Steffen Eychmüller, Sibylle Felber / March 2026

Best Evidence COMmunication in Healthcare (BECOM): The basics of evidence-based, compassionate communication

Background and need

Every day, countless conversations take place within the healthcare sector, ranging from initial consultations to ward rounds, brief discussions or handover briefings within the team, exchanges with colleagues, and conversations with relatives. These often involve life-changing situations, and in some cases, life-threatening ones for those affected. Communication is the most important tool in healthcare for comprehensively assessing situations, evaluating them, and discussing a plan for improvement that is equally understood and supported by all communication partners.

It is surprising that for this fundamental skill, there are hardly any clear quality standards or, at the very least, an internationally recognised framework outlining the components of successful communication. The closest approximation to this concept is the 'Calgary-Cambridge Guide (or Model) for Medical Interviews in the Context of a Consultation' (Silverman et al., 2013). In medical education – and to some extent in postgraduate training – there are now various courses and guidelines on communication, though the connection between their content is often unclear. Communication as such is frequently perceived as a 'soft skill', even though it is often demanded, particularly by patients. In the hierarchy of professional competencies, communication tends to rank somewhere in the middle. Many professionals tend to view communication training as a compulsory exercise and as 'tedious' or confrontational, in contrast to other skills training such as CPR or the management of emergency situations. Unlike training in life-saving measures, there is no mandatory requirement for repetitive training in communication skills – even though we certainly communicate far more frequently than we perform resuscitation.

Development of an educational framework

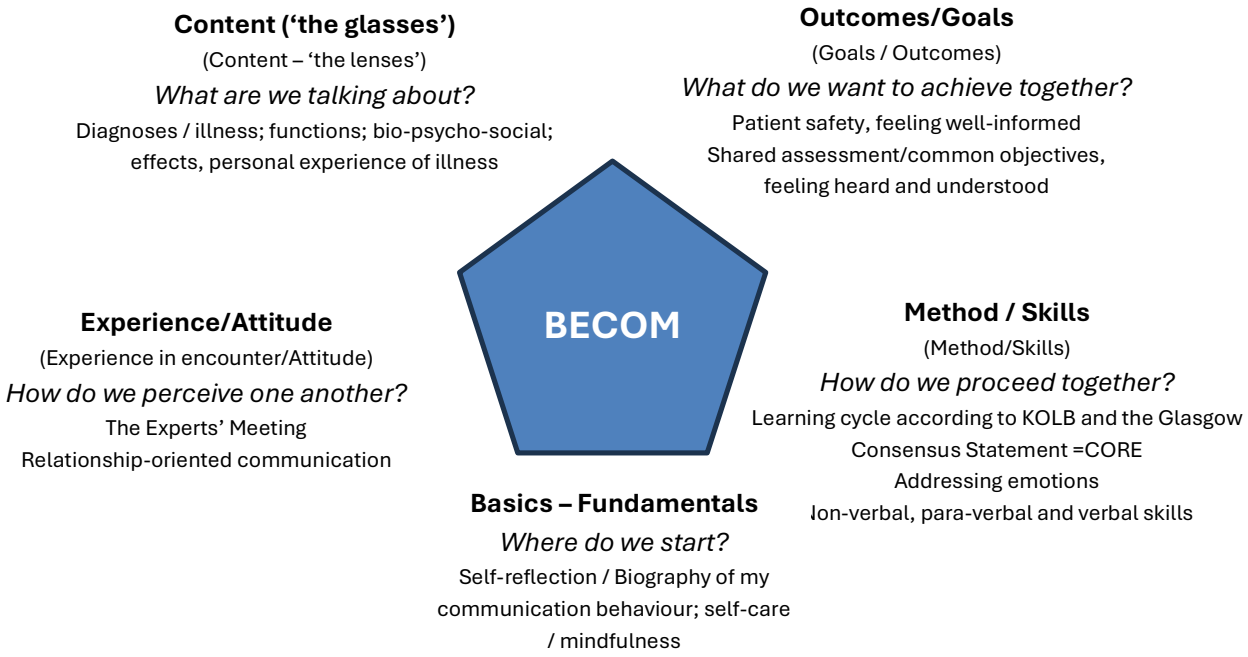
In 2024, an international consensus on the cornerstones of communication in healthcare was published for the first time: the Glasgow Consensus Statement (Makoul et al., 2024). This document builds on that consensus work and attempts to compile an evidence-based 'basics guide' to communication in healthcare. As with all skills, the idea is not to establish rigid quality standards, but rather to discover the full range of human communication as inspiring and hugely exciting, in order to modify one's own communication in a self-directed manner and to practise it regularly – like ongoing muscle training. Good communication can be learnt.

