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ARGUMENTATION IN DOCTOR-PATIENT INTERACTION: MEDICAL CONSULTATION AS A PRAGMA-DIALECTICAL COMMUNICATIVE ACTIVITY TYPE

In medical consultation, the doctor's advice (or the support for it) is not always immediately acceptable to the patient. The medical advice might, for instance, mean that the patient has to drastically change his behaviour. An important way in which the doctor can nonetheless make his advice acceptable is by presenting argumentation. In this paper, I will argue that, to adequately analyse and evaluate argumentation in medical consultation, medical consultation should be analysed as a pragma-dialectical communicative activity type.

Keywords: argumentative discourse, health communication, physician-patient consult.

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1. Introduction

In medical consultation, it is the doctor's task to advise patients about health related problems. Such advice – or the reasons for it – might not immediately be acceptable to the patient: the patient might have to drastically change his behaviour, he might be diagnosed with a life-threatening disease, or his symptoms might be medically unexplainable. An important way in which the doctor can nonetheless attempt to make his recommendations acceptable is by means of argumentation. A doctor could, for example, recommend a change of diet by arguing that the patient's cells do not properly respond to insulin and, hence, the level of glucose in his blood has to be steadied by controlling food intake.

The context of a medical consultation does not just enable the doctor to present argumentation in support of his advice; it also affects the way in which the doctor provides this argumentation. Medical care has become increasingly complex due to the development of more and more advanced treatment options, while patients are not always able to completely understand what these options amount to. Even so, the legal doctrine of *informed consent* requires doctors in various countries¹ to fully inform patients about the reasons for the diagnosis or advised treatment option(s), alternative treatment option(s) and consequences of refraining from treatment altogether. As the doctor has to accomplish these tasks while simultaneously attempting to make his advice acceptable in the limited time of the consultation, his argumentation can be expected to significantly differ from that in, say, informal interpersonal argumentative exchanges.

The analysis and evaluation of argumentative discourse in medical consultation consequently provides insights into the manner in which a specific institutionalised context may influence the discourse that occurs in it. Additionally, it can serve as a basis for advising professionals in medical practice on how to make their diagnosis, prognosis and/or advice acceptable to the patient. To adequately do so, I will argue in this paper that medical consultation should be analysed as a communicative activity type based on the pragma-dialectical theory. More specifically, I will

¹ The EU and countries such as Australia, Canada, Japan, Malaysia, Mexico and the US adopted the doctrine of *informed consent* in their legislation or case law.

discuss how the characteristics of medical consultation affect the strategic manoeuvring by the doctor and patient.

2. Pragma-Dialectical Communicative Activity Types

To analyse and evaluate argumentative discourse in medical consultation, it needs to be examined in which way the context can be taken into account when analysing discourse. Similar to Hymes (1977: 3) and Levinson (1979, also reproduced in 1992), Van Eemeren & Houtlosser (2005, 2006) introduce the concept of the *communicative activity type*² to systematically take into account the context in the analysis and evaluation of discourse. They see communicative activity types as culturally established communicative practices that have become more or less conventionalised, as they are to a certain degree institutionalised. Contrast, for example, the way in which the highly institutionalised witness examination in a court room affects the communication between the participants with a much more loosely institutionalised journalistic interview.

Van Eemeren (to be published) distinguishes between communicative activity types and instances of these activity types. He specifically regards the *communicative activity type* to concern – as the term indicates – the type of conventionalised communicative practice (such as “presidential debate”) and the *speech event* as the token of such a practice (such as “the first General Election Presidential Debate between McCain and Obama”).

In some communicative activity types, argumentation plays a vital role. This is, for instance, the case in presidential debates and arbitration. The communicative activity type can then be expected to shape the contributions by the discussion parties. In other words, it “discipline[s] the conduct of strategic manoeuvring” by the parties (Van Eemeren & Houtlosser 2006: 385), because of the fact that they have to take into account the activity type’s rules and conventions when striving to balance their dialectical aim of reasonably resolving the difference of opinion with their rhetorical aim of obtaining a discussion outcome that is in their favour.

² In the integrated pragma-dialectical theory, the *communicative activity type* is also simply referred to as *activity type* or *argumentative activity type* (see Van Eemeren & Houtlosser 2005, 2006; Mohammed 2008).

