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Pragma-Dialectical Analysis of Medical Consultation

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ABSTRACT: In medical consultation, it is the doctor's task to advise patients about health related problems. This advice might not immediately be acceptable to the patient, for instance, because he has to drastically change his behaviour. In such cases, the doctor could attempt to make the advice acceptable by providing argumentation. To analyse and evaluate argumentation in medical consultation, I will argue in this paper that, from a pragma-dialectical perspective, medical consultation could be analysed as a communicative activity type.

KEYWORDS: communicative activity type, doctor-patient communication, medical consultation, pragma-dialectical analysis.

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.

Yet, 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 countries[1] 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

[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.

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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.

In this paper, I will argue that, to analyse and evaluate argumentative discourse in medical consultation, such a consultation could be analysed as a communicative activity type based on the pragma-dialectical theory. More specifically, I will discuss how the characteristics of a medical consultation affect the strategic manoeuvring by the doctor and patient.

2. PRAGMA-DIALECTICAL COMMUNICATIVE ACTIVITY TYPES

To examine argumentative discourse in medical consultation, let me first discuss the way in which context can be taken into account when analysing discourse in general. As one of the first to study linguistic anthropology (instead of anthropological linguistics), Hymes (1977, p. 3) argues that "one needs to investigate directly the use of language in contexts of situation, so as to discern patterns proper to speech activity." He introduces the concept of *speech event* to denote activities that have distinctive speech patterns.[2] This concept might come in handy when evaluating discourse. It allows us to make a distinction between the evaluations of, for example, a joke in an informal conversation and the same joke in a mediation session.

However, a difficulty with Hymes's idea of a speech event is that it can be used to refer to both a type of rule-governed speech pattern and an instance of such a pattern. So, 'an informal conversation' could just as well be called a speech event as 'an informal conversation at friend X's birthday party.' This blend of speech pattern types and speech pattern tokens in Hymes's notion might become problematic in the analysis and evaluation of discourse. Moreover, especially for evaluating discourse, it is important to take the goal of the interlocutors' interaction into account. Are they, for instance, trying to inform or to convince each other? As Hymes does not relate his concept of speech event to the goal of the discourse, it is better to amend it for analysing argumentative discourse in specific contexts.

In such an analysis, we could take Levinson's (see 1979; also reproduced in 1992) concept of *activity type* into account. According to Levinson, an activity type is a "fuzzy category whose focal members are goal-defined, socially constituted, bounded, events with constraints on participants, setting, and so on, but above all on the kinds of allowable contributions" (Levinson 1992, p. 69). His idea of an activity type therefore differs from Hymes's speech event in that it is goal dependent and encompasses also activities that do not involve speech. Although the goal-dependency of Levinson's activity type would be useful for evaluating discourse, the fact that it constitutes—as Levinson admits—a "fuzzy category" makes his notion of activity types somewhat unsuitable for discourse analysis and evaluation.

When examining argumentative discourse, Van Eemeren and Houtlosser (see 2005; and 2006) nonetheless make use of a concept that might seem similar to Levinson's

[2] Note that Hymes (see 1974, p.4) occasionally refers to *speech events* as *communicative events*.

activity type: the *communicative activity type*[3]. However, they specify this concept by regarding 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) furthermore 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' 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, p. 385), which is due to 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 winning the discussion. Van Eemeren and Houtlosser (see 2005, p. 77; and 2006, p. 384) list four preconditions for strategic manoeuvring that differ in such communicative activity types. Because the pragma-dialectical communicative activity type is a relatively clear concept and the preconditions for strategic manoeuvring directly link argumentative discourse to the activity type, examining these preconditions in medical consultation might prove useful for the analysis and evaluation of the argumentation that occurs in it.

3. MEDICAL CONSULTATION AS A COMMUNICATIVE ACTIVITY TYPE

Before the preconditions for strategic manoeuvring can be specified for medical consultation, it has to be established whether this practice 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 or community health centres) 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 (see 1986), Ten Have (see 1991, p. 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*.

[3] 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; and 2006; and Mohammed 2008).