The potential scope of application is very broad and extends well beyond the professional sphere, into politics and private life. All areas can benefit. It is about using scientific evidence for communication. The good news: it exists. The bad news: unfortunately, it is often not followed.

In the following, we aim to develop an educational framework based on the Calgary-Cambridge model, which brings together the most important skills and content in line with the evidence currently available. This is how BECOM came into being.

The main components of 'Best Evidence in Communication'

If one follows the most important specialist books and articles, the following components can be broadly defined for high-quality communication, which is perceived by all those involved as 'successful', or in the English-speaking world as 'effective' and/or even as empathetic or 'compassionate'.



Silverman et al. (2013) speak of three skills/areas of communication:

- Perceptual skills (perceptual ability/internal processes)
- Content skills (content)
- Process skills (structure/communication techniques)

We define the areas 'Basics' and 'Experience/Attitude' as belonging to 'perceptual skills', whilst 'Content' and 'Outcomes' remain largely 'content skills', albeit with more clearly defined 'lenses' or perspectives, and 'Method/Skills' as comparable to the 'process skills' in the Calgary-Cambridge model.

The BECOM framework consists of the following 5 areas:

1) BASICS – Fundamentals

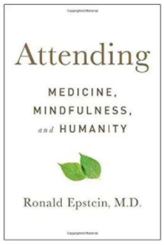
Key aspects

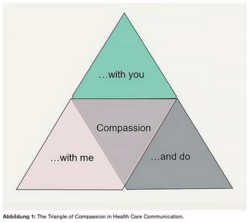
Key question: Where do we start?

What are my foundations, such as my communication behaviour and my capacity for self-reflection and self-care?

- Self-reflection, 'communication biography': a biography of my own communication behaviour / social background
- Self-compassion, mindfulness: Mindfulness-based communication; self-care/self-compassion as a key professional competence: the triangle of compassion in health communication

Relevant literature





- Epstein, Ron: Attending, 2018
- Rider E et al BMJ Open 2023
- Huston, D. C. et al. J Applied Communication Research, 2011
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Each and every one of us has learnt our own communication behaviour just as we have learnt our own language or dialect. Our family of origin usually plays a formative role in this, from the way we speak (non-verbal and paraverbal skills, see also 'Methods') to the expression of and handling of emotions, but particularly also in how kindly or rather critically we treat ourselves ('self-kindness, self-compassion').

It is also during this early period (from childhood to young adulthood) that the basic structure of self-esteem develops. This appears to play a central role in communication and, in particular, in the openness and curiosity required to modify one's own communication behaviour (Matteson 1974).

A brief reflective exercise regarding one's own biographically determined communication behaviour can be very revealing: when I think back to the period from adolescence to young adulthood, that is, between the ages of 15 and 19, what experiences did I have with communication within my own family system?

- How often was our own communication reflected upon and discussed in my family?
- Were emotions that were in the air addressed? If so, how?
- Did I tend to take on an observing or an active (communication) role?
- Was I able to freely express my emotional experiences, and did I actually do so?
- Did I generally feel heard and understood in my family – or not?

Example: if, as a young adult, I experienced in family communication that asking questions, waiting respectfully and listening were the norm, I will later use these 'skills' as 'normal' too. On the other hand, my own communication behaviour will be different if, at home, I was mostly confronted with rather brusque feedback, little understanding and little experience of 'softer tones'. This isn't about a 'mini-psychoanalysis', but rather a reflection on the extent to which these behaviours still shape my communication style today, or continue to do so. The question

then is whether I am aware of this, and whether I would like to actively modify or develop certain aspects.

Treating oneself with kindness is a skill that is rarely consciously integrated into everyday working life, where external and self-imposed demands are usually very high. Nevertheless, the way we treat ourselves and our own feelings should be trained like a muscle, every day. Only with sufficient personal energy can one be helpful and supportive, whilst at the same time engaging with another person in a focused and curious manner (Goleman, 2006; Eychmüller & Felber, 2023).

In recent years, and intensified by the COVID-19 pandemic, the realisation has gained ground that mindful self-care, or 'mindfulness', in the sense of self-reflection and self-compassion, is a highly relevant foundation for successful communication (Epstein, 2018; Huston et al., 2011), and for cooperation within teams (Rider et al., 2023). Regularly undertaking these exercises and cultivating a kind attitude towards oneself are therefore rightly considered 'BASICS' in evidence-based communication in healthcare – essential homework, so to speak.

2) Experience/Attitude

Key aspects

Key question: How do we see one another? How do we perceive one another? How do we experience one another?