Van Eemeren & Houtlosser (2005: 77, 2006: 384) list preconditions for strategic manoeuvring that can differ per communicative activity type. To systematically analyse and evaluate argumentation, it is important to specify these preconditions for the communicative activity type in which the argumentation is presented. In the next sections, I will specify these preconditions for medical consultation.

3. Medical Consultation as a Communicative Activity Type

Communication has been recognised as an important part of medical consultation. Adequate doctor-patient communication is positively related to the quality of health outcomes, patient's adherence to treatment regimes, and satisfaction of both doctor and patient (Brown, Stewart & Ryan 2003: 141–155; Deveugele et al. 2005: 265). Furthermore, argumentation in medical consultation has increasingly been studied within the fields of argumentation theory (Goodnight 2006; Schulz & Rubinelli 2008), Artificial Intelligence (Boegl et al. 2004; Patel et al. 2009), and (informal) logic and critical thinking (Jenicek & Hitchcock 2005; Murphy 1997). The focus in these studies has mainly been on the analysis of argumentation in medical consultation. It consequently needs to be further examined how to evaluate the reasonableness of argumentation in such a consultation. This is particularly important, as reasonable argumentative discourse in medical consultation can be seen as a prerequisite for adequate doctor-patient communication.

The integrated pragma-dialectical theory, as developed by Van Eemeren & Houtlosser (1999a, 1999b), provides the means to evaluate argumentative discourse while taking into account the context in which it occurs. According to Van Eemeren & Houtlosser (1999a: 164, 1999b: 481–482), in argumentative discourse, discussion parties aim to resolve their difference of opinion on the merits (i.e., the parties aim to achieve their dialectical goal). Simultaneously, the parties strive to get their standpoint accepted (i.e., they aim to achieve their rhetorical goal). Balancing these goals leads to strategic manoeuvring. As discussed in the previous section, the discussion parties' strategic manoeuvring is affected by the communicative activity type in which it occurs. So, to evaluate strategic manoeuvring in medical consultation, it has to be established whether

this consultation can be analysed as a communicative activity type and, if so, what role argumentation plays in this activity type.

Medical consultation can be seen as an institutionalised communicative practice between a doctor and patient. It only occurs in assigned places (such as hospitals and doctors' practices) and is regulated by institutions (such as departments of health and medical professional associations). Moreover, medical consultation is conducted in a more or less conventionalised fashion. The doctor generally starts out by asking after the health of the patient, the patient responds to this question by discussing his health related problem and, in so doing, requests the doctor's advice about this problem, the doctor then examines the patient and, based on this examination and his general medical knowledge, advises the patient. Following Heath (1986), Ten Have (1991: 139) summarises this organisation of medical consultation by regarding it to normally consist of *complaint presentation, verbal and physical examination, diagnosis, treatment, prescription* and/or *advice*.

During this conventionalised conversation, the doctor will try to minimise a patient's anxiety or uncertainty by delivering his advice in a reassuring manner. Tuckett et al. (1985: 7) state that the doctor "is likely to give information to the patient not only about what he suffers, but at the same time about how it came about, what is to blame, what will happen, and what should be done." The medical consultation consequently affects the communication between the participants. A doctor would go about differently when informally discussing a health related problem – say at home with a family member – than in a consultation. In a similar vein, of course, the patient would discuss his health related problem differently under these circumstances as well. One can therefore speak of the communicative activity type of medical consultation.

To see how this activity type affects the doctor-patient communication, it is necessary to be more precise about the meaning of the term *medical consultation*. By *medical consultation*, I mean a communicative doctor-patient interaction in which the patient seeks the professional advice of a doctor about a health related problem in assigned places (such as hospitals and doctors' practices). Such consultations do not solely have to consist of just the advice by a doctor, but they characteristically also include a diagnosis and sometimes even a prognosis about the patient's

health related problem. Seeking and providing advice is nevertheless the consultation's main point: medical consultations do simply not occur without the patient's initiative to seek the doctor's advice and the doctor's willingness to attempt to provide it.

Although the patient seeks the doctor's professional advice, that does not necessarily mean that he always, immediately and fully accepts this advice once it is given. With the considerable amount of medical information on the internet, a patient can, for instance, request a medical consultation after gathering information online. Once a doctor's diagnosis, prognosis and/or advice contradict(s) these previously formed ideas, the patient might request a justification by the doctor.

