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The Ethical Convenience of Non-Neutrality in Medical Encounters: Argumentative Instruments for Healthcare Providers

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1. *Introduction*

Within the field of health communication, there is a wide consensus on the idea that communication is an important mediator of clinical outcomes. In this respect, it has become clear that the quality and appropriateness of care is guaranteed also by the quality of communication between patients and health providers. This idea has received a strong theoretical and empirical support[1], and Street and collaborators have described the state of the art of this literature by referring to the direct (i.e., an empathic communication could increase the emotional well-being of patients) and indirect pathways (i.e., a clear communication could increase patient knowledge and understanding) from communication to health outcomes, thus clarifying the reason why a good/bad communication may result in better/worse health outcomes[2].

The ethical value of the connection between communication and health outcomes is self-evident, especially in the light of the patient-centered paradigm that is recognized as the most desirable approach in healthcare. In a nutshell, this paradigm suggests that the emotional, psychological and experiential knowledge of patients should be considered as core in the process of healthcare; in this context, a patient centered style of communi-

[1] E.g., R.L.J. Street, *How Clinician-Patient Communication Contributes to Health Improvement: Modeling Pathways from Talk to Outcome*, in «Patient Education and Counseling», 92 (2013), n. 3, pp. 286-291; R.L.J. Street-G. Makoul-N.K. Arora-R.M. Epstein, *How Does Communication Heal? Pathways Linking Clinician-Patient Communication to Health Outcomes*, in «Patient Education and Counseling», 74 (2009), n. 3, pp. 295-301.

[2] R.L.J. Street and collaborators, *op. cit.*

cation should guarantee a respectful management of patient's preferences and opinions, not simply because it is «positively associated with patient satisfaction, adherence, and better health outcomes»[3], but because it ethically safeguards patients' freedom and autonomy[4].

Even if it is not easy to provide a single definition for the concepts of freedom and autonomy, and consequently, a single definition of patient-centered communication[5], there is broad consensus on the idea that doctor-patient mutual understanding counts as an indispensable ethical prerequisite for any patient-centered approach[6]. Therefore, patient understanding becomes a *conditio sine qua non* in a paradigm that aims at enabling patients to be active participants in their care, for example by expressing their preferences when choosing between different treatment options. The basic idea is that a better understanding would allow an adequate shared decision-making between patients and health providers, thus enabling the proper practice of patients' freedom and autonomy. This is the first good reason for focusing on communication, since understanding and then shared decision-making are achieved by means of and within the communication process.

For their part, health providers should give clear information and also take into account the preferences of patients. But again, it is not easy to handle such amount of (provided and received) information as the one that is exchanged during a consultation, at the same time putting into practice highly complex communicative tasks, as the ones foreseen by patient-centered medicine.

[3] M. Stewart, *Towards a Global Definition of Patient Centred Care*, in «British Medical journal», 322 (2001), n. 7284, pp. 444-445, p. 445. See also Id., *Effective PhysicianPatient Communication and Health Outcomes: a Review*, in «Canadian Medical Association Journal», 152 (1995), pp. 14231433.

[4] E. Moja-E. Vegni, *La visita medica centrata sul paziente*, Cortina, Milano 2000; D. Roter-J.A. Hall, *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*, Greenwood Publishing Group, Westport (CT) 2006.

[5] E.J. Emanuel-L.L. Emanuel, *Four Models of the Physician-Patient Relationship*, in «Jama», 267 (1992), n. 16, pp. 2221-2226; R.M. Epstein-R.L.J. Street, *Shared Mind: Communication, Decision Making, and Autonomy in Serious Illness*, in «Annals of Family Medicine», 9 (2011), n. 5, pp. 454-461; H. Ishikawa-H. Hashimoto-T. Kiuchi, *The Evolving Concept of "Patient-Centeredness" in Patient-Physician Communication Research*, in «Social Science & Medicine», 1982 (2013), n. 96, pp. 147-153.

[6] J. Appleyard, *Introduction to Ethical Standards for Person-Centered Health Research*, in «International Journal of Person Centered Medicine», 3 (2014) n. 4, pp. 258-262; J.E. Mezzich-J. Appleyard-M. Botbol-T. Ghebrehiwet-J. Groves-I. Salloum-S. van Dulmen, *Ethics in Person Centered Medicine: Conceptual Place and Ongoing Developments*, in «International Journal of Person Centered Medicine», 3 (2014), n. 4, pp. 255-257.

