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Original Paper

Learning to Establish a Therapeutic Doctor-Patient Communication: German and Israeli Medical Students Experiencing Integrative Medicine's Skills

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Abstract

The doctors' clinical time collides with the increasing of the use of telecare technologies in our digital era, reducing the actual doctor-patient interaction and the potential to engage with therapeutic doctor-patient communication. In our qualitative study, we followed a collaborative German-Israeli project that trained medical students to use complementary and integrative medicine (CIM) methods in order to improve doctor-patient communication. Interviews with the participants and participatory observation revealed the ways the mentors taught CIM methods, the meaning of therapuitic doctor-patient communication and how the students learned and implemented these skills in different ways. Our findings show that students expand their communication channels and skills, notice their own somatic-sensory states, and engage with somatic knowledge in different interactions. Our findings correspond with, and signify the intercorporeal space of doctor-patient interaction in the way in which doctors' and patients' soma-sensual aspects are interact, influence each another, and enable therapeutic communication.

Keywords

Therapeutic doctor-patient communication, somatic knowledge, intercorporeal space, complementary and integrative medicine, medical students, Germany, Israel

1. Introduction

> *We experience ourselves, bodily, through the other, as visible to the other and this drives us to stabilize our relationship with them. We can either achieve communicative understanding or try to dominate them. But we must do something because their sheer presence is sufficient to affect us.*
>
> (Nick Crossley, 1997, p. 27).

Western medicine uses and maneuver between different treatment paradigms, especially the Evidence-Based Medicine (EBM) and the Patient-Centered Care (PCC). On the one hand, the EBM paradigm focuses on the patients' diseases and somatic symptoms, it relies on the doctors' gaze and interpretation of the patients' physical-chemical-genetical characteristics and refers to scientifically approved concepts and treatments. By relying on EBM paradigm, doctors tend to unify different patients with different somatic experiences and different socio-economic backgrounds to one diagnostic group. And, most importantly, EBM seeks to give the best treatment existing, based on the bio-medical historical and contemporary empirical field. On the other hand, the PCC paradigm is oriented towards various aspects and issues of the patients' illness and living experiences, it highlights the patients' uniqueness and their broad elements of living conditions, including the bio-psycho-social characteristics and conflicts that affect patients' somatic experiences. The PCC paradigm aims to put the patients' needs, norms and values as the crucial part of the treatment decision making and the healing process (Anderson & Funnell, 2005; Barry & Edgman-Levitan, 2012; Bensing, 2000; Straus et al., 2018; Timmerman & Mauck, 2005). Doctor-Patient Communication (DPC) skills, as Bensing and her colleagues argued, are manifested within the royal path of combining EBM and PCC paradigms and consider their advantages in doctor-patient interaction (Bensing, 2000; Bensing, Van Dulmen, & Tates, 2003; Derksen, Bensing, & Lagro-Janssen, 2013). Many studies show the effectiveness of good DPC on the patients' healing process, how it builds doctor-patient trust, establishes good interpersonal relationship, reduces patients' stress and motivates patients to heal (Bredart, Bouleuc, & Dolbeault, 2005; Ha & Longecker, 2010; Howick et al., 2018). Effective DPC means a therapeutic communication, enables an open dialog, addressing all the relevant information about the patients' biopsychosocial condition, the diagnostic process and findings, the possible treatments, doctors' empathy, trust and shared decision needed to foster healing (Weiss & Lonnquist, 2009:261). However, effective DPC is not easy to achieve. The DPC effective skills are developed through social interactions, professional and private socialization, self-reflection, doctors' awareness of, and coping with possible obstacles, for instance, organizational financial issues, bureaucracy issues, etc.; and also the doctors'

