Content and Process in Medical Communication

Daniel CLINCI
Ovidius University of Constanţa

Abstract: *According to twentieth-century developments in the field of medical communication, there are two aspects which need to be taught: content and process. Usually, it is far more intuitive and even necessary to focus on the content of medical communication, leaving process aside. However, recent research shows that emphasizing process leads to improved medical care and professionalism in the physician-patient relationship, which is always dependent on non-technical factors such as academic culture, the particular view on medicine that a society has, and the difference between disease, the hard scientific data, and illness, the patient's individual and social experience of disease. This paper explores the various ways in which content and process can be combined in the Medical English class with a specific focus on the Calgary-Cambridge framework. New approaches have been developed in recent years, but they should be balanced by a straightforward teaching of the social, political, historical, and medical-technical structures at play in contemporary practice.*

Keywords: *medical interview, Calgary-Cambridge framework, medical communication, Medical Humanities*

Teaching Medical English necessarily involves working through a multitude of aspects, most of which are strictly technical, such as lexis, functional language, and specific contents, while at the same time attempting to somehow create relevant links to the context of a particular medical system. Medical communication and medical history taking could be intertwined within these larger socio-cultural and linguistic networks, but they pose very specific challenges when it comes to ensuring that the students gain the necessary communication skills for their future careers as medical professionals, especially when dealing the absence of any clinical experience that one may relate to in a meaningful way. It has been emphasized that medical communication consists of two very different sides (Kurtz et al, "Marrying Content and Process"): "the content," which we may regard as the more traditional focus of medical history taking, and "the process," which is the underlying structure of basic human interaction, in which a medical professional should demonstrate qualities such as empathy, being non-judgmental, and patient-centeredness. Obviously, when resorting to purely technical teaching, the latter aspect may be easily overlooked, and understandably so, because the depth of medical technicalities can be rather

overwhelming. However, it is my strong belief that the purpose of a Medical English class is to not only provide adequate knowledge of lexis and the linguistic skills necessary for the employment of that lexis in real-life contexts, but also to focus on the so-called "soft" skills, something that is becoming more and more challenging due to greater societal changes.

This paper will try to unpack these aspects of medical communication and to find practical ways to teach medical history taking from multiple perspectives. I will look at the factors, both institutional and social, that medical communication depends on, at some of the historical models that have been proposed in order to achieve a certain degree of integration between content and process, and specifically at the Calgary-Cambridge framework. Then, I will try to find some practical solutions for teaching medical history taking, taking some cues from recent research on this topic. Combining content and process is probably one of the most difficult tasks that a Medical English class is supposed to overcome in order to teach that particular set of skills needed for a very simple and seemingly commonplace act: intersubjective communication. It is also important to keep in mind that effective communication should, at its very best, be patient-focused, not doctor-focused, and that is where the development of soft skills comes into play. However, it is obvious by now that medical communication depends on wider factors, for instance, our view on what medicine is, on what disease is, and ultimately on what a patient is.

Medicine as magic, art, and science

The relationship between physician and patient, the foundation of medical communication, comprises three elements: "the physician, the patient, and the so-called third parties, that is, society, state, and institutions" (Hellín 453). It is therefore essential that we look at the historical development of these institutions in order to understand why and how the current praxis is shaped. Throughout the history of Western medicine, including the twenty-first century, there has been a distinction between medicine as an art and medicine as a science. Moreover, since the first half of the twentieth century, the practice of medicine has been increasingly understood as a social activity. In their hugely influential 1956 paper, "A Contribution to the Philosophy of Medicine," Thomas Szasz and Marc Hollender describe three historical models of the physician-patient relationship (Szasz, Hollender 587). The first one is that of "activity-passivity," a paternalistic model that is also the oldest, historically speaking; it implies that the physician is the active participant, holding all power and controlling the decision-making process, while the patient is nothing but a passive object. In the words of the authors, "the physician does something to the patient" (Szasz, Hollender 587). We may see this model employed in very beginning of medical practice, in Ancient Egypt,

where the relationship between physician and patient evolved from that between priest and believer (Kaba, Sooriakumaran 58) in the context of a mystical-magical view of disease. This paternalistic, activity-passivity model functioned through much of the European history of medicine, with one very significant exception: Hippocratic medicine.