From a different perspective, still, these communicative tasks are strongly related to the ethical issue of healthcare providers' neutrality. Assuming that from an ethical point of view neutrality is desirable, it remains the case that healthcare providers may make their decisions and propose their therapeutic choices based on (often unconscious) cognitive biases, values, preferences and past experiences[7]. The ideal of neutrality is thus called into question from the non-neutrality emerging from the concrete communicative interactions between patients and healthcare providers. That is the reason why it would be appropriate for clinicians to learn to deal with their own non-neutrality in order to ensure the freedom and autonomy of patients[8]. Since this task is entirely communication-based, in this contribution we suggest that healthcare providers should be equipped with effective communicative and linguistic instruments to manage their non-neutrality. By proposing a case study analysis from the context of Assisted Reproductive Technology (ART), we argue that non-neutrality may paradoxically have – if it is properly managed – a higher degree of ethical convenience (§3). In summary, we show the relevance for the context of health communication of recent issues discussed in cognitive pragmatics and linguistics (§ 2); having in mind the idea that patients' autonomy and freedom is guaranteed by understanding within shared decision-making, we then introduce the argumentative theory of reasoning[9] and we discuss the significant role of argumentative instruments within patient-provider interactions. Finally, we propose a case study analysis of a medical consultation within ART and show how an ethical management of non-neutrality requires an appropriate use of communicative instruments and, more specifically, of argumentative instruments (§3). Finally, we discuss some preliminary results and sketch further lines of research (§4).

2. *Which communicative model for patient-provider interactions?*

While scholars within the field of health communication have produced a lot of evidence to support the idea that communication has direct and

[7] M. Jenicek, *Fallacy-Free Reasoning in Medicine*, American Medical Association, Chicago 2009; Truog *et al.*, Titolo?, casa editrice?, città? 2015).

[8] S. Bigi, *Communicating (with) Care*, IOS Press, Amsterdam 2016.

[9] H. Mercier-D. Sperber, *Why do humans reason? Arguments for an argumentative theory*, in «Behavioral and brain sciences», 34 (2011) n. 2, pp. 57-74.

indirect effects on health outcomes, details are still lacking about which communicative instruments can be considered effective and why. Part of the reason for this gap arises from the fact that also a comprehensive approach to human communication in this research field is missing. In this respect, Bigi has claimed that the adoption of a pragmatic-argumentative approach to the context of patient-provider interactions «can provide answers to the unanswered questions recurrently formulated by health communication scholars»[10]. Following this line of research, we are proposing to draw on recent, rather sophisticated, models for the analysis and description of human interaction outlined by pragmatists and linguists to analyze the specific institutional context of patient-provider interactions.

2.1. *A pragmatic-argumentative model for patient-provider interactions*

The dynamic between cooperation and egocentrism in communication exchanges represents the starting point behind our reasoning. There have been many discussions regarding the dimensions of cooperation and collaboration to define the specific nature of human communication[11]. Some scholars even identified in these dimensions the source of the evolutionary origin of the cognitive mechanism underpinning human communication. For example, Tomasello claimed:

> Human communication is thus a fundamentally cooperative enterprise, operating most naturally and smoothly within the context of (1) mutually assumed common conceptual ground, and (2) mutually assumed cooperative motives. […] But if we are to understand the ultimate origins of human communication, both phylogenetically and ontogenetically, we must look outside of communication itself and into human cooperation more generally[12].

While the idea of common ground understood as a facilitator for the achievement of cooperation has been adequately investigated from a cognitive point of view and still has great significance in current language models[13], the uniqueness of cooperation as a motivation to explain human

[10] S. Bigi, *op. cit.*, p. 4.

[11] E.g., P.H. Grice, *Logic and Conversation* (1975), in P. Cole-J. Morgan (eds.), *Speech Acts*, Academic Press, New York 1995, pp. 41-58; H.H. Clark, *Using Language*, Cambridge UP, Cambridge 1996; M. Tomasello, *Origins of Human Communication*, MIT Press, Cambridge (MA) 2008; Id., *A Natural History of Human Thinking*, Harvard UP, Cambridge (MA) 2014.

[12] M. Tomasello, *Origins of Human Communication*, cit., p. 6.

[13] D. Sperber-D. Wilson, *Relevance: Communication and Cognition*, Blackwell, Oxford 1995^2.

communication is becoming increasingly controversial[14]. Indeed, many scholars have experimentally examined the psychological processes that guide communication, and discovered that humans exhibit an egocentric bias[15]: humans «have the tendency to take their own perspective to be automatically shared by the other»[16]; that is, speakers and listeners focus on their own knowledge, not on the mutual knowledge assumed as part of their common ground[17]. Also, egocentric motivation is being perceived as theoretically relevant[18] and integrated in a unified model of language[19]. Stressing this latter point, the Socio-Cognitive Approach (SCA)[20] fruitfully integrates the cognitive empirical evidence on egocentrism and describes how cooperation and egocentrism operate within the dynamic process of communication. As stated by Kecskes:

> Communication is the result of the interplay of intention and attention, as this interplay is motivated by the individuals' private socio-cultural backgrounds. This approach [*the SCA*] integrates the pragmatic view of cooperation and the cognitive view of egocentrism and emphasizes that both cooperation and egocentrism are manifested in all phases of communication, albeit to varying extents. While cooperation is an intention-directed practice which may be measured by relevance, egocentrism is an attention-oriented trait which is measured by salience. Intention and attention are identified as two measurable forces that affect communication in a systematic way[21].