acknowledgement, especially after their own personal experiences of being patients, of the different power relations and inequality existing in society and how it reflects in health system, between different patients, and between doctors and patients (Goodyear-Smith & Buetow, 2001; Kitzman, 2006; Fox et al., 2009). Hence, doctor-patient effective communication embodies many barriers that relates to the micro doctor-patient-interaction aspects, such as problematic doctors' communication style, daily stress and time pressure, but also on the macro sociological level, especially the ways neo-liberalism policy affects the medical system and the different players within it. The neo-liberalism policy, as Filc and other researchers argued, turns citizens' health/illness to commodity that has different price according to the market's dynamics. This socio-economic policy aims to maximize the capital of the clinics and minimized the capital loss by reducing the medical resources on each patient (including DPC), which expand the private, expensive health care and the establishment of an unequal health system (Filc, 2005; Stoeckle, 2000). The doctors as well as patients, are crucially affected by this capitalism regime, doctors are forced to maximize their clinical work, see, diagnose, and treat as many patients as possible. The doctors' clinical time collides with the increasing of the use of telecare technologies in our digital era, and especially in our pandemic time which reduce the actual interaction and the potential of therapeutic doctor-patient communication. This problematic, bio-techno-capitalistic atmosphere together with our current pandemic panic and social distancing, fosters negative and conflicted clinical experiences, stressful clinical environment, miscommunication, mistrust, doctors and patients' uncertainty, doctors' overload, burnout etc. (Lupton, 2013; Mort Carl & Williams, 2003; Scheeres et al., 2008). These, in a way, are some of the 'pathological symptoms' of the health system of our time and there is a call for dramatic changes, to set a different clinical strategy that aims for better doctor-patient interaction and communication which are less mechanical, stressful and more holistic and humanistic interactions.

From these socio-economic and health issues, and the need to improve doctor-patient communication skills, the project titled "Improving medical student's communication skills with integrative medicine" was emerged and will be discussed in detail in this article. Some of this project's findings already published elsewhere (Ortiz et al., 2018), however in this article we focus on the ways Complementary and Integrative Medicine (CIM) skills enabled doctors to be aware of, and to experience the importance of the soma-sensual aspects existing in DPC. CIM is a wide field of diverse medical and health care systems, different practices and products that differ from the conventional bio-medical practices (Maizes, Rakel, & Niemiec, 2009; Weiss & Lonnquist, 2009). CIM perception of diseases, illnesses and the healing process significantly differs from the western bio-medical approach because of its holistic perception which includes patients' physical, mental, spiritual and the social aspects that intertwined with patients' wellbeing. According to Brinkhaus and Esch (2020), "integrative medicine and health reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic, preventive, health-promoting, or lifestyle approaches, healthcare professionals and disciplines, to achieve optimal

health and healing, emphasizing the art and science of healing. It is based on a social and democratic as well as natural and healthy environment." (2020, p. 2). For the last two decades, CIM's methods and practices became more and more popular, integrated in clinics and empirically studied (Ben-Arye et al., 2013; Maizes, Rakel, & Niemiec 2009, p. 17; Schiff et al., 2012). Many studies show positive outcomes on patients healing process and wellbeing (Korthals-de Bos et al., 2003; Rosenzweig et al., 2010). CIM among many things, focusses on the importance of effective DPC for both, the patients and the doctors, to achieve patients' optimal healing process and better care (Guarneri, Horrigan, & Pechura, 2010; Herman et al., 2014). Moreover, CIM methods enable to reduce communicational barriers between doctors and patients, establish therapeutic interaction and help to signify the *intercorporeal space.* Intercorporeality is a phenomenological term, established by the philosopher Maurice Merleau-Ponty (1968), and further investigated by Nick Crossley and many others (Crossley, 1995, 1997; Csordas, 2008; Weiss, 2013). It derives from the assumption that the human body, the flesh, is our core element of our beings, of our perception of the world. Humans' existence is a corporeal unification of physical, emotional and consciousness. The ways one thinks, talks, behaves and socially interacts are not only deeply related to one's own somatic-sensual characteristics and experiences, but also are relational to, and established by, others. Interaction with others, according to phenomenological approach, means to share a same carnal world, although from different embodied-sensual experiences, but our bodies are visible to, perceived by and affected on one's body in an inter-mundane space (Merleau-Ponty, 1968). In other words, our bodies are dynamically affect and being affected by other bodies and establish our perceptions and communicational ways. The soma-sensual emotional aspects of interaction express what we refer to as the intercorporeal space, the ways bodies interact in different settings and influence one another. We will describe how intercorporeal spaces manifested and experienced by the students in our project. This article aims to contribute both, doctors and medical students in practical manner and also to establish the theoretical and conceptual framework of soma-sensual space in social sciences fields.