Hippocrates is famous for having detached medicine from its mystical and magical roots, thus trying to give an account of disease based on somatic factors. Using the theory of the four humors (*Hippocratic Writings* 206), Hippocrates practiced what we may refer to today as a "mild medicine," including environmental and lifestyle factors into medical practice (*Hippocratic Writings* 118). But Hippocrates also revolutionized the relationship between physician and patient; even if it is not specifically present in the text of the original Hippocratic Oath as such, the phrase "first, do no harm" encapsulates the terms of this relationship. The patient is no longer an object, but a real human being, for whom the physician should demonstrate respect (*Hippocratic Writings* 57). Szasz and Hollender refer to this approach as the "guidance-cooperation' model (Szasz, Hollender 587): both participants contribute to the relationship, and even though one of them (the physician) exercises more power, it is only by assuming the role of a guide or leader. Unfortunately, this model was soon forgotten in Europe, as the Middle Ages returned to the mysticism of religion in medical practice and, consequently, to the activity-passivity model.

During the eighteenth century, with the development of the hospital and the biomedical model as a consequence of the Age of Reason, even if medicine was grounded on the scientific method instead of mysticism, the relationship between physician and patient continued to be one of activity-passivity (Kaba, Sooriakumaran 59). The biomedical model focused on objectivity, on scientific truths that were supposed to be uncovered by the physician, on a diagnosis that was hidden behind signs and symptoms. The patient had very little, if anything, to do with this truth. However, in the second half of the nineteenth century, a change came about from a newly developed field of medicine: psychoanalysis.

The beginning of the downfall of the biomedical model began with hysteria, a strange disease that affected bourgeois and high-class women during the nineteenth century. In contrast to other French physicians, who advocated for ovariotomies to cure hysteria, the famous doctor Charcot employed the use of hypnosis, believing that hysteria was a psychological condition (Scull 126). In 1885, a young Viennese neurologist, Sigmund Freud, came to Paris to study the treatment of hysteria under Charcot. Seeing that hypnosis had its limitations in regard to actually curing the patients, he then came up with a strange new practice called "talk therapy," that is, simply talking to the patient and making an account of their emotions, feelings,

dreams, and other psychological processes. Freud and his followers had become interested in the patients as persons, and there was no turning back. In Szasz and Hollender's terms, this marked the beginning of the "model of mutual participation" (Szasz, Hollender 588), a more democratic approach to medical communication:

> Philosophically, this model is predicated on the postulate that equality among human beings is desirable. It is fundamental to the social structure of democracy and has played a crucial role in occidental civilization for more than two hundred years. Psychologically, mutuality rests on complex processes of identification – which facilitate conceiving of others in terms of oneself – together with maintaining and tolerating the discrete individuality of the observer and the observed. It is crucial to this type of interaction that the participants (1) have approximately equal power, (2) be mutually interdependent (i.e., need each other), and (3) engage in activity that will be in some ways satisfying to both. (Szasz, Hollender 587)

Szasz and Hollender also mention something puzzling about the model of mutual participation, the fact that it is completely foreign to medicine. Since it is characterized by empathy, the process of identification, it is more of a partnership, thus departing from the traditional paternalistic, or doctor-oriented, medical practice. In the first half of the twentieth century, we may find previously unheard of assertions such as "the patient was not simply an object but a person" (Crichton-Miller, in Kaba, Sooriakumaran 61) or "from the beginning of his clinical career, the student should be encouraged to study his patient's personality… just as he studies his patient's physical signs and the data on the temperature chart" (the Royal College of Physicians, in Kaba, Sooriakumaran 60).