Attitude – the consultation as a meeting between experts:

- The patient as an expert on their own individual experiences and preferences.
- The professional with their expertise in health.
- Relationship-centred communication (relationship-centred approach)

Relevant literature

- Tuckett D et al, 1985
- Chou C, Cooley L, 2018

It sounds simple, yet it is often forgotten in everyday clinical practice, where technical expertise dominates almost everything: **a consultation is ALWAYS a meeting of experts!** As healthcare professionals, our role is to be experts in diagnostic classification and in defining appropriate treatment options. On the other hand, the patient is an expert on their own, individual life, on the tasks and demands relevant to their life. We learn and listen to the patient; they learn and listen to us. The result of such an approach is the experience of a collaborative partnership and a shared search for the way forward. The highly evidence-based book 'Meeting between experts' by David Tuckett et al. (1986!) impressively describes this approach and the resulting relationship between professional and patient. This approach also forms the basis for contemporary practices of 'relationship-centred communication' or the 'collaborative partnership', which are now regarded as the standard for the experience that should be provided during a consultation (Chou & Cooley, 2018).

Such a fundamental attitude – which can also be applied outside the healthcare sector – automatically fosters a sense of partnership based on mutual respect, appreciation and communication on an equal footing, even and especially when there are gaps in knowledge or hierarchical differences. Eric Berne's transactional analysis has made a fundamental contribution in the scientific field here: communication in the so-called 'Adult ego'. That we treat one another as experts, as people with life experience – in short, as adults – and do not talk down to one another from the 'Parent ego' as if to children, or express protest and resistance towards parents as 'Children'. The German title of Eric Berne's book could not put it better: 'Games Adults Play' – sadly, these can be distressing, but fortunately they are certainly avoidable.

3) Content – the substance, the 'lenses'

Key aspects

Fundamental question: What are we talking about?

- Diagnoses? Illnesses?
- Functions? Bio-psycho-social?
- Personal experiences? Suffering?

Relevant literature

- Cassell E; Illness and disease, Hastings Report 1976
- Engel G The need for a new medical model; Science 1977

The medical perspective **Medical diagnoses** Focus: ICD – DSM (shortcomings) ✓ Symptoms ✓ Pathophysiology *Disease*	The interprofessional perspective **Functions** Focus: ICF (deficits & strengths) ✓ Physical ✓ Mental ✓ Social + Self-efficacy *Disease + Illness*	The patient's perspective **Personal experience** Focus: Subjective reality/effects of the illness/change in functions on ✓ Self-esteem ✓ Meaning of life ✓ Feelings/ emotions *Illness*

Healthcare professionals primarily think in terms of the medical-diagnostic system: when I hear about certain symptoms, a timeline and connections, for example with diet or exercise, I assign these phenomena to a medical **diagnosis**. For the person affected – referred to as the patient within the medical system – the focus is on the **individual experience**: the impact of the illness or symptoms on daily life, on movement, on how one feels, right down to self-esteem and the experience of meaning. In the English-speaking world, this perspective is summarised as 'illness', i.e. what the diagnosis, or disease, does to the person and their life (Cassell, 1976). A mediating role between these lenses is often played by the assessment and categorisation of **functions**: what still works well in terms of mobility, but also cognition and social functions/tasks, and what causes difficulty. This perspective is often the domain of nursing and functional specialists, such as physiotherapy, occupational therapy, speech and language therapy, nutritional counselling, social work, etc.

In all communication within the healthcare sector, we must therefore be aware of these different perspectives, these 'lenses', and explore them, very much in the spirit of an 'expert meeting':

- For those **affected**, what counts is the **subjective experience of** illness – how the condition impacts their own life, daily routine, moods, tasks and expectations, including the effects on self-esteem and, particularly in the face of existential threats, the meaning of life.
- For professionals in **nursing and functional therapies** such as physiotherapy, psychology, social counselling, nutritional therapy, etc., the focus is on functional deficits as defined by the **International Classification of Functioning, Disability and Health (ICF)** (see also Leonardi et al., 2022).
- For **medical professionals** and the medical profession, the focus is on the abstraction of suffering in the sense of medical diagnoses based on symptoms, which then lead to diagnostic and medical-therapeutic measures in accordance with the **International Classification of Diseases (ICD**).

