, *asymmetry* of *roles* (helper, person in need of help), asymmetry of *knowledge*, asymmetry of *action*, (in)equal *treatment* or *distributive justice* when resources are scarce (e.g. in transplantations) (§ 36) etc.

In such cases, only *open communication* can help, in which the doctor follows *the principle of transparency* within the framework of *discourse ethics* (Koerfer et al. 1994, 2008, Koerfer, Albus 2015, 2018, Kettner, Kraska 2009, Kampits 1996, 2022, Duvenhage 2024) and seeks to justify to the patient all conditions of action that he himself as a doctor may regret from his professional and personal perspective by giving reasons for his medical actions.

Finally, reference should again be made to the current work of Albuquerque 2020, 2023, and Rocha, Albuquerque 2025, who explore the relationship between *patient-centred care* and *empathic communication* in the framework of a *new clinical bioethics*.

Table 2.1: Exemplary overview of traditions and topics
of medical and psychotherapeutic communication research

The preceding selection of *topics* and *literature* is by no means intended to be representative, but should only take into account works that can serve *as exemplary* placeholders for the development of research and practice in doctor-patient communication over a longer period of five decades. Although we cannot provide *a historical and systematic* outline

of these *interdisciplinary* research developments on doctor-patient communication here,[24] the aim of this handbook is to bring together the various strands of tradition as far as possible and to give the "pioneers" and "classics" of theoretical and empirical, both *clinical* and *social science* research on doctor-patient communication the opportunity to speak at length.

2.2.4 Borrowing from the "classics"

Borrowings from research traditions are also constantly made here in the form of lengthy quotations from the "classics", which should be cited not only because of the authenticity of the historical sources, but also because the basic ideas and reflexive methods for investigating and improving medical communication have often long since been formulated in an "exemplary" manner. These findings and experiences occasionally threaten to be forgotten in "modern" quantitative and qualitative, empirically oriented conversation research when it comes to the appli-

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[24] For *historical-systematic* overviews under certain (theoretical-methodological, empirical-analytical, didactic-evaluative, verbal and non-verbal, medical-historical and -ethical, etc.) aspects and for further reading on specific topics, please refer to the numerous reviews in the handbook's comprehensive bibliography. For this reason, we will limit ourselves to a small selection here: e.g. Pendleton, Hasler 1983, Fuchs 2000, Pollock 2005, Heritage, Maynard 2006, Langenbach, Koerfer 2006, Menz et al. 2008, Lehmann et al. 2009, Meyer-Abich 2010, Sator, Spranz-Fogasy 2011, Berkhof et al. 2011, Barth, Lannen et al. 2011, Nowak 2011, Lipkin 2011, Thompson et al. (ed.) 2011, Brown, Bylund 2011, Henry et al. 2012, Christianson et al. 2012, Dwamena et al. 2012, Harvey, Koteyko 2013, Beach (ed.) 2013, Moore et al. 2013, Robinson, Heritage 2014, Zill et al. 2014, Scholl et al. 2014, Hauser et al. 2015, Cömert et al. 2016, Cushing 2016, Bates et al. 2016, Kidd 2016, Frain 2018, Chandra et al. 2018, Feldthusen et al. 2022, , Grover et al. 2022, Stivers, Tate 2023, Sharkiya 2023, Zhang et al. 2023, Alkhamees, Alasqah 2023, Lehane et al 2023, Kim et al. 2024, Saxler et al. 2024, Bruch et al. 2024, Jami et al. 2024, Gil Deza 2024, Parry 2024, Ekberg et al. 2024, Barnes, Woods 2024, Pham et al. 2025, Aboushawareb et al. 2025, Fox et al (eds.) 2025. References not listed at the end of this chapter can be found in other topic-specific chapters and in the complete bibliography (with approx. 3000 references) of the handbook.

cation of highly specialised coding, rating and (conversation) analysis methods of medical and therapeutic communication (§ 40-43). The aim here is to sensitise readers to the level of reflection once achieved by the "classics" by reassuring them of the research tradition, which can be used for the interpretation of methods and results from "modern" research on doctor-patient communication.

This applies, for example, to the explanation of patients' communicative problems with the so-called *association rule,* which Sigmund Freud (1912) formulated as an *anti-maxim* catalogue in comparison with everyday communication and which should also be applied moderately in everyday doctor-patient communication (Lakoff 1977, 1980, 1983, Koerfer, Neumann 1982, Koerfer, Köhle 2007, Kächele et al. 2006) (§ 9). What was developed here in the psychoanalytical tradition as an approach to "narrative" therapy (Schafer 1995, Bothe 1994, 2011 Habermas, Fesel 2022, Habermas, Bongard 2024) has been given a specific continuation in the approach of "narrative" medicine (Greenhalgh, Hurwitz (eds.) 1998/2005, Koerfer et al. 1994, 2010, Goyal 2013, Gülich 2017, Köhle, Koerfer 2017, Kirmayer et al. 2023, Koval 2024, Fioretti 2025).

As a further example of the history of the impact of a "classic", Carl Rogers should be cited again, who not only had a significant influence on the development and theory of conversational psychotherapy, but also made an outstanding contribution to the *evaluation* of conversational techniques, when their effect was already tested on *tape recordings* (sic) with a procedure for determining a *non-directive* interview style (Rogers 1942/85, Koerfer et al. 1994, 2005), which is reminiscent of the *linguistic* procedure of the *omission test* (§ 9, 17, 19, 40).

We will return to both protagonists (Freud, Rogers) of psychotherapy research separately, while other "classics" (such as Balint, Engel, Luborsky, von Uexküll, Schafer, Lown etc.) will provide us with ongoing insights into "clinical" conversation research, for which they have made great contributions. Longer quotations from the classics are reproduced in this Handbook as learning opportunities (often in highlighted text boxes), which can of course be rejected, but can also be used in class or during self-study as illustrative learning opportunities for further reflection.[25]

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[25] Chapters 3, 4, 7, 9, 10, 13, and 17 in particular contain numerous references to further, easy-to-understand literature that is also suitable for teaching purposes.

2.3 Professional Communication Competence

As already mentioned above (§ 2.2.4: topic focus 5), a book on *medical communication competence* is committed to exploring and differentiating the extensive research on the central concept of *communication competence* in order to be able to detect and typify deficits and alternatives of (more or less) *good* and *bad* communication in empirical and comparative analyses of real conversations (Part IV) and to gain perspectives for better forms of communication (*best options*) through training and continuing education.

These perspectives will be used to differentiate aspects of the integration of *communication curricula* into a general medical curriculum, which is to be achieved through the scientific integration of various disciplines, before the communication science foundation of the specific communication curricula follows. Finally, we have developed and substantiated a *multidimensional definition* of professional medical *competence*, which is differentiated in further steps (§ 2.2.1-10) and exemplified with typifying anchor examples in the handbook (§ 3, 17-25).

2.3.1   Definitions of Medical Competence

Definitions and concepts relating to *communication competence* are discussed in several chapters, which also take into account traditional definitions of medical competence that have gained international resonance (e.g., Weinert 2001, 2002, OECD 2002, 2005, Rychen, Salganik 2000, 2003, Epstein, Hundert 2002). Weinert's well-known *definition of competence* (1999, 2001) has also been incorporated into the "Nationaler Kompetenzbasierter Lernzielkatalog Medizin" (NKLM) (2015/2021) in Germany [National Competence-Based Learning Objectives Catalog for Medicine]. In the various discussions about a general concept of competence, *key competences* are differentiated, which will be specified here for medicine.

Due to its relevance for many disciplines and fields of practice, we have placed Weinert's *multidimensional concept of competence* (English Editions 1999, 2001, 2002) in chapter 3 ("Learning Goal Communication Competence") and commented on it there in the context of further literature (OECD 2002, 2005, Rychen, Salganik 2000, Rychen, Salganik

(eds.) 2001, 2003, Descy, Tessaring (eds.) 2004, Rychen 2004, 2008). As Weinert and other authors have repeatedly emphasised, the clarification of the general concept of *competence* in research cannot be considered complete and remains as challenging today as the specific clarification of the concept of *communication competence*, which occupies a central position and function in relation to other key competences.[26]

The NKLM (2015/2021) also includes the widely used definition by Epstein and Hundert (2002), whose pioneering work on the "Definition and Assessment of Professional Competence" provided an important impetus for the development of curricula, teaching and evaluation concepts (cf. topic focus 13). Due to its relevance, the specific definition by Epstein and Hundert (2002), which is tailored to medicine but quite comprehensive, should be quoted in full here (Box 2.3).

Box 2.3 Definition of medical competence
We generated an inclusive definition of competence: the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.

<div align="right">Epstein, Hundert 2002: 226.</div>

As concise as this definition may seem at first glance, it is difficult to apply in research and teaching. In this definition, communication skills are identified as one *key competence* among many others, which must first be placed in relation to each other in a corresponding curriculum with learning goals, training, education and evaluation (see § 2.3.-9 below). Critical formulations that point to problems of application in practice (e.g. *habitual and judicious use of* ...) will also be important (see below). There is also a risk of potential conflicts between *individuals* and *communities*, which do not always share the same values, meaning that there may be different, sometimes competing ideas of benefit (cf. topic focus 15 and § 10 and 22). In the discussion of a valid and viable defini-

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[26] In addition to the already mentioned literature (see § 2.2.4: topic focus 5), particular reference should be made here and below to the topic-specific contributions by Trier 2003 (specific topic: *OECD countries*), Conczi 2003 (*Teaching and Learning*), Rychen 2003 (*Frame, Defining Key Competences)*, Quane 2003 (*Lifelong Learning*), Oates 2003 (*Assessment*), Rychen 2008 (German) (*OECD Reference Framework*), Rychen 2004 (*Assessment*).

tion, we refer to the literature with a specific thematic focus (§ 2.2.4: focus 5-15) and to chapters in the Handbook, in which the respective thematic focus is explored in depth in theory, didactics and empiricism/practice.

2.3.2 Paradigm shift: Medicine and communication

The definition by Epstein and Hundert (2001) is undoubtedly narrower than Weinert's (2001, 2002) (see § 3) because it is specifically tailored to the professional competence of physicians. However, as with Weinert, the definition is *multidimensional*, with the following distinctions initially being made as a list: e.g., communication, knowledge, technical skills, clinical reasoning, reflection, etc. This initially provides a series of *key competences* that need to be put into relation to each other in research and teaching.

At second glance, the above definition (Epstein, Hundert 2002) is quite complex and comprehensive, which means that even in the teaching process, learning objectives must be differentiated using a *taxonomy* that takes into account very different, highly complex (communicative, cognitive, technical, reflective, etc.) learning goals in order to consider their correspondences and interactions (see below). In such a competency-based learning goal taxonomy, the *key competences* to be acquired must be arranged functionally in order to integrate them into an *overall* concept:

- *Medical knowledge*, which extends to various dimensions and disciplines and can only be acquired successively (nosological, diagnostic, therapeutic) (§ 3, 8, 13-16),

- *Instrumental action* (Habermas 1971, 1981), which must be continuously tested and improved until it becomes routine (e.g., physical examination, surgery, medication, etc.) (§ 7, 8, 10),

- *Communicative action* (Habermas 1971, 1981) (§ 7, 10), which, as professional action, can differ significantly from everyday communication and therefore also need to be learned especially (§ 2.3.4) in order to be able to apply them routinely in

- *Dialogical anamnesis* and *medicine* (Mishler 1984, Uexküll 1987, 1993, Gadamer 1993, Koerfer et al. 1994, 2000, 2010, Olesen 2004, Ritschl 2004) (§ 9, 19, 20 24, 25), in which the patient - ac-

cording to the meaning of the word (*anamnesis* = to *remember*) - is asked to *narrate* their medical history (§ 7, 9, 19, 20), and all this within the framework of

- *Biopsychosocial* medicine (Engel 1977, 1981, 1992, 1997, Uexküll, Wesiack 1991, 2011, Egle et al. 2020, Egger 2020, Lugg 2022, Bolton, 2022), in which traditional dichotomies (mind-body, health-illness, etc.) (§ 4, 10) are revised and

- *Conflicts* not only between doctor and patient, but also between the individual and society must be *reflected upon* within the framework of *medical ethics* and discourse *ethics* (Pellegrino, Thomasma 1981, 1988, Koerfer et al 1994, Ritschel 2004, Vollmann (ed.) 2009, Duvenhage 2024 (§ 7, 10), whereby

- *Reflection* and *clinical reasoning* must apparently be placed in relation to the other key competences (§ 2.3.3-9, 3, 13).

Before we further differentiate these relationships in theoretical, didactic and empirical chapters (§ 3, 4, 8, 10, 13-14, 17-23), we will first draw some conclusions for the didactics of medical communication and, in particular, for competence-based *learning goal taxonomies* (see § 2.3.3 below).

Unless it is an emergency, the starting point for medical care is always a conversation in which the doctor first explores the patient's symptoms and concerns through active listening and empathetic responses, then possibly communicates suspected diagnoses and perhaps even negotiates therapies with the patient. If necessary, the doctor may already carry out a physical examination as an *instrumental* action in order to then continue the conversation with new information that requires new *shared reflections* and *dialogical decision-making* processes (negotiating), etc. (§ 7, 8, 10, 17-23).

To illustrate the paradigmatic problem of the *interrelationship* between medicine and communication using the example of a relationship between (*types* of) medical *knowledge* and *communication*: Doctors who are unwilling or unable, due to a lack of knowledge, to make the paradigm shift from pure *biomedicine* (BM) to *biopsychosocial* medicine (BPSM) (§ 4) do not need to change their *communication style*. To paraphrase Balint (1964) in a casual and ironic way:

- Doctors who adhere to *traditional medicine* can also continue to use *traditional methods of taking a patient's medical history*, i.e. they *do not* need to let the patient *speak*, but can interrupt them

continuously with targeted *questioning techniques* for their own medical purposes, for example to follow a standardised medical history form; and vice versa:

- Doctors who adhere to traditional, *interrogative* communication techniques will miss the opportunity to switch to *biopsychosocial* medicine, so that the traditional unity of *biomedicine* and *paternalistic* relationships and communication with patients will remain in place for them.

However, when changes did occur, they were introduced at different speeds in theory and practice: in practice, the dual and parallel paradigm shift, which entailed a departure from traditional, *paternalistic* medicine and a shift towards new, initially strongly *patient-centred* relationship and communication models, took place in various waves and phases (cf. overview above in § 2.2.3: Table 2.2). The paradigm shift was introduced in theory at an early stage in the English-speaking world with the works of Balint (1964), Balint, Balint (eds.) (1962), Balint, Norell (eds.) (1973) and Morgan, Engel 1969, Engel (1977) (1997), and continued in German-speaking countries primarily with the work of von Uexküll, Wesiack (1991, 1996, 2011). However, the resulting shift towards "talking medicine" highlighted gaps in the training system, which was not equipped to promote the necessary *communication competences* among students and doctors (see above Box 2.1). Despite the continuing deficiencies, as noted in the overviews by Bachman et al. (2022) and Venktaramana et al. (2022), entire fields of research have now developed that deal with both *basic research* and *empirical* conversation analysis and *educational reforms* at universities (topics 3-15) (§ 2.3.3-10, 3, 13, 14).

In the practical section (IV) of the book (§ 17-23 and 24-15), the interaction between traditional medicine (BM) and traditional communication (*interrogation*) are illustrated using empirical examples, as is the corresponding communicative paradigm shift (*narration*), which has already been described in rudimentary form under the label "narrative medicine" (see above § 2.2.4: topic focus 9) and is further elaborated on in specific chapters (§ 9, 19, 20, 24, 25) and substantiated with narrative analyses. These conversation analyses are based on a concept of *medical communication competence,* which will be elaborated on in several steps below.

2.3.3 Competence-based taxonomies of learning goals

It is not only in the field of medical competence that definitions often oscillate between Scylla and Charybdis: they run the risk of either remaining vague and abstract (as in the above definitions by Weinert 2001, 2002, Epstein, Hundert 2002) or being overly differentiated, as is often the case in learning goal catalogues. To avoid this risk, this chapter and the following chapters will take into account the complexity of the problem, which will then be gradually reduced in a context-specific manner in the didactic concepts and conversation analyses.

Practical and competence-based *learning goal taxonomies* must be *flexible* enough in order to focus on specific complex learning goal groups in specific learning processes at specific *stages of development* (see § 2.3.4 below). The taxonomy of learning goals should be constructed in such a way that it allows for extensions, differentiations, and reductions, with formal and functional placeholders reserved for specific research and teaching questions at different learning levels, at which *competences* are acquired *gradually* in several stages of development, but also with possible setbacks.

If the paradigm shift in medicine described above is to be pursued as *knowledge* and *action* integrated into the consultation, this connection must first be intensively taught in a *circular communication curriculum* through training or later through *continuous education* (§ 13-16).

Isolated training concepts: Rhetoric courses

In contrast, isolated training courses run the risk that learning units without context and continuity, which follow a one-off schematic rhetoric training course, will either have little lasting success or, in the worst case, produce counterproductive results.

Insular courses without context can offer nothing more than formal rhetoric drills, at the end of which participants will have learned to mechanically pause and express listening signals at regular intervals without meaning or purpose, because that is what they have been taught. In practice, for example in OSCEs, inappropriate accumulations of "Okay" can be observed until the simulated patient (SP) puts an energetic stop to it ("Why do you keep saying 'Okay' – nothing is okay!"). (cf. Platt, Gordan 2004: 122) (Handbook § 19). Once learned, well-established communication patterns are difficult to change.

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Helical Model: integrative training concepts

In contrast to singular training courses or more linear course sequences, learning processes (not only) in a communication curriculum should be organized according to a *helical model* in which learning goals can be repeatedly revisited, specified, and deepened in new learning contexts (Box 2.4).

Box 2.4	Helical model

Follow a helical rather than a linear model. Once and done is never enough. Effective communication, like effective teaching and learning, requires reiteration, coming back around the helix at a little higher level, taking feedback to your communication (or efforts at teaching or learning) into account at each turn. The helix serves as an excellent model for curriculum development.

Kurtz, Cooke 2011: 587 (2nd Edition 2017).

As explained in the didactic chapters (§ 13, 14), the *Cologne Communication Curriculum* (CCC) is structured as a *spiral* curriculum in which learning goals related to *biopsychosocial* medicine (BPSM) and specific *diseases* (e.g., depression, diabetes) (§ 29, 30) are repeatedly linked to *communicative learning goals* and deepened in the course of the curriculum.

In the handbook, we have also attempted to create *taxonomies* for learning goals in key didactic chapters (§ 3, 13-14) and, where possible, to structure our conversation analyses in the practical chapters (§ 17-25) in such a way that concrete *anchor examples* with specific diseases are given for the respective learning goals, which can be used in class to stimulate learning at different learning levels (§ 2.3.4).

Complex learning goal taxonomies

A preliminary, broadly oriented taxonomy of learning goals, whose learning goals are hierarchised at different levels (*macro, meso, micro learning goals*), is briefly presented here in a graphical representation (Fig. 2.4) and commented on here before being further elaborated in variants in subsequent chapters, depending on the learning occasion, specific goals, and anchor examples in the didactic and practical chapters (§ 3, 13, 17-23).
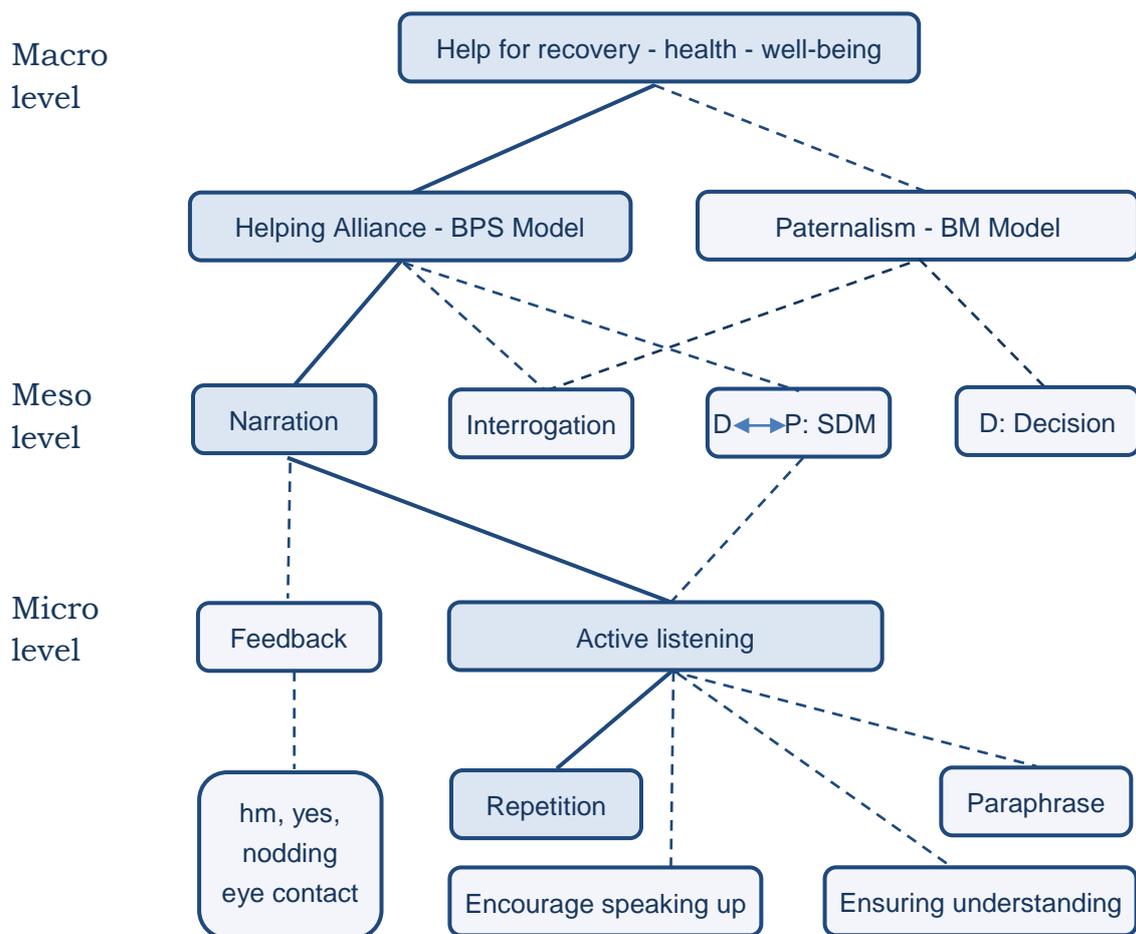
Fig. 2.4: Learning goal taxonomy (mod. after Koerfer et al. 2008, Koerfer, Albus 2018); Selection: Exemplary path for intervention type "Repetition"

The complex, competence-based learning goal taxonomy distinguishes between *macro, meso, and micro* learning goals in a standardized form that allows for *operationalization* down to the level of *manifest* communicative (partial) actions or nonverbal conversational behavior (gaze, position, gestures, etc.) in order to be able to initiate targeted and differentiated training of communicative competences and individual sub-competences after an evaluation of relevant deficits.[27]

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[27] In the literature, terms such as aims, goals, objectives, targets, etc. are often used inconsistently or distinguished terminologically, which is difficult to maintain. We mainly use the terms *goal* and *objective* and distinguish context-sensitive - where appropriate - between macro, meso, and micro learning goals in order to identify the relationships at different hierarchical levels. The use of listener signals is on a different level than verbal intervention types within the framework of a participation model (SDM) that is

Such learning goal taxonomies can be used in concrete learning processes in certain opposite directions (*top down – bottom up*). The starting point is always concrete *problem-oriented* learning opportunities, as they arise in the classroom through conversation *observation* (e.g. videos of real conversations), *simulation* (SP) or *reading critical literature* (§ 13). In this way, both care and relationship models (SDM vs. paternalism) can be addressed, as well as problematic listener signals (e.g. frequent use of "okay") or the difference between passive and active listening. If lessons are conducted using multimedia rather than just paper (page format), the focus of learning can be changed spontaneously and a change in learning goals can be set in the *learning goal taxonomies*, ideally linked to an empirical (video) example (§ 13).