During the Second World War, Nazi doctors conducted horrifying experiments on the inmates from concentration camps. After the war, investigations documented the fact that those experiments were "medical war crimes" (Weindling 2-3) and the international community decided to establish norms regulating physician-patient relationships in general (and clinical research in particular), that is, the theory and practice of informed consent. Today, informed consent is the very foundation of medical practice and, consequently, the foundation of medical communication (Bowman et al 4). In a sense, it is a return to Hippocratic medical ethics. Together with the interest in the patient's individuality and personality developed by Freudian psychoanalysis, the postwar ethics of consent sought to limit the physician's power and to create a framework for a democratic relationship, the "mutual

participation." Simultaneously, it is, at least in part, a return to the Hippocratic concept of medicine as an art.

Some historical models of the medical interview

During the 1950s, the hard-scientific biomedical model, which focused on the interpretation of symptoms and signs in order to reach a diagnosis, was questioned by a number of psychiatrists and clinicians. This interference led to the formulation of another model, the biopsychosocial one, a decisive step towards the creation of a framework for physician-patient interaction. For instance, one of the first researchers to analyze this interaction in depth was Michael Balint, who published his influential paper "The Doctor, His Patient, and the Illness" in 1955. Balint focused specifically on the relationship between physician and patient, stating that "by far the most frequently used drug in general practice was *the doctor himself*" (Balint 683; orig. emphasis); he described this power over the entire setting and also over the patient as "the apostolic function" of the physician, who "converts" the patient to their own point of view. Balint proposed that it was the physicians' duty to find a compromise between the patient's expectations and concerns and their professional perspective through the development of a wider understanding of a patient's psychological and social life.

These ideas sparked questions about medical communication as more than mere content but as process; even if they still preserved the role of the physician as an interpreter of signs and symptoms (Balint's "apostolic function"), what mattered most during the 1960s and the 1970s was the inclusion of the patient as an active participant in medical interactions. The aforementioned work by Szasz and Hollender introduced a seemingly non-technical point, that of empathy or identification, but this was actually the psychoanalytical concept of transference adapted to physician-patient relationships in the mutual participation model. In other words, the departure from the biomedical model towards the biopsychosocial model happened with a shift in the wider view on medicine. No longer only an applied science, medicine reshaped its venerable tradition as an art by introducing the complexities and variables related to each individual patient's psychosocial background. However, a framework was needed, a way to combine the more or less traditional content with the newly developed process during the medical interview.

Byrne and Long, following Balint's work, proposed such a framework after researching a great number of recordings of interactions between general practitioners and patients (Byrne, Long 21). The Byrne-Long model included six stages of the consultation, beginning with the establishment of a relationship between doctor and patient, moving on to discovering the reasons for the visit, taking a history and/or conducting a physical exam, discussing the

condition and the future course of action, and ending the consultation. However, this model was quite doctor-centered, and so a new, more patient-centered model was developed during the 1980s by Pendleton and others. The Pendleton model begins by advocating for the recognition of the fact that a medical consultation is a meeting between two people in which each brings some sort of specialized knowledge: the physician has a specialized knowledge of medicine, and the patient has a specialized knowledge of their own body, experiences, needs, and values (Pendleton et al 9). Pendleton's model, in its attempt to be extremely patient-centered, proposes five tasks to be fulfilled in a particular order: firstly, there needs to be an understanding of the patient's problem and perspective, including technicalities such as the aetiology, the history and the nature of the complaint, but also the personal and social conditions, ideas, values, concerns, expectations and so on; secondly, the physician is supposed to acknowledge the patient's perspective, to support them in choosing a certain course of action, and to enable them to stick to that management plan; thirdly, to consider any yet unspecified problems (Pendleton et al 73). As can be easily seen, the Pendleton model consists of very intricate details which make it extremely complex and, in practice, very time consuming. It can obviously serve as the groundwork for skills development in an educational setting, especially because it focuses on the patient's narrative, being a very good introduction to patient-centered medical communication.