Objectification of suffering in medicine **Medical diagnoses** Focus: ICD – DSM (shortcomings) Symptoms *Disease*	Objectification of functions in nursing **Functions** Focus: ICF (deficits & strengths) Impact of the condition on biopsychosocial functions *Disease + Illness*	The patient's perspective **Personal experience** Focus: 'IPE' (individual patient experience) Effects of the disease - On experience/feelings - On self-image/self-worth; meaning of life *Illness*

Ideally, every professional is aware of the main perspective they adopt and contributes to the search for a shared solution (Engel, 1977). For example: not every surgical professional needs to fully grasp the patient's subjective reality – but they should be aware that this 'lens' is the most relevant for that person, and is a key factor in the quality of decision-making. In emergency situations, it makes sense for the diagnostic lens to take precedence. Tumour boards are also a good example: here, a recommendation is developed from the perspective of medical diagnostics. Whether and how this recommendation then fits with the affected person, their necessary or desired everyday functions, and also with their experience – including their fears, but also their individual goals – is not something a tumour board can decide. This requires the overall view of all three 'lenses', and this must be done on an equal footing. A round-table discussion involving the patient and their relatives, alongside care staff, functional therapies/counselling teams and an integrating medical specialist, is a good example of communication in the spirit of such integration.

The importance of integrating all these perspectives, particularly when it comes to treatment decisions, is also becoming increasingly relevant in the current age of artificial intelligence: rapid diagnostic aids using artificial intelligence (AI), which query symptoms and follow algorithms based on frequency to determine the most likely diagnosis, can increase diagnostic certainty. AI can also provide support in the interpretation of imaging or in the 'objective' assessment of complex situations in oncology or cardiology within the context of multifactorial analyses.

Translating AI results into individual lives and experiences will fail if done solely through AI. This requires collaborative exploration from all perspectives.

4) Outcomes – shared goals

Key aspects

Key question: What do we want to achieve together? What are the goals?

- Patient safety, feeling well-informed
- Shared thinking, shared understanding – 'goal-concordant' care
- Feeling heard and understood; respect & trust

Relevant literature

- Eggins, S., & Slade, D. (2015). J Public Health Research
- Dzau, V. J., et al (2017). JAMA.
- Halpern, S. D. (2019). NEJM
- Epstein, R. M. (2013). PEC
- Gramling, R., et al (2016). JPSM

In recent years, patient safety, sustainability – particularly from a financial perspective – and equitable access to healthcare services have been identified as key objectives of the healthcare system (e.g. Dzau et al., 2017). From a communication perspective, the joint definition of treatment goals and plans (shared mind, shared understanding, goal-concordant care), very good health literacy and mutual respect and understanding ('feeling heard and understood') contribute to this. For patient safety, there is particularly clear evidence of the importance of high-quality communication in this context (Keshtkar et al, 2025). This systematic review also highlights the downside, namely that ineffective communication—both between healthcare professionals and patients and within teams—is a major cause of errors. Further positive effects of achieving these goals can also be seen directly in economic terms (Agarwal et al., 2010), in relation to patient complaints (Hobbs, 2023) and in terms of staff burnout (Molero, 2021).

Above all, it is essential that the conversation partners on both sides feel heard and understood. It is not only the healthcare professional who should listen carefully and understand; these requirements also apply to patients and their relatives. A give-and-take that is experienced as authentic, where ignorance is clearly signalled, and ultimately connection and trust are established (Gramling, 2016; Halpern, 2019). There is no question that these requirements are particularly challenging in the face of language and communication barriers, and also in encounters between people from different cultural regions. In such cases, the key is to set modest expectations regarding mutual understanding and the 'shared mind', and to accept that, for the most part, we will not understand one another – at least not without additional support such as translation, technical language aids, and cultural ambassadors.

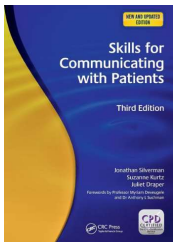
5) Methods – How do we proceed together?

Key aspects

Key question: How do we proceed together?

- Experience-oriented learning cycle & Glasgow Consensus Statement (adapted to CORE)
- Dealing with emotions
- Non-verbal/paraverbal skills