Operationalization of learning goals

In the literature (including on communication curricula), it is often assumed that operationalizations are only possible at lower learning goal levels. For this reason, operationalization usually focuses on the supposedly most concrete, *manifest behavioral level*, because only this is accessible to observation (listener signals, paraphrases, questions, assertions, advice, etc.). Although it may seem more difficult and time-consuming, it is also possible to demonstrate at higher levels of learning goals that the intended learning goals have been missed or more or less pursued.[28]

committed to biopsychosocial medicine. As explained below, we use specific terms from philosophical action theory or from pedagogy and didactics to mark the relationships between (partial) actions and corresponding (sub-)competences.

[28] For indisputable problems and limitations in the operationalization of learning goals in the tradition of Bloom's taxonomy, reference is made here to the well-known contributions by Weinert (ed.) (2001), whose definition of competence in medicine is often quoted only as a half-sentence. In the various contributions to the book, Weinert also addresses the question of goal-achieving learning, whereby the focus here is on very challenging learning goals in school education. Higher-level learning goals such as self-reflective meta-competencies, particularly in medicine, will be discussed further below (§ 2.3.7-10). Whether such a high-level learning goal as self-reflective meta-competence is achieved (or not) in real doctor-patient conversations is certainly more difficult to evaluate than in the case of biopsy-

Whether certain learning goals have been achieved at the level of *biopsychosocial* medicine can be tested, for example, through conversation analyses or ratings: If, at the end of a real consultation or a simulated session (OSCE with SP), no knowledge of previous illnesses or treatments or the patient's professional or family situation has been acquired because neither the physician nor the patient has addressed these issues, the anamnesis has remained deficient, which is reflected in the gaps in the progression of topics in the conversation.

Or conversely: although a complete medical history remains a myth (§ 22), the *biopsychosocial anamnesis* can be reflected in the *progression of topics* because the physician and patient have addressed the previous illness, the precarious professional situation, or the stressful marital problems. Whether the biopsychosocial anamnesis is more or less successful can also be evaluated relatively by means of a *rating*, as in our *Cologne Evaluation of Medical Communication* (C-EMC) (§ 17-23). If deficits in competence development become apparent here, these can be compensated for by targeted interventions and exercises at various *learning levels* (§ 2.3.4).

Formulation of learning goals

When formulating the relationships between learning goals, linguistic terms can be used as they are commonly applied in analytical philosophy of language or linguistic pragmatics for action analysis to typify the relationships between (partial) actions and their consequences ("doing y by doing x," or: "by doing x (and ...) the consequences are ..." (cf. Koerfer 1994/2013). The formulations for "listening to concerns" serve as an example to illustrate the procedure (Box 2.5).

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chosocial learning goals, the achievement of which can be determined by simple content analysis or ratings.

Box 2.5	Learning goal taxonomy for "Listening to concerns"

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 himself as a helper ("What can I do for you?").
        * and by *promoting the patient's narrative*,
            * by giving listening signals (*nodding, hm*)
            * by avoiding interruptions
            * by tolerating breaks
            * by allowing a free development of topics
        * and by active listening (verbal support)
            * by encouraging speaking up: "and then?"
            * by repeating statements verbatim
            * by open follow-up questions: "How did that come about? etc.

Further learning goal *formulations* follow the six steps/conversational functions in our *Cologne Manual of Medical Communication* (C-MMC), which can also be used to determine the learning content and sequence of learning units in the classroom (§ 3, 13, 17) (cf. appendix in this chapter). Since the preceding definition of competence cited by Epstein and Hundert (2001) proved to be quite complex and comprehensive, there are certain consequences for evaluation, which must also take into account certain levels of development in competence development, as already addressed (in § 2.2.4: topic focus 13 ("Education and Evaluation") and now to be further elaborated.

2.3.4   Knowledge and Acting: Competence development

The teaching of medical communication must be considered in terms of a number of aspects relating to the acquisition of communication competences, which can only be roughly differentiated here in order to distinguish between the various levels of development that lead from naive

novice to mastery, with which the art of medical communication can in turn be competently imparted to novices, etc.

Knowledge and Acting

First, *everyday communication* must be distinguished from *professional communication*, even though they necessarily form a unit, even if the relationship remains asymmetrical (§ 2.3.7). Ultimately, scientific language must also remain reducible to everyday language — even under conditions of (academic) scientific communication. It is already proverbial that not only *interprofessional* communication (§ 2.3.8) can be difficult, but that communication between doctors and their patients often fails or remains *misunderstood,* as is disrespectfully referred to as medical jargon. We deal with the *(in)comprehensibility* of language and communication throughout in the handbook, and in specific chapters (§ 10, 27).

The main difference between everyday communication competence and professional communication competence lies in the way it is *acquired* and the degree of *specialization.* Our *tacit knowledge* of communication is sufficient to enable us to communicate more or less *competently* in *everyday* situations. While we learn *everyday competence* naturally in interactive situations (during childhood), *professional communication competence* must be acquired through hard work. Once learned, students often use typical *medical jargon* when communicating with simulated patients (SP) in the early semesters of OSCE, which is accompanied by a *temporary loss* of everyday communication competences. In corresponding studies on competence development, a *decline* in the *empathic competence* available in everyday communication could even be observed in higher semesters (§ 20).

In order to counteract such tendencies in good time during the course of study, the connection between *knowledge* and *action* must be taught in the early semesters. Since knowledge and action form an inseparable unit, knowledge transfer can also be used to bring about behavioral changes by providing learning stimuli in terms of content. The connection between knowledge and action must not only be established (in diagnostics) between *nosology* and *physical examination*, etc., but also in *communicative action.* Knowledge of communication theories and models is one of the prerequisites for becoming aware of incompetence and deficits in communicative action.

In the didactic chapters (§ 13, 14), we described the *teaching-learning spiral*, which starts with *problem-oriented* learning impulses and then progresses in recurring, circular learning processes (problem 1: theory–reflection–training–evaluation; problem 2: theory, etc.) until the unity of knowledge and action is finally established and the process has progressed to *routine action* that takes place more or less unconsciously. In this way, learning goals and learning progress at different learning levels must be distinguished, which will be differentiated below.[29]

Competence development

Differentiated stages of *competence development* are presented in the introduction (§ 1 of the handbook) using the Cleveland model (Boissy, Gilligan (eds.) 2016, Windover 2016; cf. Hargie 2025), which distinguishes between the following stages, which will be abbreviated here with reference to our commentary on a diagram (cf. § 1):

- unconscious incompetence (routine 1)
- conscious incompetence
- conscious competence
- unconscious competence (routine 2)
- reflective competence

Accordingly, the following essential stages of development are distinguished with starting and ending points, which can be roughly differentiated as follows despite all the fluid transitions:

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[29] Because it is always a question of the *unity of knowledge and action*, it should first be noted from a didactic and methodological perspective that an additional or duplicate formulation of knowledge and action competences in the formulation of learning goals, as we have suggested above, is mostly obsolete. To illustrate this with a simple learning model that was already used by Argyle (1983) to analyze medical communication: anyone who can drive a car *competently* also *knows* how to accelerate, change gears, brake, etc. However, in driving lessons, it was previously necessary or useful to learn *basic knowledge* about how the engine works or braking distances in relation to speed and in rain and other risks before trying it out in practice. However, different learning requirements must be assumed for *novice* drivers than for *racing* drivers – to stay with this often-used image.

- naive - discovery
- beginner's mind - learning
- learning - emerging ability
- practice - mastery
- mature practice - self-study - peer reviews - teaching others

This approach also corresponds to possible stages of development, as promoted in *Balint group work* by the professional group leader, who must have a high level of special *professional competence* (self-reflective and other-reflective) ("mature practice"), which he/she can use in the group in the sense of *supervision* (handbook: § 6). (cf. above § 2.2.4: topic focus 14: "Specific Balint group work"). Specific learning concepts and evaluation results for promoting competence in training and continuing education are presented and discussed in the chapters on didactics (part III) (§ 13-16) and in the evaluation section of the book (part VI) (§ 40-43).

2.3.5   Interdisciplinary foundation of communication curricula

Communication curricula have now become established at universities worldwide. These are more or less competence-based, interdisciplinary, longitudinally and circularly organised, or offer individual courses in *communication skills training* (CST) with different goals and teaching methods. For an overview, we can only refer to the literature here (Hempel et al. 2021, Kiessling, Fabry 2021, Bachmann et al. 2022, Venktaramana et al. 2022). We have already cited further literature for previous topics (§ 2.2.4), some of which are taken up again in the chapters on didactics and evaluation (§ 3, 13, 40, 41).

Following on from chapters 1 and 2, chapter 3 differentiates the competence-based goals, which are then further elaborated in the subsequent didactic chapters 13 and 14 within the framework of the *Cologne Communication Curriculum* (CCC). Not only in Cologne, but also at other universities, communication curricula involve various disciplines that are represented with varying degrees of emphasis in medical communication teaching. At the University of Cologne, the focus of communication training was on *Psychosomatics* in collaboration with the *Dean of Studies*. As a rule, universities (in German-speaking countries) involve a wide variety of disciplines, such as:

- Dean of Studies
- Medical psychology
- Medical sociology
- Psychosomatics
- Internal medicine
- Surgery
- Palliative Medicine
- Medical ethics, etc.

This list alone shows the involvement of many disciplines in teaching medical communication, but there is a *lack of interdisciplinary foundation* and integration.

According to *reviews of communication curricula*, interdisciplinarity plays little or no role; it is rarely or never mentioned, and the curricula are still a long way from achieving interdisciplinary integration. Although there are good, very comprehensive textbooks (e.g. Deinzer, von dem Knesebeck (ed.) (2018-) with specific contributions on the doctor-patient relationship and communication), there is a lack of interdisciplinary foundations for teaching medical communication as a whole.

Interdisciplinary foundations: deficits and desiderata

Progress in integrating a *common literature canon* leaves much to be desired; the disciplines remain largely isolated from one another, as was already lamented over 30 years ago by Stewart, Roter (1989) and, most recently, at the beginning of the last decade by Parrott, Kreuter (2011), who will be quoted again here because their statements are clearly still relevant today (Box 2.6 and Box 2.7).

Box 2.6	Deficit: Interdisciplinary teams building
Until very recently, researchers have worked in single disciplines rather than on interdisciplinary teams building.	

Stewart, Roter (1989: 252)

Box 2.7	Dilemma: Lack of awareness of what other disciplines are doing
One dilemma facing academics from different disciplines who are in pursuit of health communication is a lack of awareness of what other disciplines are doing.	

Parrott, Kreuter: 2011: 4

This deficit or dilemma does not appear to have been resolved or eliminated in this decade; according to the latest review by Venktaramana et al. (2022): "A systematic scoping review of communication skills training in medical schools between 2000 and 2020"), the deficiency seems to relate not only *to interdisciplinarity*, which is hardly mentioned at all, but the authors also lament a fundamental lack of *communication skills training* (CST) at present (Box 2.8):

Box 2.8	CST remains poorly represented …
Communication skills training (CST) remains poorly represented and prioritised in medical schools despite its importance.	

<div align="right">Venktaramana et al. 2022: 997</div>

Statements made over several decades still reveal a *discrepancy* between *aspiration* and *reality* that needs to be addressed. The call for "talking medicine" or even specifically "narrative medicine" (§ 2.2.3, 9, 19) has become increasingly vocal and well-founded in research, but students (even in advanced semesters) still do not immediately recognise the difference between an *interrogative* and *narrative* doctor-patient conversation when spontaneously observing the doctor-patient videos recorded by. It seems that students (especially novices in their first semesters) lack the necessary *awareness of the problem* to recognize the weaknesses of an extremely *interrogative* D-P conversation in their observations.

Problem awareness and observation

On the contrary: some students initially find a conversation that, on closer inspection in conversation analysis, proves to be more of an "inquisition without any discernible output" to be particularly effective because it is obviously "short and sweet". The conversation was ended after two minutes, and both parties "fled" to the physical examination.[30]

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[30] The conversation is examined in detail (in § 19) in a conversation analysis using qualitative and quantitative methods and is also suitable as an introduction for teaching purposes, for which it has often been used (cf. Koerfer et al. 1994, 1996, 2008). Even in the continuing education of long-practicing physicians, we still observed a preference for a shorter, interrog-

One actual effect of this type of conversation was that the patient did not even come back to find out the results of the ECG.

The spontaneous reactions of students often make it clear that *merely observing* an object does not necessarily lead to an *awareness* of the *problem.* Rather, according to Karl Popper (Box 2.9), the problem must precede observation.

Box 2.9	Without a problem, no observation

My thesis is that every scientific development can only be understood in terms of its starting point being a problem or a problematic situation, i.e., the emergence of a problem in a specific situation within our overall knowledge (...) This can be easily demonstrated by the following thesis: *without a problem, no observation.* If I ask you to "Please observe!", you should ask me, in accordance with common usage: "Yes, but what? *What* should I observe?" In other words, you are asking me to specify a *problem* that can be solved by your observation (...) But if I pose a very trivial *problem* to you, then the situation is different.

Popper 1972/1994: 19 (*italics there*)

The question of the relationship between problem and observation leads directly to the didactic issues surrounding *problem-oriented learning* (POL), which has already been mentioned and is dealt with in detail in the didactic chapters (§ 3, 13, 14). A *good starting point* for a *teaching-learning spiral* is usually a critical theoretical text that can be used to create *problem awareness* and overcome *naive incompetence* (in the above sense of Windower 2016).

At an advanced stage of development, we chose a *comparative* approach as a further starting point, in which extremely *poor* (interrogative) conversations are *contrasted* with extremely *good* (narrative) conversations in direct observation, which usually requires a certain awareness of the problem, which can be promoted by reading critical texts on communication theories and models in medicine (§ 13). This should be done while maintaining the *unity of knowledge and action* as described above: the acquisition of knowledge should not be an end in itself, but should remain linked to real medical conversation practice

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ative interview style in which emotions are primarily defended against (cf. Koerfer et al. 2005).

and one's own training practice, which can also be evaluated in the form of self-observation and external observation through acquired knowledge (§ 13, 40). Under these conditions, the following *communication theories and models* should also be integrated at different learning levels in the classroom and in continuing education, where they can contribute to both problem awareness and problem solving.

2.3.6   Communication theories and models

As outlined above, *interdisciplinary foundations* are repeatedly called for in communication training and communication curricula (cf. § 2.3.4: topic focus 5, 13). In order to meet these requirements, we conducted ongoing research from the outset during the development of the *Cologne curriculum*, which covered the structure, learning goals, and content of the curriculum and didactics, as well as specific communication theories that are relevant to the promotion of communication competences. Before summarizing the results of the accompanying research below (§ 2.3.10, Table 2.5), we will first briefly describe the *communication theories and models* that should be the basics for a communication curriculum.

In the *Cologne Communication Curriculum* (CCC) (§ 13, 14), we have endeavored not only to underpin the concrete, illustrative teaching with empirical *case studies* as teaching impulses, but also to underpin the *interdisciplinary teaching* of medical communication by reading classics that go beyond the (usual) classics from the textbooks (e.g., Antonovsky, Balint, Engel, Freud, Kübler-Ross, Piaget, Skinner, Parsons, Rogers, Uexküll, Watzlawick etc.). The so-called classics are often frowned upon as so-called difficult reading, but there are often simple texts (by them or others) that we have endeavored to select and excerpt in class. The following literature is mostly quoted, paraphrased and commented on in the theoretical chapters (§ 4, 7, 8, 9, 10), so that these texts can be used in extracts as direct teaching materials.[31]

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[31]   For research and teaching purposes, many theoretical and didactic concepts as well as empirical examples are now freely available in two languages in this handbook (cf. Koerfer, Albus (eds.) 2018). Chapter 13 (*Medical Communication Training*) also suggests specific texts for use in teaching.

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In order to provide a *scientific basis for communication curricula* with complex learning goals for medical communication, various theories and models of communication were presented in the topic-specific chapters (§ 4, 7, 9, 10) in order to connect them with the specific approach of *dialogical medicine* (as described above in § 2.2.3):

- *Anthropological, medical-philosophical and discourse-ethical theories and models*

  Jaspers 1958/86, Pellegrino, Thomasma 1981, 1988, Gadamer 1993/2006, Koerfer et al. 1994, Ritschl 2004, von Uexküll 1997, Langenbach, Koerfer 2006, Kettner, Kraska 2009, Meyer-Abich 2010, Chandra et al. 2018, Duvenhage 2024.

- *Semiotic communication models, some of which serve as biosemiotic models for the justification of biopsychosocial medicine*

  Bühler 1934/82, Krampen et al. (eds.) 1981, Sebeok 1981, von Uexküll 1981, 1997, 2001, Nöth 2000, von Uexküll, Wesiack 1991, 2011, Giorgi et al. 2020.

- *Philosophy of language, speech act theory, discourse ethics*

  Austin 1962, Searle 1969, 1992, Stegmüller 1975, Meggle (ed.) 1979, Apel 1990, Apel, Kettner (ed.) 1992, Koerfer 1994/2013, Scambler (ed.) 2001.

- *Cooperation theory, everyday conversational maxims versus association rule.*

  Freud 1912, 1913, Grice 1975, Lakoff 1982, 1983, Koerfer, Neumann 1982, Kächele et al. 2006, Koerfer et al. 2008, 2010, Koerfer, Albus 2015, 2018.

- *Linguistic pragmatics, discourse analyses* (*partly institutional communication: medicine and psychotherapy*)

  Wunderlich 1976, Labov, Fanshel 1977, Ehlich, Rehbein 1979, Bliesener 1980, 1982, Mishler 1984, Bliesener, Köhle 1986, Rehbein 1986, 1994, Ehlich et al. (eds.) 1990, Redder, Wiese (eds.) 1994, Koerfer 1994/2013, Scarvaglieri et al. 2013, Gee, Handford (eds.) 2014, Scarvaglieri et al. (eds.) 2022.

- *Conversation analyses of medical and therapeutic communication*

  Heritage, Maynard (eds.) 2006, Collins et al. (eds.) 2007, Peräkylä et al. (eds.) 2008, Robinson, Heritage 2014, Robinson 2011, Buchholz, Kächele 2017, Koerfer, Albus (eds.) 2018, Barnes 2019, Montiegel, Robinson 2021.

- *Theory of communicative action and discourse ethics*

  Habermas 1971, 1981, 1991 (English Editions 1984, 1987), Scambler 2001, Scambler, Britten 2001, Mishler 1984, Honneth, Joas (ed.) 1988, Koerfer et al. 1994, Koerfer 1994/2913, Duvenhage 2024.

- *Communication psychology relationship models*
  Watzlawick et al. 1967/2011, Watzlawick, Weakland (eds) (1966/1990): Schulz von Thun 1981, 1989, 2007.

- *Narrative theories and models specific to medicine and psychotherapy*
  Bliesener 1982, Ritschel 1991, Schafer 1992, Brody1994, Koerfer et al. 1994, 2000, Boothe 1994, Mishler 1995, Meares 1998, 2005, Hurwitz et al. 2004, Charon 2006, Koerfer et al. 2010, Boothe 2011, Goyal 2013, Scheidt et al. 2014, Köhle, Koerfer 2017, Charon 2022, Habermas, Fesel 2022, Kirmayer et.al. 2023, Koval 2024, Fioretti 2025.

These approaches have now also found specific resonance in medicine: *systemic* and *semiotic* models were used by the German pioneers of the development of *biopsychosocial* medicine, v. Uexküll, Wesiack (1991), (2011) (English Edition 1997) to justify the approach, which they explained using a *case study* of an obese patient. To this end, we have developed a *learning unit* (§ 4) in which learners can reconstruct the *biopsychosocia*l relationships in the case and reflect on alternative forms of communication (*narration* versus *interrogation*).

Habermas' *Theory of Communicative Action* (1981, English Editions 1984, 1987) was applied early on in medical communication research (e.g., Scambler 1987, Scambler, Britten 2001, Scambler (eds.) 2001, Greenhalgh et al. 2006, Walseth, Schei 2011, Harvey, Adolphs 2014). Similarly, Gadamer's (1993) more *philosophical-hermeneutic* approach ("Die Verborgenheit der Gesundheit"; English Edition 1996) is used, for example by Chin-Yee et al. (2019), Thomas et al. (2020). The book by Gadamer (1993), which was also published in English (2006: "The enigma of health"), reads like a plea for a *dialogical anamnesis* (see above § 2.2.3, and § 7) that is very compatible with Balint's approach.

2.3.7 Medicine versus Lifeworld

A particularly pioneering work was the theoretical and empirical study by Mishler (1984: "The Discourse of Medicine"), in which he takes basic distinctions from the early writings of Habermas (1970, 1971) and transfers them to the doctor-patient relationship and communication. Without explicitly addressing the concept of *communicative competence,* which is central to Habermas' theory and has been widely received (§ 7, 10), Mishler draws significant conclusions for medical training practice

and daily communication with patients in his empirical-critical investigations.

Mishler's empirical-critical analyses

Applying Habermas' fundamental distinction between the *lifeworld* and the *system*, Mishler distinguishes in his (transcript-based) studies between *medicine* (as a system) and the *lifeworld* (of patients) and draws the conclusion from his empirical conflict analyses that the "voice of the lifeworld" should be given more weight and validity than the "voice of medicine". Contra factually eliminating or at least reducing the prevailing dominance of medicine would be possible in principle simply by ensuring that doctors have both *medical* and *everyday language competences*, enabling them to speak both the everyday and medical codes, as Mishler pointedly described in his summary:

Box 2.10	Translation between Medicine and Lifeworld

The aspect asymmetry of the medical interview is that physicians are communicatively competent in both codes. They can speak in either the voice of the lifeworld or of medicine, but the patient is competent only in one (...) For this reason, the burden of translating falls primarily on the physicians. For communication to produce mutual understanding, physicians must provide equivalences in meaning between statements in one voice and the other and explain differences between alternative contexts. In other words, physicians must translate patients' lifeworld statements into medical terms, and medical statements into patients' terms.

