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Conflict and consultation: Strategic manoeuvring in response to an antibiotic request

Nanon Labrie
Università della Svizzera italiana

Douglas Walton
University of Windsor

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NANON LABRIE

Institute of Communication and Health
Università della Svizzera italiana
Via Giuseppe Buffi 13, 6900 Lugano
Switzerland
nanon.labrie@usi.ch

ABSTRACT: In recent years, the model of shared decision-making has become increasingly promoted as the preferred standard in doctor-patient communication. As the model considers doctor and patient as coequal partners that negotiate their preferred treatment options in order to reach a shared decision, shared decision-making notably leaves room for the usage of argumentation in the context of medical consultation. A paradigm example of argumentative conflict in consultation is the discussion that emerges between doctors and their patients concerning antibiotics as a method of treatment for what is presumed to be a viral infection. In this paper, a case of such argumentative conflict is studied, using the extended pragma-dialectical theory to argumentation. It is examined how a patient and her physician manoeuvre strategically in order to maintain a balance between dialectical reasonableness and rhetorical effectiveness, as well as an equilibrium between patient participation and evidence-based medication, while arguing their case for and against antibiotics respectively.

KEYWORDS: Medical consultation, shared decision-making, pragma-dialectical theory of argumentation, strategic manoeuvring, antibiotics.

1. INTRODUCTION

In the field of argumentation studies, and within the pragma-dialectical approach to argumentation (van Eemeren & Grootendorst 1984, 1992, 2004) more specifically, recently, the interaction between doctor and patient has been characterized as an inherently argumentative activity type (van Eemeren 2010). It has been aimed to demonstrate that doctor-patient consultation can be analyzed as an argumentative exchange in which both parties interact as discussants that strive to convince each other of the acceptability of their own pre-existing views with regard to diagnosis, prognosis, and treatment options (Pilgram 2009; Snoeck Henkemans 2011).

This paper aims to add to this pragma-dialectical endeavour by investigating the argumentative discourse of doctors and their patients during medical consultation that is aimed at *shared decision-making*. It aims to show that—even though the medical encounter is traditionally not always perceived to be argumentative (Schulz & Rubinelli 2006, 2008)—argumentative discussions may arise during medical consultation and that, in accordance with the pragma-dialectical theory of argumentation, the argumentative partners make use of what is termed strategic manoeuvring (van Eemeren 2010) in order to come to a resolution of the medical dispute at hand. That is, in strategically selecting and phrasing their contributions to the discussion, doctors and patients aim to maintain a balance between the (dialectical) reasonableness and the (rhetorical) effectiveness of their argumentative moves.

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Using a case study, it will be explored how doctor and patient, in order to resolve their difference of opinion regarding the treatment of an upper respiratory tract infection, manoeuvre strategically subsequently to a patient's request for antibiotics. In particular, it will be explored how argumentative conflict in medical consultation is dealt with in light of the shared decision-making model: a mutuality-based model of doctor-patient communication that advocates a participatory treatment decision-making process in which both the doctor and the patient actively take part (Charles, Gafni & Whelan 1997, 1999; Edwards & Elwyn 2009). It is examined how in consultation aimed at shared decision-making, patient and physician present their treatment preferences for antibiotics and acetaminophen respectively in a rhetorically favourable way while simultaneously demonstrating that they are adhering to the shared decision-making ideal: How do doctor and patient, in argumentative practice, aim to maintain a balance between dialectical reasonableness and rhetorical effectiveness, as well as an equilibrium between patient participation and evidence-based medication?

2. ANALYZING SHARED DECISION-MAKING AS A CRITICAL DISCUSSION

Shared decision-making has been increasingly promoted over the past decade as the preferred standard of treatment decision-making in doctor-patient communication. In contrast to alternative models of doctor-patient interaction, in which either the physician is assumed to 'know best' and is regarded the primary decision-maker (paternalistic model) or in which the patient decides upon a treatment method after having received 'sufficient' information from the doctor (informed model), the shared decision-making model advocates a medical decision-making process in which both doctor and patient actively take part as coequal discussion partners (Charles, Whelan & Gafni 1999; Edwards & Elwyn 2009). Whereas the model regards the doctor as an expert holding specialist medical knowledge, the patient is considered to bring a unique personal perspective to the consultation that captures individual feelings, expectations, and treatment preferences. As a result, doctors' and patients' viewpoints are considered to be highly distinct, yet of equal importance to the medical decision-making process.