Relevant literature



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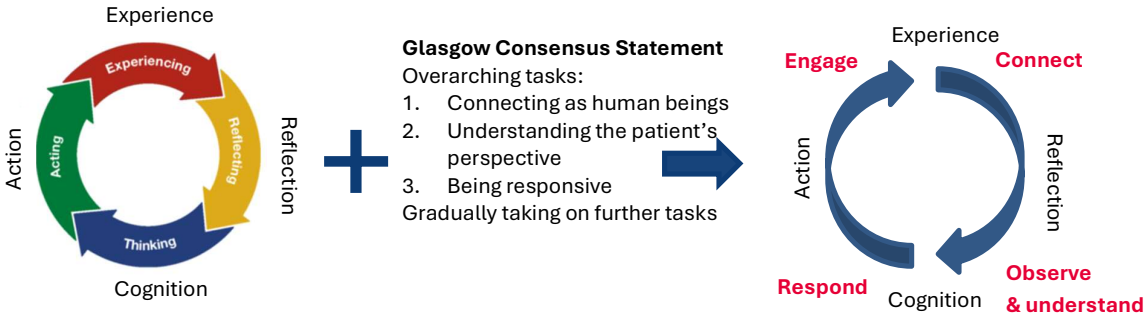
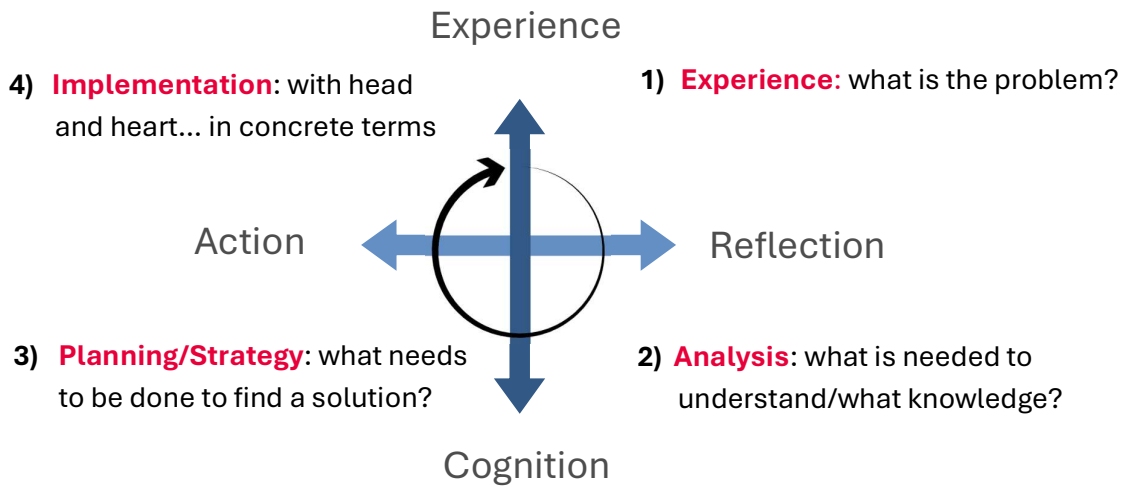
- Makoul, G., et al, 2024. Patient Education and Counselling, 122, 108158.

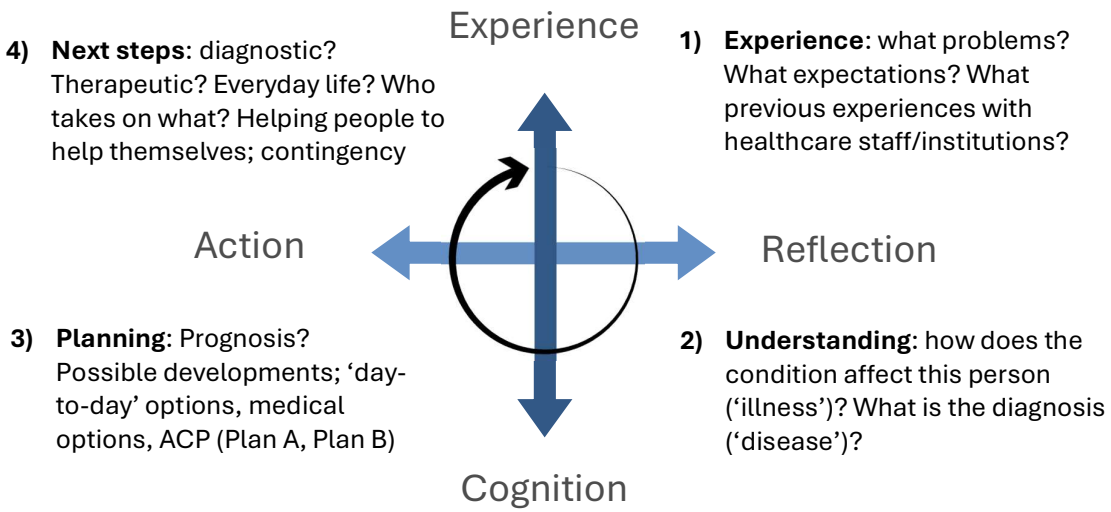


HOW we interact with one another in conversation or consultation, and the communication process we go through, is very well supported by evidence. The Calgary-Cambridge model, for example, provides a clear roadmap here, though it is often perceived as a rather complex construct. The idea should be that a collaborative solution emerges from a joint discussion based on partnership, starting from one or more problems. A particularly well-evaluated model of such a jointly designed learning and problem-solving process is the 'experiential learning cycle' and the 'learning styles' model by David Kolb (2013). David Kolb's process helps to consider the various steps in this process in sequence: engaging with one another **emotionally** as human beings , sharing experiences, then reflecting/observing together on what might lie behind the problem and attempting **to 'understand' it cognitively**, and then moving to **the 'action side'**, initially with more strategic, overarching goals and solution options, and then to **concrete action.** An additional advantage of this 'cycle' is that people have different preferences for how to begin such a process: some people respond very well to emotions and concrete experiences, whilst others need 'facts and figures' first, and thus need to build trust initially.