Mishler 1984: 172

The key findings of his conflict analyses, which Mishler aptly characterises in the subtitle of his book as "Dialectics of Medical Interviews", will also be used here to develop an expanded concept of *medical communication competences*, which will be established in several steps and finally presented and discussed in summary form with a *taxonomy of learning goals* (§ 2.3.9).

Multidimensional definition of professional competence

If, in a first step, we add the self-evident *clinical competence*, which was previously differentiated by Epstein and Hundert in 2002, to *the* overall *professional competence* of a physician (Table 2.1), we arrive at a threefold *clinical-communicative competence*, including dual *everyday* com-

munication competence (6C) and *medical* communication competence (6D-E).

The distinctions made above between knowledge and acting (§ 2.3.4), which remain relevant for training and professional practice, will be detailed in further steps for clinical competence, divided into individual work by the doctor (5B) and teamwork (5A), and the dual communicative competence (2C-E) of physicians in conversations with their patients, in which they must demonstrate their translation competence (5C-E) with which they seek to minimise conflicts between medicine and the lifeworld.

1		Meta-Competence of the good doctor				
2	Professional competence	Clinical Competence		Dual communication competence		
3		Clinical reflection competence		Communicative reflection competence		
4		Medicine as system		Lifeworld	Medical communication competence	
5		Doctor & Team	Doctor	Doctor's translation competence		
6		Knowledge Competence	Acting (IAC) competence	Everyday competence	Knowledge competence	Acting (CAC) competence
		A	B	C	D	E

Table 2.1: Professional Competence of the good doctor (1st step)
(Cf. the explanations on the extended table 2.4 in § 2.3.9)

Depending on the context, we will often pragmatically (abbreviated) refer to this threefold concept of competence as *professional competence* and, where appropriate, differentiate it in terms of content and analysis in the relevant chapters (§ 3, 4, 9, 10, 17, 19-22).

As is well known, theoretical concepts and empirical analyses of common practice should be interrelated. The term "practice" applies here both to later medical practice, which is essentially daily medical conversational practice, and to the preceding training practice, in which the course is set for later conversational practice, which cannot then be changed without effort, as the Balint group work clearly shows (§ 2.2.4: topic focus 14, and § 6).

If Mishler attributes the "burden of translating" primarily to medicine as a permanent task, then it is above all the training practice that needs to be changed preventively: In this training practice, prospective doctors must acquire specific competences, including not only *translation* competence (5C-E), but at the same time develop *meta-competences* (1A-E, and 3A-E, cf. § 2.3.9) in order to *reflect* on their joint conversa-

tion practice with their patients and, if necessary, change it in the event of deficits. Both types of competence (*translation, self-reflection*) will be differentiated below and assigned to professional competence before the results can be summarized in an overall presentation and definitions of communication competence and corresponding learning goal taxonomies can be established (§ 2.3.9-10).[32]

Differentiation of sub-competences and specific deficits

First, however, analytical differentiation is necessary if, for example, it becomes apparent in the conversation analysis that *dual communication competence* lags behind *clinical competence* (or vice versa). Only in this way can *deficits* in clinical or communication competence be identified from an evaluative perspective, or can a meaningful distinction be made between *good* and *poor* communication in empirical conversations (§ 2.2.4: topic focus 13: "Education and Evaluation") (§ 13-16, 40-43).

If one wishes to adhere to such an *evaluation* perspective, the concept of competence must be further differentiated. Just as we complain about *poor listening*, a *lack of empathy* or *insufficient information* in everyday life, doctors can also be *poor, inattentive* or *non-empathetic* listeners in their professional practice or express themselves *ambiguously* or provide *insufficient* or even *incorrect* information, etc.

As soon as problems of *mutual understanding* between doctor and patient are identified in empirical conversation analyses, the concept of communication competence must be differentiated by distinguishing specific *(sub-) competences* (Box 2.11).

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[32] To avoid any possible misunderstanding: we consider the *professional communication* competences of physicians to be explicitly *clinical* competences, but in the absence of better (unambiguous) terminology, we have had to distinguish between the traditional terms (*clinical* competences – *communicative* competences of physicians) and choose between them. This always refers to *clinical* communication competences, which are integrated into the *general* concept of *professional* competence of physicians. Similarly, a distinction is made between *clinical* and *communication* knowledge, reflections, actions, etc. (cf. § 2.3.9 below).

Box 2.11	Communicative sub-competences
	• Listening competence • Comprehension competence • Questioning competence • Informing competence • Formulation competence • Empathic competence • Intercultural competence • Interprofessional competence etc.

see § 3, 17-22, 27-28

This differentiation is neither exhaustive nor can individual definitions be considered settled in research and teaching. For example, the common distinctions between so-called *open* and *closed questions* are still being passed on, and advice or instructions are given in training literature and courses without distinguishing between different forms and functions of (types of) questions in medical communication or therapeutic communication, in which certain types of so-called "suggestive" questions are not frowned upon, but can even be useful.

In the empirical chapters, an attempt was made to use sample analyses to contribute to the typology of *detailed explorations* (§ 21) in anamnesis or *empathic interventions* (§ 20), or to comprehensibility in *specialist* communication (§ 21, 27) or *intercultural* communication (§ 28), but not without reservation for further clarification through research.

Regardless of such research questions, however, a blanket concept of communication competence must be overcome by differentiating between *sub-competences*, even if their scope and definitional problems need to be clarified.

These sub-competencies should later be incorporated (as placeholders) into a practical definition of communication competence for doctors in order to detect and classify deficits in conversational practice and to initiate appropriate measures for the development and improvement of specific (sub-)competencies, so that students or doctors not only listen to their patients better in future, interrupt them less or respond more empathetically, but also to inform their patients more effectively, i.e. in a more comprehensible manner, and to negotiate a suitable therapy with them through joint deliberation (§ 10, 22), etc.

The questions that remain open in research generally concern clarifying the distinctions and relationships between *key competencies* and *sub-competencies*. Specific research projects have also addressed questions about what makes a *good doctor* and a *good team*, which in turn raise questions about *good communication*.

2.3.8 The good doctor and the good team

In the distinctions made so far (§ 2.3.1-2.3.7), we have assumed an ideal model of medical practice in which the physician acts sufficiently good – just as, according to Winnicott, the mother only needs to be sufficiently good. Only with such an ideal orientation can empirical studies detect deficits that can be remedied through training and continuing education. This applies to good doctors as well as to good teams.

The good doctor

On the one hand, critical empirical analysis shows that students and even doctors often have little or no awareness of problems in their practical work and also display deficits in empathy (see § 2.3.5, 19, 20, and Koerfer et al. 2004, Neumann, Obliers, Albus 2012). On the other hand, at least doctors reveal a critical self-image of their profession when asked about their specific ideas of what makes a good doctor, as was initially asked of professors from various disciplines of medicine:

- When is a doctor a good doctor?

In a content analysis study (Herzig et al. 2006), we analysed the answers to this question and arrived at the following results with a relative ranking of key medical competencies, which can be summarized in a graph (Fig. 2.5).

Such a content analysis study on answers to the question of what makes a good doctor must be viewed with methodological reservations, of which only the homogeneous group composition will be mentioned here: Since the question was addressed to professors of medicine, a bias had to be taken into account in the sense that an academic idea of a good doctor with specific weightings of key competencies was to be expected.

We therefore asked the same question to practicing family doctors and obtained results that were partly congruent and partly divergent: The main differences (compared to the professors) could be interpreted

as different weightings in the "theory-practice" ratio, with general practitioners wanting to see greater emphasis on *action competence* (14%) and *patient orientation* (18%) on the one hand, and greater emphasis on *reflexivity* (11%) on the other hand (cf. § 6).
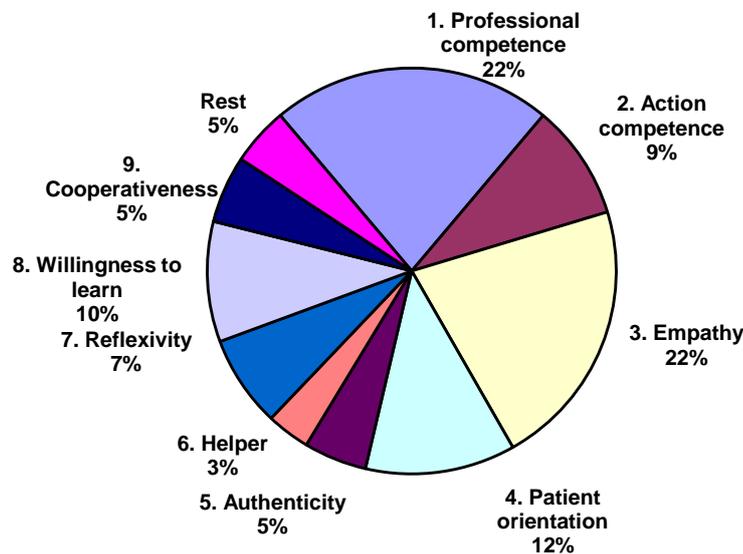

Fig. 2.5: Categories 1-9 (mod. on Herzig et al. 2006, Herzig, Koerfer 2018)

These initial study results on questions concerning the good doctor and his or her *key competences* were structured in a specific *professional model* based on the *Scottish three-circle model* (Harden et al. 1999, Simpson et al. 2002, Ellaway et al. 2007) (cf. § 6). In order to be able to adequately perform their professional and practical competences ("inner circle") with the necessary *patient orientation* and *empathy* ("middle circle"), doctors must have acquired a range of individual competences ("outer circle") which they must continuously demonstrate in their conversations with patients. These include not only a constant *willingness to learn, reflexivity, cooperativeness,* and *authenticity,* but also medical *helpfulness,* which should remain a primary medical virtue in a *post-Hippocratic medical ethic* that can now be specified by a *discourse ethic* (cf. above § 2.2 and § 7, 10).

Despite all *methodological* restrictions and shortcomings, the content analysis study on the question of what makes a good doctor clearly shows that there is a heightened *awareness of the problem* (cf. § 2.3.5 above) among both academics and practicing physicians, which can also be used as a starting point in teaching (§ 13).

The *research literature* on the two questions of what constitutes a good doctor and what key competencies distinguish them is now quite

extensive, so we can only provide a few examples here: Steiner-Hofbauer et al. 2017, Schnelle, Jones 2022, 2023, Fleck et al. 2024. Further studies are listed in Chapter 6, which presents the results of our content analysis studies in relation to training and continuing education concepts (e.g., Balint group work, cf. topic focus 5, and 14 in § 2.2.4).

The good team

Medical practice is not only about communication with patients, but also about the more or less effective *communication within* the *team*, in which doctors and nurses from different disciplines (surgery, anesthesia, internal medicine, palliative medicine, etc.) work together not only for the general well-being of patients, but specifically for *patient safety*. Good teamwork is not only challenged during surgery, but also during case conferences in which optimal treatment measures are discussed (*clinical reasoning*).

The dialogical case discussions, which should be organized with flat hierarchies as far as possible, also focus on the development of an *error culture* in which potential *risks* and *errors* are avoided or minimized or, if they do occur, analyzed in order to better anticipate risk situations. Risk analyses focus on *communication problems* within teams, which often leave much to be desired because they frequently prove to be a *source of errors*.

In this respect, training and continuing education in team communication is less about teaching so-called "non-technical skills" (NTS) and more about promoting *interprofessional* communication competences (§ 6, 13). There are now a number of training programs available, to which we can only refer to here as examples (Flin et al. (eds.) 2016, WHO 2021, Donaldson et al. (eds.) 2021, Mahmood et al. 2021, Hathaway et al. 2022, Alsabri et al. 2022) (cf. *Cologne Manual of Interprofessional Communication* (C-MIC) in appendix 2.8.3 of this chapter).

Further reading specifically on *interprofessional* communication competences can be found in topic focus 12 ("Specific Competences and Fields of Practice"). First, reference should be made to Fox et al. 2021, Fox et al. (eds.) 2025, and in particular the contribution by Karam, Brault (2025), providing an overview of *interprofessional* education (IPE) with a distinction between seven *sub-competences* (cf. IPEC 2023).

2.3.9   Professional communication competence

Following the fundamental distinctions between the *lifeworld* and *medicine as a system* established by Mishler (1984), a *multidimensional* concept of *professional medical competence* was proposed, in which the traditional understanding of *clinical competence* (in the narrower sense) was expanded to include *dual communication competence* (§ 3.7.8). With this *dual* competence, physicians can make use of both their *everyday* communication competence, which they can draw on in the same way as their patients due to their *shared* lifeworld, and their medical *communication competence*, which, however, must first be acquired during training.[33]

As with the acquisition of medical competence (in the narrow sense), a distinction must be made between *knowledge* and *action* competences, which must, however, form a *unity* (§ 2.3.4). While the unity of knowledge and instrumental action in clinical competence seems unproblematic at first glance, dual communication competence poses the *ongoing problem* that physicians must competently *mediate* between the everyday world and medicine, which requires a specific *translation competence* in communicative action that must also be learned, developed, and promoted. Whether or not the mediation between the lifeworld and medicine is successful requires regular monitoring and, if necessary, correction, which in turn requires a higher-level *meta-competence* with which one's own practice must be *evaluated self-reflectively* in order to be able to initiate the necessary self-corrections.

Self-reflective meta- competences

Analogous to *clinical* practice, in which specific diagnostic or therapeutic measures are routinely subject to critical reflection (clinical reason-

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[33]   Previously, a distinction had already been made repeatedly between *clinical* competence (in the narrow, traditional sense) and *communicative* competence: In order to prevent any possible misunderstanding, given the lack of established *terminology* for differentiation, it should be emphasized once again that we are not assuming a *dichotomy* here, but rather explicitly regard *communicative* competences as *clinical* competences (cf. § 2.3.3-7).

ing, self-reflection) (§ 3, 13), *communicative* acting must also be subject to constant monitoring and self-reflection. In both cases, these self-reflexive competences have been described as *meta-competences* that *critically accompany* medical practice in parallel.

In their comprehensive "Theory of Human Medicine" (1991), von Uxküll and Wesiack describe in detail in a "final consideration" the role of what they call a "meta-doctor," who, so to speak, looks over his/her own shoulder *self-critically* while acting and, for example, recognizes his/her mistakes and weaknesses in conversation with the patient and, if necessary, *compensates* for or *corrects* them in *ongoing* communication with the patient. The lengthy final consideration in the book by von Uexküll and Wesiack (1991: 649-659), which should definitely be read for teaching purposes in class, can only be reproduced here in a short excerpt (Box 2.12) to illustrate the *self-reflective meta-competence* of the *meta-doctor*.

Box 2.12   Critical-reflexive self-observation of the meta-doctor

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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 travel report 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, considerations, decisions and actions. The report (...) is about the attempt to build a reality that is accessible to both doctor and patient (...).

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von Uexküll, Wesiack 1991: 649f

The need to develop (self-)reflective meta-competence, which is used to observe and, if necessary, correct one's own practice, was formulated early on for medicine by von Uexküll and Wesiack (1991), but has since become established as standard in educational research as a whole and generally applies to *institutional learning processes* in schools, universities, medicine, business, management, etc.[34] In medicine, self-reflection

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[34] For medicine and other institutional learning processes, see the following reference: Harden et al. 1999, Weinert 1999, 2001, 2002, Rychen, Salganik (eds.) 2001, Rychen, Salganik, McLaughlin (eds.) 2003, Koerfer et al. 2008, OECD 2005, etc., etc. Mathews 2013, Koerfer, Albus (eds.) 2018, Ramírez-Montoya et al. 2022, Zenk et al. 2024, Sheikhbahaeddinzadeh et al. 2025.

had already been taken into account, at least additively, in the definition of medical competence by Epstein, Hundert (2002) (§ 2.3.1), while in the Cleveland Model it can be developed to the highest level of development (§ 2.3.4), in which mastery is achieved, as it were.

Self-reflective meta-competences should be developed as early as possible in training in order to initiate appropriate self-correction processes in both *self*-observation and *external* observation (§ 13, 40). This should apply to all levels of medical (*instrumental* and *communicative*) action, but self-reflective meta-competence should be promoted in a special way for *communicative acting* because communication with patients directly affects the *relationship* and *disturbances* and *dangers* must be recognized as early as possible. In order to counteract problematic *psychodynamics* in conversations in a *timely* manner, basic *psychotherapeutic competence* is required, as taught in clinical semesters in the *Cologne Communication Curriculum* (CCC) (cf. below § 2.3.11-12, and § 13, 14).

Psychotherapeutic competences

Professional knowledge competences include not only traditional *medical knowledge* (nosology, pathology, diagnostics, etc.) (§ 2.3.9 and § 3, 13, 14), but also knowledge of the *psychodynamics* of communication with patients in order to be able to respond in a timely manner to their specific communication behavior or even communication disturbances. Such disturbances do not only occur in defined psychotherapies, but are part of everyday practice in clinics and doctors' consultations.[35]

First, knowledge must be acquired about the differences and similarities between everyday communication and medical communication, to which different conversational maxims apply. The differences can be worked out in class (in excerpts) through a critical comparison of theories in the context of Freud's formulation of the *psychoanalytic* basic rule for the patient (1913) and Grice's *everyday* conversational maxims (1975), which can also be condensed into a table (Table 2.2).

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[35] Only a few communication problems and disorders can be addressed here. For specific problems in dealing with patients with depression, anxiety, pain, somatoform disorders, etc., please refer to the relevant chapters in Part V of the handbook.

Freud (1913)	Grice (1975)
Whereas otherwise you rightly try to hold the thread of the connection in your presentation,	Be relevant; Be orderly
and reject all disturbing ideas and secondary thoughts,	Be orderly
in order to avoid, as they say, going from the hundredth to the thousandth, you should proceed differently here (...)	Avoid overinformativeness
You will be tempted to say to yourself: this or that does not belong here, or it is quite unimportant (...)	Be relevant
Never give in to this criticism (...) So say everything that crosses your mind.	Make your contribution to the conversation as required by the accepted purpose (...).

Table 2.2: Comparison of the conversational maxims of Freud (1913) and Grice (1975)

Freud's message to the patient reads like an anticipation of a *negation* of the *maxim catalog* that the philosopher of language Grice formulated fifty years later (1975) for *everyday* communication. These everyday maxims are now to be *suspended* in conversation with the therapist or doctor in favor of the *association* rule—contrary to all habits of everyday communication (cf. Koerfer, Neumann 1982). With such a *comparative* perspective, the *specific learning goal* to be pursued (§ 2.3.10) is that Freud's *rule of association* should be applied *moderately* (sic) in medical communication in order to promote the corresponding patient *narratives* in *dialogical medicine* (§ 2.2.3), which open up space for the patient to express their complaints, suffering, and life stories (§ 9, 19).

However, preferring a *narrative* style of conversation over an *interrogative* style is not a guarantee of an unproblematic, productive conversation. If communication problems arise in further communication with the patient, specific psychotherapeutic competences are required that relate to the possible psychodynamics of conversations between doctor and patient. In addition to general knowledge of dealing with *transference, countertransference, defense mechanisms, rationalization,* etc. (e.g., Sandler et al. 1973/1979, Krause, Merten 1999, Remmers 2023), this also includes knowledge of how to deal with particularly "dif-

ficult" patients, who can be roughly classified according to a typology described in detail in a specific chapter (§ 34) (by Wöller, Kruse):

- The demanding and dependent patient
- The invalidating patient
- The compulsively self-reliant patient
- The blameful aggressive and passive aggressive patient

Wöller, Kruse (cf. § 34 of this handbook)

The handling with these patients is not only a problem in psychotherapy, but also in general practice, internal medicine, surgery, etc. This requires *psychotherapeutic competencies* that are also taught in a rudimentary form in medical training and continuing education (§ 13-16, 29, 30). It would also be counterproductive to respond to a patient with strong defensive tendencies with *confrontational* interventions. Instead, *tentative* interventions should be chosen, in which the right timing is crucial in order not to jeopardize the relationship (Cf. Menninger, Holzman 1958/1973, Sandler et al. 1973/1979, Heenen 2014), which takes precedence over any risky or merely premature interpretation:

- Relationship building comes before interpretation.

Albus et al. 2018: 398 (cf. § 29-32)

As we know from our everyday experience, *inappropriate* comments at the wrong *time* and in the wrong *place* can lead to *relationship disturbances*. This is particularly true in the doctor-patient relationship, where patients often feel helpless and misunderstood anyway. For this reason alone, *supportive* rather than *confrontational* interventions should be chosen in cases of doubt. However, this does not mean that patients should not be challenged by interpretations in order to initiate a therapeutic change.[36]

The problem of change applies not only to psychotherapy, but also, for example, to patients with chronic physical illnesses, for whom a change in attitude is a necessary prerequisite for successful treatment (§ 29). The choice between alternative interventions is often a balancing

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[36]   Cf. chapter 17 on the problem of change in medicine and specifically on change in psychotherapy: Bruschweiler-Stern et al 2002, Stern 2004/2010, Stern et al. 2010/2012, Ribeiro et al. 2011, Voutilainen et al. 2011, Bucci 2020.

act in which, when in doubt, the relationship should take precedence in accordance with the above maxim.

In order to maintain and stabilize an often unstable relationship with the patient, psychotherapeutic competences are just as necessary as they are in critical cases where a relationship must be terminated for good reasons if trust has been lost. In both these positive and problematic cases, all practitioners must have the necessary *psychotherapeutic competences*, which must be integrated into the general *fitting competence* of physicians.

Fitting competence

When dealing with potential communication and relationship disturbances, *fitting competence* is required to anticipate problematic developments in the conversation and to ensure that the professional's verbal and nonverbal interventions can be fitted to the ongoing conversation so that they do not cause unnecessary irritation but rather *stimulate* the conversation to progress. This applies to "minimal" interventions of active listening (§ 19) as well as to "maximal" interventions (*confrontations*, *interpretations*, etc.) (§ 3, 21), which are intended to challenge the patient to new narrations or reflections.

Overall, medical and therapeutic communication presents two problems: the *placement* and *dosage* of verbal and non-verbal interventions.[37] These will be briefly outlined here before being addressed as ongoing problems in empirical conversation analysis in the practical section (IV) of the handbook.