Providing the most commonly cited and generally accepted conceptualization of shared decision-making, Charles, Gafni & Whelan (1997) concisely define the practice of shared decision-making as follows:

> [Shared decision-making concerns the] involvement of both the patient and the doctor, a sharing of information by both parties, both parties taking steps to build a consensus about the preferred treatment, and reaching an agreement about which treatment to implement. (Charles, Gafni & Whelan 1997: 681)

According to Frosch & Kaplan (1999), the model of shared decision-making goes several steps further than the legal doctrine of *informed consent*. Beyond merely presenting the patient with medical information, shared decision-making promotes a process in which both doctor and patient explicitly voice their preferences as well as their underlying rationale. It is assumed that both parties have a legitimate investment in the treatment decision process and, moreover, make a commitment to resolve any disagreement that arises during consultation in a mutually respectful manner. Such disagreement may surface, for example, when there is no clear, unambiguous evidence about the best treatment option to

implement or when doctor and patient disagree about the implications of a certain method of treatment. "Physician and patient are then in conflict, and a solution needs to be negotiated" (Towle & Godolphin 1999: 768).

Promoting a decision-making process in which physician and patient should ideally aim to build consensus about the appropriate treatment to implement and to coequally negotiate a resolution to any disagreement that arises during consultation, shared decision-making notably constitutes more than explicitly engaging in a dialogue. Shared decision-making can be said to involve a *social*, *verbal*, and *rational* process in which the participants act as critical, reasonable discussion partners that are not only expected to provide a rationale for their own treatment preferences, but that are also capable of critically evaluating their interlocutors' argumentation. That is, both parties are assumed to uphold a certain standard of reasoning that contributes to finding the best treatment option available, having rationally considered and weighed the arguments advanced by both parties. Therewith, the shared decision-making process significantly denotes a *resolution-oriented* process that is essentially aimed at reaching a shared treatment decision. Walton (1985: 13) provides a characterization of medical consultation that—albeit not specifically focused on shared decision-making—seems to capture this:

> Medical treatment is a complex two-person interaction where each party has a distinct role. Underlying the interaction is a technical or productive process, an action. Partly physical in nature, the action also has a purposeful element. And overlaying the action is a network of communicative interchange, a dialogue or reasoned exchange of information and argumentation (Walton 1985: 13).

The model of shared decision-making shares its resolution-oriented stance with the ideal model for critical discussion as introduced in the pragma-dialectical theory of argumentation (van Eemeren & Grootendorst 1984, 1992, 2004). As noted by Snoeck Henkemans (2011), shared decision-making appears to be similar to small-group problem solving discussions "a type of discussion that van Rees (1991: 285) considered to be 'a plausible candidate for reconstruction as a critical discussion'." According to van Rees (1995: 344), in problem-solving discussions, by definition, participants try to reach a solution to a problem through discussion. During the process, participants may encounter various differences of opinion. Participants may disagree about the existence and nature of a problem, about its possible solutions and their implications, and about what the final decision should be. The way in which the participants involved aim to resolve these potential differences of opinion is "open to analysis and evaluation" (van Rees 1995). The discussions that arise in medical consultation aimed at shared decision-making, as well, can be analyzed and evaluated using insights gained in the pragma-dialectical approach to argumentation. In section 4 of this paper, an analysis of a medical consult is provided. Yet, first it needs to be briefly clarified what it means for doctor and patient to *manoeuvre strategically* during medical consultation.