2. Method

2.1 How to Improve Medical Students' Communication Skills with CIM? German-Israel Collaborative Project

This project aimed to integrate different CIM methods and skills with the medical students' existing medical knowledge. The overall project's goals were to gather German and Israeli students and mentors in order to learn about different CIM methods with a focus on practical and personal experiences and exchange, and to research on how CIM methods can improve communicational skills. Finally, various Educational Modules (EM) were collaboratively established to be shared with other medical students and professionals. We conducted a qualitative study and followed this project's activities, process and participants. The main question in the qualitative study were, how do mentors

teach CIM methods? How do CIM methods improve DPC skills? How do students learned and implement CIM's methods?

2.2 Data Collection and Analysis

Our German-Israeli collaborative project included 33 participants; twenty-two medical students, the students were in the 3 and 4 year of medical school, eleven students from both countries (13 female, 9 male students), nine mentors (five Israelis, four German; two female, seven male), and two public representatives and qualitative researchers, one from Israel and one from Germany (two female). The mentors were eight medical doctors and one psychologist and experts in herbal medicine, Chinese Medicine, Anthroposophical Medicine, Homeopathy, various Touch therapies (Shiatsu and Massage), Hypnosis and Mind-Body Medicine (e.g. meditation and mindfulness practices). The students were recruited through medical schools' mailing lists and postings at Charité - Universitätsmedizin Berlin and various medical schools in Israel. The selection criteria focused on the candidate's professional interest in CIM, fluency in English and prior experience in team work and work with patients. The mentors were experts in various CIM methods in Israel and Germany and asked for participation by the Principal investigators (BB, ES). Between 2017 and 2018 all participants gathered in three workshops, each for three days in Berlin or Haifa.

The three workshops took place in Berlin, Haifa and again Berlin. At the first meeting the students were introduced to and experienced different CIM methods, the mentors used Word Café methodology (Brown & Isaacs, 2005; Fouché & Light, 2011), in order to work with, and teach CIM aspects in small groups and discussed the participants experiences, feedback and issues which emerged in different 'sensual stations'. By the end of the first meeting the students were asked to choose one CIM methods interested them most. The four main CIM methods were Mind-Body, Move and touch, Chinese traditional medicine and herbal medicine. Each group had Israeli and German mentors. At the second meeting the different CIM groups exchanged about the experiences they had gathered in between the meetings and discussed different communicational skills and how to use it in DPC. The students started to gather ideas for the development of the educational modules. These ideas were developed further in between the workshops for the final project meeting. On the third meeting, each group finalized their educational module and presented it to the group, received feedback from mentors and the other participants and co-worked in each group to improve and change their ED's accordingly. We, LMD, VB and BS participated in each of the project's workshops, followed the project's activities and participants by participatory observation method. The data consisted out of more than 90 hours of participatory observation throughout the project's meetings, in both, the theme groups and in the big group gatherings of all participants; we collected the participants' feedback through set of questions after every project meeting, we also conducted half structure interviews with four mentors and four students before the project began. At the final meeting, we conducted two group interviews, one with the students and one with the mentors.