HOW communication in healthcare works according to the 'experiential learning cycle'

The aim of every consultation/communication, in the context of the learning cycle, is to go through the entire cycle together – the 'full cycle' – starting with sector one, involving active listening to concerns, questions and expectations, right through to sector four, with a clear definition of the next step, even if it is simply a follow-up appointment (or perhaps not). ONCE sector four has been reached, the next step is to follow up with a brief 'check' on how the emotional experience is or was at the end of the consultation (see below: Feedback & Evaluation): "How are you feeling now at the end of the conversation?", "Do you feel heard and understood?", "Have your expectations been met, or what is still unresolved/was not discussed?" This then brings us full circle, the shared journey from listening/observing/reflecting to planning and final action.



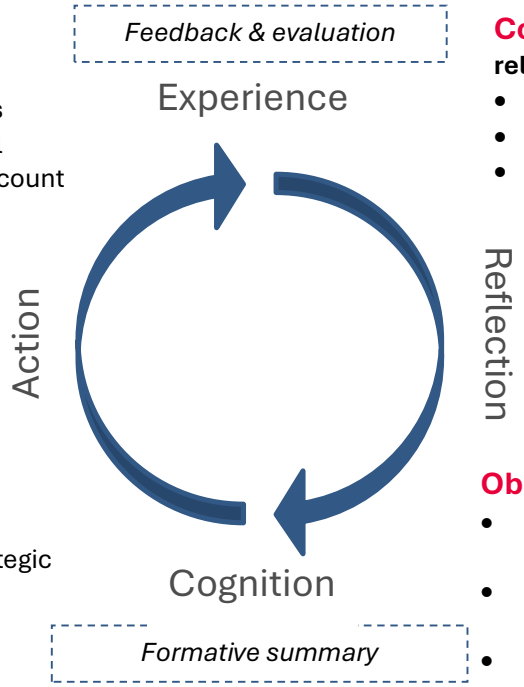
In January 2024, a guideline was published for the first time that defined criteria for the quality of communication in clinical settings. This document focuses primarily on the method, the 'how' of

communication: the **Glasgow Consensus Statement** (Makoul et al, 2024). Combining the evidence from David Kolb's collaborative learning and problem-solving approach with the content of the slightly adapted Glasgow Consensus Statement results in a four-step process: Connect – Observe/understand – Respond – Engage. This gives rise to the acronym CORE..... which is, in fact, the core of all understanding and collaborative-participatory communication. CORE, as an acronym for the dialogue process, is a proposal by the Comlab Centre (www.comlab.ch) at the University of Bern.

Basic rule: we should spend 75% of the conversation time on 'input' – that is, listening ('Connect' and 'Observe & Understand') – and only 25% on 'output' ('Respond, Engage'), i.e. providing information and advice! Then there is a very high probability that we will feel heard and understood by one another, that emotional knee-jerk reactions will be avoided, and that a dialogue will emerge, not a monologue (Barden, A et al (2024).

An important step occurs when 'switching sides' from reflection to action, i.e. from 'Observe & Understand' to 'Respond': this involves the so-called 'formative summary', an initial subjective summary from the professional's perspective (according to Prof. Peter Martin, Megan Chiswell, Deakin University, Melbourne).

Engage – joint plan
- Develop
- Clarify responsibilities
- Take interprofessional competencies into account



Connect as humans – building relationships
- connecting as people
- Current problems/concerns,
- Clarify agenda/expectations

Respond – address the obvious problem
- Problem-solving / strategic plans
- Options (illness and suffering)

Observe – observe and understand
- the patient's experience of the illness
- the medical staff's understanding of the illness
- the obvious problem that nobody wants to address

The ‘formative summary’ consists of the following steps:

1. Announcement	• Asking for permission: may I summarise what I have understood? (see above) • Please correct immediately if this is incorrect
2. Summary	• What I have understood: 1. What is the diagnosis? (disease) 2. What impact does the condition have on daily life/functions? (illness) • What fears/concerns are present? • Wait 3–5 seconds after each statement to allow for possible correction
3. ‘Breaking bad news’ and options	• Address the elephant in the room (e.g. SPIKES; warning shot: clear and brief): ‘There’s no getting round it: unfortunately, the disease is progressing’. • Possible options? • Ideally, the patient takes the lead in considering possible options for daily life • The doctor is often chosen as the guide

These steps are used to create a ‘shared care plan’: each participant takes on not only strategic tasks (‘what are the options I can or must take into my own hands?’), but also very practical, organisational ones. As in problem-based learning, the outcome of the problem-solving cycle depends on both (or more) participants. The solution does not come from the specialist, but from mutual reflection, classification and ation (cognition), followed by participatory planning and concrete action taken jointly.