The placement problem

The term *fit* itself is not intended to imply an 'absolute' fit, but merely a 'relative' fit (§ 3, 17). Although the interventions of a physician or therapist should be "tailor-made" in the specific consultation with this individual patient and his/her specific illness, there should still be room for flexibility in the fit, as described in the constructivist and systemic-therapeutic research with the conceptual distinction between *match* and

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[37] In doing so, we address in more detail problems that are often described using the terms "appropriate" or "proper" (or "*habitual and judicious of …*" as already used in the definition by Epstein, Hundert (2002) (in § 2.3.1). See, for example, Morgan, Engel 1969/1977, Platt et al. 2001, Skelton 2011, 2016, Silverman 2016.

fit (von Glasersfeld 1981/1987, de Shazer 1985/2003). According to this, a specific verbal or nonverbal intervention does not always have to fit like a specific key to a specific lock, but rather it is enough to function as a kind of "pass key" that can initially open a sufficient number of locks.

The *art of medical communication* therefore consists primarily in the use of "pass keys" that fit more or less well, or at least fit well enough to open the first relevant doors – to stay with this not entirely unproblematic image (of the patient as a "building"). This pass key function applies not only to higher-level interventions (confrontations, interpretations), but also to individual ("smaller") types of intervention involving active listening, which, however, must be placed fittingly in a larger context. Certain forms of communication are not an end in themselves but fulfill their functions only in the context of higher-level goals that are specified in the framework of a *biopsychosocial* and *narrative* medical history, in which the *art of medical communication* (Box 2.13) must prove itself through communicative fit.

Box 2.13   The art of medical conversation: communicative fitting

The communicative functions of paraphrases or word repetitions should be used in the benefit of narrative-based, biopsychosocial medicine. The art of medical conversation lies in the communicative fitting of the doctor's verbal interventions, which must not be arbitrary but context-sensitive in order to, for example, initiate, promote, or elaborate on a narrative at this point in the conversation.

Koerfer et al. 2008: 47, Koerfer, Albus 2018: 627

Although the risks of *misplacement* increase with higher-level interventions (e.g. confrontations, interpretations), the fitting competence should apply to all intervention techniques, which must be fitting at every moment of the conversation and ultimately throughout the entire conversation. If the fitting placement of an intervention at a specific moment in a conversation is the *qualitative* side of the art of medical communication, then there is also a *quantitative* side, which, in analogy to medicine, can be described as a *dosage problem*.

The dosage problem

As with the prescription of medication, the use of verbal and nonverbal interventions in conversations can also lead to *misdosages*, in both di-

rections: *under-dosing* and *over-dosing.* There are certainly no fixed boundaries here, only *fluid transitions* where *recommendations* can turn into *warnings* (Table 2.3). This is the well-known connection that *quantity* can turn into *quality.* It is certainly not the one question that is asked too often, but it is the *sum* of far too many questions that makes the *difference* between a *narrative* and *interrogative* interview style.

The art of medical communication lies precisely in striking a *balance* between the two extremes of misdosing, which should be warned against in teaching, preferably using negative anchor examples (§ 13, 19). It has already been explained (in § 2.3.3) why medical communication training should not be confused with *rhetoric training,* in which the use of listener signals, word repetitions, or paraphrases is practiced, which can lead to the inappropriate *inflation* of these forms of communication without meaning or purpose and can even become counterproductive: The mere accumulation of listener feedback such as word *repetitions* can be perceived as parroting, just as the physician's prolonged *silence* can be interpreted as embarrassment or helplessness, or sustained *eye contact* can be perceived as threatening control (§ 17-19).

Recommendations		Warnings
Less of the same	More of the same	Too much of a good thing
Doctors' speaking Interrupting Information questions Suggestive information questions Ignoring emotions Rebuking Teaching Instructing Change of topic	Silence (= letting the patient speak) Eye contact Listener feedback (*hm, yes, okay, nodding, etc.*) Active listening (repetitions, paraphrases) Comprehension questions Addressing emotions Commendation Enlightening Counseling Topic reactivation	

Table 2.3: The dosage problem – recommendations and warnings

Accordingly, teaching must convey that the shift from interrogative to narrative medicine postulated in research (§ 2.1 and 2.2) can only be understood as a *shift in focus*, in which dosage problems must also be taken into account. A doctor who merely listens silently without empathic feedback to a dramatic patient narrative can cause just as much

irritation to the patient as a doctor who asks only suggestive information questions or funnel questions (§ 19, 21).

Silence and *asking* questions are not alternatives, but rather must be balanced with fitting competence in such a way that a certain *mix* of specific types of intervention enables a conversation in which the doctor allows the patient to adequately express their complaints and concerns without neglecting their medical duties to complete the medical history by asking detailed questions (§ 22).

Although the patient should enjoy the *privilege of speaking*, this must be sufficiently stimulated by so-called "small" verbal interventions of active listening (§ 19), which do not significantly interrupt the patient's narrative flow, but allow a so-called continuation of speech "as if uninterrupted" (Duncan 1974, Flader, Koerfer 1983, Koerfer, Albus 2018) (§ 19). Before these forms of intervention can be used in practice, they must be taught in order to raise the necessary awareness of the "subtle" differences in intervention techniques, for which reference examples are given throughout the practical section of the handbook (especially § 19-22).

The problems described above regarding the *placement* and *dosage* of interventions will recur as *two sides* of the *same coin* when specific methods of *qualitative* and *quantitative* conversation analysis are to be combined in the evaluation, as applied in the practical section (IV) and the evaluation section (VI) of the handbook.

Professional clinical and communication competence

Based on the traditional concepts of competence in medicine cited at the outset (Epstein, Hundert 2002, NKLM 2015/2021) (§ 2.3.1), essential distinctions were made in several steps (§ 2.3.2-8) that must be taken into account in a concept of *professional medical* competence, which will be summarized here with a focus on *communicative* competence. It is assumed (prima facie) that the concept of (medical) (sic) communication competence cannot do without the concept of medical competence, but rather presupposes it.

This relationship between the two competences is to be captured precisely by the concept of *translation* competence, which is intended to mediate the problems and conflicts between medicine (as a system) and the lifeworld (of patients) described above by Mishler (§ 2.3.7).

The following summary also refers to a *tabular overview* (Table 2.4), which is then commented on by way of example. A *multidimensional*

concept of professional medical competence was developed and justified in advance (§ 2.3.2-8), which will be summarized and differentiated here in three steps (cf. Table 2.4):

1. **Clinical and communication competences**

   The professional competence of physicians consists of traditional clinical competence (2A-B) and dual communication competences (2C-E), comprising everyday (naturally acquired) communication competence (4C), which we all possess as participants in the world we live in, and specific medical communication competence (4D-E), which is divided into knowledge competence (6D) and action competence (6E) and is taught in medical training through the teaching of theory (8D) and training (8E).

2. **Translation and fitting competences**

   With *dual* medical communication competences, specific *translation* competence (5C-E) must also be developed in order to anticipate and, where possible, minimise or compensate for potential problems and conflicts between *medicine* as a system and the *lifeworld* (of patients). The choice of both instrumental (diagnostic, therapeutic) actions and communicative actions is made on the basis of *fitting* competence (7A-E), which must be used in a patient-oriented and context-sensitive manner.

3. **Meta-competences**

   Communication between doctors and their patients should be *evidence*-based insofar as *instrumental* action (B8-9) and *communicative* action (E8-9) are continuously subjected to *rational control* and, if necessary, *correction* from the perspective of *self-reflective meta-competence* (1), in line with the current state of scientific development. Meta-competence is divided into *clinical* (3A-B) and *communicative reflection* competence (3C-E), which is used to reflect on the extent to which the *translation* between *medicine* and the *lifeworld* has been successful, the appropriate level of narrative self-expression by patients has been found, gaps in the medical history still need to be filled, etc.

		A	B	C	D	E
1		Meta-Competence of the good doctor				
2		Clinical competence		Dual communication competence		
3		Clinical reflection competence		Communicative reflection competence		
4		Medicine as system		Lifeworld	Medical communication competence	
5		Doctor & Team	Doctor	Doctor's translation competence		
6		Knowledge Competence	Acting (IAC) competence	Everyday competence	Knowledge competence	Acting (CAC) competence
7		Fitting competence				
8		Theory	Training	Natural P & D	Theory	Training
a	Professional medical competence	Nosology/ Diagnostics –Disease –Illness –Well being History taking: –Life story –Details: pain, etc. –Medication, etc.	Physical Examination –Palpation –Auscultation –Measuring blood pressure etc.	Knowledge/ Acting	Manual*C-MMC	Examples:
				Grice's Maxims:* Cooperation principle: Be relevant Be orderly Be brief, avoid ambiguity, etc.	Special Maxims:* Freud's Therapeutic Association Rule: Moderate application in medicine	Allowing/ providing (P's) unstructured associations: P may be disordered, unclear, irrelevant, etc.
b		Specific diagnostics –Diabetes* –Depression*	ECG Radiation Pain scale Questionnaire	General maxims turn taking: Symmetrical	Specific maxim: turn taking preference for patient	Preferred choice P⟶D⟶P P's turns "as if uninterrupted"
c		Therapy –primary care –surgery	Medication Physiotherapy Operation	Nonverbal –eye contact –mimics	Face to face Reducing PC work	Sorry, I just have to enter the data …
9		Psyotherapeutic Knowlege	PT- Instrumental acting (IAC)	Informal talk small talk	Institutional talk *Manual*C-MMC	Functions/ Steps 1-6*
a		Psychodynamic defense: –rationalization –denial, etc.	Questionnaire –Pain –Anxiety HADS-A	Greeting Topic flow Closing up	1 Relation –Greeting –Situating –Orientation	Hallo Mrs. A. I'm Dr. B., please sit down and …
b		KA Menninger: Transference Counter- transference	–Manual *DD* Diabetes & Depression * –HADS-D	Reporting: Concerns Listening	2 Listening to Concern –Feedback –Listening signals	Opening question: What can I do for you?
c		Interview styles: C Rogers: directive vs. nondirective	Personality tests: –FPI	Questions Signals of Understanding	–D ⟶ P –Free choice of topic	Encourage Speaking up: And then?
d		George Engel: Interrogation vs. Narration	–MMPI –Neo PI-R	Narration Illness story Life story	3 Eliciting Emotion NURSE	Naming an emotion after a narration
				Answering	4 Details	Detailed Quest.
e		KA Menninger: Interpretation: Tentative vs. Confrontational	Information aids –Sheets –Multimedia	Advice Reject Negotiating Decision	5 Decision Model Paternalism Business SDM D⟷P	Present options, benefits, risks Discussing Informed consent
f		Topics (follow up)	Coding – data	Say goodbye	6 Resume	Next meeting

Table 2.4 Professional Medical Competence –
*Manuals & Maxims see Appendix of this chapter 2 (cf. § 3, 13, 14, 17-23, 29, 30)

While the development of competences during training is still largely controlled by *external observers* (teacher, rater), this control function can later be increasingly performed independently with the *higher-level meta-competence* by making the necessary corrections on one's own initiative in the *critical self-observation* of one's own instrumental (B7-8) and communicative training practice (E7-8), which will in any case be one's own *responsibility* in later professional practice.

The preceding distinctions between clinical and communicative competences are summarised in Table 2.4, which will be discussed here by way of example and with additional commentary.

The tabular presentation is a *didactic reduction* insofar as *interactions* and *relationships* between instrumental and communicative knowledge and action, for example, must be neglected in the presentation, but can be taken into account later in a graphical representation with a flow chart (see below § 2.3.10).

Therefore, certain *precondition-consequence relationships* must always be *presupposed*. For example, *clinical reasoning* (2A-B) will run in the background of doctor-patient consultations (8-9E) during case discussions in a team (5A) or by an individual doctor (5B), without necessarily being apparent to the patient unless it is specifically addressed between the doctor and patient (e.g. when communicating the diagnosis) – a challenge for the doctor's *translation* competence (3A-E) in translating medically coded knowledge into understandable everyday language.

Once again, the development of essential professional competences should ideally be based on a sufficiently *advanced curriculum* in which the *key competences* distinguished above are developed optimally in *theory* (8-9A-D) and *training* (8-9B-E), as is the higher-level *meta-competency* (1), which is divided into *clinical* (2A-B) and *communicative reflection* competences (2C-E), which should be promoted in parallel from the beginning of medical studies.

Medical *knowledge* competences (6A) and *instrumental action* competences (6B) are preconditions for evidence-based communication, which, based on relevant *communication theories and models* (8D), extends from taking a patient's medical history to communicating the diagnosis and decision-making (E9a-e). The central *translation* competence (5C-E) is required in all phases of the conversation, and is particularly important in the communication of *information* and *decision-making* (9e, D-E).

Clinical knowledge and practice already take into account essential theories and models/techniques relating to *medical knowledge* (nosology, diagnosis, therapy) (A8a-c) on the one hand and the corresponding *instrumental acting* competences (IAC) (e.g., physical examination, surgery, ECG) on the other hand (B8a-c). *Communicative knowledge* competences and *communicative acting* competences (CAC) integrate important models and techniques for *medical* and *therapeutic communication* (A9a-f), which can also be supplemented by instrumental *diagnostic* procedures (tests, questionnaires, etc.) (B9a-f).

The table already takes into account, in rudimentary form, the specific *sub-competences* that are differentiated by the *six conversation steps* or *functions* in the *Cologne Manual of Medical Communication* (C-MMC) (D9a-f), of which only a few typical examples are given in this abbreviated overview (E9a-f). The Cologne Manual forms the didactic basis for the practical section of the handbook (IV), which also contains *empirical anchor examples* for the six manual steps.

Although the table already contains all the essential distinctions, their reductions should be reversed in the following graphic representation, which also allows the *interactions* and *relationships* between *meta-competences, key competences* and *sub-competences* to be depicted in a *flow chart* (Fig. 2.6 in § 2.3.10).

Subsequently, *exemplary learning goals* to be pursued in a competence-based curriculum will be formulated, followed by a presentation of the interdisciplinary accompanying research on the *Cologne Communication Curriculum* (CCC) (§ 2.3.11) and an overview of a series of *learning modules* from the Cologne Communication Curriculum (CCC) will be provided (§ 2.3.12).

2.3.10 Learning goal medical communication

In a competency-based curriculum, medical learning goals (in the narrow sense) must be taught alongside communicative learning goals. When formulating learning goals, it is important to bear in mind that patient narratives and empathetic feedback are not ends in themselves, but rather serve *higher-level learning goals* that arise from the requirements of *biopsychosocial* and *dialogical* medicine (§ 2.2 and § 4, 7), i.e. that a different type of communication with the patient is required, which is determined, for example, by the *shift* from *interrogation* to *narration*.

If students/doctors are to develop *meta-competence* in order to be able to observe their own conversational practice self-critically and correct it if necessary, the complex hierarchy and interaction of learning goals should be reflected in the training. This is the only way to identify deficits in the conversational context at an early stage, for example when early interruptions of patient narratives later result in relevant gaps in the biopsychosocial anamnesis (§ 3, 4, 17-20).

Learning goal taxonomies: macro, meso and micro learning goals

Previously (§ 2.3.3), exemplary groups of learning goals had already been differentiated, which are located at various *macro, meso and micro levels*, whose relationships could be represented in a flow chart. The reductions in the tabular representation can now be reversed in a graphical representation in which the *interactions* and *relationships*, for example, from meta-competence to fitting competence to a concrete verbal intervention (e.g., emotion naming) can be represented in a flow chart (Fig. 2.6).

Furthermore, the specific conversation steps (1-6) from our Cologne Manual (C-MMC) are already presented in the *flow chart* (Fig. 2.6) as communicative alternatives that a doctor can choose from at a specific moment in the conversation from the repertoire of possible intervention alternatives, which is already pre-structured by the *Cologne manual* (C-MMC) (Fig. 2.6). To illustrate this, we will refer to an anchor example (E 2.01) taken from the chapter on emotion and empathy (§ 20). This example is also intended to illustrate how learners can be interactively involved in a multimedia program during the discussion of alternative intervention options, which can only be presented here in excerpts and in printed form. (cf. § 13).

E 2.1a	Multimedia programme (1. Listening)	Comment
01	(…)	[Listening]
02 P	(…) because he said, when I'm a pensioner, we do so many things … and it's just the opposite .	[long omission here, then:] Complaining about her husband

E 2.1b	Multimedia programme (2. My intervention)	Comment
T	What would be your intervention at this point in the conversation? It's your turn:	T = Teacher or multimedia programme
L	My intervention:	L = Learner

E 2.01c	Multimedia programme (3. Real conversation)	Comment
	[Real intervention of the real doctor:]	
03 D	a huge disappointment .	Manual: 3.4: Naming emotions
04 P	yes . a re:al . real disappointment! I have to say, he's doing his job, but . he's already doing everything, no . but then there's always the drinking and then (...)	Strong confirmation through repetition + topic expansion

The doctor's naming of "disappointment" is already suggested by the patient with her relation of opposites, when she compares her husband's promise ("then we'll do so many things") with his real behaviour ("and it's just the opposite"). In naming the emotion, the doctor's utterance stands in a specific hierarchical paraphrase relation to the patient's previous utterances in the sense that the doctor carries out a *conceptual abstraction* of the more concrete patient utterances.

The *accuracy of the fitting* is usually proven by the reaction of patients, from which the doctors can "read" how much they have "hit the mark". The reactions of patients can range from minimal feedback through simple, affirmative listening signals (*yes, hm*) to stronger feedback (*exactly, right*) to multi-part affirmations. The fact that the doctor in this case has accurately *named* the patient's *emotion* with his term "huge disappointment" is manifested by her feedback, in which she repeats the doctor's term with a slight modification, which is at the same time emphasised as "re:al, real disappointment". In this example, the emotional patient offers are *upgraded in relevance* through the naming, which the patient can use to further expand the topic she has started.
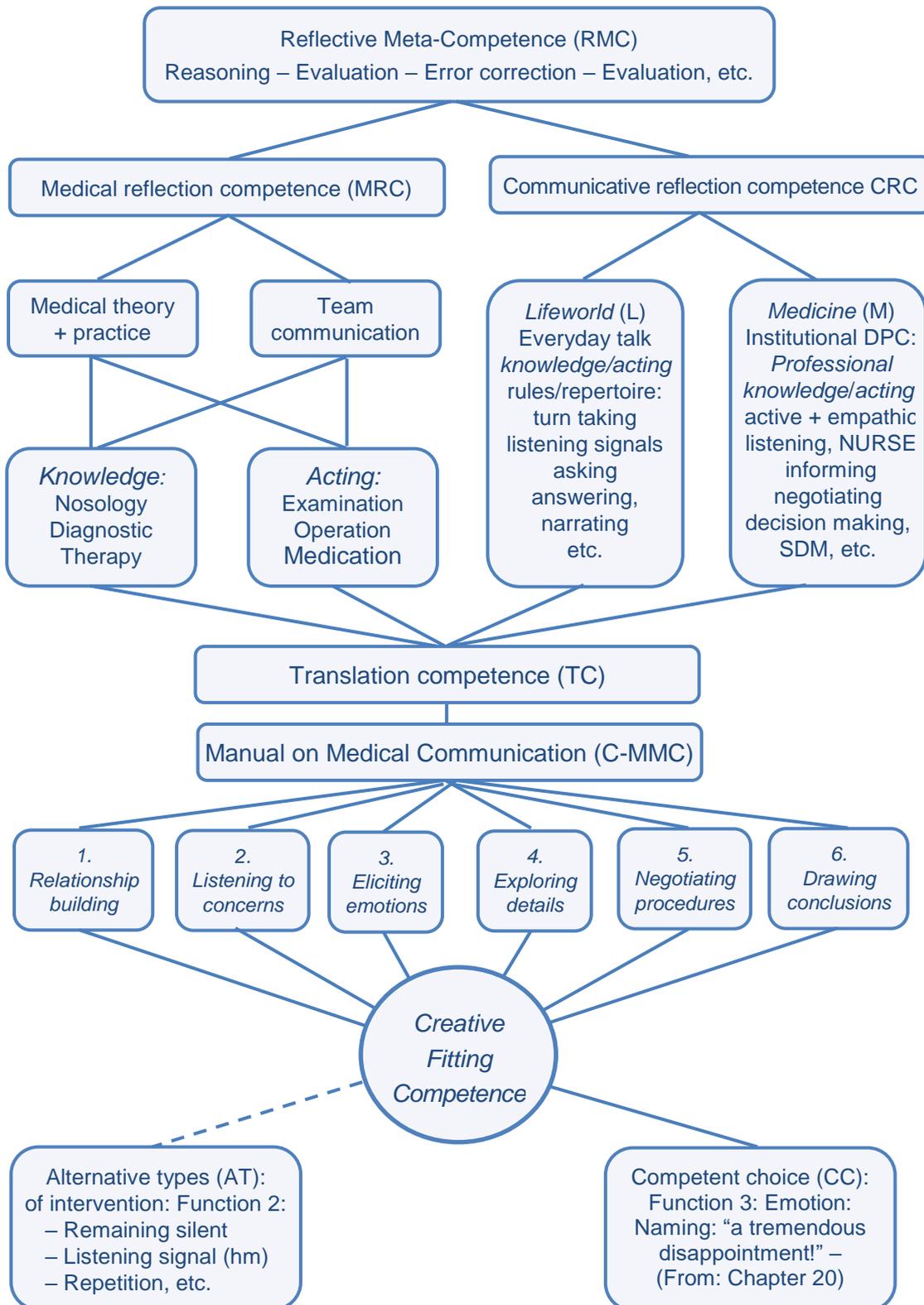
Armin Koerfer, Pauline Albus, Katharina Koerfer, Christian Albus

Reflective Meta-Competence (RMC)
Reasoning – Evaluation – Error correction – Evaluation, etc.

Medical reflection competence (MRC)

Communicative reflection competence CRC)

Medical theory + practice

Team communication

Lifeworld (L)
Everyday talk
knowledge/acting
rules/repertoire:
turn taking
listening signals
asking
answering,
narrating
etc.

Medicine (M)
Institutional DPC:
*Professional
knowledge/acting*
active + empathic
listening, NURSE
informing
negotiating
decision making,
SDM, etc.

Knowledge:
Nosology
Diagnostic
Therapy

Acting:
Examination
Operation
Medication

Translation competence (TC)

Manual on Medical Communication (C-MMC)

1.
Relationship building

2.
Listening to concerns

3.
Eliciting emotions

4.
Exploring details

5.
Negotiating procedures

6.
Drawing conclusions

Creative Fitting Competence

Alternative types (AT):
of intervention: Function 2:
– Remaining silent
– Listening signal (hm)
– Repetition, etc.

Competent choice (CC):
Function 3: Emotion:
Naming: "a tremendous
disappointment!" –
(From: Chapter 20)

Fig. 2.6: Simplified flow chart (key and sub-competences) for professional competence
(see this example in context: Chapter 20, transcript E 20.18)

This was merely an abstract example that can only be presented here in paper form and pencil. In class, at this point in the conversation, where the patient makes a dramatic statement, the video would be paused and either the participants would be asked to suggest an intervention spontaneously, or a *multimedia programme* would be used to offer alternative interventions, which could be evaluated immediately after the choice had been made (cf. Koerfer et al. 1999, 2008, Koerfer, Albus 2018, and § 13). For this purpose, the less fitting and creative interventions can be used for *comparison,* with which the doctor could have limited himself to mere silence or minimal listening signals (*hm*) (Fig. 2.6: AT: function 2).