On the other hand, the doctor could also simply assume that the patient is hesitant about accepting or following the medical advice. He could then provide argumentation, even if the patient is not actually expecting it. A doctor might additionally feel compelled to do so from a legal point of view. By adequately arguing in favour of his advice, he could practically reduce his professional liability, which might be valuable given the substantial frequency with which medical malpractice litigation occurs (Bal 2009). Schulz & Rubinelli (2006, n.p.) even argue that "it is probably not an exaggeration to claim that argumentation is actually the only instrument at a doctor's disposal that makes a reasoned compliance of the patient possible, where the patient takes a certain course of action advised by a doctor because s/he has understood and believes in the inner motivation behind it." In any case, medical consultation can be analysed as a communicative activity type in which argumentation can play an important role.

4. Preconditions for Strategic Manoeuvring in Medical Consultation

Now that medical consultation has been analysed as a communicative activity type that lends itself to the presentation of argumentation, the preconditions for strategic manoeuvring in this activity type can be specified to determine how the consultation affects the argumentative discourse that occurs in it. According to Van Eemeren & Houtlosser (see 2005: 77, 2006: 384), the combination of the following four preconditions is unique for every activity type: (i) the activity's confrontational trigger, (ii) its starting points, (iii) the discursive means used in the activ-

ity and (iv) its possible outcomes. To analyse a discussion party's strategic manoeuvring, it is useful to examine these preconditions for the activity that the discussion party is engaged in. Through such an examination, the relevant opportunities and limitations for participants in the activity can be determined. Moreover, it enables specifying the specific soundness criteria for the evaluation of argumentation in the communicative activity type. Let me therefore outline the preconditions for strategic manoeuvring in medical consultation.

The (i) confrontational trigger in medical consultation is a lack of agreement between the doctor and patient about the doctor's medical advice or the doctor assumes that the patient hesitates to fully accept or follow the medical advice. This (assumed) lack of agreement could not only consist of the patient's hesitation to adopt the doctor's advice or accept parts of it (such as a diagnosis), but also of real opposition by the patient to (parts of) the advice.

Whether and how the lack of agreement between a doctor and patient can be overcome in medical consultation is up to both discussion parties. Each of them could, in principle, provide arguments in favour or against the medical advice, and (partly) retract their advice, doubt or opposition. It is nevertheless important to note here that a (ii) starting point in medical consultation is that the doctor acts as discussion leader and he is, in this respect, more influential in the manner in which the lack of agreement is overcome. In medical consultation, it is typical that the doctor and patient differ in the amount of knowledge they possess about health related issues. Although doctor-patient communication has shifted from a paternalistic approach to a patient-centred one since the early 1970s (Bensing et al. 2006; Goodnight 2006: 79; Zandbelt 2006: 10), this disparity in knowledge still means that the doctor largely determines how the consultation proceeds. Even so, the doctor has to obtain the patient's agreement on his proposed medical advice, which makes the patient the more influential party in determining whether actual agreement is acquired during the consultation.

A variety of other (ii) starting points affect the argumentative discussion between a doctor and patient as well. To present a systematic overview of these starting points, the pragma-dialectical distinction between *procedural* and *material* starting points comes in handy. According to the pragma-

dialectical theory, the discussion parties' commitments should be reconstructed as either procedural or material starting points in a critical discussion. Procedural starting points concern the discussion rules and the division of the burden of proof, while material starting points consist of propositions that the discussants may use in their argumentation (Van Eemeren & Grootendorst 2004: 60). The starting points that have been discussed so far – the doctor acting as discussion leader and his obligation to obtain the patient's agreement – are examples of (implicit) procedural starting points.