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, Boulton, Olson and Williams (1985, p. 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. We 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.' According to the *Merriam-Webster Online Dictionary*, a medical consultation is "a deliberation between physicians on a case or its treatment." However, this is not the kind of consultation that I have in mind. My use of the term 'medical consultation' is more in line with the definition that *The Free Medical Dictionary* provides next to the one from Merriam-Webster, namely: "The seeing of a patient by a general practitioner." We can even be more specific, by emphasising the goal, means and setting of such a consultation. In addition, we can broaden the definition by speaking of a 'doctor' instead of a 'general practitioner,' for a medical specialist could just as well provide a medical consultation. So, a medical consultation is 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 or community health centres). 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 seems to accept this advice once it is given. This could be because of the fact that patients usually experience the symptoms of their health related problem for some time before requesting a medical consultation (see Tuckett, Boulton, Olson and Williams 1985, p. 11). Until the consultation, a patient can cope by consulting friends, relatives, colleagues and the like. Besides, with the considerable amount of medical information on the Internet, a patient can 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 (see Bal 2009). Schulz and Rubinelli (2006, n.p.) even go as far as to say 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, we can analyse the medical consultation as a communicative activity type in which argumentation may play an important role.

4. PRECONDITIONS FOR STRATEGIC MANOEUVRING IN MEDICAL CONSULTATION

Now that the medical consultation has been analysed as a communicative activity type that lends itself to argumentative discourse, 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 and Houtlosser (see 2005, p. 77; and 2006, p. 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 activity and (*iv*) its possible outcomes.[4] To analyse a discussion party's strategic manoeuvring, it is therefore handy to take a look at these preconditions for the activity that the discussion party is engaged in.

Let me illustrate this by briefly discussing the genre of activity types that pragma-dialectics calls *negotiation*. Argumentative discourse that occurs in negotiation starts out with (*i*) a conflict of interest. There are usually two parties, each of them interested in something the other has to offer. This interest is, however, self-motivated and does not seem to be appealing to the other party on first blush. When making explicit their interests, the negotiation parties can hence be expected to manoeuvre strategically in a way that diminishes the conflicting nature of their interests. The (*ii*) starting points in negotiations are semi-explicit constitutive rules, and sets of conditional and changeable explicit concessions. Here, semi-explicit rules should be understood as statements like "negotiation only occurs if interlocutors bargain," which might or might not be made explicit during a negotiation session. Furthermore, in a negotiation, a party could tactically begin with a demand for an extremely high counter-offer and then gradually lower this demand to make his own offer look more appealing. When employing such a strategy, the negotiation party manoeuvres strategically by changing his set of conditional concessions. As his (*iii*) discursive means, the party could employ argumentation incorporated in exchanges of offers, counter-offers and other commissives. A negotiation party could, for example, strategically make use of these means by presenting an offer as a package deal. The (*iv*) possible outcomes of these exchanges are a conclusion of the

[4] It should be noted that Walton (see 2008, p. 8) discusses somewhat similar distinctive features for dialogue types; the dialogue's *initial situation*, its *goal*, the *goal of the participants* and the different *procedural rules for achieving these goals.* Except for information-seeking dialogues, Walton's idea of a dialogue's initial situation is similar to the activity type's confrontational trigger in pragma-dialectics, and Walton's different procedural rules are included in the pragma-dialectical starting points. Furthermore, the goals of the dialogue and its participants that Walton mentions are, in terms of pragma-dialectics, the dialectical and rhetorical aims that lead to strategic manoeuvring. In this paper, I will nevertheless refer to the preconditions for strategic manoeuvring, since they encompass only those features that are inherent to the argumentative activity and also include, for example, the material starting points and the discursive means used in the activity—both of which are essential to argumentative discourse and could vary per communicative activity type.

conflict by means of a compromise between the parties as mutually accepted agreement or a return to the initial situation. An overview of these preconditions can be found in *Figure 1*.