We thickly described our and the participants experiences, our self-reflection of the meetings experiences, the participants' interactions and different group activities. We captured and analyzed the meaning and features of the different participants 'experiences' (Sokolowski, 2000; Starks & Trinidad, 2007). The data analysis based on the grounded theory method (Charmaz & Belgrave, 2012), we shared our observations data, compared our main subjects and discussed about the main themes. After every workshop we co-wrote a report (three reports in sum) which summarized the meetings 'goals, the students' learning process, the mentors' experiences, the groups work, the atmosphere and dynamic, and the different aspects of CIM and DPC relations. The half-structured interviews and the groups' interviews were analyzed thematically by focusing on the participants' significant statements, their meaningful experiences and issues related to CIM skills and DPC (Creswell, 2007, p. 61). We used pseudonyms in using quotations to keep the participants' privacy and anonymously.

Our research project was approved by the Ethic committee of Bnai Zion hospital (00-24-17-BNZ).

3. Results

3.1 Teaching and Learning to Communicate with the Senses

> *I think many times, the doctors have a kind of a tunnel vision,*
> *they look through a pipe and have a peripheral blindness.*
> *Because they are taught to come and choose the things that fit their puzzle, so they will not look beyond.* (Dr. Gilad, Israeli mentor).

How and why do the medical students learn to communicate with their senses? How do the medical students experience sensual communication? And, how does sensual communication improve DPC? This section refers mostly to the students' learning experiences at the kick-off meeting. In a World Café setting different 'sensual stations' were introduced. The World Café methodology is a flexible format for hosting large group dialogue. Its aim is to give the participants the possibility to experience different aspects of a theme and to express their ideas and feelings in a creative conversation through a series of small group discussions (Fouché & Light, 2011). The mentors perceived the importance of sensual communication in DPC for the doctor's meaningful humanistic work and wellbeing, as Prof. Tal, one of the Israeli mentors explained, *"it is a kind of an inner search for connecting with one another, not through one's illness, but to try to figure out where this person is stated in its life journey and why, what is the question of its journey?"* In order to emphasize the importance of using/be aware to different senses in DPC by self-experience, the project's mentors provided five sensual stations: seeing, hearing, touching, breathing and listening for the students. In each station, one or two mentors introduced the sensual station activity (15-20 minute each station) and asked the students to share their experiences and think about how it relates to, and contribute to DPC. On each station there were big sheets placed for collecting the student' sensual experiences and how it related to DPC. As examples we will present two of the sensual stations, seeing and touching, in order to describe and exemplify the

experiences and practices of communicating with the senses, as well as the knowledge and messages existing in different intercoporeal spaces.

3.1.1 Seeing

At the 'seeing station', the students were asked to split into pairs and conducted an interview while sitting back to back without eye contact. Next, the students were asked to switch partners and to be divided to German-Israeli pairs and to conduct an interview by using their mother tongue, but this time they were sitting face to face. Observing and experiencing these practices, we noticed how in both exercises, all the participants were eager to listen and understand one another, some of the participants closed their eyes in order to concentrate and focus on their partners' messages. The face to face interview, by using the mother tongue, which was not understood by the other, invoked laughter at first, it seemed strange to try to have an interview with different languages, however the more the exercise continued it seemed that the participants' linguistic gap took less space and replaced by other physical communication channels (e.g. mimic, tone of the voice, body language). By paying attention to these other aspects, it seems to us that the participants understood one another on soma-emotional level. The content and the meaning of the verbs were blur and vague, but the different emotional states of the speaker seemed to be clear. The students' feedback of their 'seeing' station experiences include:

- *"We can understand many physical aspects of one another even when we do not have a visual input or speaking the same language."*
- *"Lack of seeing, enable us to focus on many physical and emotional details, the voice, the intonation, gestures and body language."*

By challenging the dominancy of seeing one another and speaking the same language in face to face communication and interaction and communication, the mentors aimed to broaden the student's sensual communication skills and taught the students to be open to many other soma- emotional messages, existing in face to face setting, which are usually ignored, but might be very useful for better communication.