Such post-Balint ideas about the wider scope of medical communication prompted the development of "Biographical Medicine" (Armstrong) and "Narrative Medicine" (Shannon). Mead and Bower created a conceptual framework for patient-centeredness, including relatively older concepts such as the biopsychosocial perspective (including an entire range of patient difficulties, not only the strictly medical ones), the patient-as-person (the patient as an experiencing individual with a specific biography and a particular narrative of disease, and not as an object), sharing power and responsibility (a departure from the paternalism of the activity-passivity model, greater patient involvement), and the doctor-as-person (since the biomedical model considers the doctor to be simply a tool within the entire process, patient-centeredness transforms the relationship between physician and patient into that between two human beings) (Mead, Bower).

Taking all these perspectives into account, it would be easy to assume that any Medical English class is properly equipped to teach medical communication by focusing on non- and less technical issues and employing some medical humanistic strategy to achieve its objectives. However, the initial question of this paper was related to both content and process, and to how these may be taught together. Currently, the Calgary-Cambridge framework provides a way to conduct the medical interview in a relatively fast

and meaningful way, while simultaneously focusing on establishing rapport with the patient and uncovering their biography.

Content and process in the Calgary-Cambridge model

In 1996, Kurtz and Silverman published their initial framework for the medical interview, the Calgary-Cambridge model, whose aim was to promote the development of communication skills specifically targeted at the medical interview (Kurtz, Silverman 83). In 2003, the framework was enhanced to include three explanatory diagrams and to include the patient's perspective in the process and the content of communication (Kurtz et al, "Marrying Content and Process" 39). The framework posits that three sets of skills are needed for effective communication: content skills (what is being said, the technical aspect), process skills (how it is being said, the verbal, non-verbal, and relating process), and perceptual skills (reasoning, decision-making, empathy, respect, and so on) (Silverman et al 10; Kurtz et al, *Teaching and Learning* 32).

In terms of content, the Calgary-Cambridge framework proposes the "traditional medical history" (Kurtz et al, *Teaching and Learning* 34; Silverman et al 12), including the chief or the presenting complaint (what the patient's main symptom is), the history of the presenting complaint (a history of the symptom(s), in which aspects such as site, onset, character, radiation, associated symptoms, duration, severity, and so on, are investigated), a past medical history (any previous medical conditions), a family history (any medical conditions that run in the family and that may have a hereditary or lifestyle-related cause), a personal and social history (including any relevant aspects of the patient's biography, such as workplace/occupation, home environment, habits like smoking, drinking alcohol, exercising, family life, diet), a drug and allergy history (previous or current courses of medication and potential allergies), and a systems review (inquiry regarding the functioning of the various bodily systems). In most of the medical encounters, these aspects will be emphasized, and indeed even proponents of integrated frameworks such as Kurtz, Silverman, and others have recognized the strengths of this approach: it is a scientific, biomedical way of obtaining information in a structured, clear, and concise way. On the other hand, the Calgary-Cambridge framework makes a useful distinction between *disease*, as the biomedical perspective opened up by symptoms, signs, histories, and diagnoses, and *illness*, which is the patient's perspective, including ideas, concerns, expectations, effects on their life, and their individual experience (Silverman et al 65). Habitually, physicians will consider that the *illness* is a superfluous expression of the *disease* and will focus on the hard scientific data offered by test results and history-taking forms. However, in the words of Silverman et al:

> We need to take into account both our own traditional disease agenda and our patient's very personal illness agenda. When a patient presents with joint pains, the doctor may see his role in terms of diagnosis and treatment of any underlying disease. However, the patient's main concern may be the possibility of loss of future independence – the patient's agenda may concern discussing prognosis more than diagnosis. These two agendas overlap but without addressing the patient's beliefs and concerns as well as diagnosing the disease process, the doctor will not have fully served the patient as an individual. The patient-centered approach enlarges the doctor's agenda to take account of both disease and illness. (Silverman et al 66-67)

There are also very practical reasons for considering the patient's perspective, in addition to the improvement of healthcare as such. For instance, the illness may be the result of lifestyle-related factors like stress, personal unhappiness, or anxiety, and the biomedical model is very limited in explaining them adequately.