Evaluative feedback essentially identifies the *best* intervention (Fig. 2.6: function 3: competent choice = CC) from among more or less fitting intervention alternatives, allowing individuals to assess their own current competence development by *comparison* (§ 13), which may then be confirmed or corrected by an *external* rating (§ 13, 40, 41).

Similarly, video- or transcript-based conversations used to inform patients can be evaluated to determine the extent to which *translation* competence (Fig. 2.6: TC) has been successful in mediating between the medical world and the patient's lifeworld before the patient agrees to an operation, for example. *Good* and *bad anchor examples* (§ 22) can also be used for this purpose.

Similarly, after an abrupt interruption of a narrative by the doctor, the question of the meaning of the *association rule* (Table 2.6: 8aD-E) and its function in the context of *narrative* medicine, but also remain at the level of turn-taking and highlight differences to alternative interventions that allow the patient to continue speaking uninterrupted ('as if uninterrupted') (§ 19). Similarly, the learning concept of shared *decision making* (SDM) can be the theoretical learning opportunity that first expands *medical knowledge* (M) (Fig. 2.6: M) before the theory is illustrated with empirical examples (§ 22).

General learning goal *Medical Communication*

The two forms of tabular and graphical representation, which are also suitable for teaching purposes in a further didactic reduction, can also be expanded and specified in order to flexibly change the *learning focus* with corresponding learning goals and adapt it to current learning opportunities (§ 2.3.3). However, learning in different directions (*top-down – bottom-up*), which also enables a shift between theory and practice

(empiricism), poses particular challenges for the formulation of learning goals (§ 13).

Since the promotion and development of communication competences must be based on different *learning levels* (§ 2.3.4), learning goal taxonomies must also be designed and used flexibly with formal placeholders so that they can be reduced, specified or expanded depending on the learning focus.

In summary, the *general learning goal* of medical communication (Box 2.14) should also be formulated in a sufficiently open manner so that, depending on the learning occasion, the formal placeholders (including ...) can be filled with appropriate content.

Box 2.14   General learning goal *medical communication*

Students/doctors can provide competent care for their patients within the framework of biopsychosocial and dialogical medicine by possessing sufficient knowledge of medical and communicative theories, models and methods/techniques, which they apply competently, i.e. in a patient-oriented and context-sensitive manner, with sufficient clinical and communicative acting competences (including ...) in their instrumental acting (IA) and communicative acting (CA), by performing specific actions ($SA_{1,2,3}$ ...) according to their current state of knowledge and the moment of conversation.

If problems arise in theory or practice with regard to *fitting* competence or decision-making (SDM), the general learning goal formulation would need to be modified or specified, i.e. the gaps (including ...) would need to be filled in concrete terms. Some examples of learning goals relating to *narrativity* and *participation* in medicine are given below.

Exemplary learning goal formulations

When formulating learning goals, the formulation pattern to be applied to all learning goals had already been specified in advance in order to take into account the relationships between higher-level learning goals (at the macro and meso levels) and learning goals at the micro level (§ 2.3.3). There, an exemplary learning goal formulation was given using the example of *active listening*, which was based on the 'by relations' used in both action analysis and educational research.

Below are two examples of learning goal formulations in abbreviated form, which may need to be further differentiated in class if a new learning focus requires it.

Box 2.15   Specific learning goal: Narration versus Interrogation

Learners
- are *knowledgeable* about the differences (in the rules) between *everyday* communication and *therapeutic* communication (§ 2.2.3, § 9) and
- *can moderately apply* Freud's *association rule* in *medical* communication,
    - by *practicing* a moderately *narrative* interview style instead of a merely interrogative one (§ 19),
    - by *promoting* patients to tell their *stories*,
    - by *actively listening* to them and *encouraging* them to continue talking and
    - by responding to their narratives with *empathetic feedback* and, where appropriate, *interpretations* (§ 20, 25),
    - to initiate a further dialogical *new construction* of the narrative for *therapeutic* purposes (§ 19, 20, 25).

Box 2.16   Specific learning goal: Decision making

Learners
- are *knowledgeable* about the key differences between *paternalistic, libertarian* and *discourse-ethical* decision-making *models* and their variants (§ 10) and
- *can promote patient participation* wherever possible, depending on the situation (§ 10, 22),
    - by establishing a *translation* between medicine and the patients' lifeworld,
    - by exploring patients' *information needs* regarding diagnostic findings and treatment options (§ 10, 22, 25) and
    - by proactively involve their patients in decision-making (§ 10, 22, 25) based on their explored ideas and preferences
    - so that the result is not *confused consent*, but *informed consent* (§ 10, 22).

For further learning goals, ranging from higher-level learning goals to micro-behaviour (eye contact, listening signals, etc.), reference can only be made here to the relevant chapters (§ 17-25). An exemplary graphic with a broader learning focus is used below (§ 2.5) to illustrate learning goal taxonomies when drawing conclusions for teaching from empirical conversation analyses, which also form the basis of medical communication training (§ 13).

The learning goals for teaching should not only be guided by experts and teachers, but should also be made clear to learners in accordance with the principle of *transparency* in teaching, in order to provide guidance in specific learning modules, which will be presented below (§ 2.3.12). First, however, a brief overview of the development of the *Cologne Communication Curriculum* (CCC) (§ 14) will be provided, within the framework of which the learning modules were developed.

2.3.11 Research on Cologne communication curriculum (CCC)

As the emergence and development of communication curricula is considered in other recent reviews (e.g. Bachmann et al. 2022, Venktaramana et 2022), we will limit ourselves here to an overview of the *Cologne Communication Curriculum* (Table 2.5, cf. § 13, 14). Since the mid-1990s, a research focus and a study reform with new teaching and examination formats have been established at the University of Cologne.

The paradigm shift from biomedicine to biopsychosocial medicine described above (§ 2.1 and § 2.3) and the parallel shift from paternalistic and directive medicine to partnership-based and dialogue-oriented medicine has been taking place in Cologne since the mid-1990s, when the curriculum reforms were underpinned by accompanying scientific research (see Table 2.5).

Not only were new learning concepts such as problem-oriented learning in small groups and learning through role-playing and, since 1998, with simulated patients tested, but new content (disease, illness, salutogenesis, etc.) and relationship and communication models (narration, participation, NURSE, BBN, SDM, etc.) were also taught. In addition, new methods of empirical conversation analysis were used (§ 2.4), which enabled the development of new evaluation tools (rating, coding) based on the observation of recorded doctor-patient conversations (§ 2.6. and § 40-43).

The specific communication curriculum was developed in co-operation between the *Dean of Studies* (under the direction of Jürgen Koebke, Stefan Herzig, Christoph Stosch) and the *Department of Psychosomatics*, which took the lead in research, teaching and evaluation in the development of communication competences for students (*training*) and doctors (*continuing education*), initially under the direction of Karl Köhle and from 2005 under the direction of Christian Albus.

The *scientific foundation* and *accompanying research* of the new curriculum was ensured on an *interdisciplinary* basis through the involvement of staff from various disciplines (medicine, psychology, linguistics, media studies, etc.).

Since the 2000s, reform developments have been driven by increasing interdisciplinary cooperation between various pre-clinical and clinical disciplines. A variety of *interdisciplinary projects* were developed at the University of Cologne (between psychosomatics, medical sociology, medical psychology, surgery, dermatology, pharmacology, medical ethics, dentistry, etc.). The results of the interdisciplinary projects have been continuously integrated into the *Cologne communication curriculum* (CCC) (§14), which has been structured

- interdisciplinary
- competence-based,
- circular,
- longitudinal

The reforms of the Cologne curriculum have been described in numerous publications (Table 2.5). Stosch et al. (2000, 2001, 2008), Zims et al. (2019) provide an overview of the Cologne Curriculum as a whole. The developments, functions and structures of the *Cologne Communication Curriculum* (CCC) are described in detail in the relevant chapters of the handbook (§ 3, 13, 14, 16, 40, 41, 43), so that we can limit ourselves here to a synoptic presentation, in which we also list references for the *scientific and interdisciplinary foundation* as well as the *accompanying research* of the *communication* curriculum (Table 2.5).

Cologne Communication Curriculum (CCC)				
	Research & Education	Disciplines & Topics	References Selected literature	Ch.
I	Scientific foundation	Institutional Communication	Koerfer 1994/2013, Koerfer et al.1994, 2008, Koerfer, Albus 2015, 2018	5 7
		Relationship models	Koerfer et al. 1994, 2008, Koerfer, Albus 2015, 2018	7 10
		Communication theories & BPSM	Koerfer 1994/2013, Koerfer et al. 1994, Koerfer, Koerfer 2018, Koerfer, Albus 2018	4 7
		Narratology Psychotherapy & BPS-Medicine	Koerfer, Neumann 1982, Koerfer et al. 1994, 2000, 2010, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2017, Koerfer, Albus 2018	9 19 20
		Emotion & Empathy	Koerfer, Obliers, Köhle 2004 Neumann, Obliers, Albus 2012	20 25
		Decision making BBN & SDM Palliative medicine	Hauser et al. 2015, Koerfer et al. 2008, Vitinius et al. 2013, Obliers, Köhle 2017, Köhle 2017, Koerfer, Albus 2015, 2018	10 16 22
		Discourse ethics	Koerfer et al. 1994, 2005, 2008, Koerfer, Koerfer 2018, Koerfer, Albus 2015, 2018	7 10
II	Inter-disciplinary cooperation	Surgery (& Psychosomatics)	Eggers et al. 2007, Bollschweiler et al. 2008	39
		Pharmacology (& Psychosomatics)	Hauser, Koerfer, Kuhr, Albus, Herzig, Matthes 2015, Hauser, Koerfer, Niehaus, Albus, Herzig, Matthes 2017	10 26
		Dean of Studies (& Psychosomatics)	Herzig ... Schmeisser, Koerfer 2006	6
		Dentistry (& Psychosomatics)	Haak, Rosenbohm, Koerfer et al. 2008	40
III	Education & Didactics	Competence- & Problem-based	Köhle et al. 1999, Antepohl, Herzig 1999, Koerfer et al. 1996, 1999, 2008	13 14
		Manual-based learning	Köhle et al. 1997, 1998, Koerfer et al. 1999, 2004, 2005, Albus 2020, 2022	17 -23
		Role-playing Simulated P	Koerfer et al. 1994, 1996, 1999, 2008, Obliers, Koerfer, Albus 2018	13 40
		Multimedia: Training/ & patient information	Koerfer et al. 1999, 2008, Eggers et al. 2007, Bollschweiler et al. 2008, Chon et al. 2018, Koerfer, Albus 2018, Zims et al. 2019	13 39
IV	Evaluation	Training, PJ OSCEs (SP) Rating	Koerfer et al. 1994, Neumann, Obliers, Schiessl, Stosch, Albus 2011, Obliers, Koerfer, Albus 2018	13 14 41
		Continuing educ: Rating, Coding	Köhle et al. 1995, 1996, 2001, Kaerger 1999, Vitinius et al. 2013, David et al. 2025	40 43

Table 2.5: Cologne Communication Curriculum (CCC) (Overview, selected literature)

From the beginning of the reforms to the present day, the focus has also been on the unity of teaching and research, whose essential function was evaluation, which related to both medical studies and the continuing education of doctors (§ 13-16, 40-43). The principle that only what has been taught should be examined should apply (§ 3, 17).

The *Manual of Medical Communication* (C-MMC), which is also used at other German-speaking universities, was central to teaching and to evaluation. The manual was developed in 1998 and is still used today in its 6th edition for the evaluation of OSCEs (Evaluation: C-EMC), which have also been carried out in Cologne with simulated patients (SP) since 1998 (§ 13, 14, 41). The manual also includes the communication of serious diagnoses (BBN), which is mainly used in higher semesters (§ 14) and in continuing education (§ 16, 43).

Variants of the manual that refer to specific diseases (*diabetes and depression*) (C-MMC-DD) are also used there (§ 29, 30) (cf. Appendix). The manual is also the basis of the handbook, which contains the corresponding *anchor examples* in its practice chapters (§ 17-25), which have been analysed for research and teaching purposes and tested in training and continuing education.

Further details on the didactics of medical communication in the *Cologne Communication Curriculum* (CCC) can be found in chapters 3, 13, 14, 16, 40, 43. The following section provides an overview of some of the learning modules that were developed as part of the Cologne Communication Curriculum (CCC) before being included in this handbook, with references to the relevant chapters.

2.3.12 Learning modules on dialogical medicine

Over the last three decades of reform of the Cologne curriculum, various *projects* have been pursued in *teaching* and *continuing education* in which *learning modules* have been developed so that they can be tested in teaching practice and corrected if necessary. An overview differentiates between 12 selected learning modules on a specific *dialogical medicine* (DiaMed) (Box 2.17) and lists the relevant chapters from the handbook (right-hand column) in which the corresponding topics are dealt with.

The learning modules are based on different learning levels and degrees of difficulty, meaning that some are only suitable for higher semesters or continuing education. Thus, different choices are made in

the first pre-clinical semester than in the fourth clinical semester (§ 14), where the unity of clinical reasoning and communicative reflection can already be assumed on the basis of developed competences (§ 13). While parts of the learning module on 'biopsychosocial medicine' (§ 4) can already be used in the first preclinical tutorial (§ 14), the learning module on 'psychotherapeutic competences' is reserved for higher semesters and the practical year (§ 14).

Box 2.17   Learning Modules on Dialogical Medicine (DiaMed)

Modules		Title	Chapters
1	MR	Biopsychosocial medicine and relationship models	4, 8, 10, 13
2	EM	Everyday talk and medical communication	1-3, 7, 9, 13, 17-25
3	AL	Active listening and verbal Intervention	3, 9, 13, 19
		a. Medical conversations maxims	2, 3, 7, 19-22
		b. Interrupting speech	3, 9, 13, 19
4	NM	Narrative medicine	9, 19-22, 24, 25
5	EC	Empathic communication	3, 9, 20
6	ED	Exploring details	8, 19, 21
7	DM	Medical decision-making	8, 10, 22, 24-25
8	PC	Psychotherapeutic competences	13, 14, 15, 16, 29-39
		a. General practice and psychooncolgy	13, 14, 16, 42, 44
		b. Psychocardiology and Diabetes education	13, 14, 29
9	FM	Forms und functions of metaphors	11, 19-22
10	NV	Nonverbal interaction and communication	12, 18, 25
11	IP	Interprofessional Competence	2, 6, 13
12	CS	Competences in specific fields	5, 13, 14, 24-39

The selection of parts of the learning modules (theories, clinical pictures, video examples, role plays, exercises with SP, etc.) depends on the level of difficulty, as, for example, *empathic* communication (§ 20) with a patient with an acute cold is different from that with patients with *chronic physical illnesses* (§ 29) or *depressed* patients (§ 30) or particularly *'difficult'* patients (§ 34) or *dying* patients (§ 38).

However, specific *sub-competences*, such as *active listening* (§ 19), can be promoted across all semesters, even if different learning levels arise here as well. For example, in the Cologne Communication Curriculum (§ 14), simulated patients are already used in the first pre-clinical semester (SP) (§ 13, 41) with 'simple' illnesses, and their role is

then changed in higher semesters to patients with sometimes severe and chronic illnesses.

Although the learning modules are based on different learning levels and degrees of difficulty, they share common *theoretical, didactic, empirical* and *evaluative* foundations, which will be briefly outlined here:

- **Theoretical foundations** of these learning modules are excerpts from texts by so-called classics (Balint, Engel, Freud, Rogers, von Uexküll, etc.). Chapter 4 presents an exemplary selection, using easily understandable texts by Descartes, Popper, Eccles, Engels, and von Uexküll to explain the biopsychosocial model for teaching purposes. Previously (§ 2.3.9), theoretical pieces by Freud and Grice had already been cited to aid understanding of narrative medicine, which are supplemented in chapters 9 and 19 in particular with further literature, including from our accompanying research (see § 2.3.11 above).

- **Didactic foundations** are problem- and research-based learning, which begins early in preclinical training and is deepened at various learning levels during clinical training (§ 13, 14). In clinical training and in continuing education specifically for medical communication, our Cologne Manual (C-MMC) is used, which is intended to be a structuring aid for conversational practice (§ 17-23). Since the principle should apply that only what has been taught beforehand is examined, the manual also serves as an *evaluation tool* that can be used for self-evaluation and external evaluation (§ 13, 40, 41).

- **Empirical foundations** of the learning modules is a corpus of more than 300 doctor-patient conversations, some of which have also been integrated into a *multimedia programme* (§ 13). These conversations also formed the basis for the empirical conversation analyses in the *accompanying research* (§ 2.3.12) and in the *practical section* (IV) of this handbook. The empirical conversation analyses dealt with issues such as the use of *listener signals* (e.g. *hm, okay*), the completeness of a *biopsychosocial anamnesis, empathic communication,* and *participation problems,* etc.

- **Evaluative foundations** must already be applied when the taking of medical history is assessed as an *interrogation,* or the empathic communication of doctors as *deficient,* or the use of listening signals as *inflationary,* which has already been described as a *dosage* problem (§ 2.3.9, cf. § 17). The *premises* often *tacitly* made in the evalua-

tion must first be made *explicit* before they can be applied in qualitative and quantitative conversation analyses (§ 2.5-6, § 17-23, 40).

A number of the latter *methodological* questions and problems of empirical and evaluative conversation analysis have been addressed in many works on research and teaching in medical communication as accompanying research to the *Cologne communication curriculum*, which was referred to earlier (§ 2.3.11).

Compared to merely (incomplete and distorted) *remembered* communication, which had to serve as the sole source of experience in case reports even in Balint's day, the *empirical-evaluative shift* (cf. above § 2.1) is certainly a great advantage, because the recorded conversations guarantee an intersubjective access to objectively verified conversation data.

The associated problems of *empirical* conversation analysis are discussed below (§ 2.4), before drawing *didactic* conclusions from these conversation analyses (§ 2.5) and finally presenting perspectives for *evaluation* (§2.6), for which a gold standard (Sg.) has yet to be found before it can become established.

2.4 Empirical research method

As already emphasised in the introduction (§ 1), a special feature of this handbook is that its case and anchor examples relevant for research and teaching were obtained "strictly" empirically wherever possible. Unless specifically marked otherwise for reasons of didactic variation, the examples are largely taken from *authentic* conversations that were recorded with sound and images in real situations during medical consultations and ward rounds and then transcribed.

2.4.1 Intersubjectivity in research and teaching

This "strictly" empirical approach has multiple methodological motivations. A prerequisite for the *intersubjective* verifiability of conversation analyses and the *didactic* communication of conversation characteristics in teaching is the *recording of* communicative data in order to overcome the fleeting nature of face-to-face communication. Otherwise, the

intended object of study or teaching would be considerably missed in the case of merely *remembered* communication due to the loss and distortion of perception and memory (Koerfer 1985). Even minor communication phenomena such as delays by the speaker on difficult or sensitive topics or listener signals (*hm, yes, oh well*) would fall through the spontaneous attention grid of a direct observer, whose selective perception could hardly stand up to intersubjective scrutiny if, for example, the following questions were to be clarified:

Box 2.18   Empirical research questions in conversation analysis

- What (type of) opening did the doctor choose and to what extent (length of contribution) was the patient able to present their concerns?
- What (type of) other questions did the doctor ask and how often?
- How did the patient respond in each case (and with what length of contribution)?
- How often did the doctor interrupt the patient, in what form and with what effects?
- What was the quantitative proportion of the conversation between the two participants, measured in terms of number of words/speaking time?
- How often has the patient paused (e.g. on sensitive topics) or delayed or not completed their contribution?
- How often did the patient laugh (out of embarrassment, insecurity, etc.)?
- How often did both interaction partners laugh together (and about what)?
- Who initiated, continued or discontinued which topic?
- How did the doctor initiate the end of the conversation (*opening up closing*)
- How did the patient react to this (acceptance, restart)?

What is already difficult to track from direct observation and memory for individual conversations is even more so for a large number of conversations if, for example, one were to ask (with a pre-post design) in a group comparison for typical differences as a result of an intervention measure (such as Balint group work), to which we will return systematically under the aspect of evaluation (§ 40-43).

The methodological reservation about merely *remembered* communication also applies to merely constructed dialogue sequences or even entire conversation constructs, which merely represent an artificial variant of *imagined* communication, as is also common in "poetry" (plays, novels, etc.). Here, "texts" are fantasized "out of the head", with which at best characteristics of written communication can be reproduced that have little in common with oral dialogues (Koerfer 1979, 1982). Many textbooks on doctor-patient communication are also subject to the suggestion of constructed dialogues, as if they had taken place in one way or another. With their "smoothness" or "brittleness", the text examples then speak their own "sterile" language.[38]

Overall, a "database" that is limited to merely *remembered* or *imagined* communication, especially if it was obtained through the memory and imagination of individual (however competent) individuals, cannot do justice to *the claim of intersubjectivity* in current research and teaching on doctor-patient communication. With the "empirical-evaluative" turn in clinical and social science conversation research already outlined above (§ 2.1), certain *standards* have developed here, which have been established not least with the technical, audiovisual recording methods, which will be discussed in more detail below because they also affect our specific teaching approach in this handbook.

2.4.2   The "microscope" of conversation research

The methodological point of a specifically empirically based approach in research and teaching is *expressed metaphorically* by John Heritage, a protagonist of (American) *Conversation Analysis* (CA), in the foreword to the "Handbook of Patient-Provider Interactions" (Beach 2013) (Box 2.19), in which he views the recording procedures in the social sciences in general as the equivalent of a "microscope":

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[38] However, there are a number of (even older) textbooks which, following research, are based on empirical conversation, particularly in the English-speaking world (e.g. Coulehan, Block 1992). For the German-speaking world, the excellent textbook by Adler and Hemmeler (1989) should be mentioned as an example, which substantiates its analysis categories using selected excerpts from conversations.

Box 2.19   We have a microscope. We should use it.

Recording technology can, without exaggeration, be described as the so-cial scientist's equivalent of the microscope (...) Conversation analysts, in particular, have always insisted on the value of group work on tran-scribed materials in the presence of the tape record itself. Anyone who has taught medical students, or trained physicians in CME courses, will be vividly aware of the compelling educational value of real data, in which real clinicians deal with real dilemmas of real patients in real time. Recordings have the power to evoke analysis and reflections that is wide and deep and that is, on occasion, an important stimulus to changes in practice. We have a microscope. We should use it.

Heritage 2013: XI f

This appeal to make greater use of the *microscope* that has long been available is directed both at research, which should develop into an "ev-idence-based discipline" (ibid.), and at the teaching of doctor-patient communication, to use the "educational value of real data" that has been generated under "realistic" conditions (real conversation partners, problems, time, etc., see above).