3. STRATEGIC MANOEUVRING IN CONSULTATION AIMED AT SHARED DECISION-MAKING

The way in which doctors and patients aim to resolve their tacitly assumed or openly expressed differences of opinion during consultation aimed at shared decision-making can be said to constitute an interesting starting point for analysis and evaluation using the pragma-dialectical theory to argumentation. Yet, in order to conduct a proper analysis and evaluation of the argumentative discourse used in medical consultation aimed at shared decision-making, first it has to be examined how the context in which the discourse is situated, can be taken into account as such that any contextual elements shaping the participants' argumentation are included in the analysis. After all, argumentation in practice does not occur in a contextual vacuum. Communicative practices are generally connected to specific institutionalized contexts in which "they serve certain purposes that are pertinent to the *raison d'être* of the institution—i.e., purposes relevant to realizing the institutional point" (van Eemeren 2010: 129). As a result of this context-dependency, the institutional rules, norms, and conventions, prevailing in the communicative practice concerned may significantly shape the ways in which arguers argue and, more specifically, manoeuvre strategically. That is, the institutional context may affect the ways in which they select (*topical selection*) and present (*presentational choices*) their arguments as such that they meet the audience's demand (*adaptation*), therewith ideally achieving a rhetorical effect while simultaneously remaining within the realms of the dialectically reasonable (van Eemeren 2010).

Although the shared decision-making model itself does not include an explicit normative body of rules for argumentative conduct, such as the ten context-independent commandments formulated in pragma-dialectics (van Eemeren & Grootendorst 1984, 1992, 2004), a number of context-dependent rules, regulations, and norms can be distinguished that significantly shape the argumentative context of consultation and set this context apart from other argumentative contexts. First, a doctor is legally committed to adhere to the physician-patient privilege and to maintain patient confidentiality. Disclosure of any confidential medical information during and after consultation is regarded a breach of both ethical and legal norms and is only allowed under specific circumstances (American Medical Association 2010). Second, under the legal doctrine of informed consent, the doctor is at all times bound by his legal obligation to inform the patient of all treatment options available and their corresponding advantages and disadvantages, prior to any form of medical care. As a result, the doctor is legally obliged to always assume his patient's doubt regarding the treatment advice provided and, thus, to argue his case.

In addition, it should be noted that the patient or patient's surrogate decision maker is free at all times to make the final decision regarding the treatment option of his choice—given that there are a number of equal options—or to even refuse care. This specific right, referred to as *patient autonomy*, implies that whenever a medical dispute is not reasonably resolved, the participants may either decide to settle the dispute in favour of the patient (i.e., the doctor complies with the patient's request under the provision that this will not harm the patient), or the doctor may refuse to settle the dispute (e.g., because he judges that the patient's wellbeing might otherwise be risked) and, following legal obligations, choose to refer the patient to colleague for a second opinion. Naturally, also the patient has the right to request a second opinion. A return to the initial, argumentative situation of the consultation is never possible.

Despite the institutional rule that a patient has the right to ultimately decide upon a course of treatment, it can be safely assumed that both doctor and patient first and foremost aim to argue soundly in an attempt to conclude the dispute in a reasonable way. That is, they will both aim to find the solution that is 'best', all considerations taken into account, and that is mutually accepted by the parties involved. Yet, doctor and patient will not solely strive to argue reasonably. In practice, they will also want to argue effectively in order to successfully convince the other party to accept their own view and to 'get their way'. Consequently, when faced with conflict doctors and patients too will manoeuvre strategically in order to maintain a balance between their aims of dialectical reasonableness and rhetorical effectiveness.

4. STRATEGIC MANOEUVRING IN RESPONSE TO AN ANTIBIOTIC REQUEST: A CASE IN POINT

In the medical consultation of which fragments will be discussed below,[1] eight-year-old Tracey (T) is brought to her doctor (D) by her mother (M). Tracey has been suffering from repeated sore throats caused by an inflammation of the tonsils. To treat her daughter's *tonsillitis*, Tracey's mother requests a course of antibiotics. However, as the physician suspects that Tracey's tonsillitis is caused by a viral rather than a bacterial infection, he prefers a different treatment method: a combination of acetaminophen and fluids. As a result, a difference of opinion arises between D and M, regarding the best treatment option available for young Tracey. The two propositions at the heart of the discussion can be formulated as follows:

(P1) Antibiotics are the preferred method of treatment for T's tonsillitis.
(P2) A combination of acetaminophen and fluids is the preferred method of treatment for T's tonsillitis.

Whereas, on the one hand, M takes up the role of the protagonist, defending her positive position towards proposition P1, D challenges this proposition and, thereby, assumes the role of the antagonist. D, on the other hand, takes up the role of the protagonist of his positive stance towards proposition P2. M opposes this standpoint, assuming the role of the antagonist. As a result, following the pragma-dialectical theory of argumentation, the discussion between D and M can be analyzed as multiple and mixed.