[14] E.g., R. Giora, *On Our Mind: Salience, Context and Figurative Language*, Oxford UP, Oxford 2003; I. Kecskes, *The Paradox of Communication-Socio-Cognitive Approach to Pragmatics*, in «Pragmatics and Society», 1 (2010), n. 1, pp. 50-73; U. Peters, *Human Thinking, Shared Intentionality, and Egocentric Biases*, in «Biology & Philosophy», 31 (2016), pp. 299-312.

[15] E.g., N. Epley-B. Keysar-L. van Boven-T. Gilovich, *Perspective Taking as Egocentric Anchoring and Adjustment*, in «Journal of personality and social psychology», 87 (2004), n. 3, pp. 327-339; K. Savitsky-B. Keysar-N. Epley-T. Carter-A. Swanson, *The Closeness-Communication Bias: Increased Egocentrism Among Friends Versus Strangers*, in «Journal of Experimental Social Psychology», 47 (2011), n. 1, pp. 269-273.

[16] U. Peters, *op. cit.*, p. 307.

[17] E.g., D.J. Barr-B. Keysar, *Making Sense of How We Make Sense: the Paradox of Egocentrism in Language Use*, in H.L. Colston-A.N. Katz (eds.), *Figurative Language Comprehension: Social and Cultural Influences*, Erlbaum, Mahwaw (NJ) 2005, pp. 21-41.

[18] E.g., B. Keysar, *Communication and Miscommunication: the Role of Egocentric Processes*, in «Intercultural Pragmatics», 4 (2007), pp. 71-84.

[19] E.g., I. Kecskes-F. Zhang, *Activating, Seeking, and Creating Common Ground: A Socio-Cognitive Approach*, in «Pragmatics & Cognition», 17 (2009), n. 2, pp. 331-355; Id., *Intercultural Pragmatics*, Oxford UP, Oxford 2014.

[20] Proposed by I. Kecskes, *The Paradox of Communication-Socio-Cognitive Approach to Pragmatics*, cit.; Id., *Intercultural Pragmatics*, cit.; and I. Kecskes-F. Zhang, *op. cit.*

[21] I. Kecskes, *The Paradox of Communication-Socio-Cognitive Approach to Pragmatics*, cit., pp. 58-59.

Avoiding to consider only egocentric motivation in communicative interactions, this model seems useful to offer a solution for the potentially pervasive problem of miscommunication and misunderstanding: the existence of egocentric biases appears to give sufficient grounds for considering misunderstandings as problematic, particularly in relation to decision-making in asymmetrical communicative contexts. By focusing both on cooperation and egocentrism, however SCA avoids this problem and proposes a dynamic model of meaning, in which processes behind the co-construction of the emergent common ground – the specific and dynamic knowledge created through interaction – can explain why we manage to understand each other.

To explain how SCA is supposed to work, Kecskes reclaims the distinction between prior and situational context and makes clear how cooperation (by means of relevance) and egocentrism (by means of salience) are both involved within communicative interactions. By using this distinction, Bigi offers a detailed discussion of SCA in the medical context and states:

> following egocentric behaviors, hearers will be guided by what is salient to them in the effort to make sense of what their interlocutors are communicating. The most salient information is usually the most accessible information, i.e. the most easily recalled, the most familiar to the individual, etc. If speakers' and hearers' salience (or private contexts) does not coincide, then the parties will resort to the actual situational context to disambiguate the language and achieve understanding[22].

Bigi analyzes a few cases of alignment and misalignment during medical encounters between the private and actual situational contexts, thus illustrating meaning construction within the dynamic model proposed by SCA[23]. In a similar vein, the following exchange between a nurse (N) and a patient (P) in a diabetes clinic typifies the practical usefulness of SCA in the context of diabetes care[24]. More specifically, this exchange exhibits a case of misalignment between the patient's and nurse's private contexts.

[22] S. Bigi, *op. cit.*, p. 44.

[23] *Ibidem*.

[24] The example is taken from a corpus of videos of follow-up consultations in the context of diabetes care. See S. Bigi, *Healthy Reasoning: The Role of Effective Argumentation for Enhancing Elderly Patients' Self-Management Abilities in Chronic Care*, in «Studies in Health Technology and Informatics», 203 (2014), pp. 193-203.

Speaker	*Text*
1. N	your legs' skin is drier
2. P	dry, yes
3. N	drier than the feet's skin
4. P	they [skin marks] come out… Are they caused by the youth? These skin marks?
5. N	you know, dry skin breaks easily
6. P	oh…
7. N	and you know very well that all these cuts
8. P	but I have every possible lotion at home
9. N	but you leave them in the drawer!