In terms of process, the Calgary-Cambridge framework proposes a set of components that also include taking a traditional history. In the first stage, "initiating the session" (Silverman et al 35), the physician should establish a proper setting for the interview (that is, making sure that the environment is welcoming and that there are no sources of distraction or stress), initiate the relationship with the patient by greeting and obtaining their name and consent, and identify the reason for the visit (traditionally referred to as "the chief/presenting complaint") by using open questions and carefully listening to the patient's answer. The second stage, "gathering information," consists in taking the traditional medical history. Thus, it is at this point that the biomedical information, the *disease*, will merge with the biopsychosocial and biographical factors, the *illness*. According to Silverman et al, the process skills at this stage are: firstly, to be able to explore the patient's problems by listening to the their personal narrative, facilitating their response, and summarizing what has been said in order to offer the patient the opportunity to add or retract statements; secondly, to explore the patient's point of view regarding the cause of their condition, the expectations that they have, and the effects the condition has on their life; thirdly, to encourage the patient to express their feelings (Silverman et al 73).

If these first two stages seem quite natural to the process of history-taking, given that they include the commonsensical and rather intuitive traditional components, the following stages are more closely process- and patient-centered. "Explanation and planning" deals with offering relevant information to the patient in balanced amounts and with checking that they understand and agree with the proposed course of action. It should be noted

that, from a patient-centered perspective, these will be "suggestions and choices, not directives" (Silverman et al 158). Silverman et al identify two historical models of this communicative exchange, roughly based on the wider perspectives that I discussed in the previous sections: the shot-put approach and the frisbee approach. The old method, the shot-put approach, focuses entirely on the transmission of the message, that is, on explaining and giving instructions to the patient, and that is when communication and, generally speaking, the medical process (at least in General Practice) ends. The newer method, developed mostly in the 1960s, the frisbee approach, as the name suggests, involves a communicative exchange that goes on beyond mere directing and emphasizes "interaction, feedback, and collaboration (Silverman et al 160).

In addition to these stages, the Calgary-Cambridge model includes two overarching principles: "building the relationship" and "providing structure to the interview." The former encourages physicians to have genuine acceptance of their patient's point of view, to actively employ empathy in order to show understanding of the patient's condition, to be display availability and offer support, and to involve the patient in the medical process by sharing thoughts and ideas (Silverman et al 124-125). The structure of the interview, the latter component, should be made overt by summarizing the information already received and the transition between the stages of the history should be made in a clear manner (Silverman et al 111-112).

It is worth noting that the Calgary-Cambridge framework was developed, first and foremost, as a teaching tool for medical educators and as the basis for potential curricula. The question that arises is how to effectively teach the medical interview in the Medical English classroom?

New approaches to teaching content and process

The range of difficulties that a Medical English class faces when it comes to the medical interview according to the Calgary-Cambridge method is seemingly insurmountable. Of course, there can be a direct teaching of the structure and requirements of the model, maybe even including some examples, but this alone does and should not count as effective education. As we have already seen, medicine and medical education do not happen in a vacuum; they are dependent on many other factors, from the answer we give to the question "what is medicine," to the formal and informal curricula, and oftentimes to our students' lack of technical knowledge and practical expertise. Among these, the major challenge is the idea of medicine strictly as an applied science, deeply embedded in the formal and informal curricula. Thus, any Medical English class that includes teaching effective communication among its objectives should begin by questioning this assumption in an open debate and only then attempt to develop communicative, critical, and "soft" skills.

Luckily, research has provided various experiments which prove valuable in allowing the students to experience the other aspect of medicine, that of an art. Keifenheim et al created a systematic review of the educational approaches to teaching the medical interview and found a very heterogenous set of interventions, ranging from traditional methods like the use of videos and templates, to experiential learning methods like role-play and small-group workshops, and to creative approaches such as improvisational theater and a LEGO™ simulation. Likewise, the more traditional interventions focused more on content, while the more creative ones tended to emphasize the process.