In arguing for their treatment preferences, both the physician and the patient's mother manoeuvre strategically in order to effectively convince their opponent of the acceptability of their views. Notably, the manoeuvres made by both parties are not only often connected and mutually dependent, but they are also shaped by the context of shared decision-making. While aiming to present their treatment preferences for antibiotics and acetaminophen respectively in a rhetorically favourable way, they simultaneously aim to

[1] Tracey's medical consultation is set a within routine general practice session in an urban part of Cardiff, United Kingdom, and the transcript records the first encounter between the patient and her physician. The transcript was taken from (Elwyn, Gwyn, Edwards & Grol 1999), who recorded and transcribed the consultation. The general practitioner is known to have an interest in the involvement of patients in treatment decisions (Elwyn, Gwyn, Edwards, & Grol 1999: 107). Because of this, application of the shared decision-making model rather than any other model of interaction is anticipated.

demonstrate that they adhere to the shared decision-making ideal. Some of the most noteworthy strategic moves will be discussed below.

4.1 Advocating antibiotics, arguing for acetaminophen

Exploring the patient's feelings and preferences for treatments, health states, and outcomes forms an essential component of consultation. Especially within the shared decision-making ideal, it is of utmost importance that both the physician's and the patient's ideas are explored and considered in order to reach a treatment decision that is truly shared. Over the years, patients have become increasingly proactive in advocating their specific needs and ideas during consultation and whereas traditionally doctors held the role of decision-maker within consultation, today physician and patient play coequal parts in the medical encounter. But even though modern patients have become active advocates of their own treatment preferences, explicit forms of medication-related pressure on doctors are still rare (Stivers 2002). Also within the case of Tracey, M seems to formulate her preference for antibiotics proactively but tentatively.

In the opening lines of the dialogue between D and M, M strategically steers the conversation towards the topic of antibiotics. By referring to a past experience with antibiotics, she indirectly 'pressures' the doctor to prescribe her daughter Tracey a course of antibiotics.[2]

M doctor A he's seen her last he gave her
one load lot of (.) antibiotics and then he gave me
a pre prescript repeat prescription then (2.0)
to have the other to get it right out of the system

According to Stivers (2002), mentioning a past experience with antibiotic treatment forms one of four prominent ways for patients to explicitly communicate pressure for antibiotics. Whereas she considers requests or statements of desire to be relatively direct means of pressure, Stivers (2002) argues that referring to past experience, like inquiring about antibiotics, is a comparatively indirect method of pressure. "While it conveys a position in favour of antibiotics and overtly raises antibiotics for discussion, it does not explicitly state that preference and thus can be treated as simply providing information" (2002: 120). Indeed, at first glance, M's contribution to her conversation with D seems to be a mere provision of information, a statement about her daughter's poor health. Yet, when closely examining the utterance, there appears to be more to her conversational contribution.

Following the pragma-dialectical theory of argumentation, M's assertion that doctor A prescribed Tracey antibiotics on a previous occasion should be analyzed as an authority-based argument—or, in Stivers' (2002) terms: pressure—for M's standpoint that antibiotics are the preferred method of treatment for T's tonsillitis—a standpoint that thus far has remained implicit (and will continue to be so up until the final part of the discussion). M's argument of past experience is presented in the form of an argument by sign that draws upon the authority of doctor A's medical expertise: doctor A, who is a medical

[2] In the excerpts, the transcription symbols as used by Elwyn, Gwyn, Edwards, and Grol (1999) were maintained. Brackets containing a stop indicate a pause of less than two seconds. Numerals in round brackets indicate the length in seconds of other pauses. An equal sign means that the phrase is contiguous with the preceding one without pause. Square brackets that contain three stops indicate an omission.

expert as well as D, deemed antibiotics a suitable method of treatment in a similar situation. Consequently, M seems to argue, D should prescribe the medication this time too.