Other procedural starting points in medical consultation are explicitly stated rules such as the legal requirement of informed consent (see, for example, the Canadian Supreme Court's decision in *Reibl v. Hughes* [1980] 2 S.C.R. 880 for relevant case law, and the Dutch civil code's *Wet op de geneeskundige behandelingsovereenkomst* [Law on the medical treatment agreement], 1995, Art. 448 for relevant legislation) and explicitly incurred commitment codes of ethics such as the Hippocratic Oath. Additionally, the pragma-dialectical theory states that the division of the burden of proof belongs to the procedural starting points. This division depends on the kind of roles that the participants fulfil in the discussion. Since the doctor has to advise the patient about a health related problem, he can be regarded as the protagonist in the discussion with the patient. The doctor incurs the burden of proof for his advice by presenting it. The patient can be said to perform the role of the antagonist: he at least seems to be hesitant about accepting or following the doctor's medical advice. Schulz & Rubinelli (2008: 426) observe that the doctor does not only provide information about the patient's physical well-being, but also "attempts to convince the patient that he has/does not have a certain specific condition [...] and, if he has it, that he has to follow a certain specific treatment."³

In practice, a patient might also feel the need to give reasons as to why he requests some of the doctor's time. A patient could, for instance, argue why the issue about which he asks the doctor's advice constitutes

³ Schulz & Rubinelli (2008: 426) therefore characterise the medical consultation as an "info-suasive" dialogue, "a dialogue blending information and persuasion in an inextricable manner." Yet, Garssen (2008: 433–434) points out that this characterisation is problematic: not all medical consultation is argumentative (and hence persuasive) and medical consultation is more than purely information-seeking (and hence informative).

a problem, why he thinks this problem is health related and/or why he could not come up with a solution for it himself. Although a doctor cannot refuse a patient's request in his professional capacity, the patient assumes the doctor is not fully convinced of the necessity of looking into his problem. This means that the patient acts as a protagonist, while the doctor is to be the antagonist. Such a situation does, however, not always occur and, if it does, it only functions as a prelude to what is really at stake: the doctor's advice. Indeed, Goodnight (2006: 79) points out that "doctors and patients are protagonists and antagonists. When reasons matter most, the doctor proposes, the patient disposes."

To adequately fulfil their discussion roles, the doctor and patient have to establish the propositions that they can use in their argumentative discourse: their material starting points. They can again implicitly or explicitly establish these starting points. For instance, to provide the patient with medical advice about his health related problem, the doctor might need to physically examine the patient. Through such an examination, the doctor obtains facts about the health of his patient. If the doctor and patient proceed to have a discussion about the doctor's medical advice, these facts can function in a manner similar to the concessions in dialectical approaches to argumentation.⁴ They can, hence, be used as internal proof in the discussion, even if they have remained implicit in the consultation so far. The doctor also verbally examines the patient. From a pragma-dialectical perspective, the doctor then explicitly establishes material starting points.

Certain material starting points in medical consultation are not established during the consultation itself, but introduced into the consultation. A clear-cut example of a starting point that could function as external proof in an argumentative discussion between a doctor and patient is medical knowledge. The doctor could, for instance, introduce the patient to new scientific insights into the patient's health related problem or the

⁴ Dialectical approaches to argumentation characteristically regard a standpoint as conclusively defended if the defence is performed *ex concessu*: a standpoint can only be proven tenable based on the concessions (also referred to as commitments) of the discussants. For instance, Hamblin (see 1970: 263) introduces the notion of the discussants' *commitment-store* and deems it necessary for "the operation of a satisfactory dialectical system." Barth & Krabbe (see 1982: 56–68) adopt a similar concept, the discussants' *set of concessions* in their formal dialectical theory.

patient could draw the doctor's attention to medical claims on the internet about this problem. Another example of a starting point that is not established in consultation itself is the fact that the doctor can be regarded as an authority on health related problems. It is exactly this authority that makes the patient seek the doctor's advice.

As their *(iii)* discursive means, the doctor and patient can provide argumentation based on these material starting points. More specifically, the doctor and patient could present argumentation based on the interpretation of concessions in terms of medical facts and evidence. Unlike argumentation in negotiation, the discussion parties cannot (easily) change their starting points to make their argumentation more effective. Once physical examination, for instance, shows that a patient suffers from hypertension, it is difficult for him to argue that this is not the case, simply to be more effective in opposing the doctor's advice. Furthermore, the advice of the doctor has to be based on medical facts and evidence; the potential seriousness of a health related problem does not allow for sheer guesswork.