My body as a communicator: non-verbal and paraverbal communication

How do I come across? How do I feel? What do I sense? Is there a connection with the other person? The congruence of verbal, non-verbal (e.g. posture) and paraverbal (e.g. tone of voice) communication is what makes me feel authentic and, ideally, ensures I am perceived as such by the other person.

A ‘body check’ in communication, from head to toe, is therefore so fascinating, and can and should be consciously practised. I observe myself, but also the other person. Example: when we concentrate on looking the person sitting opposite in the eyes, this creates a special connection that ideally signals focus and undivided attention (note: cultural context). If I look at the screen, I convey to the other person that other information is currently more important (e.g. ‘phubbing’, ‘you-it communication’ according to D. Goleman).

There are countless scientific reports on body language, some of which are quite critical. This is particularly true with regard to a possible overestimation of non-verbal communication/body language (Patterson, 2023). Nevertheless, our body is our most important communication tool. It is only through our bodies that social interaction becomes possible in an encounter; an interpersonal resonance and response arises.

The perception of non-verbal and paraverbal cues applies to both myself and the other person.

Body part	Communicative significance	Modification
Eyes	Focus, attention, curiosity	E.g. cultural (no direct eye contact with married women of the Muslim faith)
Ears	Signals listening, 'all ears'	Hearing loss?
Nose	Breathing: feeling one's own breath, speed, depth; also that of the other person	Stress? Relaxation (also in conjunction with the shoulder girdle/back)
Hands/arms	Open arm/hand posture: interested, wants to 'grasp' the situation	Can emphasise the importance of what is said; caution: pointing with the index finger ('schoolmasterly')
Legs/feet	Tension/relaxation; calm/restlessness; time/no time	A casual leg position can be interpreted as a sign that the other person is unimportant
Shoulder girdle/back	Tension/relaxation	Usually in conjunction with breathing and tone/pitch of voice

Additional non-verbal cues/impact on the atmosphere in the room:

Shaking hands when greeting or the 'Corona variant' – hand on the heart	Attention	With deliberate eye contact: Focus
Seating arrangement/table shape	Round = open conversation Opposite: beware of 'interrogation'	Also: what else is on the table? A glass of water? A computer? A notepad?
Standing/sitting	Eye level/equal status	
Distance	Physical proximity – is touch possible? Support or distress	'Test touch' – how does the other person react?

Examples of non-verbal signals of active, observant listening in practice

- Calm eye contact; allow them to look away
- Open arms/hands; calm movement
- Legs relaxed without 'shuffling', leaning back in the chair/shoulders lowered
- Deep, calm breathing
- Adjusting the volume of one's own voice to match that of the other person (note: hearing impairment)
- Occasional handwritten notes (ideally a notepad or tablet)

Examples of non-verbal signals of 'appeal', directive communication/counselling (output)

- Focused eye contact; avoid looking away
- Hands/arms emphasise the importance of what is being said

- Leaning forward
- A strong, audible voice with clear articulation

Pauses: long recognised, and always room for improvement: they play a major role in ensuring successful listening. I wait at least 8 seconds before replying. Knowing when to use and maintain pauses is a very important skill!

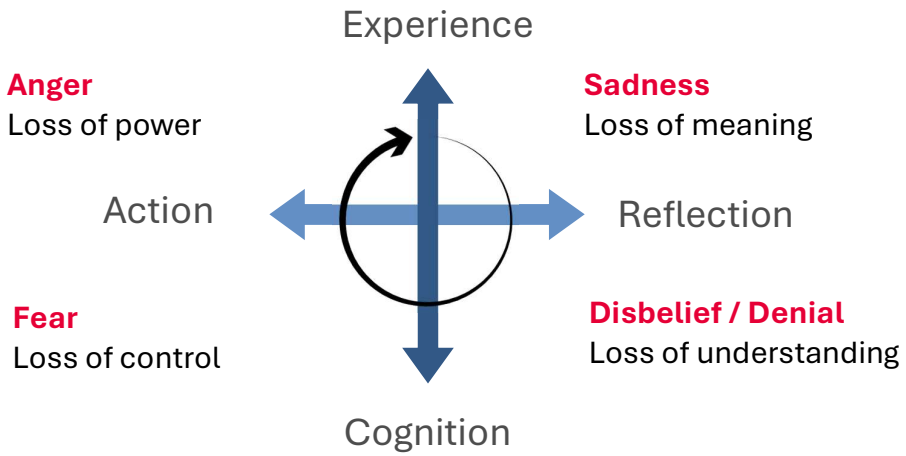
Be aware: our bodies are constantly communicating. This is made possible, among other things, by our mirror neurons (e.g. unconscious reactions to facial expressions). Two 'circuits' are involved in this (see Goleman D, 2006):