D's response to M's reference to her previous experience with doctor A, which from the perspective of strategic manoeuvring can be analyzed as a topical choice on M's part, is particularly noticeable. In response to M's argument concerning doctor A, D turns to young Tracey and says:

D you're eight now how many times have you had
what we say is tonsillitis (3.0)

Up until this point in the conversation, neither the term sore throat nor its medical counterpart tonsillitis has been used. As Tracey's sore throat is audible, her condition has not been labeled as such. Remarkably, the first time her condition is mentioned explicitly, D uses medical jargon rather than layman's terminology. Although D does attempt to diminish the effect of his usage of a medical term by adding 'what we say", his rather complex formulation can be analyzed as a deliberate presentational choice in reply to M's assertion about doctor A's assessment of Tracey's condition.

Using Latin terminology rather than ordinary arguers' language in response to M's argumentation, D presumably aims to indirectly convey his medical expertise and authority. This intention is clearly distilled by M, who subsequently aims to reinstate her credibility by communicating her understanding of the medical origin of Tracey's sore throats:

M […] because she's seeing a speech therapist about her tonsils
being really enlarged
D they are rather enlarged but nothing out of the ordinary
lots of children have tonsils of this sort of size

D yeah okay (.) okay well the first thing to emphasize I guess
is that this is a sore throat (.) you're right to call it a tonsillitis
cos that's just a Latin name for a sore throat

After a short and direct response that Tracey's tonsils are nothing out of the ordinary, D seems to aim to restore the relationship of mutuality between the two discussion partners and emphasizes that he acknowledges M's expertise ('you're right to call it a tonsillitis').[3] Moreover, he also explains his earlier usage of medical jargon by stating that tonsillitis is just a Latin name for a sore throat ('cos that's just a Latin name for a sore throat').

In the opening lines of the dialogue between D and M, it thus becomes clear that M does not directly state her preference for antibiotics, but that she takes a more indirect approach by merely referring to her prior experience with the medication. Yet, it is not only the patient who advocates her standpoint regarding her preferred method of treatment indirectly. D as well refers only implicitly to the treatment option of his choice. His view that a combination of acetaminophen and fluids is to be preferred over a course of antibiotics has to be inferred from the argumentation he advances (see Labrie 2010). M's indirect, confrontational approach can be explained as an attempt to diminish her intrusion on the physician's medical expertise and authority in relation to prescribing decisions (Stivers 2002), an assumption that is supported by a remark made by M halfway through the consult: 'I mean you are the doctor I'm not telling you your job'. D's 'silent

[3] Note that M has in fact not used the medical term *tonsillitis* herself.

confrontation' can be explained from the perspective of the shared decision-making model. As the shared decision-making model promotes the involvement of both the patient and the doctor in the resolution process, each carefully weighing all arguments for the treatment options available, the doctor will most likely want to avoid presenting the matter as having been decided upon confrontation already—thereby respecting the patient's autonomy. To cite Wolf (1988):

> If the physician presents himself as certain of the one right course, and fails to divulge the range of options and the uncertainties that attend each, *there is little to discuss.* The conclusion seems to be foregone. Without knowledge of the alternatives, and without information about the pros and cons of each, the patient has no tools with which to enter the discussion in any meaningful way. The patient is effectively foreclosed from grappling with the treatment decision and reaching her own conclusion, whether it might be the same or different from the physician's. There is no opportunity for conflict over the proper treatment course because the decision-makers have been reduced from two to one. The patient is not operating as a decision-maker; the patient is being told what to do. (Wolf 1988: 197 f.)

4.2 Establishing authority, exhibiting expertise

The predominantly implicit means of standpoint presentation by D and M can be seen to be the result of the modern, complex relationship between a physician and his patient. Whereas doctor and patient are considered coequal partners striving to reach the same goal—an improvement of the patient's health—they essentially play different roles within the consultation. The doctor, on the one hand, should be seen as a medical expert holding essential information regarding all health-related issues, the patient, on the other hand, should be considered an expert on his own feelings and preferences regarding health states, treatment options, and outcomes. While the doctor's authority and expertise is, thus, predominantly evidence-based, the patient's expertise is based on experience.