The nurse is running a diabetes foot exam and observes the patient legs' skin with the communicative intention to require a greater skin hydration. The patient's misalignment is very clear (line 4). The patient doesn't understand what the nurse is saying and why it is salient; that is, she focuses on the senile lentigos which are salient in the patient's private contexts but not in the actual situational context (e.g., diabetes foot exam). Thus, the nurse needs to explain why it is important to hydrate the skin before reaching a solid common ground and a successful common understanding.

2.2. *Argumentative instruments for shared decision-making*

The tension between egocentrism and cooperation commonly found in communication exchanges and the need to build a solid common ground to enable understanding are two central aspects affecting decision-making. In the Introduction, we pointed out the ethical value of understanding between patients and healthcare providers within the patient-centered paradigm of care. Indeed, the precarious success of communication is a central issue in asymmetrical contexts such as patient-provider interactions. In these contexts, the distribution of knowledge and procedures is often not shared by speakers: on the one hand, healthcare providers have an advantage with regard to information about procedures, therapeutic regimen and clinical understanding; but on the other hand, patients have an advantage with regard to information about their subjective experience with illness, which can be particularly helpful in establishing diagnosis and plays a major role in disease monitoring. Patients also have an advantage when

they are called upon to express their preferences and values on treatment options. This is why the management of appropriate linguistic instruments by providers is extremely relevant to support patients in expressing their autonomy and freedom[25]. Our contention is that argumentative strategies are one of the linguistic instruments available to healthcare providers to achieve this goal.

Abandoning the often implicit idea that argumentation is just a form of manipulation, scholars are showing an increasing interest for the role of argumentation in medical settings and are increasingly proposing argumentative discourse as an adequate instrument ensuring a transparent discussion about different opinions. A pragmatic-argumentative model of communication for patient-provider interactions allows to integrate the interplay between intention and attention, egocentrism and cooperation to account for the complex dynamics at play in deliberation sequences. The asymmetrical social and dialogical roles, the different background knowledge each participant brings to the interaction and the different individual goals of the participants all play a part during deliberation, in both its components, i.e. information sharing and argumentative exchanges. More specifically, through a description of the processes of argument production and (mis)interpretation, it is possible to reconstruct the tension between the individual and the social dimensions, also explaining cases of misunderstanding and misalignment of intentions[26].

These ideas are also consistent with recent insights developed in cognitive science and, more specifically, by theories of reasoning. Particularly relevant for our discussion is the proposal advanced by Mercier and Sperber to consider argumentation as the main function of reasoning[27]. Indeed, the so-called argumentative theory of reasoning claims that «the main function of reasoning is to exchange arguments in dialogical contexts in order to improve communications»[28]. At a theoretical level, this model

[25] S. Bigi, *Communicating (with) Care*, cit.; Id., *Communication Skills for Patient Engagement: Argumentation Competencies as Means to Prevent or Limit Reactance Arousal, with an Example from the Italian Healthcare System*, in «Frontiers in Psychology», 7 (2016); M.G. Rossi, *Metaphors for Patient Education: a Pragmatic-Argumentative Approach Applying to the Case of Diabetes Care*, in «Rivista Italiana di Filosofia del Linguaggio», 10 (2016), n. 2, <http://www.rifl.unical.it/index.php/rifl/article/view/403>.

[26] S. Bigi, *Communicating (with) Care*, cit.

[27] H. Mercier-D. Sperber, *op. cit.*

[28] H. Mercier-M. Boudry-F. Paglieri-E. Trouche, *Natural-Born Arguers: Teaching How to Make the Best of Our Reasoning Abilities*, in «Educational Psychologist», 52 (2017), pp. 1-16, p. 1.

uses the empirical evidence on individual reasoning failures in a positive way: the authors focus on the epistemic function and claim that many biases or errors of reasoning are less puzzling when analyzed by considering reasoning as an argumentation instrument in social dynamics[29]. In this context, argumentation is characterized by a cooperative and adversarial dimension at the same time: on the one hand, argumentation involves a public exchange of reasons by introducing the obligation for the participants to listen to each other; on the other hand, the ultimate goal is "egocentric": the production and evaluation of arguments have the final outcome to convince others and change their mind with respect to the object of discussion.

The implications of this theoretical model are relevant for the topic of this contribution. Indeed, Mercier and collaborators[30] underline links (and benefits) of this new theory of reasoning for the educational domain and, in particular, for improving critical thinking in the context of group discussions and collaborative learning. In contrast to individualist theories of reasoning, they use empirical evidence to point at the fact that in small groups, where subjects have different and contrasting opinions, teaching aimed at improving reasoning is possible to achieve. This may be the case, for example, of the management of shared decision-making between patients and healthcare providers.

3. *A case study analysis in the context of Assisted Reproductive Technology (ART)*

We are proposing that: (1) argumentative instruments are effective to manage the shared decision-making phases within medical interactions, and (2) improvements in the way these instruments are being taught to healthcare providers are necessary. However obvious these concepts may seem, they are actually quite controversial in the literature on doctor-patient communication. Indeed, it is easy to find that argumentation is confused with manipulation[31] and thus rejected as an appropriate means of

[29] See also F. Ervas-E. Gola-M.G. Rossi, *Metaphors and Emotions as Framing Strategies in Argumentation*, in «CEUR-WS», 1419 (2015), pp. 645-650.