- First reaction (amygdala – thalamus) = a quick and unconscious response to the other person's signals. Mood, emotion, e.g. anger, sadness, openness, warmth
  → transference/countertransference

- Second reaction (prefrontal cortex) = conscious, slow, perception of the 'emotional tone' of the other person and of the self→ self-awareness, self-reflection; perception of the unconscious reaction (including one's own body tension/facial expressions); addressing the emotions where appropriate

An important skill is therefore also 'IN & UP': I rise above our conversation like a bird or a drone and look down from above. This is an immediate technique for analysing emotional states: what is happening here right now? What emotions are present, in me, in the other person? Are there too many emotions at play right now, so that we can no longer search for a way forward together in a rational/cognitive manner? Discrepancies between verbal and non-verbal communication?

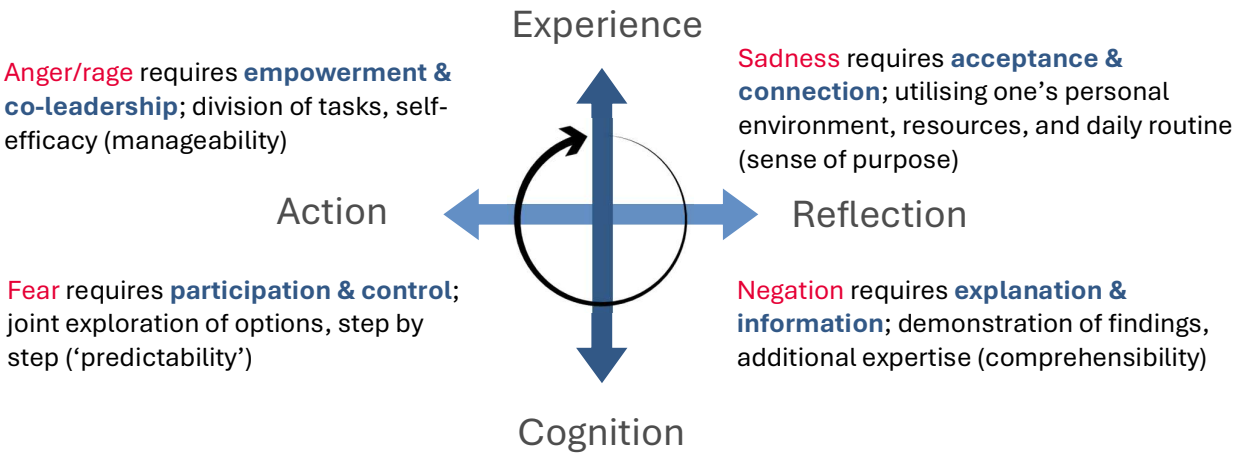
A cross-check of the most common emotions reveals (according to Stewart Dunn, Sydney) the following four emotions, which occur in both myself and my counterpart and can predominantly be attributed to understandable causes:



Example: When someone communicates in a highly accusatory or angry manner, this may be because they feel powerless ('loss of power'), or do not know or cannot find a way to deal with the situation. By analysing and understanding the potentially underlying emotion, we can try to

offer the other person ways in which these emotions can be 'resolved' in the best possible sense – guided by the 'sense of coherence' of salutogenesis (Antonovsky, 1987):

- Anger/rage: ways are needed to regain 'power', empowerment
- Sadness/resignation: it often requires expanding the support network/involving other supporters to make the situation bearable
- Denial: cognitive explanation/clarity is needed, possibly a second opinion, but also an active search for underlying emotions such as fear
- Fear: the aim is to regain control – clear, small steps, regaining self-efficacy.



Is there a basic guide to communication in healthcare?

Yes. There is very good evidence on many topics relating to communication in healthcare. That is why, with BECOM, we are trying to create a foundation for further development and discussion. Some points may sound very much like common sense, which they are. However, this common sense is often not applied in everyday practice – leading to potentially avoidable crises, annoyance and frustration. What is striking is that we have no systematic communication training, either at school or in vocational and further education, in most professions. Everyone, without question, undergoes thorough theoretical and practical training to take part in road traffic. How we interact with one another on the roads is based on generally accepted and valid rules. We pay for this driving licence; if we break the rules, we pay fines. No question about it.

In the field of communication, there is neither systematic theoretical and practical training nor any form of certification or qualification, nor are there clear rules or penalties for breaches of these rules. Wouldn't our interactions be far more humane, respectful and – simpler – if such training and such an important qualification existed?

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