For analysing and evaluating the strategic manoeuvring in medical consultation, it is also important to note that a doctor and patient convey their argumentation in cooperative conversational exchanges. This, in principle, means that they can directly react to the one another whenever utterances are unclear or unacceptable. However, in practice, patients do not always ask their doctor for clarification, explanation or information about medical advice (Bensing et al. 2006; Robinson 2003; Ten Have 1991). This could be explained by the patient's dependency on the doctor. Due to the patient's insecurity about his health related problem and the potential seriousness of this problem, he might be hesitant to ask questions as to avoid offending the doctor. Because of the sensitive nature of the patient's health, the doctor might be also hesitant to react in a direct manner to a patient's remarks to avoid the patient taking offence. In other words, politeness considerations play an important role in the cooperative face-to-face conversational manner in which a doctor and patient convey their argumentation. In stark contrast with activity types such as presidential debate, each discussion party will consequently manoeuvre strategically in a way that limits the other party's potential face loss.

Once the argumentative discussion in medical consultation has come to an end, the *(iv)* outcome could be agreement between the discussion

parties about the patient following the doctor's medical advice. If the doctor has made his advice sufficiently acceptable to the patient, this agreement comes down to the explicit commitment by the patient to following the advice. If the doctor has been unable or unsuccessful in making his advice sufficiently acceptable to the patient, he could refer the patient to a specialist or the patient could request a second opinion. Because of the fact that the patient's health related problem might potentially be serious, the doctor and patient cannot return to the initial situation of their discussion. Yet, the doctor and patient could start the consultation again once new starting points enter the discussion (such as the discovery of alternative treatment options). An overview of the preconditions for strategic manoeuvring in medical consultation can be found in Table 1.

Table 1: Preconditions for Strategic Manoeuvring in Medical Consultation

<i>Communicative Activity Type</i>	<i>(i) Confrontational Trigger</i>	<i>(ii) Starting Points (Material, Procedural)</i>	<i>(iii) Discursive Means</i>	<i>(iv) Possible Outcomes</i>
Medical consultation	(assumed) lack of agreement between a doctor and patient about (part of) the doctor's advice concerning the patient's health related problem; decision up to the parties	explicit rules (e.g., <i>informed consent</i>); implicit rules (e.g., the doctor acts as discussion leader); explicitly established concessions (e.g., results of a doctor's verbal inquiry after the patient's health); implicitly established concessions (e.g., results of a doctor's physical examination of the patient)	argumentation based on interpretation of concessions in terms of medical facts and evidence; conveyed in cooperative conversational exchanges	agreement between the doctor and patient about the patient following the discussed medical advice; and / or referring the patient to a specialist; and / or a request for a second opinion (no return to initial situation)

5. A Case in Point

Let me briefly illustrate how the characteristics of a medical consultation affect argumentative discourse by an example taken from actual practice (Example 1). In this fragment of a paediatric consult, the parents (P_F = father; P_M = mother) of a toddler with behavioural and developmental problems seek the professional advice of a paediatrician (D = doctor). This is not the first time that they visited the doctor. In fact, the doctor is about to report the results of tests on samples they collected earlier.

Example 1: Paediatric Consult (example obtained from the database compiled by the Netherlands Institute for Health Services Research; my transcription and translation from Dutch)

- 1 D: Erm, [to child] Mathilda, right? We're just going to get you [parents] up to date ...
- 2 P_F : Yes.
- 3 D: because, of course, I've still got some results in a report for you here. And I'd of course like to know some things from her. But shall I first inform you [parents] about the results? Erm ...
- 4 P_F : Please.
[*Doctor discusses results of various tests*]
- 12 D: There's, yeah, there's a very small indication that there's an anomaly in that [the child's] digestion, but they [the lab] say that we can only determine or see that if we take another blood test.
- 13 P_M : But that that doesn't function well or, or, how do I erm ...
- 14 D: Roughly speaking, erm, you do have to think about that. That there's a small mistake somewhere there in the digestion, which, erm, could explain the problems. But, I've got to say, erm, I think it's just an indication though. I don't think like "Oh, now, great; we've found something and, erm, we can work with that." I'm like "Well, yeah, it's an indication" and I'm like, well, God, if you get such a test, and so you already did those steps, and if they advise that – and it's a good bunch of people that check that – then I'd be tempted to do that in any case.
- 15 P_F : Yes.
- 16 P_M : Yes.