[30] H. Mercier *et al.*, *op. cit.*

[31] S. Rubinelli, *Rational Versus Unreasonable Persuasion in Doctor-Patient Communication: a Normative Account*, in «Patient Education and Counseling», 92 (2013) n. 3, pp. 296-301.

communication in medical encounters. Moreover, there is sometimes confusion between what is measured through participants' satisfaction scales and the assessment of the quality of decision-making provided by the analyst. In particular, it is perhaps too strong a claim to assume that the former is a direct reflection of the latter. With regard to this point, Elwyn and Miron-Shatz have recently advocated that more theoretical and empirical efforts are required to evaluate the quality of deliberation[32], which also corresponds to the major component of the shared decision-making process. By taking a closer look at the context of Assisted Reproductive Technology (ART), in the following section we discuss these points in more detail[33].

3.1. *A controversial use of argumentation in an ethically sensitive context*

According to recent surveys, ART is a field with high levels of dissatisfaction: from a clinical point of view, the treatment success rates are still low, around 30%[34]; from a communicative point of view, previous studies have connected patient dissatisfaction with poor communication and low-quality relationships between patients and healthcare providers[35]. Moreover, research showed that ART patients want to be assertive and prefer to have an active role in medical decision and procedures[36].

[32] G. Elwyn-T. Miron-Shatz, *Deliberation Before Determination: the Definition and Evaluation of Good Decision Making*, in «Health Expectations: An International Journal of Public Participation in Health Care and Health Policy», 13 (2010), n. 2, pp. 139-147.

[33] See also G. Lamiani-S. Bigi-M.E. Mancuso-A. Coppola-E. Vegni Lamiani, *Applying a Deliberation Model in Haemophilia Consultations: Implications for Theory and Practice in Doctor-Patient Communication*, in «Patient Education and Counseling», 100 (2016), n. 4, pp. 690-695.

[34] A.P. Ferraretti-V. Goossens-M. Kupka-S. Bhattacharya-J. de Mouzon-J.A. Castilla-K. Erb-V. Korsak-A. Nyboe Andersen, European IVF-Monitoring (EIM) Consortium for the European Society of Human Reproduction and Embryology (ESHRE), *Assisted Reproductive Technology in Europe, 2009: Results Generated from European Registers by ESHRE*, in «Human Reproduction», 28 (2013), n. 9, pp. 2318-2331.

[35] S. Gameiro-J. Boivin-L. Peronace-C.M. Verhaak, *Why Do Patients Discontinue Fertility Treatment? A Systematic Review of Reasons and Predictors of Discontinuation in Fertility Treatment*, in «Human reproduction update», 18 (2012), n. 6, pp. 652-669; R.C. Leite-M.Y. Makuch-C.A. Petta-S.S. Morais, *Women's Satisfaction with Physicians' Communication Skills During an Infertility Cconsultation*, in «Patient Education and Counseling», 59 (2005), pp. 38-45; M. Malin-E. Hemmink-O. Räikkönen-S. Sihvo-M.L. Perälä, *What Do Women Want? Women's Experiences of Infertility Treatment*, in «Soc Sci Med», 53 (2001), pp. 123-133.

[36] E.A. Dancet-I.W. van Empel-P. Rober-W.L. Nelen-J.A. Kremer-T.M. D'Hooghe, *Patient-Centred Infertility Care: a Qualitative Study to Listen to the Patient's Voice*, in «Human Reproduction», 26 (2011), pp. 827-833; V.L. Peddie-E. van Teijlingen-S. Bhattacharya, *Ending*

The analysis we propose has a twofold purpose: on the one hand to show, through an example of suboptimal management of a deliberative sequence, how argumentative competence on the part of the clinician can be a means to safeguard patients' freedom of choice and autonomy in conditions of psycho-emotional fragility and lowered cognitive capacities; on the other, what it means that in many cases participants' perceptions are not a good measure of the quality of the interaction. The example we propose is an excerpt of a visit from a corpus of 85 visits videotaped in eight Italian ART Centers within a broader research project on doctor-patient communication in the ART context.

The excerpt corresponds to one of the deliberative sequences in the consultation; the participants are the doctor and a couple who is consulting her to begin treatment for assisted reproduction. In this particular phase, the woman states that she is willing to undergo only one cycle of treatment and puts forward her reasons for this decision. The clinician has reasons to consider this an ill-informed decision, thus tries to persuade her that she should go for more than one cycle of treatment. The analysis of this deliberation has been conducted using the Method for Dialogue Analysis (MeDA), which allows the description and assessment of dialogical sequences. The method codes dialogue moves according to 7 different categories[37] and is a direct development of the model of types of dialogue[38].