   We try to meet both requirements here by combining research re-sults, mostly from our own and occasionally other projects, with teach-ing in order to capture and convey the "reality of conversation" as it took place under real practical conditions. If this is not specifically marked otherwise for *didactic* reasons (e.g. in the case of alternative formulations of medical interventions), our handbook uses directly ob-tained data of oral communication in the form of recordings and tran-scriptions of authentic conversations, as is generally done in the tradi-tion of discourse analysis (e.g. Edwards, Lampert 1993, Gee, Handford 2014) or specifically in research on doctor-patient communication (e.g. Ehlich et al. (eds.) 1990, Redder, Wiese (eds.) 1994, Heritage, Maynard (eds.) 2006) in order to meet the requirement of intersubjectivity already at the *data collection* stage.

2.4.3   Recording and transcription

For the purpose of conversation analyses, as they are also the basis here, two steps are necessary for data acquisition and must be methodically controlled, namely the audiovisual *recording* and the *transcription*. In both fixation processes, in the direction from the "original event" to the recording (*data documentation*) and from the recording to the transcription (*data presentation*), we are dealing in each case with medial transformations, in which specific data losses and gains are to be expected (Koerfer 1981, 1985). In order to be able to compensate for the unavoidable data losses of each transcription, the investigators must always go back to the recording in order to gain certain auditory impressions ("friendly") for a rating, for example (Kruse, Tress 2010, Koerfer et al. 2010). In contrast to the holistic experience from the internal perspective of participants or the external perspective of a participating observer, the AV medium is also highly selective because visual or olfactory information (e.g. blushing, sweat) may be lost in downstream perceptions of the image document ("monitor").

On the other hand, repeated observations and corresponding systematic notations of observations are the only way to perceive phenomena that elude spontaneous, synchronous observation in the fleeting "original situation", although they are subtly perceived and processed there by the partners involved. Their interaction can of course also be spontaneously "registered" by a non-participating observer as a listener and spectator, but not systematically perceived and "recorded" at the same time. For example, the facial expressions or gaze behaviour of the participants or their body movements are subject to such "fast-moving" changes that they can hardly be tracked in spontaneous observation, let alone noted (written down, coded) "online" accordingly, which is dealt with separately under the aspect of non-verbal communication (§ 12, 18). Here, the still image and slow motion are indispensable for analyses in order to be able to recognize body posture, gestures and especially gaze behaviour during *turn taking*, which is essentially regulated by (interruptions during) eye contact and should therefore be given special attention.

2.4.4   Verbal and non-verbal data presentation

The following example (E 2.2) of verbal and non-verbal data presentation is intended to briefly illustrate the special significance (of the notation) of eye contact, namely in the case of an initiative speech just begun by the patient, which is interrupted early on by the doctor. Whether there is eye contact or not is guessed by the transcriber from the camera perspective and marked with "[+]" (plus) or "[-]" (minus) in our working transcription (E 2.2).

At this point, attention should only be drawn to the phenomenon of *eye contact*, which is particularly noted here because of its significance in the context. In the video recording, we see the doctor from behind and have a view of the patient's face and upper body. After the doctor's question about the reason for the consultation, the patient has just started to answer. The doctor interrupts her without need, as soon as she has started. The patient's gaze was directed neither questioningly nor seeking help from the doctor, but "digressively" upwards to the left, which is typical behaviour when one is thinking while speaking (inner concentration) and does not want to be "distracted" from the outside.

E 2.2		"What are your main complaints?"	Comment
01	D	[both sit down] [+] so Mrs A, what brings you here? . [+]	Opening question: Reason for consultation
02	P	[+] so, in general [-] now um ... [looking up to the left, thinking]	Start of the answer
03	D	where are [+] your main problems, what/or main complaints are you coming for? [+] .	Early interruption/funneling
04	P	I have often experienced heart pain, i.e. stitches in the heart area .	Focus: "Main complaints"
05	D	since when have [-][TL] [1] you had these stitches? ... [3] ... [1P] [1P scratches her shoulder]	TL = thoughtful look from P
06	P	[-] a little [+] longer, so in 2001 it was really bad, and that's when I had my tonsils removed. [+]	Last sustained eye contact from P to A
07	D	yes .	Handset signal
08	P	that was still the case with Dr Müller . [+]	Pre-treatment

With his renewed intervention (03D: "what are your main problems, what/or main complaints, what are you coming for?"), the doctor not only interrupts the flow of speech that has just begun at an early stage, but also quite obviously the patient's train of thought that has just developed ("so, generally now um ..."). This not only abruptly stops the current flow of thoughts, but also verbally focuses the patient's possible further cognitions by first narrowing the range of answers to "main *problems*" and then, with a self-correction, to "main *complaints*", namely through the suggested contrast: Whereas in the short term only "secondary" problems were excluded, but at least "main problems" were still allowed, fractions of a second later the doctor's self-correction means that only the patient's "complaints" are "under discussion", or more precisely only "*main* complaints".

Instead of following the patient "in sound and vision", i.e. giving her full attention while she is talking, the doctor draws the patient's attention back to himself and verbally directs her attention to the focus he wants, which she then "willingly serves" with her body-related description of the complaint ("heart pain").

The *biomedical focus* established by the *form*, *content* and *placement* of this (all too) early interruption is perhaps already the beginning of the end of a conversation whose early *conditioning* (§ 9) neither actor can escape so quickly. Before we return later (§ 19.6) to the actual course of the conversation in detail, this initial sequence should above all emphasise the importance of *eye contact*, which is worth paying attention to both in the subsequent analysis of the conversation, but also beforehand in the medical action itself, for which an initial *maxim* and its justification could be formulated in advance:

- *Maxim*: If possible, do not interrupt your patients if they are still looking away 'thoughtfully' while talking.
- *Reason*: Such "digressive" glances while talking are usually to be taken as a "sign" that the other person has not yet finished speaking and wants to continue talking.

The risk that the patient's "digressive" gaze could perhaps lead to "digressive" thoughts should not only be endured by the doctor at the beginning of an initial consultation (sic), but should be particularly encouraged. We will return to this topic of the "fertility" of digressive thoughts (§ 9) when it comes to the moderate application of Freud's as *sociation rule* not only in psychotherapy, but also in the everyday professional life of medical consultations and ward rounds.

2.4.5   Transcription rules

Not every gaze is as significant as in the previous example, for which we have particularly sharpened the observation of the interplay between verbal and non-verbal communication for illustrative purposes. However, such phenomena should receive special attention from the doctor. The lowered gaze and the sluggish and quiet voice of the depressed patient should not escape the doctor's notice, just as the loud voice of the aggressive patient is "unmistakable" anyway. However, phenomena such as a hesitant response ("ranting") should also not be ignored, especially if they occur in front of "sensitive" topics (§ 21.6), the problems of which can subsequently be "laughed away" and thus trivialised if the patient's distress becomes too great, etc.

Compared to the outlined *complexity* of oral communication, which will be systematically discussed later (§ 12, 18), any transcription, however "complete", remains deficient. At different levels of systematic notation of verbal and non-verbal communication, there can only ever be an approximation of the "reality of conversation", so that empirical analysis must "live with compromises", especially if readability for practical applications in research and teaching is not to be jeopardised (Koerfer 1981, Birkner, Stukenbrock 2009). Our transcripts in this handbook are at the "intermediate" level of a *semi-interpretative* working transcription (HIAT) (Ehlich, Rehbein 1976, Ehlich 1982, 1993). Depending on the need for analysis, the working transcription should remain modular in order to reduce overcomplexity (Koerfer 1982, Spiegel 2009).

To use the image used by Heritage (see Box 2.19 above): The "microscope" must always be readjusted, i.e. "focused" on individual phenomena or completely replaced by another "device". In most cases, however, a standard setting is sufficient. Thus, in the following transcription, certain *non-verbal* (eye contact, gestures, facial expressions) and *paraverbal* phenomena (emphasis, volume) are not systematically included in the transcription, which is based on a standard variant, but only optionally.

The extent to which oral communication is "written down" should not jeopardise *legibility*. A *literary* transcription was chosen to take into account the oral nature of a conversation to a certain extent. Listener feedback (such as "hm", "yes"), which allows the current speaker to continue speaking "as if uninterrupted", is noted in a separate line (cf. Duncan 1974, Ehlich 1979, Flader, Koerfer 1983, Koerfer et al. 2000,

2009, 2010). Simultaneous speech by doctor and patient was only taken into account in obvious ("inaudible") cases with square brackets. Since dots are replaced by commas in otherwise normal punctuation and dots are used exclusively as pauses, the corresponding capitalisation after dots is removed. Essentially, the following transcription characters are used:

Sign	Transcription explanations
D	Doctor
P	patient
MA	Medical assistant
[indicates neck]	Comments (non-verbal etc.)
here [file]	Comments (cognitive, meaning: patient file)
Word . Word .	short pause (no punctuation!)
Word ... Word	middle pause
..... [5]	Pause of approx. 5 seconds
ähm	Filled break of the speaker (turn-internal)
hm	Listening signal (example 1)
oh	Listening signal (example 2)
aha	Listening signal (example 3)
yes?	Listening signal (example 4 with question intonation)
je:sterday	Emphasised yesterday
he/she has	Self-correction
P [	simultaneously to speaker D
D [	simultaneously to speaker P
[+]	Eye contact
[-]	Eye contact interrupted
[l-]	Start "louder" (relative to "normal")
[-l]	End "louder" (return to "normal")
[q-]	Start "quieter" (relative to "normal")
[-q]	End "quieter" (return to "normal")
[f-]	Start "faster" (relative to "normal")
[-f]	End "faster" (return to "normal
[s-]	Start "slower" (relative to "normal")
[-s]	End "slower" (return to "normal")
(word)	presumed wording (unintelligible)
word-	Contribution/intonation not (yet) finalised/(still)
word=word	Fast connection
lemme	Literary transcription (e.g., for dialects) (= let me)
gotta	Literary transcription (= got to)
etc.	

Table 2.5: Transcript form

Some signs (such as eye contact) were not used systematically and compulsorily for reasons of complexity reduction in favour of better readability, but rather optionally depending on the specific purpose of the analysis (as in example E 2.2). The transcriptions of conversations in this handbook not only vary according to the respective research interest, but also follow the requirements of scientific factual analysis and didactic reduction. As is well known, not everything can be demanded and promoted at the same time in a subject as complex as medical communication.

2.5 Conversation analysis and didactics

Communication is usually intended for a specific purpose. This applies to our everyday communication as well as to communication in specific institutions, including medical communication in the consultation or ward round. Doctors and patients also follow certain purposes of action, which they can achieve or fail to achieve, which can be reconstructed in a *pattern analysis* of their actions.

2.5.1   Functions and patterns of action

In medicine, a distinction is made between different types of so-called "*endpoints*" of medical action, which we will come back to in detail at (§ 8).[39] In general, a distinction is made between types of (short-, medium- and long-term) endpoints, which can be arranged in a hierarchy (§ 8). On the way to the "major" endpoints, which undoubtedly include the *recovery* or at least *improvement of* the patient, many "minor" and "smallest" endpoints (*informing, understanding*) usually have to be achieved.

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[39] We only use the term "*endpoint*" because it has now become established in German and English-speaking countries (e.g. Schmacke 2006, Mühlhauser, Meyer 2006, Sawicki 2006, Sachverständigenrat 2009, Haes, Bensing 2009). Otherwise, there is no reason not to continue talking about treatment *goals, purposes, functions, tasks* or *outcomes* (e.g. Woopen 2001, Bollschweiler 2001, Hulsman 2009, Street et al. 2009). Depending on their function in the context, we prefer different terms, but for the sake of common usage (in the clinical context) we will mainly stick to "endpoint".

Their *functionality* for higher-ranking purposes of action of different types (*satisfaction, adherence to therapy*) is to be specifically examined here in a *pattern analysis* of medical acting, in which both the *hierarchy* of purposes/goals and the *rationality* of the instrumental and communicative means are to be reconstructed in *micro-, meso- and macro-analytical* perspectives (Koerfer 1994/2013). Rationality is demonstrated in the alternating and interaction of *communicative* action (medical history, information) and *instrumental* action (surgery, medication), which is ultimately presented in an *ideal-typical process model* (§ 7, 8, 17, 40).

The pattern analysis of medical action here follows the principles and methods of *functional-pragmatic* communication analysis – in line with the *turning points* in medicine (§ 2.1) – as applied to other institutions (courts, schools, universities) (e.g. Ehlich, Rehbein 1977, Hoffmann 1983, Koerfer 1994/2013) and specifically for communication between doctor or therapist and patient (see overview § 2.2). This involves, for example, the reconstruction of *question-answer patterns* or *narrative patterns* for the purpose of obtaining information when taking an anamnesis, which should be specifically identified as a *biographical-narrative* approach (§ 9, 19).

Furthermore, methods of *conversation analysis* (CA) will be considered, which has a long tradition of also dealing with the medical or therapeutic field of action (e.g. Maynard, Heritage 2005, Heritage, Maynard 2006, Peräkylä et al. 2008, Koenig, Robinson 2014, Robinson, Heritage 2014, Buchholz, Kächele 2013, 2016, Barnes 2019, Scarvaglieri et al. (eds.) 2022, Barnes, Woods 2024, Ekberg et al. 2024, Parry 2024) (§ 2.2). We will return to the results of these studies, particularly with regard to *micro-analytical* phenomena such as the *organisation of the exchange of speech* between doctor and patient, *eye contact* or specific medical *questioning techniques*. Here we will also look at the function of the so-called *suggestive question* (§ 21), which only ever proves to be appropriate or inappropriate in relation to certain *conversational situations* and *relationship models* (paternalism, service, cooperation) (§ 10).

2.5.2   Learning goals in comparative model learning

This type of *functional-pragmatic* conversation analysis should also make it possible to determine the *learning goals* that are to be conveyed in evidence-based guidelines/manuals for conducting medical communication "in small steps" (§ 17-23), without losing sight of the "big" endpoints of medical acting. As already explained in the examples above (§ 2.3-4), empirical analyses of doctor-patient conversations and the didactics of medical communication should go hand in hand if the learning goals are not to remain in a vacuum or only apply to experts and teachers, who themselves apparently only follow them to a limited extent. [40] Rather, in accordance with the principle of transparency, the learning goals should be present for all participants so that the achievement of the goals can be tracked jointly.

Theory-based and manual-based learning

First, the learning stages previously differentiated using the Cleveland model (§ 2.3.4) must be considered. While naive incompetence can be assumed before any theoretical knowledge and practical experience, conscious incompetence must be developed at an advanced stage in order to achieve conscious competence, which can be awakened by various learning stimuli (§ 13). It may always remain an 'ideal solution' for autonomous learning when learners work through problems without any guidance, because it is more sustainable, as is known not only from recent learning psychology, but was already known to Kant:

Box 2.20   Autonomous learning
The greatest aid to understanding is generation. One learns most thoroughly and retains best what one learns, as it were, from oneself.

Immanuel Kant 1803/1964: 736

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[40] Cf. Steffens et al. 2018 on the usability of the (German) NKLM 2015, for which experienced lecturers ("Most of the participants had 6-10 years of teaching experience") were surveyed. In addition to various critical reservations expressed by the respondents, one result was: "During the evaluation of the NKLM, usability was rather poorly rated".

As much as autonomous learning should be preferred, for example in problem-oriented learning (POL) (§ 13), in practice it often requires very time-consuming learning processes that take up more learning time than can be allocated in a medical curriculum or should be allowed due to other priorities (extensive learning content, etc.).

Despite all the advantages of completely *autonomous learning*, which will remain the exception (§ 13), theoretical and practical guidance is usually indispensable in order to accelerate learning in practice or to get it started in the first place. Since learning goals can hardly be taught and 'internalised' in the abstract, they must be conveyed through self-observation and observation of other practical cases, which, on the other hand, in the sense indicated by Popper (1972/1994) (cf. above § 2.3.5) always require a certain *awareness of the problem*, with which observation must be stimulated if it is not to remain blind.

This awareness of the problem can be raised, for example, through selected texts on *biopsychosocial* medicine (e.g. Engel 1977, Uexküll, Wesiack 2011) (§ 4) and specifically on *narrative* medicine, in order to highlight the difference to *interrogative* medicine (e.g. Engel 1997, Greenhalgh, Hurwitz 1999, Koerfer et al. 1994, 2010, Köhle, Koerfer 2017) (§ 9). Similarly, the differences between more *paternalistic* and more *partnership*-based *decision-making models* can initially be explored by reading relevant texts (e.g. Charles et al. 1997, Koerfer et al. 1994, Koerfer, Albus 2015, Elwyn et al. 1999, 2025) (§ 10), in which the essential models are already differentiated.[41]

In order to apply the theoretical basic knowledge acquired in this way in practice in a condensed form, it was supplemented by *manual-based* knowledge that can be used to structure self-observation and external observation of practical cases. Our *Cologne Manual of Medical Communication* (C-MMC) can also be used as an evaluation tool (C-

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[41] For teaching purposes, we provide examples of English and German literature references, which can of course be replaced or supplemented from the wide range of literature available (see the respective topic focus in § 2.2.4). In addition, *theories and models* for shaping relationships and communication should be taken into account, which were differentiated above (§ 2.3) and are dealt with in detail in specific basic chapters (§ 4-12) of the handbook. With mere fragments of theory (e.g. Watzlawick, Schulz von Thun), which are referred to in learning goal catalogues (such as the NKLM 2015/2021), the universally postulated *interdisciplinary foundation* of communication curricula (§ 2.3) can hardly succeed.

EMC), allowing for a critical comparison of different doctor-patient conversations from everyday professional practice (consultations, ward rounds), as well as the learners' own training practice. Theory- and manual-based learning forms the basis of a *circular teaching-learning spiral* (§ 13), the core of which then consists of *comparative learning* based on more or less successful conversations that can serve as examples of alternative relationship and communication models.

Comparative learning with alternative models

Once the initial theoretical and practical learning stimuli have been established, early successes in *comparative learning* can be achieved by offering *good* and *poor* conversation examples for class comparison—without labelling them in advance. This opens up options for *autonomous learning*, which, however, should not proceed with *naïve incompetence* (§ 2.3.4) but be guided by theory.

Since these learning processes are dealt with separately (§ 13), we will focus here solely on a *manual-based structuring aid* for learning, which can be achieved through graphical representation in the form of a *flow chart* leading from the *macro goals* of relationship and communication models to the *micro goals* at the level of *manifest* conversational behaviour (Fig. 2.7). The criteria for (re)constructing such representations in a flow chart have already been explained above (§ 2.3), so that we can limit ourselves here to the structuring function in teaching.

Using this flow chart, which is intended to capture *alternative decision-making paths*, empirical examples of conversations can be used to reconstruct which relationship and communication models doctors (students) pursued or when they *changed* course and deviated from an *ideal line* for whatever reason (cf. § 2.5.3). A distinction is made between *ideal-typical* models as alternatives between *biopsychosocial*, *narrative* and *participatory* medicine on the one hand and traditional, *paternalistic* medicine on the other, which is essentially based on *interrogation* and *instruction*.

In a broad spectrum based on approximately 300 conversations from general practices, some of which were also the subject of an evaluation project (§ 40), *empirical conversation analyses* were used to identify ideal-typical cases, which were also applied in Cologne teaching and are used in the practical chapters of the handbook (§ 17-23) to promote *comparative model learning* using empirical practical examples that serve as *anchor examples*.
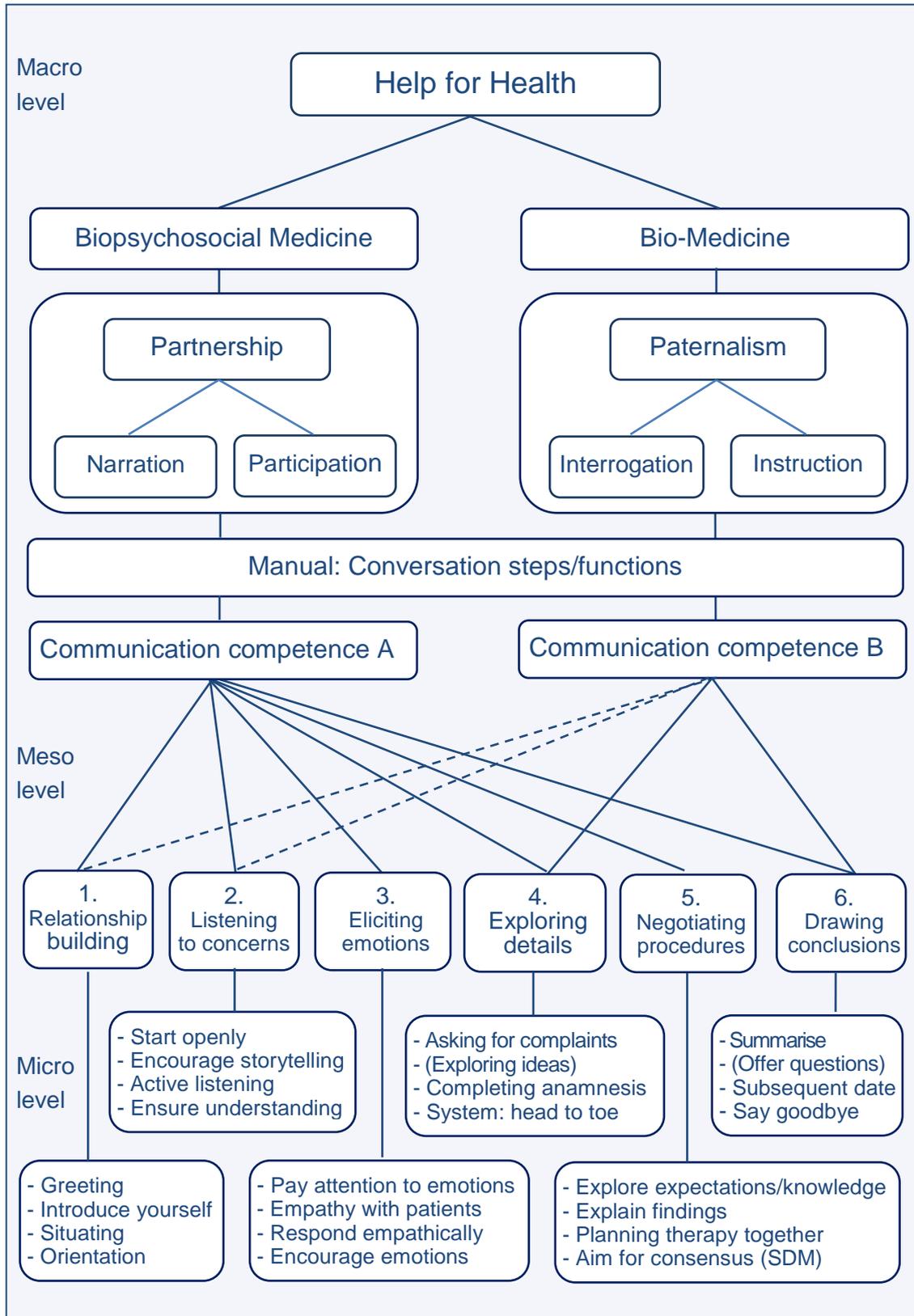
Fig. 2.7: Alternative relationship and communication models in medicine
(cf. Cologne Manual of Medical Communication (C-MMC) (Appendix § 2.8)

These practical chapters present examples of conversations in which doctors use their *communication competence* in such a way that the *six functions* of the manual are largely *fulfilled*, which can be demonstrated across the macro and meso structural levels down to the micro structural level of conversational behaviour (Fig. 2.7). In these examples, in which patients are given ample opportunity to express their *concerns*, *narratives* and *emotions*, the *biopsychosocial* anamnesis also proves to be almost *complete*, insofar as this can be expected in an initial consultation. Because patients were given sufficient *privileges* to speak, they were able to provide much of the information relevant to a *biopsychosocial* anamnesis themselves, without the doctor having to laboriously ask them for it. Patients were also proactively involved in the decision-making process, as can be demonstrated for both initial and follow-up consultations.