3.1.2 Touching

In the 'touching station' the students experienced different exercises, the first was a handshake, the students were asked to shake hands and pay attention to the physical-emotional experience of this particular touch. In the second exercise the students were asked to focus on ways of touching without actually touching. The students held their hands close to each other's bodies, and changed their hands' distance while self-monitoring the feelings arising in their palms and other body parts. In the final exercise the students were asked to touch hands, shoulders, neck and face of the partners and pay attention to their experiences through the modes of touch, which touch they experienced as more relaxing, comfortable, and which touch was uncomfortable, too intimate etc. The students summarized their experiences with these following themes:

- "Touch is both, a personal and subjective experience, while we are touching others, we are also being touched."

- "Touch is unique and it is experienced differently each time, even by the same person on the same physical location."
- "We do not know how others experience our own touch. We should be aware of the cultural and gender differences and taboos pertaining to the meaning of touch, physical areas such as face, neck, shoulders which are more intimate than hands, legs. There is a gray zone between professional touch and intimacy that should be acknowledged.
- "We can experience touching/presence without physically touching, e.g. like a tingling sensation in the palms."

How do the students relate their sensual practices and experiences in the sensual stations to an effective and better DPC? Summarizing the students' feedback of the sensual stations practices and how it relates to effective DPC, we found that the students understood the value of many physical aspects that not only exist in DPC, but are also important in their daily social interactions. The body language, the facial expressions, the voices tone, the modes of touch, the inner noises that interfered with listening to others, which usually are "ignored" or "taken for granted", as the students argued, become central communicational channels and a useful source for knowledge. The students, during the whole project, learned how to be sensitive to and communicate with and through their own and other's sensual bodies, in different interactions. After the kick off meeting and during the four months between the first and the second project's meeting, the students were asked to collect information and make first personal experiences in their chosen CAM method and to work and develop DPC skills together with their group members.

3.2 Learning to Establish Therapeutic DPC

> *I think in the age of Google, Facebook, and the Internet, the issue of doctor's role is significant. What is the value of doctor's role? While many aspects of doctor's role are reduced and replaced by technology, I think that the most important value of doctors is to establish a significant relationship and communication with patients. Knowing how and what to ask the patients, questions that are relevant to the patients' personal life, their social, familial changes that might affect their emotions and health states…* (Roi, an Israeli medical student).

The second meeting focused mainly on self-experiencing and learning CIM aspects of DPC and working group sessions to develop future educational modules. In this section we will describe two main CIM skills that helped in establishing therapeutic communication and were manifested through the project's sessions, groups' learning process and experiences. These skills include the "breathing space", which focuses on how our breathing changes dynamically in different interactions and situations, its' mirroring affect and therapeutic elements. And the "mindful touch", which includes various ways and meanings of touching and being touched. We chose to focus on these practices because of three main reasons, first, these practices were dominated throughout the project's sessions,

and perceived by the mentors, and later on by the students, as significant and useful for DPC. Second, we experienced these practices ourselves during the group meetings and how it influenced our own soma-emotional states: we were more concentrated, relaxed and open to learn. Third, these practices are simple and useful tools to reduce anxiety, pressure, and to be present in the moment. Being mindful and present through using these practices, not only reduces stress and helps one to be focused, as many students expressed in group discussions and feedback, but also, to be open to our physical and emotional aspects while interacting with others, which could open many communicational channels, various corporeal information, that have therapeutic potential for both, doctors and patients.