Before turning to the analysis, it is important to add that patients reported high satisfaction for this consultation, which also received high patient-centeredness scores, calculated with the Roter Interaction Analysis System (RIAS), one of the most recognized methodologies for the analysis of medical encounters[39]. The patient-centeredness mean score for all 85 visits was 0,526, where a score of "0" indicates low patient-centeredness, and "1.0" and above indicates high patient-centeredness; the visit from

in-Vitro Fertilization: Women's Perceptions of Decision Making, in «Human Fertility», 7 (2004), n. 1, pp. 31-37; V.L. Peddie-E. van Teijlingen-S. Bhattacharya, *A Qualitative Study of Women's Decision-Making at the End of IVF Treatment*, in «Human Reproduction», 20 (2005), n. 7, pp. 1944-1951.

[37] F. Macagno-S. Bigi, *Analyzing Dialogue Structure. From Types of Dialogue to Dialogue Moves*, in «Discourse Studies», in press.

[38] D. Walton, *Informal Logic*, Cambridge UP, Cambridge 1989; D. Walton-E. Krabbe, *Commitment in Dialogue*, State University of New York Press, Albany 1995.

[39] D. Roter-S. Larson, *The Roter Interaction Analysis System (RIAS): Utility and Flexibility for Analysis of Medical Interactions*, in «Patient education and counselling», 46 (2002), n. 4, pp. 243-251.

which the excerpt was extracted has a patient-centeredness score of 0,98, which is very good. Based on these qualitative and quantitative data, it would seem appropriate to assume also a good management of argumentation during the shared decision-making phases.

In what follows we present the excerpt and its analysis. Doctor (D) is giving information to a couple (labeled MP, for male patient, and FP, for female patient) for completing informed consent. In particular, patients have to decide with respect to the embryo-freezing and D explains why, in their case, they don't have to give consent. Using the model developed by Macagno and Bigi, we have analyzed the dialogical goals of the communicative interaction by coding the various types of dialogical moves[40].

Speaker	*Text*
1. D	since it's better to use a bigger number of egg cells, we can't freeze them, [otherwise]
2. FP	[no::: no::: no no (unint)]
3. D	so, no, we start all over again
4. FP	no, I already decided to go for one try
5. FP	and that's it, because, I think, I mean, I don't think I would be able be able to… start all over again another time. I mean, if it's God's will, otherwise it's like starting a farm…
6. D	wow, you sure sound negative, don't you?
7. FP	[I'm not being negative], I'm a little fatalist
8. FP	because, I feel that I am already forcing a bit… what is supposed to be, [I mean…]
9. D	[but why (unint)]?
10. FP	ah, I don't know, but… that's it
11. MP	well, doc, she's always been kind of negative about kids
12. FP	yeah, I mean, it's not like I've ever been head over heels about kids, I mean, it's not like I'm dying to become a mother. I realize it's something he really wishes, it's probably the age. Kids are cute, all right, but when I was in my thirties I was thinking, no way, I don't want any. Then you grow older and maybe you change your mind, maybe [the context]
13. D	[things change]

[40] F. Macagno-S. Bigi, *op. cit.*

14. FP	things change a bit. But it's not like I've always thought that I wanted to be a mother. No, I wanted to be a woman, a daughter, that's it. So, I've already tried, did everything that was possible, treatm- everything, 'cause, the past four years we've spent always travelling around the place…
15. FP	this is the last time, I'm trying once and then [then that's it]
16. D	[listen]
17. FP	[because I'm fata-]
18. MP	[listen to me, doc, in the end]
19. FP	[because] I'm fatalist
20. FP	because then,,,, I see people who don't have any children, people who get children… what if you get a child… that's not one hundred per cent… I know myself, so
21. D	yeah, well, all right, but then [in any case technology (unint)]
22. FP	[I know that but then…] yeah, sure, techn- of course, but, you know, I'm already forcing the hand…. For me this is forcing nature
23. D	we sure are funny, aren't we? (chuckling softly)
24. D	you know why, I was thinking, we never have these thoughts [look]
25. D	for example, you get pneumonia
26. FP	it's true
27. D	and you take antibiotics, when you get cancer- now [mind you, I'm not putting them on the same level]
28. FP	[yeah, of course not, no no no]
29. D	but it's funny though, because then you don't think that you're forcing nature, and instead on this thing about children
30. D	[do you know why] I'm telling you? Because it's something I get from so many [couples]
31. FP	[really?] eh
32. D	it's something a lot of people feel, this thing about forcing nature because probably it really comes=
33. MP	[and then after all]-
34. D	[=it's felt] like something that [should be natural]
35. FP	[should probably be natural] it's all, mm… a cultural thing we carry with us, I don't know if it's something…
36. D	I guess so
37. FP	yeah, probably it's all a cultural thing, not anything else