In *contrast*, there are prototypical consultations based on the traditional, *paternalistic* model, in which the *interrogation* is dominated by detailed questions and decisions on further diagnostics (physical examinations, laboratory tests, ECG, etc.) or therapy (diet, medication, etc.) are communicated to the patient as *announcements* or *instructions*. In *extreme* cases of paternalistic medicine, after a minimal greeting (function 1) and a question about the reason for the consultation (2), only two basic functions of the manual (Fig. 2.7: 4, 6) were performed in a rudimentary manner: The medical history was reduced to physical complaints, i.e. neither possible further (psychosocial) concerns (function 2), nor emotions (3), nor patients' own ideas about their illness or treatment (5) were addressed, nor were options for open questions allowed (6).[42] Instead, at the end of the conversation, conclusions were drawn and communicated with medical autonomy and authority, without formally expecting the patient's consent.

As already emphasised above (§ 2.4) in the methodological justification of *empirical conversation analysis*, these are not constructed conversations, but real conversations that challenge comparative evaluations not only in research, but also in teaching. However, it is not only the extreme typological cases that need to be taken into account, but also the broad spectrum of conversations, which – for more or less good

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[42] Because the corresponding sub-functions are realised in partnership-based conversations but not in paternalistic ones, they have been placed in brackets in the flow chart (4, 5). Dotted lines indicate functions that are marginally realised for this type of conversation.

reasons – are characterised by a high degree of *individuality* and *variability* in conversations, in which the doctor's communication competence must prove itself.

2.5.3   Flexibility in medical communication

In line with this individuality and variability, *comparative learning* based on positive and negative conversation models must be differentiated in more advanced learning phases, in which communicative competence must be developed in order to be able to react *flexibly* to *changing conversation situations*. The subsumption of conversations under *ideal types* does not mean that these (groups of) empirical conversations can be assumed to be congruent. Rather, in teaching, attention should be drawn in good time to the *individual conversation dynamics* in participatory observation, according to which certain mixtures and focal points arise that can no longer be captured in the *linear* sequence of a manual. A manual, which is necessarily arranged from top to bottom and from left to right, cannot do justice to the *complexity* of conversations. Although the placement of the opening and closing functions (1, 6) is fixed, the middle conversation functions (2-4) can also be realised in other sequences, in specific mixtures and with varying degrees of thematic depth. In this respect, there are already significant differences between initial conversations and follow-up conversations, which are based on different *situational definitions*.

Changing situation definitions

Participants in the conversation may be involved in these situational definitions with varying degrees of *power* and *control*, which they can exercise in different ways. While in the *paternalistic* model, power and control lie primarily with the doctor, in the *partnership* model they are shared to a certain extent. Because the patient is given the floor, especially at the beginning, and is allowed (sic) to determine the topics, this appears to be a *paradox*, as described in the special case of psychoanalytic therapy (Box 2.21), in which the speaking and interaction roles seem to be distributed asymmetrically in favour of the patient.

Box 2.21	Paradoxical conversation situation

(...) the analyst has the power to determine how the discourse shall proceed and exercises this power by allowing it to proceed at the patient's whim. Moreover, although the analysist thus controls the discourse, he does not directly control choice of topic. He governs the inception and termination of the discourse, but not the subject-matter. Thus we are dealing with a conversational situation replete with paradox.

Robin Lakoff 1980: 11

Even though psychoanalytic conversation is a special case of doctor-patient communication in which the association rule is only to be applied moderately (§ 2.3.9), certain privileges of speech and topic are granted not only by the therapist but also by the doctor, which their patients should be able to use freely. Admittedly, this option of granting privileges is apparently within the power of the doctor, who, according to Freud (1913: 194), 'lets the patient talk' (sic), but who in turn, ideally, makes use of the privileges granted in such a way that this is in the interests of the therapeutic goals of both conversation partners, without jeopardising the dialogical symmetry or the dialogical principle of genuine conversations as a whole. [43]

Rather, the doctor who listens competently receives information from the patient who is telling their story that the doctor who merely asks questions may miss, as Balint summed up simply: 'When you ask questions, you only get answers to them – but nothing more' (1964/1988: 186). However, if certain questions remain unanswered despite the narrative privileges granted, the doctor will have to ask the necessary questions about topics that the patient has not addressed – for whatever reason (different assessment of relevance, repression, denial, etc.). In these cases, the definition of the situation will also change, which both conversation partners will mutually acknowledge, often through explicit meta-communication.

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[43] The problems of power and control in (a)symmetrical doctor-patient communication, which we have already discussed (§ 2.2.3, 2.3.7), is revisited from various perspectives in many theoretical and empirical chapters: § 2.6.2, 3.1, 7.5, 17.3, 22.7.

While at the beginning of the conversation, the definition of the situation is often linked to an invitation to talk ('tell me about …'), which can be repeated during the conversation, it is explicitly marked when there is a change ('I have a few more questions …'). If the partners are unsure about the validity of the situation definition, patients in particular begin with reassurances ('are you interested in that?') in order to obtain a licence to tell their story with a doctor's affirmation. If open situations between unknown conversation partners can be assumed in initial conversations, these can become increasingly narrow for follow-up conversations, without, however, allowing oneself to close off to new situation definitions. In both cases, the challenges to the flexibility of medical communication remain and need to be further differentiated.

Hexagram of medical communication

While the manual can only assume ideal-typical conversation patterns, in reality there are many good reasons why many variations can develop, which must be differentiated according to subtypes (§ 17). These good reasons have to do with the individuality of patients, their personalities, their specific illnesses, their subjective concerns and attitudes (intentions, hopes, fears, etc.), to which doctors must adapt *flexibly* with their *communication competence.*[44]

As soon as patients are granted spontaneous *speaking* and *topic privileges* in *narrative* medicine (§ 3, 9, 19), from a medical professional perspective, 'unstructured' conversations are often to be expected, for example because patients follow their *own narrative logic* when recounting their individual medical history, which may conflict with the order of conversation preferred by doctors. For example, patients may begin by discussing the threat of job loss or divorce and the emotions associated with these issues before commenting on the onset of their illness, its duration or previous treatment. Other patients immediately express their expectations to the doctor at the beginning of the conversation by requesting a specific examination ('full check-up', "gastroscopy") or a specific therapy ('antibiotics', 'painkillers') or even demanding them, without first engaging in a communicative 'negotiation of the procedure' (function 5) with the doctor, etc.

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[44] This is where specific *fitting competence* of the doctor is required, with doctors having to mediate between *medicine* (as a system) and the patients' lifeworld (cf. § 2.3.7-9).

If doctors here are willing to respond *flexibly* to spontaneous patient initiatives, this often results in a certain 'deviant' (*non-linear*) conversation structure, in which the middle conversation steps or functions (2-5) are realised in *circular*, possibly repetitive and redundant conversation sequences with specific *conversation dynamics* (§ 17-23). The potential and then manifest conversation dynamics can be taken into account using the *hexagram* representation of medical conversation (Fig. 2.8), which eliminates the *linearity* of a manual and allows *circular*, criss-crossing or retrograde connections to be taken into account.
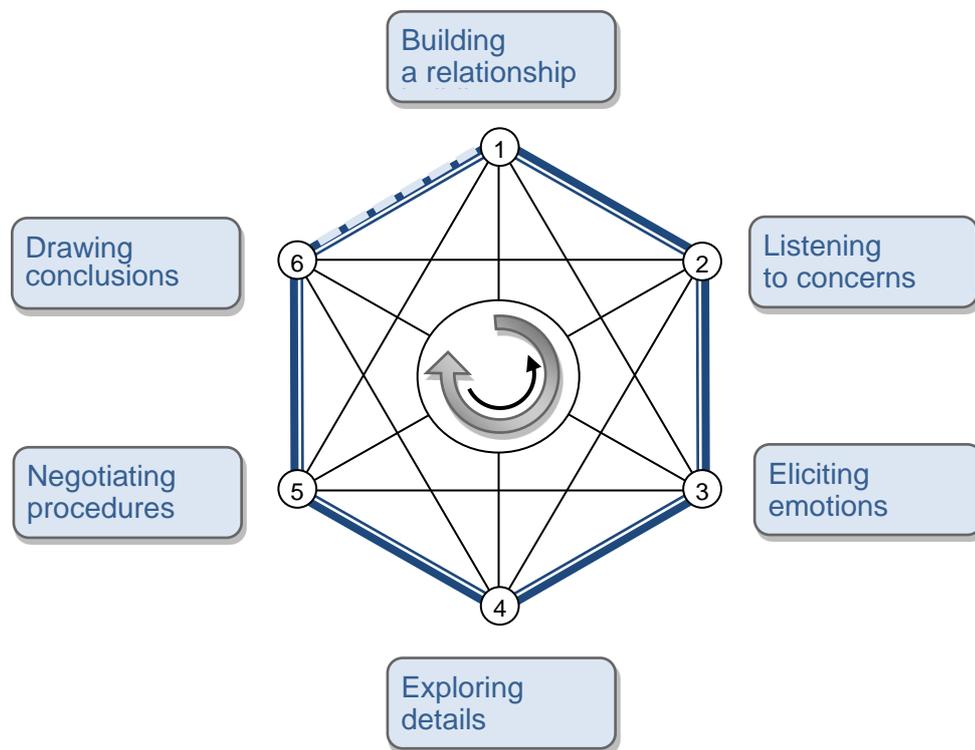
Fig. 2.8: Hexagram of medical communication
(modified on Koerfer, Albus 2018: 765)

This hexagram representation captures the main structures in the development of a conversation, which are rarely or never realised in the assumed ideal-typical sequence (outer ring 1-6). The dotted line/edge marks the transition from step/function (6) of one conversation to step/function (1) of a subsequent conversation. If this representation initially assumes a 'uniformity' in the weighting of steps/functions, this is also an ideal-typical assumption that may not apply in the initial conversation, because the thematic development of the conversation and the formation of focal points may initially be subject to a strongly

patient-centred, emotional conversation dynamic with dramatically narrated stories of illness, suffering and life (3) before further clarification of specific concerns (2) and details (duration and course of the illness, previous treatments, etc.) (4) become possible, etc. (§ 17-23).

When using a *manual* in teaching, it is necessary to clarify that these are not steps (in the narrow sense) that must be followed strictly in sequence (2-3-4-5), but rather *functions* that can be performed either continuously, in mixed form or overlapping during the *conversation process*. For example, *active listening* (manual: sub-function 2.3) is not to be practised in one step, but continuously throughout all phases of the conversation. Similarly, *emotions* can have a function not only in patient narratives, but also in decision-making (function 5), when patients (nonverbal) show or explicitly express *worries* or *fears* about diagnostic or therapeutic measures, to which the doctor must respond with *empathy*.

It is even more important to expect 'imbalances' in *follow-up conversations*, because certain conversation steps/functions may already be sufficiently 'saturated' in preliminary conversations: Since both conversation partners have a *shared history of interaction*, they can already refer to a shared pool of knowledge and decisions that they may have already secured several times in previous summaries (function 6), so that they can concentrate on a specific topic (function 5: procedure) here and now.

However, taking a patient's medical history should never be considered a finished task; rather, it must remain open to new developments in the patient's current life (new symptoms, career changes, etc.). Although the *completeness of an anamnesis* according to Lipkin et al. (1995) is a *myth*, they recommend certain lists of questions and important topics that can serve as reminders and guidance for recording any outstanding points in specific subject areas (e.g. review of systems, past medical history, social, psychological, sexual history) (cf. function 4 of the manual). The aim here is to fill in the gaps that the patient has left – for whatever reason.

In view of the risks associated with *routine* medical acting, which may have lost some of their *sensitivity*, systematic or at least regular communicative 'control procedures' should be incorporated into follow-up discussions in order to counteract ingrained routine patterns of communication (D: 'Everything else the same?' – P: 'Everything's fine!') with dialogue-based *reassurances* (D: 'Is everything really fine? Nothing new?' – P: 'Well, if you ask me, then …'). What can only be poorly illus-

trated here by constructed examples is explained in detail in the practical part of the handbook (§ 17-23) using empirical anchor examples.

With these *dialogical reassurances* of understanding in mind, *new topics* should be opened up again and again: for example, in order to allow the necessary space for discussion in *new rounds of anamnesis* on topics such as current stress at work or increased sleep and concentration disorders, etc., it may be necessary to explore these topics in greater depth in all intermediate steps/functions (2-5), which, when new decisions are made (§ 10, 22), may even lead to further diagnostic steps or significantly modified or even completely new therapy plans.

Structured and flexible communication

While the *alternative* decision paths were previously differentiated in an *ideal-typical process model*, in which a choice must be made between *paternalistic* and *partnership-based* communication (§ 2.5.2), a *hexagram* of medical communication was used to illustrate the potential process structures that can be *flexibly* implemented in individual consultations. At the same time, the *limits* of the *manualisation* of medical communication became clear. Like all manuals, our Cologne Manual can at best be a *structuring aid* that can give learners initial orientation. In practice, the *balancing act* between *structuring* and *flexibility* remains, which Silverman described as a paradox (Box 2.22).

Box 2.22	Paradoxically, structure sets us free

Without some form of structural model, it is all too easy for consultations to be unsystematic or unproductive and for experimental communication teaching to appear random and opportunistic. Paradoxically, structure sets us free – it provides us with an awareness of the distinct phases of the interview as we consult and the flexibility to move away from a fixed path when appropriate, with the security of understanding how to return to our structure in due course.

Silverman 2018: 8

This *balancing act* between structure and flexibility can only be taught using *practical* cases in which doctors make more or less competent decisions that need to be evaluated through critical reflection. Here, too, a distinction must be made between *strong* and *weak* conversation developments, because, for example, a doctor may have started the conversa-

tion well by opening up sufficient space for the patient to tell their story, but then 'took a wrong turn' because they interrupted the patient's narrative flow too early with their detailed questions (about the course, duration and previous treatment of the illness). In contrast, there are *ideal-typical* cases in which the *narrative* medicine approach was consistently pursued from start to finish in initial consultations, but also in follow-up consultations without restrictions.

Manual and didactic anchor examples

In summary, it should be noted for teaching purposes that although manuals help to structure the practice of medical communication, the limits of *manualisation* in conversational practice should not be underestimated. The usefulness of a manual can only be proven through repeated application to other practitioners' and one's own practice, for which the handbook provides ongoing suggestions.[45]

The perspective of dynamic conversation practice, in which doctors must respond *spontaneously, flexibly* and *tailor-made* to changing situations, is concretised in empirical conversation cases. This is a main concern in the practical part (IV) of the handbook, in which the empirical conversation analyses can also be used for *didactic* purposes. Where possible, we have didactically prepared the presentations of the empirical analyses in the specific chapters (§ 17-23), which are structured according to the Cologne manual, as anchor examples so that they can be used directly in *teaching.*

Although the didactic presentation was initially designed for a multimedia project, much of the information and presentations (conversation examples, transcripts, comments, tables, graphics, quotations, etc.) can also be used in paper form. This applies to both *qualitative* and *quantitative* conversation analyses, in which, for example, the total amount of speech by the doctor and patient (in words) is indicated, or *narrative* analyses are represented by the length of speech contributions in bar diagrams (Practical Part IV). A specific chapter on *communication training* (§ 13) provides suggestions and instructions that are suitable for both *group learning* and *self-study.*

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[45] We will return to the use of our Cologne manual later with Luborsky (1984/1988: chapter 3), who has already described the necessary repetition in practice using the example of his psychotherapeutic manual, cf. § 17.

2.6 Problems and perspectives of evaluation

Research and *teaching* on doctor-patient communication should not be considered separately, but as a *unit* (Makoul 2003, Koerfer et al. 2008). A common evaluation perspective of doctor-patient conversations should be assumed. The fact that patient narratives should be encouraged and suggestive questions of a certain type should be avoided is, on the one hand, the recognised result of interdisciplinary conversation research and, on the other hand, an established component of conversation theory. Even the "classics" (Balint, Engel, Uexküll) formulated certain maxims of conversation (§ 3, 7, 9, 17), which refer to an "ideal" medical conversation.

Our *Cologne* Manual on Medical Communication (C-MMC) (§ 17-23) aims in the same direction, with the goal of improving 'prevailing' conversation practices. At the same time, the formulation of *conversational maxims* implies (*ex negativo*) their possible 'violation', which is *evaluated* as a 'deviation' from the 'ideal' conversational practice.[46] In this respect, *evaluation* is an inherent component of a *conversation manual*, which should *ideally* be in line with the findings of *social science* and *clinical conversation research* on doctor-patient communication.

2.6.1 The basic evaluative vocabulary

However, methodological differences between a (purely) *descriptive* and *evaluative* analysis perspective are occasionally emphasised in conversation research. In contrast to *discourse analysis* (DA), variants of (American) *conversation analysis* (CA) in particular tend to claim a "theory asceticism" (Levinson 2000). Although in the following empirical conversation analyses we seek to benefit from both *discourse* and *conversation* analytical work on doctor-patient communication under the general label of *conversation analysis*, we cannot go into the methodological controversy surrounding the evaluation problem any further. As an example, we merely refer here to controversial positions such as those represented by ten Have (1990) and Koerfer et al. (1994).

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46 Such "deviations" from the "norm" can certainly be graduated, as we will see in the application of our *Cologne Evaluation of Medical Communication* (C-EMC) (see appendix C-M+EMC) (§ 13, 17-23, 40-41) (which was developed analogously to our *Manual of Medical Communication*).

Nevertheless, attention should be drawn here to the thoroughly *evaluative* basic vocabulary (such as "suitable" - "appropriate"), which is used as a matter of course in many variants of empirical conversation analysis. This *evaluative vocabulary* comes into play above all with its "negative" connotations, whereby the "critically" intended uses can "speak volumes" in terms of evaluation (as with "inappropriate", "inadequate", "interruption", "truncation" or more strongly: "cutting off the word", "stalling", "shooting off" etc.); not to mention expressions such as "inquisition", "cross-examination" or "coercion" and "manipulation" (through "leading or suggestive (information) questions").

These *evaluative* expressions represent an exemplary selection that are often used in this or similar ways in (German- or English-language) communication theories and empirical conversation analyses, which we will recur to with references where appropriate.

The perspective of analysis can become more complicated if we are not only talking about 'power', which is presented as (de facto) exercised, but also the possibility of an "attempt at domination" (Gadamer 1993: 172), which the doctor could pursue more or less intentionally. While Gadamer denies the danger of an "attempt at domination" by the doctor in the *maieutic* type of conversation ('midwifery') in principle, the traditional Socratic "style of dialogue" is generally *assessed* as "manipulation" by Thomä and Kächele (1989, vol. 2: 285ff, English Edition 2012), which is why they ar gue for a specifically "psychoanalytic maieutics" in contrast to this tradition.

This controversy about the medical *art of midwifery*, to which we will return in the *biographical-narrative* anamnesis survey (§ 9), exemplifies the importance of the basic evaluative vocabulary, the use of which is sometimes (rightly) placed on the 'gold scale' in theoretical and empirical research, although Thomä and Kächele adjust it quite finely. Whether (more or less) "manipulation" takes place according to the model of *traditional maieutics* or that of *psychoanalytic maieutics* is ultimately a question that can only be answered after empirical analyses of real conversations in the respective consultation hours of doctors and therapists in critical comparison, to which we want to contribute in this handbook.

However, a systematic meta-analysis of the basic evaluative vocabulary of empirical conversation analysis (of various kinds) is probably still pending. Possible approaches to this have been outlined elsewhere (Koerfer et al. 1994/2013), which will be briefly outlined here and linked to a series of *theories guiding knowledge*, which will initially only

be presented here and later described in more detail (§ 4, 7, 9, 10). The aim is to demonstrate that the basic evaluative vocabulary can be derived from general *theories and models* of (medical and therapeutic) communication, even if the references often remain implicit in the empirical conversation analyses.

2.6.2   Knowledge-guiding theories

In a systematic meta-analysis of the basic vocabulary, the explicitly or implicitly underlying *evaluative premises* of the conversation analysis would emerge more or less clearly (Koerfer et al. 1994). The practical questions pursued in the empirical analysis are not formulated "without sense and reason", but are usually derived from a more or less explicit (pre-)theoretical (everyday) knowledge about "good" communication, which is often already handed down in canonised form in research anyway. As a rule, certain qualitative and quantitative aspects of analysis are linked to "um-to-motifs" in which the evaluative premises of "good" medical communication are expressed more or less clearly, as in the following exemplary variants:

- Count *words* (per speaker) to determine "(a)symmetrical" *parts of speech* of the interlocutors,
- Define, identify and quantify *interruptions* and their "early" placements in the conversation (by seconds) to determine the extent to which the patient's own words *encourage* or *discourage* proactive formulations of concerns,
- Examine *technical terms* in a comparison of everyday and technical communication in order to check their *(in)comprehensibility* for patients,
- Define, identify and quantify *open* versus *closed* or even *suggestive* questions in order to reveal "asymmetrical" *power relations* or even "manipulations".

Those who pursue such questions more or less explicitly follow a *normative* model of 'ideal' communication, which is also asserted for the conversation between doctor and patient (§ 40). Even if the *evaluative premises* of conversation analyses often remain hidden, they can still be reconstructed in the form of *maxims* of conversation. The observance or violation of conversational maxims (such as "Avoid interruptions, suggestive questions" etc. or "Ask open questions", "Formulate comprehen-

sibly" etc.) makes a difference by which the doctor's conduct of the conversation can be *measured.*

For their part, the maxims of conversation must be derived from general principles and models of verbal and non-verbal communication, which must also be specified as prerequisites for understanding and communication between doctor and patient. At this point, a selection of more or less normative theories and models of communication will be listed in advance, which have already been mentioned above (§ 2.3) and will be discussed in detail later (§ 4, 7, 9, 10):

- Semiotic model of biopsychosocial medicine
- Organon model
- Theory of (indirect) speech acts
- Model of cooperation and discussion maxims
- Theory of communicative action
- Axioms of human communication
- Communication square and four-ear model
- Philosophy of conversation and dialogical principle
- Maieutic communication model ("midwifery")
- Conflict theory of understanding ("lifeworld" vs. "medicine")
- Symmetrical participation model (*SDM*)

Such a compilation of relevant theories and models of communication, which can also be seen as "epistemologically guiding" for the empirical analysis of doctor-patient conversations (§ 4, 7, 9, 10), may initially appear relatively heterogeneous.[47] The accusation *of eclectic* borrowing can be made here, but this must be tolerated in view of the current state of research (Koerfer 1994/2013). As long as a uniform theory for doctor-patient communication in particular is still lacking, possible criticism can only be dealt with in such a way that the previous attempts and approaches should be understood as invitations to further research contributions with which an approximation to the "gold standard" of *good* doctor-patient communication can be achieved.