3.2.1 The Breathing Space

During the second meeting, the mentors started the day/or the session with meditation exercise. This exercise included deep and long breathing, clearing the thoughts and inner noises and to be present and mindful to ones' own feelings. We notice, after experiencing the various exercises, how it created an open communicative group atmosphere, positively influencing our focus, concentration and group cooperation. The mentors highlighted the significance of deep breathing for the doctors and the patients' wellbeing, and how deep breathing exercises could reduce daily stress and clear the mind. In one of the breathing exercises, the students were asked to sit in pairs, back to back and breath, and to focus on the different sensations that arose. The students experienced the differences in their own breathing and their partners', between a deep and long breath to short and fast breathing. They noticed how different breathing affects their heart beats, their body warmth, and their emotional state. The students' elaborated breathing relation to DPC by emphasizing that breathing is more than a mechanical physical experience, it would be a source of knowing and touching one self and the other, a skill which would raise their awareness of how different interactions influence the ways they breath, and how breathing has mirroring effects, and that we react on each other's' breathing. While the *breathing space* was an important communicational channel to all the students in this project, the mind/body group deepened the breathing aspects in their group sessions and developed educational module based on these skills. In this group, deep and long breathing was the main aspect of communication and healing, the students experienced various breathing and meditation practice; hypnosis exercise; and auto-genetic training. Each of these CIM skills, according to the students' feedback, helped them to be focused, relaxed their bodies and enabled them to be more sensitive to their personal as well as others' somatic issues, pain, stress, etc.

3.2.2 A Mindful Touch

Engaging in different project's sessions, the students experienced different modes of touch, the meaning and the significant role of touch in DPC. The students learned to be aware of the soma-emotional messages transmitted through different modes of touch, how, for instance, touch has a therapeutic aspect, including how it can transmit a feeling of security, warmth and trust. Moreover, the students learned about the negative modes of touch, such as mechanistic alienated touch or too intimate/uncomfortable touch, for instance to be sensitive to avoid touching intimate body parts if not

medically necessary, and to consider gender issues while engaging in physical examination. Negative modes of touch might create traumatic and even abusive patient's experience which would damage doctor-patient interaction, communicational and trust.

The "mother hand" technique in Shiatsu's therapy involves the both hands of the doctor/care giver; one hand as the "mother hand" which is the steady, comforting hand, and the other hand as the more active (treating, diagnosing, moving) hand. The importance of this technique to the doctor-patient communication, as the group's mentors described, is that it calms the patients, make them feel comfortable and help them to relax. The students learned to use this technique, practice it with other partners and how it could be used in various future examination with patients, such as a pulse test, lungs' test, abdominal test etc. Moreover, the mother hand technique was said to transmit many information on the patients' physical-emotional state, for instance, the patients' temperature, the characteristics of the patient's breathing, skin and which physical areas are more/less sensitive.

The breathing space and the mindful touch involved various soma-socio-cultural aspects of DPC. The ways we/doctors/patients' breath and touch are two physical examples, out of many possible others, such as, listening, seeing, tone of our voices, moving, etc. to describe and acknowledge the intercorporeal space and how it establishes DPC. The students learned and experienced during the breathing, touching and other different exercises, the significant meaning of being in the moment while communicating with others. They learned to acknowledge, and to be sensitive to their own bodies, senses, emotional and feelings while interacting with other bodies. This intercorporeal space, the various soma-emotional experiences exist in interacting with others, should be the heart of DPC. In intercorporeal space, bodies are influenced and communicate with one another in different ways. Focusing on how doctors'/patients' bodies interact and transmit various messages might be useful for both, doctors and patients in the diagnosis process and healing journey. However, as we mentioned before, it is not easy to establish a DPC sensitive to intercorporeal space in daily pressured clinical setting. In the next part, we will describe how the students, based on their learning process and their different experiences, created useful Educational Modules (EM) to establish better DPC with CIM methods. And also, we will describe how the students related and dealt with different communicational barriers.