For instance, in teaching medical communication with a focus on the importance of open-ended questions, Harding Rutledge and D'Eon begin by noticing that first-year students care very little about the development of their communication skills because they tend to focus on acquiring technical knowledge. They propose an approach in which the students are being taught physician-patient interviewing from their first week of medical studies, an approach that bypasses the need for technical knowledge using LEGO pieces. In short, students, in pairs, assume the roles of physician and patient. The "patient" is given a simple LEGO assemblage; the "physician" is given a number of pieces. Then, they have to communicate in order for the "physician" to re-create the LEGO structure without seeing it (Harding Rutledge, D'Eon 131). Thus, the activity imitates a patient-centered setting in which the physician must use a variety of questions to gain information and create a medical history. This creative approach can be very effective because it does not focus on the content of the verbal communication alone, but also on the process of (literally) "building" a structured result.

From a communicative perspective, the common way to deal with such topics in the classroom is role-play. Keifenheim et al found that this kind of experiential learning (learning-by-doing) can be effective provided that the students already possess a relatively solid technical medical background (Keifenheim et al 8). A step up from role-play and an interesting idea that could be explored in further detail is the use of a creative intervention, improvisational theater (Watson 1260; Keifenheim et al 9; Watson and Fu 591). Watson in particular develops the use of techniques borrowed from improvisational theater in medical communication classes by focusing on power-plays between participants in non-medical scenarios meant to prove that role and status are important to keep in mind in a patient-centered framework. Since medical communication is rarely following a strictly pre-designed plan, improvisation techniques present a few advantages in the development of communicative skills: they build the confidence necessary to adapt to new situations and contexts; they help some students overcome a fear of public speaking; they help with the development of a patient-centered perspective and

a higher degree of empathy and acceptance of other viewpoints by literally experiencing them.

The two techniques described above, the LEGO building exercise and the medical improv activity, have the advantage of not needing highly specialized medical knowledge, making them accessible and suitable for first and second-year students. However, in keeping with the Calgary-Cambridge framework, I believe that these and other methods should be used in conjunction with a process of uncovering the reasons for which we use a patient-centered approach in merging content and process, its historical roots, and its advantages over the traditional approach. Using theoretical lectures that explain the transition towards the contemporary models may be helpful in providing structure to what may otherwise be a confusing experience. Even if it is now believed to be a more traditional method, the use of videos as examples that allow the students to focus on both the content and the process of medical communication is a valuable tool in the Medical English classroom. Only after providing this foundation can creative methods be used in order to raise the students' awareness regarding the process of physician-patient interaction.

Ultimately, the success of merging content and process in medical communication classes depends, as I have already mentioned, on the formal and informal curricula. In the words of Suchman and Williamson:

> Students of medicine learn first and foremost from what they see and experience, rather than from what's written in the syllabus. If they witness respectful and collaborative interactions; if they experience listening, empathy, and support; and if they see difference approached with curious inquiry and dialogue rather than conflict and domination, then these interactions will frame their expectations for the nature of relationships in medicine. But if instead they see powerful figures in medicine routinely entering into non- healing or even negative relationships with one another and their patients; if they see their mentors emphasizing the importance of expert technical knowledge above all else, especially above knowledge of self and other; and if they experience hazing or humiliation as standard techniques of medical pedagogy, then they will develop a very different template for their lifelong practice. (Suchman, Williamson, in Silverman et al 123)

Until there is a considerable shift in the general approach to medical education and a move towards more medical humanities classes, the Medical English classroom is one of the few spaces that can offer an alternative point of view on medicine in general and on medical communication in particular.