38. D	that is rooted
39. FP	that is rooted in- in-… all that catholic thing and bla bla bla you grow up with, it's probably that, but then in the end it's such a part of you that=
40. FP	= for me, that I didn't even want to become a mother, when I was… I mean, we started late for that reason, because when I was thirty the last thing I wanted was to become a mom so… now I'm forty and at this point I think, if I make it that's good, otherwise I go on too much and I feel like a grandma and I don't… I mean, I get all those thoughts, that when my child is thirty I'm seventy [all this kind of stuff, you know, so]
41. FP	one thing- one time, I try
42. MP	sure
43. FP	and then
44. D	ok, so, this decision is very [personal]
45.FP	[sure]
46.D	and I really don't want to interfere because…
47. FP	no no
48. D	although I would really like to tell you something, that will maybe make it a little easier for you

The doctor is giving detailed clinical and procedural information to justify why embryo-freezing is not necessary in this case, when the woman starts sharing her ideas and arguments to support her decision of making just one attempt (from line 4). She explains her position by sharing preferences regarding her individual well-being (e.g., line 12) and advancing arguments that are very often emotionally charged (e.g., line 20):

Justifications for FP's decision of making just one attempt:
1) She feels fatalist (lines 7 and 19);
2) By undergoing ART treatments FP thinks she is forcing nature (lines 8 and 22);
3) In any case, she never wanted to become a mom (lines 12, 14, 40);
4) FP is afraid to have an unhealthy baby (line 20).

The ethical value of these preferences and arguments is out of the question, because they all concern the patient's individual autonomy and freedom in an area such as ART that is *per se* value-laden and emotionally charged. Nevertheless, D's reply is emotionally very strong and ethically undesirable and consists of two main argumentative steps. First, she proposes an undue analogy by building correspondences between different health conditions and their related medical treatments:

a) pneumonia (line 25) and antibiotics (line 27)
b) cancer (line 27) and chemotherapy (implicit)
c) fertility problems (line 29) and Assisted Reproductive Technology (implicit).

In spite of D's *excusatio* at line 27, the analogy is completed at line 29.

The second step taken by D seems to give legitimacy to FP's doubts and ethical preoccupations by aligning FP's feelings with those of many other couples (lines 30, 32, 34, 36); at first, this step may sound as an indication of patient-centeredness. However, the dialogical effect on FP is not encouraging; in fact, she starts considering her worries merely as a byproduct of a cultural influence and consequently she dismisses them (lines 37, 39). D's arguments seem to undermine the patient's values and identity. Indeed, D's persuasion moves are quite personal and difficult to contrast, even more so for patients who are already in an emotionally complex and delicate situation. Furthermore, D's arguments do not relate to clinical or procedural issues, which should of course be shared with patients; instead, they concern personal values and choices, something that does not seem appropriate in this context. The doctor improperly discusses the patient's ethical preferences instead of clarifying why the proposal of a single attempt has a good chance to be unsuccessful from a clinical point of view.

In the final part of this excerpt, FP returns on her main worry (she never wanted to become a mom) and goes on to discuss the consequences of her past choices that are affecting her current decisions (she is feeling too old to become a mom, line 40). At this point, D stops presenting arguments and brings up the issue of neutrality. As shown in lines 44 and 46, she states that it is a personal choice and that is why she does not want to interfere. However, these declarations of neutrality come at the end of the sequence, after she has expressed very strong opinions regarding the patients' doubts and preferences.

Looking at the patient satisfaction score and patient-centeredness scores reported by patients for this consultation (both very high), it could be hypothesized that D's 'profession of neutrality' at the end of the sequence has the effect of canceling in the patients' perception the pragmatic value of her previous moves as arguments in a deliberation, instead suggesting that they have only been attempts at sharing ideas. However, the whole sequence had been triggered by D's comment that the procedure would have to be repeated, generating FP's reply that she had already decided to try it only once (lines 3-4). The interpretation of this sequence as conflict of opinion on a decision, and thus deliberation, is also confirmed

by the conclusion of the issue, which comes towards the end of the consultation: the patient postpones the final choice and decides to evaluate her reactions to the first cycle, because later on in the conversation D explains to her that the chances of success are very low in any case, so trying more than once would give her more opportunities to actually get pregnant.

Assuming that the doctor is in good faith and has no hidden agenda, her management of the argumentative phases of this deliberative sequence clearly puts an unwarranted psycho-emotional pressure on the patient, causing her to dismiss her own legitimate doubts and worries, thus not fostering an ideal psycho-emotional condition for further decision-making on the issues at stake.

It is important to note here that the reconstruction of this exchange as an example of inappropriate argumentation by the doctor depends on the theoretical assumptions underlying MeDA[41]. Indeed, it could be argued that D correctly defuses an irrational worry voiced by FP (i.e., "I fear I am forcing nature"), while showing respect and even a tactful handling of a valid concern she presents (i.e., "I am not so sure I want to have children"). Namely, D should consider the first worry as patently unfounded for at least two reasons: first, if "forcing nature" is a genuine worry of FP, she should not even try once; second, if trying ART means going against nature, then the same should be true of curing whatever health problem one happens to have – which is precisely the analogy drawn by D[42]. To explain why this reconstruction should not be adopted we need to further specify and define what it means that healthcare providers should use non-neutrality in a proper way.