3.3 Educational Modules to Apply CIM's Communicational Skills

The EM's evolved from the participants' experiences, interactions and interest in different CIM methods and skills, as well as from the collaborative work in the thematic groups. The touch and move group developed two EMs, including Mindfulness and Mindset' and 'Mindful Touch' (links to students' EM attached at the appendix). On the 'Mindfulness and Mindset' the students provided different knowledge on mindfulness and various useful techniques. Mindfulness, as described in this EM, characterizes the process of how one becomes physically, emotionally and mentally aware, attentive and present. It highlights the significant value of how to be-present in the moment, and how to avoid automatic reactions, thoughts and behaviors. Mindset, on the contrary, reflects our set of values, our

thoughts and believes about ourselves and of others. The mindfulness techniques that this group described could enable doctors and other users, to be sensitive to their physical, emotional and mental aspects in order to be present and better communicate. For instance, doctors, even in their daily clinical routine, between one patient to another, could use the mindfulness techniques. One technique is to use washing hands as an awareness ritual, that give time to be aware and sensitive to one's own body, e.g., by feelings the water and the soap, getting aware of the movement of the hands and how they touch one another. This exercise, could help doctors to clear their minds and open their senses, be present and aware of their soma-emotional states, before engaging and interacting with the next patient. The second EM of this group, the Mindful Touch focuses on doctors' mindful touch in the context of physical examination. It highlights the significance of the doctor's touch in DPC and offers different techniques for mindful touch with video illustration. It includes gradual touch techniques as well as meditation techniques and doctor-patient mirroring affect.

The mind/body group established a booklet, which was organized like a buffet. It presents a variety of ways to improve self-awareness on the one hand, and DPC on the other based on self-experiences of the group members. Self-awareness, as the booklet emphasizes, is crucial and interrelated to both, our daily routine and the doctor-patient interactions. The booklet invites the readers to experience different dimensions of mindfulness techniques, including reflective diaries, reading poems, drawing pictures, autogenic training and pacing/leading technique. The students wrote in their booklet's introduction: "*During our work we realized that there is not one right way or one technique to learn because everyone - every patient, every doctor - has a different background and different needs. What helped us the most, was for every one of us to find an activity that leads to more self-awareness and conscious communication {…} Our aim is to give you a little inspiration and maybe you find your own personal way to a more conscious communication according to the needs of your patients.*"

The Traditional Chinese Medicine (TCM) group designed an EM that focuses on two main topics for improving DPC (Note). The first was to characterize the patients by using the main principles of the five-element theory. The five elements theory in TCM describes the natural and forceful elements that exist in our universe as well within every human being (Lao, Xu, & Xu, 2012). Fire, Water, Earth, Metal and Wood characterize different physical, emotional and behavioral qualities that the doctors should define and address within their patients as a base for therapeutic approaches. The second part of the EM provides TCM based skills that emphasize using different senses when interacting with patients. This technical part shortly presents the senses and the different physical features that doctors should be aware of. According to this group the classification system of the five elements might reduce or narrow the ways doctors interact with their patients, by putting them in one or the other category, hence, doctors should take these elements as only one of their communicational tool box.

In the Herbal medicine group, the students shared their experiences on herbs and herbal therapies from different perspectives and in different settings. The diverse experiences they brought with them built a broad picture of herbal therapy concept, in relation to users/patients, and healthcare practitioners. The

students in the group discussed in general on the misconceptions of herbal medicine and a lack of knowledge of toxic herbs, which could even lead to dangerous misuse of herbs. The group created EM that includes a video and a pocket card with short instructions that illustrates interaction between patient and doctor, how they communicate on herbal medicine, the effective and important questions doctors should ask patients who want to use specific herbal drag. This video also illustrates problematic DPC and misuse of herbal drag. This EM also offers practical ways to engage research on different herbs, their interaction with different medicaments, and refers the reader to a web site dealing with potential problematic interactions.