Conclusions

This paper explored the divergence and convergence of content and process in medical communication in the Medical English class. Since the content is the historically privileged aspect of medical communication, merging it with the process in the Calgary-Cambridge framework provides a helpful set of guidelines for the development of a patient-centered practice. Even though there are a number of recent attempts to teach content and process in innovative and creative ways, these may be used in addition to an explanation of the structure and history of medical communication, because the biggest challenge that needs to be overcome is the informal curriculum (in addition to the formal one) that, generally speaking, tends to reward technical competence over simple, commonsensical, and genuine human interaction.

Works Cited

Armstrong, David. "The Emancipation of Biographical Medicine." *Social Science and Medicine* 13 (1979): 1-8.

Balint, Michael. "The Doctor, His Patient, and the Illness." *The Lancet*, April 2, 1955: 685-688.

Bowman, Deborah, John Spicer, Rehana Iqbal. New York: Cambridge University Press, 2012.

Byrne, P. S., B. E. L. Long. *Learning to Care*. Edinburgh: Churchill Livingstone, 1973.

Harding Rutledge, Sheila, Marcel F. D'Eon. "Using a Lego™-Based Communication Simulation to Introduce Medical Students to Patient-Centered Interviewing." *Teaching and Learning in Medicine: An International Journal* 13 (2001): 130-135.

Hellín, T. "The physician-patient relationship: recent developments and changes." *Haemophilia* 8 (2002): 450-454.

Kaba, R., P. Sooriakumaran. "The evolution of the doctor-patient relationship." *International Journal of Surgery* 5 (2007): 57-65.

Keifenheim, Katharina, Martin Teufel, Julianne Ip, Natalie Speiser, Elisabeth J. Leehr, Stephan Zipfel, Anne Hermann-Werner. "Teaching history taking to medical students: a systematic review." *BMC Medical Education* 15 (2015): 1-12.

Kurtz, Susanne, Jonathan Silverman, John Benson, Juliet Draper. "Marrying Content and Process in Clinical Method Teaching: Enhancing the Calgary-Cambridge Guides." *Academic Medicine* 78 (8) (2003): 802-809.

Kurtz, Susanne, Jonathan Silverman, Juliet Draper. *Teaching and Learning Communication Skills in Medicine*. Boca Raton, FL: Taylor and Francis Group, 2004.

Kurtz, Susanne, Jonathan Silverman. "The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmes." *Medical Education* 30 (1996): 83-39.

Hippocratic Writings. Edited with an Introduction by G. E. R. Lloyd. Translated by J. Chadwick and W. N. Mann. London: Penguin, 1983.

Mead, Nicola, Peter Bower. "Patient-centeredness: a conceptual framework and review of the empirical literature." *Social Science and Medicine* 51 (2000): 1087-1110.

Pendleton, David, Theo Schofield, Peter Tate, Peter Havelock. *The New Consultation. Developing doctor-patient communication*. Oxford: Oxford University Press, 2003.

Scull, Andrew. *Hysteria. The Disturbing History*. Oxford: Oxford University Press, 2011.

Shannon, Mary T. "Giving Pain a Voice: Narrative Medicine and the Doctor-Patient Relationship." *Journal of General Internal Medicine* 26 (10) (2011): 1217-8.

Silverman, Jonathan, Susanne Kurtz, Juliet Draper. *Skills for Communicating with Patients*. Boca Raton, FL: Taylor and Francis Group, 2013.

Szasz, Thomas S., Marc H. Hollender. "A Contribution to the Philosophy of Medicine." *A. M. A. Archives of Internal Medicine* 97 (5) (1956): 585-592.

Watson, Katie, Belinda Fu. "Medical Improv: A Novel Approach to Teaching Communication and Professionalism Skills." *Annals of Internal Medicine* 165 (2016): 591-593.

Watson, Katie. "Perspective: Serious Play: Teaching Medical Skills with Improvisational Theater Techniques." *Academic Medicine* 86 (2011): 1260-1265.

Weindling, Paul Julian. *Nazi Medicine and the Nuremberg Trials. From Medical War Crimes to Informed Consent*. New York: Palgrave Macmillan, 2004.