Figure 1
Preconditions for strategic manoeuvring in argumentative discourse in negotiation and medical consultation (based on Van Eemeren & Houtlosser 2005, p. 79)

(Genre of) Communicative Activity Types	(*i*) *Confrontational Trigger*	(*ii*) *Starting Points (Material, Procedural)*	(*iii*) *Discursive Means Used*	(*iv*) *Possible Outcomes*
Negotiation	conflict of interests; decision up to the parties	semi-explicit constitutive rules; set of conditional and changeable explicit concessions	argumentation incorporated in exchanges of offers, counter-offers and other commissives	conclusion by compromise parties as mutually accepted agreement (or return to initial situation)
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., *informed consent*); implicit rules (e.g., the doctor acts as discussion leader); explicitly established concessions (e.g., a doctor's verbal inquiry after the patient's health); implicitly established concessions (e.g., 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)

In a similar vein, we could specify in which ways medical consultation shapes the strategic manoeuvring by a doctor and patient. This does not only provide insight into the opportunities and constraints that the consultation presents to these interlocutors, but also enables us to be more specific about the soundness criteria that apply to the evaluation of their argumentative discourse. Let me therefore start by discussing the confrontational trigger in medical consultation. In such a consultation, there is (*i*) a lack of agreement between the doctor and patient about the doctor's medical advice or the doctor assumes that his 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 posses about health related issues. Although doctor-patient communication has shifted from a 'paternalistic' approach to a 'patient-centred' one since the early 1970s (see Bensing et al. 2006; Goodnight 2006, p.79; and Zandbelt 2006, p. 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 (see Van Eemeren & Grootendorst 2004, p.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). 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 hesitate about accepting or following the doctor's medical advice.

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 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, p.79) points out that "doctors and patients are protagonists and antagonists. When reasons matter most, the doctor proposes, the patient disposes."

In any case, 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.[5] They can, hence, be used as internal proof in the discussion, even if they have remained implicit in the consultation so far (as in 'You really should quit smoking. The spirometer showed your lung capacity is far too small'). 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 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 the authority on the patient's health related problem. 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 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. Indeed several

5 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, p.263) introduces the notion of the discussants' 'commitment-store' and deems it necessary for "the operation of a satisfactory dialectical system." Barth and Krabbe (see 1982, pp.56-68) adopt a similar concept, the discussants' 'set of concessions' in their formal dialectical theory.

studies show that patients rarely ask their doctor for clarification, explanation or information about his advice (see Bensing et al., 2006; Robinson, 2003; and Ten Have, 1991). An explanation for these findings could be that the cooperative face-to-face conversational manner in which a doctor and patient convey their argumentation increases the importance of politeness considerations (avoiding face threatening acts) and sequence organisation (presenting adequate adjacency pair parts). As a result, in stark contrast with activity types such as presidential debate, each discussion party will manoeuvre strategically in such 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 the patient's health related problem might potentially be serious, the doctor and patient cannot return to the initial situation of their discussion; a lack of decisions about the health related problem is extremely undesirable. Yet, the doctor and patient could start 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 *Figure 1*.

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 consultation, the parents (P_M = mother; P_F = father) 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 consultation (example obtained from the database compiled by the *Netherlands Institute for Health Services Research*; my transcription and translation from Dutch)

1 D: Uhm, [to child] Mathilda, right? We're just going to get you 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? Uhm…
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 uhm…
14 D: Roughly speaking, uhm, you do have to think about that. That there's a small mistake somewhere there in the digestion, which, uhm, could explain the problems. But, I've got to say, uhm, I think it's just an indication though. I don't think like "Oh, now, great; we've found something and, uhm, 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.

17 P_F: Yes.

18 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 ("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 announces she is about to fulfill the requirement of obtaining informed consent.

Interestingly, the doctor uses 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 in the parents' situation. 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* indicates that taking the blood test is the wise thing to do. 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 non-professional behaviour. Indeed, the parents explicitly accept the doctor's medical advice in turns 17 and 18.

6. CONCLUSION

By analysing medical consultation as a pragma-dialectical communicative activity type, I have attempted to show how this consultation affects the possible 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 or community health centres). This institutionalised communicative practice shapes the discourse that occurs in it.

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. In a similar vein, it affects the way in which the patient expresses possible doubt about or objections against the medical advice.

To adequately analyse and evaluate argumentative discourse in medical consultation, specifying the preconditions for strategic manoeuvring by the doctor and patient might prove useful. It does not only provide insight into the opportunities and constraints that medical consultation offers for the argumentative discourse of its participants, but can also be used as a starting point for determining the soundness criteria for the evaluation of this discourse.

Link to commentary

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