Another important aspect of how to reduce DPC barriers, which students learned through the project's meetings, is the ability to be open and free from schematic methods and patients' categorization. While categorization and treatment methods are central in medicine, the students learned to see the doctor-patients interaction as a mutual corporeal journey and that the physical symptom of diseases are only one part of this journey's path. Other paths of this journey is to be able to use holistic approach, to be open to the soma-sensual elements exist in DPC, pay attention to the intercorporeal space exist between the doctor and the patient, which will help to reach broader context of the patients' living experiences and social issues. The meaning of this journey for the students manifested in the ways their "medical tool box" expanded with different CIM's skills, and enabled them to dynamically investigate different techniques and better use for specific patients and for specific interactions. These communicative skills might exist when they are soma-sensual present, in here and now with the patients, as well as aware of the intercorporeal space exist between them and their patients. This unique space includes many important soma-sensual messages that help to build trust, reveal knowledge and help with therapeutic process. For instance, one German student described, at the end of the project, how she *"valued greatly the 'in-betweenness' in interacting with her patients."* An Israeli student described how she uses different CIM's techniques with different patients:

> *The repetition of the patient's words and the sense of listening to what it created establishes trust and contributes greatly to the patient-therapist relationship. Another technique I use here is to synchronize my breathing with the patient or his parents [in pediatrics]. I have found that this method created a positive atmosphere near the patient's bed. By using these methods, I enter the patients' world, get various useful information for optimal treatment.*

And, another Israeli student, express how his communication practices with patients changes after the project:

> *I am significantly more aware of the importance, meaning and reciprocal influence of communication skills on our daily clinical life. I want to emphasize that this change isn't abstract at all, I reap the results of the program every day while talking to patients in the hospital. I learned very practical tools which improved my anamnesis,*

my physical examination skills, and other clinical abilities. I see a huge change when I compare myself today to myself at the beginning of the project approximately two years ago.

4. Discussion

Through the learning and working experiences of students and mentors in this German-Israeli project, we studied how various CIM methods and techniques revealed and expressed the intercorporeal space. That is, not only crucial and a rich source for communication and understanding one another, but also, a shared space for therapeutic potential. By acknowledging and openly relating to these soma-emotional sources of communication, doctors and patients might reduce uncertainties and communicational barriers. Intercorporeal spaces might therefor be a source for healing processes and therapeutic interactions. As our study revealed, using simple techniques, such as, mindful touch and breathing exercises, could help doctors and patients to reduce stress, anxieties, to build trust and establish better and open DPC. These findings invite other studies to focus on the intercorporeal space in doctor-patient interaction and communication, especially its effect on the patients' healing process and doctors' professional satisfaction and reduce, if any, doctors' burnout.

Although the project aimed to educate medical students to use different CIM skills, and create educational modules for other medical students and health care professionals, we found that this project achieved many other important qualities that students learned. For instances to learn to work and cooperate together, to share their struggles and feelings, to foster respect and understanding, to be open to different perspectives and languages and exploring the heart of their relationships with patients, which we think, it is a crucial part of DPC healing process. The lessons from this project shows that every new doctor-patient interaction is a beginning of a joint journey, the doctors' and the patients' journeys are at the same time separated and connected to one another. In this journey, many paths, socio-cultural-physical-elements and contexts are involved, interfered and intertwined, hence this project signifies how each journey, each doctor-patient interaction, is unique, and should be highly valued. If we take this projects' goals and outcomes seriously, and doctors would be more sensitive to the intercorporeal space in DPC, it could help to positively reflect on patient' trust to doctors, on patients' hopes and doctors' hopes and cooperation of the healing process, and could establish more certainty within the often-uncertain atmosphere existing in hospitals and clinical settings.

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Appendix

Mindful Touch https://prezi.com/view/kxN2SWxihRqtmaXqc1rA/

Students' EM- http://www.b-zion.org.il/pages_e/6683.aspx

Video Illustration on DPC and Herbal use https://lms.fu-berlin.de/bbcswebdav/courses/CUB-MSM_GAEDH_07_SEM_w17P/Ortiz_Patient-Doctor-Communication/Modul_patient-doctor-comunication/video.html

Mind Body Buffet https://www.b-zion.org.il/download/files/The%20Mind%20Body%20Buffet_1.pdf