D's and M's attempt to establish authority and express their expertise within the consultation is both reflected in the presentation of their standpoints and in the formulation of their arguments. While in the opening lines of the encounter, M refers to her past experiences with consultation (e.g., experience with doctor A, speech therapy), tonsillitis (e.g., understanding of enlarged tonsils), and antibiotics (e.g., doctor A's repeat prescriptions) predominantly indirectly so, notably further on in their conversation M also refers to her past experience explicitly, often even adding degree adverbs such as *guaranteed* and *certainly* to add presentational strength to her arguments (italics added):

M I'd be *guaranteed* back tomorrow
because she seems to (.) this now is nothing
to how she usually goes down with it

she *certainly* reacts better (.) I would say so
out of experience

I (.) have given her paracetamol [acetaminophen] I was sent away
going back a while ago

D asserts his medical expertise by advancing evidence-based argumentation (e.g., tonsillitis is caused by a virus, viruses are not affected by antibiotics, and scientific research is ambivalent about the effects of antibiotics on tonsillitis' side-effects). He uses a combination

of symptomatic (argumentation by sign) and pragmatic (argumentation by cause) argumentation to describe Tracey's medical condition and to argue his case in favour of acetaminophen. Remarkably, D often presents his arguments relatively tentatively (*italics added*):

D it's *probably* caused by repeated viruses coming and going
what I am saying I *guess* is that (.)
the best guess we can do is that this is a viral illness
some people like to have a course of antibiotics
because *they feel* it makes a difference (.) and (.)
the (.) science on this is *a bit 50/50* (.)
sometimes it does (.) *sometimes* it doesn't (.)
and as you've *probably* heard from the papers
people are *a bit wary* of giving antibiotics

D's tentative phrasings can be seen to serve several functions. First, and most prominently, D seems to leave room for M's interpretation and negotiation—something that is deemed important from the perspective of shared decision-making. Especially his argument regarding scientific evidence ('sometimes it does, sometimes it doesn't') allows M an alternative interpretation. Second, D's cautious formulations can be analyzed to serve as a form of hedging. Although D presumes that Tracey is suffering from a viral infection, he cannot be absolutely certain. This small level of uncertainty is reflected in his choice of words: Tracey's sore throat is only 'probably' caused by a viral infection. Moreover, D's adverbs are used to soften his statements: M has 'probably' read in the papers that people are 'a bit wary' of giving antibiotics. Lastly, D's quantifying adverbs also serve to emphasize that not everyone, and certainly not D, is that keen on antibiotics, rather it is just 'some' people.

4.3 Reaching a shared decision, settling a dispute

It becomes clear from the above examples that, despite the fact that they use different strategies to do so, D and M both aim to communicate their authority and expertise within the consultation in order to convey their capacity as decision-makers. They each manoeuvre strategically in their argumentation by selecting and presenting their arguments as such that they are adapted to their audience's demand. In doing so, the doctor and his patient try to establish their specific authority-roles of the evidence-based expert and the experience-based expert respectively. A continuous balancing act seems to be in play. While on the one hand the participants aim to share a decision, on the other hand, they also would like to see their own treatment preference to be accepted. This act of balancing objectives is similar to that of pragma-dialectical discussants who, on the one hand, aim to resolve the dispute at hand on reasonable grounds, yet, on the other hand, also preferably want to do so in their favour. The participants' continuous efforts to establish a decision that is shared and ideally also based upon their own convictions is reflected in all stages of the argumentative discussion in consultation. A prominent strategy belonging to the opening stage of the discussion is to create a broad zone of agreement. Within the case of Tracey, D employs this strategy routinely. By explicitly asking for confirmation in response to his evidence-based arguments, he strategically adds to the shared set of starting points that exist between D and M, thereby steering the discussion in his own favour:

D okay (.) it's probably caused by repeated viruses (.) right =
M right
D = like (.) repeated colds
M yes

According to Stivers (2002: 1118), tokens such as *okay* and *yes* are typically used by parents when they agree to physician proposals of treatment. By using such tokens, thus, M explicitly appears to agree to D's arguments for a treatment with acetaminophen and thus gradually seems to bring the discussion closer to a 'shared' resolution.

Besides explicit requests for confirmation, D also tries to broaden the zone of agreement by phrasing his arguments favourably. By presenting arguments as self-evident and as if they already belong to M's set of starting points, he strategically manoeuvres the discussion in his favour. An example (italics added):

D *y'know* when you get a cold or a flu it's a virus

[…] the difficulty with viruses is
which *I am sure you know* is that
antibiotics (.) don't do a dickie bird for them
M right (.)