In turns 12 and 14 of this fragment, the doctor indirectly advises the parents to let their child undergo another blood test (respectively “they [the lab] say that we can only determine or see that, if we take another blood test” and “I’d be tempted to do that in any case”). From the reasons that the doctor provides for this advice in turn 14 (“if you get such a test, and so you already did those steps, and if they advise that – and it’s a good bunch of people that check that”), it appears that the doctor assumes the parents are hesitant to follow her advice – otherwise there would be no need for the presented argumentation. The discourse can therefore be reconstructed as an argumentative discussion in which the doctor acts as protagonist and the parents as antagonists.

The doctor clearly is in control of this discussion: in conformity with the procedural starting point that the doctor acts as discussion leader, she determines which topics will be addressed in what order. However, the doctor seems to realise that she cannot just provide information and argumentation as she pleases, since that might come across as impolite in the cooperative conversational exchange that she is engaged in. She consequently actively includes the parents in the conversation by, for instance, directly asking for their agreement in turn 3 (“But shall I first inform you [parents] about the results?”). Simultaneously, by asking this question, the doctor indicates she is concerned with obtaining informed consent.

Interestingly, the doctor uses – amongst other things – the discursive means available to her in such a way that she argues in favour of the medical advice by emphasising what she would personally do if she were in the parents’ situation (“I’d be tempted to do that in any case” in turn 14). Because it is a material starting point in medical consultation that the doctor can be regarded as an authority on the health related problem under discussion, this appeal to *ethos* seems to be an effective way to convince the parents of letting their child undergo another blood test. The doctor’s reference to her personal behaviour in the parents’ situation indicates that opting for the blood test is the wise thing to do. Yet, a precondition for strategic manoeuvring in medical consultation is that the doctor is an authority *on health related problems*. This raises the question whether the personal preferences of the doctor in Example 1 can be reasonably regarded as part of her authority on health related problems. On the one hand, taking a blood test seems to be a purely medical issue. On the other

hand, it is not the medical knowledge that the doctor presents about the patient's health related problem, but, in fact, her lack of medical knowledge and trust in other medical professionals that seem to be the reason that she appeals to *ethos*.

The doctor manoeuvres strategically by avoiding making a clear distinction between her non-professional behaviour and her authority on health related problems. Additionally, the ethical appeal makes it strategically very difficult for the parents to object to the advice. If they do, they would not only disregard the advice of the doctor and laboratory, but also perform a direct face threatening act by disqualifying the doctor's personal behaviour. Indeed, the parents explicitly accept the doctor's medical advice in turns 15 and 16.

6. Conclusion

By analysing medical consultation as a pragma-dialectical communicative activity type, I have attempted to show how such consultation affects argumentative discourse between a doctor and patient. Medical consultation can be regarded as a communicative doctor-patient interaction in which the patient seeks the professional advice of a doctor about a health related problem in assigned places (such as hospitals and doctors' practices). This institutionalised communicative practice shapes the discourse that occurs in it. A doctor would present his medical advice, for instance, differently to a patient during a medical consultation than to a family member at the dinner table.

Due to, amongst others, the increased patient literacy on health issues and the doctor's increased professional liability, argumentation can play an important role in medical consultation. The doctor cannot simply tell the patient what to do, but has to convince the patient of his advice. The context of the medical consultation affects the manner in which the doctor does so. For instance, in argumentative discourse in medical consultation, the idea that the doctor can be regarded as an authority on the patient's health related problem can be regarded as a material starting point. The doctor is also bound to the procedural starting point of having to obtain the patient's informed consent before prescribing a certain treatment. This means that the doctor cannot just simply command a

patient to follow a treatment, but he can emphasise his authority when presenting argumentation in support of this treatment. In a similar vein, the context of the medical consultation affects the way in which the patient expresses possible doubt about or objections against the doctor's medical advice.

Specifying the preconditions for strategic manoeuvring by the doctor and patient is useful for the analysis and evaluation of argumentative discourse in medical consultation. By determining what can characteristically be regarded as the confrontational trigger of argumentative discourse in medical consultation, the discourse's starting points, the discursive means used in it and its possible outcomes, the analyst can systematically analyse the opportunities and constraints that a medical consultation offers to the doctor and patient for their argumentative discourse. Moreover, based on these preconditions, the specific soundness criteria for argumentation in medical consultation can be determined. Based on these specific soundness criteria, the reasonableness of contributions to argumentative discourse in current medical practice can be evaluated. This provides a means for making recommendations to medical professionals with respect to their argumentative contributions in medical consultation.

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