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Comments on 'Arguing 'for' the Patient. Informed Consent and Strategic Maneuvering in Doctor–Patient Interaction'

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Schulz and Rubinelli's project 'Informed consent and strategic maneuvering in doctor–patient interaction' provides an excellent opportunity for studying argumentation in a specific institutional context because a medical consultation is a special communicative activity type that may involve argumentative discussion. Before engaging in empirical research regarding such a consultation it is necessary to make a conceptional analysis of this type of doctor–patient interaction. One first needs to give a general characterization of the type of interaction concerned: what is the structure of the interaction in a doctor–patient consultation in terms of speech acts, role taking and time constraints? For doing so a better understanding is required of the type of difference of opinion that will be at issue in such a consultation. What type of standpoint initiates the discussion? Which parts can be distinguished in the activity type of medical consultation and which of them are typically or potentially argumentative? What are the roles of the two participants in each of these cases? Is it the doctor or the patient who initiates the discussion by putting forward a standpoint or can this be done by either of them?

Schulz and Rubinelli characterize doctor–patient interaction as an 'info-suasive dialogue.' This characterization is, however, problematic. The authors claim that the interaction partly can be seen as an instance of an information-seeking dialogue and partly an argumentative encounter, 'at a higher level.' But in a consultation argumentation is not necessarily required. The patient may be in complete agreement with everything the doctor says and the doctor may not expect the patient to disagree with him so that no anticipation of doubt is necessary. Since argumentation is not a constitutive part of this activity type it is not automatically a 'persuasive' type of dialogue. Of course the moment one the parties has reason to believe that the other party is not or will not be in full agreement with him,

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the doctor–patient encounter may be considered part of an argumentative discussion. On the other hand, this activity type is neither a purely information-seeking dialogue, because in the interaction, more is at stake than just information seeking (as in an interview): the doctor may have to come to a decision about the diagnosis and may have to explain this decision to the patient, etcetera.

Schulz and Rubinelli mention some problems or constraints they see as obstacles to the conduct of a critical discussion and are of the opinion that they 'favor the dominance of rhetorical components in the doctor–patient interaction.' The first problem relates to the freedom rule. Unlike in a legal context, Schulz and Rubinelli observe that in a medical encounter there is no clear conflict. This, however, is by no means the most salient difference between legal argumentation and doctor–patient argumentation. Argumentation is a constituent part of the legal process while in a medical consultation argumentation is not a necessary component. Only when a doctor is faced with doubt he may feel obliged to defend his claim and the same goes for the patient. But this does not automatically means that the difference of opinion is unclear.

In some cases, the difference of opinion may become apparent because the doctor or the patient explicitly expresses a standpoint. In other cases, the different of opinion may not be so clearly defined because one of the parties just anticipates doubt and provides argumentation in anticipation of such doubt. In this case, it is harder to interpret the utterance as argumentation because it may be just an explanation. It could even a strategic move to present the argumentation as if it were merely an explanation.

In view of an adequate reconstruction of the confrontation stage it is important to know in what part of the consultation the standpoint is put forward: is the doctor talking about the diagnosis, about the prognosis or about the desired treatment of the problem? In all of these matters, the patient may have doubt about what the doctor has to say. Whether the patient dares to voice his doubt is, of course, a different matter. Even though the diagnosis is based on a doctor's expertise, a conflict about its outcome may arise. This happens, for instance, when a patient complains of headaches and the doctor says this pain is clearly stress-related pain, while the patient goes saying that he suffers from nausea as well and adds: 'could this not be something more serious than just stress?'

If the difference of opinion concerns a matter of treatment, a conflict may arise more easily. When in the context of 'informed consent' a doctor justifies his decision concerning the proposed therapy and the patient has not expressed doubt at all, we may take it all the same that he anticipates doubt and tries to justify his choice of treatment. In this way, knowledge of the activity type helps us to reconstruct the difference of opinion, even though this difference of opinion has not been made explicit. It is important, however, to realize that even in the context of 'informed consent' argumentation is not absolutely necessary.

Second, Schulz and Rubinelli point at problems pertaining to the burden of proof rule. According to Schultz and Rubinelli, the verification of this condition in the medical encounter is difficult because in the doctor's view, the clinical reasons for achieving a certain decision may be too technical to be used in argumentation. This situation may cause the doctor to violate the burden of proof rule, when the doctor simply refuses to back up his point of view, but this is not an automatic outcome. If the doctor still intends to discuss the matter, it is more likely that he will resort to

argumentation based on authority, referring to his experiences with similar cases—or he may try to simplify the matter. This does not automatically involve a burden of proof problem. It is clear that in this particular activity type, because of time constraints and because of the unequal distribution of power, there will be certain limits as to the obligations of a doctor to defend his claims to the full satisfaction of the patient.

A third problem mentioned by Schulz and Rubinelli has to do with the argument scheme rule. Schulz and Rubinelli claim that the distinction between what is a normatively good or poor argument in medical encounters has not yet been addressed. According to the authors authority argumentation is not the best way to inform patients of the reasons behind a certain treatment, while causal argumentation is 'definitely not an appropriate argument scheme for enhancing informed understanding.' The authors seem to mix up arguing and providing information—or at least they see arguing and providing information as speech acts that are put forward simultaneously by means of the same utterance. When a doctor is just informing the patient, however, and the patient accepts the information presented to him, no argumentation is necessary, so that there are no problems concerning argument schemes. On top of that, it is not very likely that 'informed consent' obliges the doctor to explain every detail and technical aspect of a diagnosis or treatment. For an adequate analysis 'informed consent' of doctor–patient communication it would be good to have a better understanding of the obligations of the doctor and the rights of the patients.

Argumentation becomes necessary when a patient expresses doubt about any of the doctor's statements. As Schulz and Rubinelli explain, the appropriateness of the argument schemes that are used in the argumentation is largely an intersubjective matter: the use of argument schemes is appropriate only if both parties in the discussion are in agreement about the use of these schemes. There is no reason for thinking that the choice of causal argumentation or argumentation based on authority will be problematic in doctor–patient interaction. The analysis of actual use of these argument schemes is a different matter. A further analysis of the context may enable us to specify the criteria going with each of the argument schemes.

In conclusion, the problems that Schulz and Rubinelli mention can be seen as constraints of an activity type that help us understand the strategic maneuvering that goes on in this activity type. Characterizing these constraints enables the analyst to understand the choices made by the doctor and by the patient in getting their respective points across. It is clear that doctor–patient dialogues are structurally different from other institutionalized interaction. It is certainly not the case, however, that the unequal distribution of power and expertise make this type of interaction unsuitable for a pragma-dialectical analysis. On the contrary, these characteristics, which define this specific communicative action type and indicate the constraints, are of great help to us when analyzing the strategic maneuvering that takes place in doctor–patient interaction. Schultz and Rubinelli's choice to focus on the concept of informed consent opens up new venue for studying doctor–patient communication.