The second half of the consultation between D and M is primarily concerned with resolving the dispute and reaching a shared decision. In doing so, D uses some distinct presentational techniques in manoeuvring strategically. By presenting the conclusion of the consultation as a characteristically and inherently shared endeavour, D makes a final attempt at reaching a resolution that is favourable to him personally while adhering to the ideal of shared decision-making. After having stressed that there are two options to choose from, using the plural pronoun *we* to emphasize D and M's shared decisive effort ('we've got two choices'), D resumes his positively oriented pragmatic argument in support of acetaminophen (i.e., Tracey will build up natural immunity) and his negatively oriented pragmatic argument against a treatment with antibiotics (i.e., the tonsillitis will come back).

Although D's tactic seems a rhetorically strong and dialectically sound manoeuvre, M is persistent and insists on treating Tracey with antibiotics. M advances an additional argument from which her negative experience with acetaminophen becomes clear. As a result of this, D seems to back down to allow a negotiated agreement, a settlement of the dispute (Stivers 2002: 1123). Remarkably, in response to D's withdrawal, M too appears to aim to somewhat diminish her sturdy stance, to reinstate her relationship with D, by adding an argument based on what Stivers (2002) terms 'life world circumstances':

M I'm (.) a busy person myself
back and forward to jobs you know

Yet, the dispute is concluded and M's initial stance is accepted by D, even though the prescription seems 'interactionally driven' (*cf.* Stivers 2002) rather than based upon conviction on D's part. Reasons for such settlement might include, for example, the doctor's fear of losing his patient to another doctor, time pressure, or the patient's fundamental right to make the final decision regarding the treatment option of his choice—in spite of both the individual and societal risk of antimicrobial resistance.

5. CONCLUSION

Over the past years, patients have gained an increasing right to make autonomous decisions about their medical care and to actively take part in the decision-making process during doctor-patient consultation. Existing research has shown that this legal right of patient participation not only reflects modern patients' demands, but is also positively associated with increased health outcomes, patient adherence, and overall satisfaction (Elwyn, Gwyn, Edwards & Grol 1999; Stivers 2002). The ideal model of shared decision-making captures the modern trend of patient participation by considering the doctor and his patient as coequal partners within the conversation who carefully negotiate all treatment options available in order to reach a shared decision.

In this paper, it was studied how in argumentative, medical practice, doctor and patient manoeuvre strategically aiming to maintain a balance between the dialectical reasonableness of their argumentative moves and their rhetorical effectiveness, while simultaneously—directly and indirectly so—conveying their adherence to the shared decision-making ideal. In an exploratory analysis of a consultation transcript, a number of manoeuvres were identified that showed the connection between the arguers' strategic moves within the argumentative discussion and the institutional aim of participatory decision-making. A continuous balancing act seemed to be in play. While on the one hand, both doctor and patient aimed to convey their own medical expertise and experience in arguing their case, they simultaneously also strived to communicate their understanding of their opponent's expertise and their own willingness to share the treatment decision.

Case analyses such as the one presented in this paper could provide a starting point for further research that combines the study of argumentation with insights from the field of health communication. From the perspective of argumentation theory, it would be of interest to develop an even more solid characterization of the argumentative activity type of medical consultation that is specifically aimed at shared decision-making. Such characterization, including a thorough description of the institutional preconditions for strategic manoeuvring in this specific discussion context, could in turn provide a solid basis for evaluating the soundness of doctors' and patients' argumentative moves in cases like Tracey's. For scholars and practitioners working in the context of health communication, insights gained from case analyses like the present could ultimately serve an educational purpose and form the starting point for improving physicians' argumentative skills. For in modern medical practice, the doctor no longer simply 'knows best'. Rather, he should argue his case.

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Commentary on "CONFLICT AND CONSULTATION" by Nanon Labrie

DOUGLAS WALTON

CRRAR
University of Windsor
2500 University Avenue West
Windsor N9B 3Y1
Canada
dwalton@uwindsor.ca

1. INTRODUCTION

I agree that the topic of the overuse of antibiotics through over-prescription due to patient pressure is an issue of concern that is relevant to this paper. I agree that the study of argumentation can shed new light on antibiotics-related conflicts in medical consultations. I agree that the modern doctor needs to critically discuss the patient's request in this case. However, I would like to widen the scope of the study reported in this paper in three ways, (1) by stressing the importance of the physician's need in cases of this kind to use evidence-based medicine as an important part of the basis of the argumentation, (2) by showing how other parties are involved in these kinds of deliberations, and (3) by pointing out that a certain kind of logical reasoning traditionally identified with the *post hoc* fallacy is involved.