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[47] The common aspect of evaluation sometimes only becomes apparent at second glance, for example in the theory of *indirect* speech acts, which is accompanied by a more or less explicit theory of "politeness" (§ 7). This politeness is again relevant when, for example, patients do not *directly* demand their treatment wishes, but rather *indirectly* put them forward as a possibility ("perhaps one could ...", "I wonder if ...").

2.6.3 Gold standards of conversation

Nevertheless, a positive interim assessment can be made if one does not demand the one gold standard (sg.) that covers all facets of medical communication in all areas of competence in clinics and practices, but is content for the time being with certain standards (pl.) in specific areas of activity. A number of standards have now become widely accepted, both at the level of *theories and models* and at the level of *conversational maxims*, which can be tested at the level of *observable* conversational behaviour. Before we pursue both levels of evaluation further (§ 3, 7, 9, 10, 17, 18-23, 40), the essential connections should first be shown by way of example.

Paternalism* versus *participation

The connection between the two levels of evaluation can easily be demonstrated hypothetically by *negating* established *maxims of conversation,* which would go hand in hand with a relapse into traditional *relationship and communication models*: Why should a doctor allow the patient to "have their say" on certain topics at all and then still "talk it out" and not immediately "interrupt" if, from their professional perspective, they already notice at the beginning of a patient's speech that the patient is "on the wrong track" with the presentation of their *subjective theory of illness* or even harbours doubts about the doctor's preferred treatment option and builds up resistance accordingly? According to a *paternalistic* relationship and communication model, a "symmetrical" *participation* of the patient in therapy planning would be "superfluous" to "disruptive" anyway, as the patient should merely "comply" with the (*power* and *coercion* of) *strategically* enforced medical *order* or *prescription,* if possible "without objections", which was captured by the older concept of *compliance.*

  If the "docility" of the patient were guaranteed in this sense, a change from a *paternalistic* to a *participatory* relationship and communication model would seem obsolete. However, as research on patient *(non-) adherence* has shown, a stronger, more *egalitarian* ('symmetrical') *participation of* the patient in medical *decision-making,* which should be based on information, insight, motivation and consent in *dialogical* exchange with the patient, is necessary for 'pragmatic' reasons alone in order to achieve long-term *adherence* (§ 10, 26). The new *standard* of *participa-*

tory decision-making (English: SDM; German PEF) can "pay off" twice over: *Sustainable treatment adherence* can both *conserve* objective *resources* (time, costs) and help *alleviate* the subjective *suffering* of patients in particular.

Interrogation versus *narration*

New standards have also been established for *taking medical histories*, which, although they logically precede the decision-making process (§ 8), are known to be never complete and must be constantly renewed because, for example, patients' circumstances or treatment preferences may have changed etc. (§ 10). What is the case in each individual situation can hardly be ascertained by *asking* specific *questions*, but rather requires a kind of *invitation* to the patient to talk, which he or she can understand as an *invitation to tell his or her story*, to express his or her *concerns* (problems and worries, fears and anxieties, hopes and doubts, etc.) in his or her *own words*.

The patient's flow of words and thoughts does not necessarily have to be *structured*, as it may seem appropriate from the doctor's point of view, but may *be associative*, just as it "comes to the patient's mind". This principle of *association* is constitutive for a *biographical-narrative history-taking* (§ 9, 17, 19), which, with the paradigm shift from a *biomedical* to a *biopsychosocial* approach to care (§ 4), has established itself as an "appropriate" standard of conversation compared to the traditional, *interrogative* history-taking.

Although the medical consultation or ward round should not be confused with *psychoanalytic* therapy in terms of *free association* (Koerfer, Neumann 1982, Flader 1990, Heenen-Wolff 2014, Kächele 2016), minimal approaches to an *associative* flow of speech and thoughts by patients should not be nipped in the bud by their GPs or ward doctors. Here too, according to Engel and Morgan (1977: 41), the doctor must not "conduct the case history in the manner of a cross-examination". Rather, he must find an appropriate relationship ("right balance") between the "two goals" of "encouraging the patient's spontaneous associations and guiding the history" (ibid.). This is one of the essential *conflicts of maxims* (§ 3, 17) that the physician has to balance. The fact that conflicts between maxims of conversation are often resolved in favour of "the kind of cross-examination" (in the sense of Morgan, Engel 1977) is manifested again and again in the practice of conversation. Doctors often enforce "their" style of conversation through forms of *strategic* action

(in the sense of Habermas 1981) (§ 7). However, individual *interruptions* or *suggestive questions* are rarely "decisive" for the entire course of the conversation - which of course they can be in individual cases (§ 19, 21).

In order to arrive at evaluative *tendency statements*, we must assume a *predominant use of language* in the sense of Habermas (1981), who certainly recommends his *theory of communicative action* for use in empirical communication analyses (§ 7), if we are to provide empirical evidence of differences between *strategic* and *communicative* action for entire conversations.[48] Accordingly, the analysis of conversations must be changed from *local* to *global* conversational developments, so that beyond *sequences* of conversations, longer *phases* of conversations for various *purposes* (anamnesis, diagnosis communication, decision-making, etc.) (§ 8, 17, 19-23) and finally entire *conversations* are examined and evaluated in critical comparison with other (types of) conversations (§ 40-43). In these concluding chapters on evaluation, some of the results from the *comparative* research and teaching approaches will be summarised in order to put further paths to the *gold standards* of *good* conversation into perspective.

2.7 Further information

The turning points in medicine outlined above are discussed in more detail in § 4-10, which lay the theoretical foundations and also provide further reading on relationship and communication models. Further reading on didactics, communication training and communication curricula can be found in § 3, 13-16. Manual-based conversation analyses with further reading can be found in the practical chapters (§ 17-23). Specific literature on fields of action and competence in medicine is provided in Part V (§ 24-39) of the handbook, and literature on evaluation is supplemented in Part VI (§ 40-43).

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[48] For the distinction between *communicative* and *strategic* action and the relative weighting in empirical conversation analyses, see Habermas 1981: Vol. 1: 440ff, Vol. 2: 458ff, 470ff, 512ff (English Edition: 1985: Vol. 1: Chap. III (6) and Vol. 2: Chap. VIII.). On Habermas' Theory of Communicative Action, cf. § 7 in this handbook.

Specific overviews of the state of research and methods of interdisciplinary conversation research can be found in the literature cited in § 2.2.4 (Focus 1-15); examples of which are listed here: Pendleton, Hasler 1983, Lehmann et al. 2009, Berkhof et al. 2011, Barth, Lannen et al. 2011, Henry et al. 2012, Christianson et al. 2012, Dwamena et al. 2012, Beach 2013, Moore et al. 2013, Robinson, Heritage 2014, Zill et al. 2014, Scholl et al. 2014, Hauser et al. 2015, Cömert et al. 2016, Bates et al. 2016, Cushing 2016, Kidd 2016, Cooper, Frain 2018, Chandra et al. 2018, Barnes 2019, Feldthusen et al. 2022, Saxler et al. 2022, Grover et al. 2022, Kondo 2022, Hathaway et al. 2022, Alsabri et al. 2022, Bachmann et al. 2022, Venktaramana et al. 2022, Stivers, Tate 2023, Sharkiya 2023, Zhang et al. 2023, Alkhamees, Alasqah 2023, Lehane et al 2023, Kim et al. 2024, Bruch et al. 2024, Jami et al. 2024, Gil Deza 2024, Barnes, Woods 2024, Ekberg et al. 2024, Parry 2024, Jenkins et al. 2024, Fava et al. 2024, Wang, Zhang 2024, Van Bostraeten et al. 2025, Pham et al. 2025, Aboushawareb et al. 2025, Fox et al. (eds.) 2025. A systematic review of observational coding systems is provided by Hillen et al. 2025.

From the extensive research of more than 4 decades, the reader by Beach (ed.) (2013) should be emphasised again, in which 52 widely scattered publications on English-language research (from 1957-2007) are compactly collected on 800 pages – a treasure trove for those particularly interested in research history.

The importance and transcription of *non-verbal* communication is dealt with in the relevant topic chapter "Non-verbal interaction" (§ 12) by Lausberg with further literature, which is supplemented in the chapter "Building relationships" (§ 18).

References can be found at the end of the chapter after the appendix.

2.8   Appendix

2.8.1   Cologne Manual & Evaluation of Medical Communication (C-M+EMC)

2.8.2   Cologne Evaluation of Medical Communication – Diabetes and Depression (C-EMC-DD)

2.8.3   Cologne Manual of Interprofessional Communication (C-MIC)

2.8.4   Conversation maxims (according to Morgan & Engel)

2.8.5   Transcription rules: Verbal and non-verbal transcriptions

See next pages

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

1 Framing
  - Enable confidentiality
  - Avoid disturbances
2 Greeting — ⓪❶
  - Make eye contact
  - Verbal greetings, shaking hands
  - Address by name
3 Introducing yourself — ⓪❶
  - Introduce yourself by name
  - Communicate function ("ward doctor")
4 Situating — ⓪❶
  - Speak sitting down (chair to bed)
  - Ensure convenience
  - Coordinate proximity/distance
5 Orientation — ⓪❶
  - Structure conversation
  - Goals, time frame

4 Exploring details — ☐☐ 12

1 Inquire about complaint dimensions — ⓪❶❷❸❹
  - Localisation and radiation
  - Quality, intensity *(scale 0-10)*
  - Dysfunction/disability
  - Accompanying symptoms
  - Time (beginning, course, duration)
  - Condition "In what situation ...?"
2 Exploring subjective ideas — ⓪❶❷❸❹
  - Concepts *"What do you imagine?"*
  - Explanations *"Do you see causes?"*
3 Complete anamnesis — ⓪❶❷❸❹
  - 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)

2 Listening to concerns — ☐☐ 10

1 Start the conversation openly — ⓪❶
  - Offer "What can I do for you?"
  - Occasion *"What brings you to me?"*
2 Encouraging storytelling - feedback — ⓪❶❷❸❹
  - Listener signals *hm, yes,* nod, etc.
  - Avoid interruptions
  - Allow pauses, free choice of topics
3 Active listening - verbal support — ⓪❶❷❸❹
  - Encourage speaking up
  - Repeating statements verbatim
  - Paraphrase statements
  - Openly ask further: *"How did that come about?"*
4 Ensure understanding — ⓪❶
  - Ask "Do I understand correctly ...?"
  - Summarise

5 Negotiating procedures — ☐☐ 12

1 Plan an evidence-based approach
  - What is secured?
  - Do diagnostics have consequences?
2 Clarify expectations — ⓪❶❷❸❹
  - Ideas, wishes, hopes *"What did you have in mind?"*
  - Control beliefs *"What could you change yourself?"*
3 Explaining previous findings — ⓪❶❷❸❹
  - Communicate diagnosis
  - Communicate problems — ⓪❶❷❸❹
4 Examination or therapy plan
  - Explore decision model (SDM)
  - Discuss proposals and risks
  - Consider reactions
  - Strive for consensus

3 Eliciting emotions — ☐ 8

1 Pay attention to emotions
  - Verbal (e.g. metaphors)
  - Non-verbal (e.g. gestures, facial expressions, gaze behaviour, etc.)
2 Empathise with patient's situation
3 Respond empathically — ⓪❶❷❸❹
  - Offer appropriate help and comfort
  - Acknowledge burdens, coping
4 Promote emotional openness — ⓪❶❷❸❹
  - Addressing *"I perceive that ...?"*
  - Naming *"You are sad then?"*
  - Clarify *"What do you feel then?"*
  - Interpret *"Your fear may come from..."*

6 Drawing conclusions — ☐ 4

1 Summarise the conversation — ⓪❶
  - Reason for consultation, complaints,
  - Diagnosis, therapy agreement
2 Offer clarification of outstanding issues — ⓪❶
  - Information *"Do you still have questions?"*
  - Satisfaction "Can you handle it? "
3 Arrange follow-up appointments — ⓪❶
  - Examination appointments
  - Set a meeting date
4 Say goodbye to the patient — ⓪❶
5 Complete documentation
  - Coding & conversation impressions
  - Topics for follow-up talks

⓪❶ [⓪ = not met; ❶ = met] ⓪❶❷❸❹ [⓪ = not met ...❹ = fully met]

Fig. 2.9: Cologne Manual & Evaluation of Medical Communication (C-M+EMC)

Armin Koerfer, Pauline Albus, Katharina Koerfer, Christian Albus

Cologne Evaluation of Medical Communication - DD	C-EMC-DD
OSCE checklist for physician discussion of co-morbidity: diabetes, depression	[1]2009
© Department of Psychosomatics and Psychotherapy, University of Cologne	[2]2018

No.	Course	Interviewer	Date	Patient (SP)	Rater	Sum:
						☐☐ 73

1 General anamnesis	☐☐ 18	4 Additional symptoms depression	☐ 7

1 Establish a relationship   ⓪❶
- Greeting and introduction
- Situating and orienting (time, goals)

2 Listen to concerns   ⓪❶❷❸❹
- Encourage storytelling
- Actively listen and support

3 Allow emotions   ⓪❶❷❸❹
- Respond empathically
- Promote emotional openness

4 Explore details   ⓪❶❷❸❹
- Exploring dimensions of complaints
- Complete general medical history

5 Coordinate procedure   ⓪❶❷❸❹
- Clarifying information and expectations
- Negotiate therapy plan (SDM)

6 Draw a conclusion   ⓪❶

1 Concentration   ⓪❶
"How about your ability to concentrate (at work, reading the newspaper)?"

2 Self confidence   ⓪❶
"How would you rate your self-esteem (self-confidence)?"

3 Guilt   ⓪❶
"Do you often blame yourself?"

4 Future prospects   ⓪❶
"How do you see your future - more optimistic or more pessimistic?"

5 Sleep "How (good) is your sleep?"   ⓪❶

6 Appetite "How is your eating behavior and appetite?"   ⓪❶

7 Suicidality "Do you sometimes think that you'd rather be dead?"   ⓪❶

2 History of diabetes	☐☐ 20	5 Anamnesis Depression (cont.)	☐☐ 12

1 Symptoms   ⓪❶❷❸❹
- Thirst, nausea, etc.
- Hypoglycemia, nocturia, etc.

2 Start and course   ⓪❶❷❸❹
- Diagnosis made when, by whom?
- Phases (condition, findings)

3 Preliminary examinations   ⓪❶❷❸❹
- Referrals (specialist)
- Briefings (current occasion)

4 Pretreatments   ⓪❶❷❸❹
- Therapy plans (nutrition, insulin, etc.)
- Therapy success (adherence, coping)

5 Complete medical history   ⓪❶❷❸❹
- Risk factors (CHD, cholesterol)
- Concurrent / secondary diseases (CHD, retinopathy, nephropathy, etc.)

1 Onset and course   ⓪❶❷❸❹
- Beginning "When did this start?"
- Phases/episodes
  "What were the worst times?"
  "Were there times of improvement?"

2 Subjective ideas   ⓪❶❷❸❹
- Concepts
  "What do you imagine depression, etc. to be?"
- Explanations
  "Do you see causes yourself?"

3 Findings and pretreatments   ⓪❶❷❸❹
- Diagnoses with comorbidity
  "What have you been in treatment for (depression, anxiety, etc.)?"
- Therapies (medication, psychotherapy)

3 Anamnesis depression	☐ 4	6 Coordinate procedure	☐☐ 12

1 Introduction open   ⓪❶
"How are you doing mentally?"

2 Suspected diagnosis: 2-question test
- Main symptom 1   ⓪❶
  "Have you felt mostly down, sad, or depressed in the last 14 days?"
- Main symptom 2   ⓪❶
  "In the past 14 days, have you mostly lost interest in things that usually bring you joy?"

3 Follow-up question after affirmation
- Main symptom 3   ⓪❶
  "Did you feel mostly tired and exhausted during this time?"

1 Clarify expectations   ⓪❶❷❸❹
- Ideas, wishes, fears
  "What do you think might help?"
- Control beliefs
  "What can you change about your lifestyle (diet, exercise, etc.)?"

2 Communicate information   ⓪❶❷❸❹
- Info Need "Do you have any questions?"
- Diabetes sequelae/prevention
- Comorbidity: "During depressive episodes, you seem to be extremely neglectful of your self-care."

3 Negotiate therapy plan (SDM)   ⓪❶❷❸❹
- Adherence or change of therapy
- Psychotherapy or consult
- Topics/targets for follow-up appointments (rounds)

⓪❶   [⓪ = not met; ❶ = met]   ⓪❶❷❸❹ [⓪ = not met ...❹ = fully met]

Fig. 2.10: Cologne Evaluation of Medical Communication – DD (C-EMC-DD)

Cologne Manual of Interprofessional Communication	C-MIC
OSCE checklist for team communication	TEAM
© Department for Psychosomatics and Psychotherapy at the University of Cologne	2021

No	Course	Team member(s)	Date	Patient (SP)	Rater	Total
						☐☐ 72

1 Communication − Basics ☐☐ 12

1 Informing and instructing — ⓪①②③④
- Discuss the current situation (*briefing*)
- Clarify the responsibilities, tasks, and readiness of team members

2 Conducting tailored conversations — ⓪①②③④
- Concise, clear, and goal-oriented
- Exchange information reciprocally
- Let team members finish speaking
- Listen actively *hm, yes, really? what*?
- Respond appropriately to questions and criticism (*speaking up*, doubts)

3 Ensuring understanding — ⓪①②③④
- Use people's names
- Ask questions ("Do I understand correctly ...?")
- Feedback type 1 (*call back*):
  A: The infusion is finished − B: Good
- Feedback Type 2 (*Closed loop*)
  A: Pulse? − B: 62 − A: Okay!
- Summarize interim/final results

4 Leadership − Management ☐☐ 12

1 Authority and leadership — ⓪①②③④
- Take responsibility as a leader
- Demonstrate and assert authority
- Resolve team conflicts objectively (i.e., not *"Who is right?"* but *rather: "What is right?"*)
- Strive for consensus where possible

2 Planning, delegation, and control — ⓪①②③④
- Develop and agree on plans by consensus wherever possible (5.3)
- Delegate functions and tasks
- Perform control (checklists)

3 Resource management — ⓪①②③④
- Timing according to plan (*just in time*)
- Adapt pace to all team members as far as possible (including *time out*)
- Check workload and correct if necessary (*workload, stress coping, burnout, etc.*)

2 Situation awareness ☐☐ 12

1 Patient: Monitoring − Responding — ⓪①②③④
- If responsive: see C-M+EMC [5]2010
- Condition or state
- Findings (data: images, values, etc.)

2 Team: Monitoring − Responding — ⓪①②③④
- Verbal TM* (cues, information, alarm)
- Visual TM (gaze, gestures, etc.)
- Paraverbal TM (questioning, hesitant, friendly, mocking, annoyed, etc.)

3 Process: Monitoring − Responding — ⓪①②③④
- Standard procedure (team routine)
- Anticipated complications
- Critical events (sudden bleeding, respiratory arrest, technical defects, etc.)

5 Decision-making ☐☐ 12

1 Timely problem identifying — ⓪①②③④
- Address critical event
- Name the problem

2 Communicating the problem to team — ⓪①②③④
- Assess relevance and risk
- Classify within the ongoing process
- Put consequences (emergency, etc.) into perspective (*think ahead*)

3 Developing decisions within the team — ⓪①②③④
- Explore information, views, criticism, and options of team members
- *Shared decision making* whenever possible
- If necessary, decide alone
- Create and execute plan A or B

3 Teamwork − Cooperation ☐☐ 12

1 Supporting team members — ⓪①②③④
- Encourage initiative (*support*)
- Strengthen individual and subject-specific skills (*coaching*)

2 Providing feedback — ⓪①②③④
- Reward commitment (*feedback*)
- Take concerns and feelings seriously

3 Cooperation and participation — ⓪①②③④
- Proactively involve team members
- Promote team building, working atmosphere, open communication
- Improve coordination of activities, intentions, and cognitions within the team (*shared mental model*)

6 Debriefing − Reflection** ☐☐ 12

1 Debriefing of the "incident" — ⓪①②③④
- Summarize the process
- Reflect on critical situations

2 Discussing new plans within the team — ⓪①②③④
- Explore opinions and suggestions of team members
- Develop alternative plans and keep them available (*think ahead*)

3 Reflecting on unresolved issues — ⓪①②③④
- Identify the need for clarification
- Set a date for further discussion of similar incidents
- Prepare a meeting with specifically qualified team members

⓪①②③④ [⓪ =not fulfilled ...④ =fully fulfilled] – *TM=team members – **optional with max. 12 points

Fig. 2.11: Cologne Manual & Evaluation of Team Communication

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 2.23:
from: Morgan, Engel (English 1969; German 1977: 31-75)
(selection and emphasis ours).

Sign	Transcription explanations
D	Doctor
P	patient
MA	Medical assistant
[indicates neck]	Comments (non-verbal etc.)
here [file]	Comments (cognitive, meaning: patient file)
Word . Word .	short pause (no punctuation!)
Word ... Word	middle pause
..... [5]	Pause of approx. 5 seconds
ähm	Filled break of the speaker (turn-internal)
hm	Listening signal (example 1)
oh	Listening signal (example 2)
aha	Listening signal (example 3)
yes?	Listening signal (example 4 with question intonation)
je:sterday	Emphasised yesterday
he/she has	Self-correction
P [	simultaneously to speaker D
D [	simultaneously to speaker P
[+]	Eye contact
[-]	Eye contact interrupted
[l-]	Start "louder" (relative to "normal")
[-l]	End "louder" (return to "normal")
[q-]	Start "quieter" (relative to "normal")
[-q]	End "quieter" (return to "normal")
[f-]	Start "faster" (relative to "normal")
[-f]	End "faster" (return to "normal
[s-]	Start "slower" (relative to "normal")
[-s]	End "slower" (return to "normal")
(word)	presumed wording (unintelligible)
word-	Contribution/intonation not (yet) finalised/(still)
word=word	Fast connection
lemme	Literary transcription (e.g., for dialects) (= let me)
gotta	Literary transcription (= got to)
etc.	

Table 2.5: Transcript form

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