2. THE POST HOC FALLACY

According to Dr. Brad Spellberg , an infectious disease specialist at UCLA's David Geffen School of Medicine, "there are already 100,000 deaths a year from antibiotic resistant infections in the United States alone" (Spellberg 2009: 12). This trend is highly likely to become much more common in the future as more strains of bacteria develop countermeasures to antibiotics. Research is in a race to produce new antibiotics and the new versions that will be developed will have to be much more complex and hard to administer, more like powerful cancer drugs than the simple injections we are used to. One of the main causes of the evolution of drug-resistant bacteria that are untreatable by antibiotics is the common medical practice of prescribing antibiotic treatment for a cold at the urging of a patient who uses anecdotal evidence to argue that this treatment has worked in the past. This problem is difficult to deal with, because even though it is known that antibiotics are ineffective for treating viral infections like colds, a patient who is really determined to get antibiotic treatment for a cold can "shop around". In other words, if her doctor refuses to give her an antibiotic to treat her cold, she can look around for another doctor who can be persuaded to offer this kind of treatment.

The problem here is basically the *post hoc* fallacy. People are not very good at distinguishing causality from randomness. For example, patients tend to seek treatment when their symptoms are worst, and then by a natural process of reasoning they attribute their recovery to some ineffective remedy or pill. Because illnesses tend to have a natural cycle, it is likely that they would have recovered naturally anyway without having taken the pill. But it is very hard to resist the natural heuristic of the following argument: I was

Zenker, F. (ed.). *Argumentation: Cognition and Community. Proceedings of the 9th International Conference of the Ontario Society for the Study of Argumentation* (OSSA), May 18-21, 2011. Windsor, ON (CD ROM), pp. 1-2.

sick, and then I took this pill, from that point onwards I started to recover, and now I am well; therefore taking the pill caused me to become well. It is this kind of thinking that has led to the widespread practice of physicians agreeing to patients' demands to prescribe antibiotics to treat the common cold. The results of using this kind of reasoning have led to this very serious public health situation about drug-resistant bacteria that are untreatable by antibiotics.

Physicians are well aware that antibiotics are ineffective against viral infections like colds. Posters to this effect are now often displayed in waiting rooms. They are also aware, or should be, that research is in a desperate race to develop more powerful antibiotics as countermeasures against bacteria that are resistant to the best antibiotic medications we now have. Physicians are also under a legal obligation to treat patients according to the standards of care that are accepted in medicine at any given time. Although their primary obligation is to the single patient they treat, they also have an ethical obligation not to contribute to creating public health disasters in which millions of people die of bacterial infections that can't be treated in a timely manner.

For these reasons I would frame the structure of the argumentation in the case of Tracey by drawing attention to the features of the framework of dialogue that are wider than merely that of a critical discussion in which strategic maneuvering is taking place between Tracey's mother and her physician. Other people are involved, and the consequences of the possible actions that are involved in this kind of situation need to be looked at in a much broader perspective of public health. Reasoning on the basis of a single instance of anecdotal evidence of cause and effect is not a good way of supporting argumentation in a deliberation on what to do, especially where potentially dangerous consequences may be outcomes of the chosen course of action.

3. CONCLUSION

I agree that patients have the right of informed consent, and the right to make up their own minds on how to make decisions about their own health. I agree that the argumentation between Tracey's mother and the physician is typical of the modern, complex relationship between patient and physician in arriving at mutually acceptable treatment decisions. I have long been an advocate of patient autonomy in medical treatment decision-making (Walton, 1985). However, I think there are notable limits to patient autonomy, especially where important public health concerns are involved, and where evidence-based medicine is something to be concerned about. Basing medical argumentation concerning treatment decision-making on evidence is not easy, however, given the ever-present danger of committing the *post hoc* fallacy.

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