What "proper way" means from a pragmatic-argumentative point of view is defined in terms of "dialogical relevance", i.e. the ability of single dialogical moves to be coherent with the joint dialogical goal[43]. Especially in institutional contexts such as the medical encounter, the joint dialogical goals correspond to the institutional goals and admissibility rules may be in place in relation to the dialogical moves that can be used to realize them[44]. In the excerpt analyzed above, the medical explanation about the

[41] F. Macagno-S. Bigi, *op. cit.*

[42] We thank one anonymous referee for pointing out to us this alternative compelling reconstruction of the exchange.

[43] F. Macagno-S. Bigi, *op. cit.*

[44] S. Levinson, *Activity Types and Language*, in P. Drew-J. Heritage (eds.), *Talk at Work*, Cambridge UP, Cambridge 1992, pp. 66-100; S. Bigi, *Communicating (with) Care*, cit.

low success rates to get pregnant has a dialogical relevance for the realization of the higher order intention of explaining from a clinical point of view why the proposal of a single attempt has a good chance to be unsuccessful. On the contrary, D's analogy against the worry voiced by FP is not dialogically relevant in view of the joint clinical goal. A proper managing of non-neutrality requires at least the recognition of what is dialogically relevant in the light of a specific role in a specific context: from our perspective, D must face the doubts and worries expressed by PF clarifying how and why they may have an impact at the clinical level (non-neutrality managed in a proper way); D should not tackle the doubts and worries expressed by PF with a view to challenge her ethical preferences and opinions (non-neutrality managed in an improper way). And obviously, this assessment of the quality of deliberation may be further detailed to include the analysis of its argumentative structure[45].

4. *Conclusions*

Our analysis of the excerpt from an ART visit in the previous section shows a discrepancy between the high measures of both patient satisfaction and patient-centeredness, and the low quality of argumentation during a deliberative phase. Even if this analysis is just an illustration and further data are necessary to evaluate the reliability of this provisional result, new assessment tools seem necessary in order to evaluate understanding and shared decision-making in a more appropriate way. In this respect, argumentative models and tools might offer a better assessment of understanding and shared decision-making. A study by Lamiani and collaborators goes in this direction and constitutes a first step to systematically evaluate the quality of deliberation by using a pragmatic-argumentative model of language and communication[46].

Regarding the issues discussed in this contribution, there are two main concluding remarks:

(1) socio-cognitive models of language and reasoning such as those discussed in the previous sections, offer solid theoretical backgrounds for

[45] See G. Lamiani *et al.*, *op. cit.*; F. Macagno-S. Bigi, *op. cit.*

[46] G. Lamiani *et al.*, *op. cit.* See also S. Bigi, *Communicating (with) Care*, cit.; F. Macagno-S. Bigi, *op. cit.*

interdisciplinary research in the fields of education and health communication; we focused mainly on their importance for the education of healthcare providers, but the same applies also for patient education[47];

(2) concerning argumentative instruments, our general point is that healthcare providers must learn to properly use these instruments in order to guarantee understanding and manage the shared decision-making phases with patients. More specifically, precisely to avoid ambiguous and improper use of neutrality, above all in highly value-laden and emotionally charged argumentative contexts such as ART, healthcare providers should use non-neutrality in a proper way – from an argumentative and ethical point of view. Patients seek advice on the desirability of treatments, healthcare providers must be ready (and trained) to provide it properly.

It is the time to make a concerted and interdisciplinary effort to integrate knowledge and methodologies; this is the only way to view communication in institutional settings as the product of a range of skills that can (and must) be taught, and stop considering it merely as a personal talent, happening only in a few, fortunate cases[48].

Abstract

Many scholars have shown the relevance of communication as an instrument of care by arguing that the quality of the doctor-patient relationship – also based on the quality of verbal communication – affects the engagement and outcomes of patients. This understanding of such therapeutic role of communication paves the way to a re-consideration of ethical questions in clinical contexts: if communication is a therapeutic instrument, then healthcare providers need to be able to properly use it. Our main aim in this contribution is to argue that it is possible and desirable to adopt and manage non-neutral communication strategies to safeguard patients' freedom and autonomy in making decisions. More specifically, we use a pragmatic-argumentative model of verbal communication to deal with the topic of neutrality.

[47] M.G. Rossi, *op. cit.*

[48] The authors would like to thank the anonymous reviewers for their helpful comments that contributed to improve a previous version of the article. This article has been developed within the framework of the research project "Healthy reasoning: strategies and mechanisms of persuasion in chronic care", supported by a grant from the Italian Ministry of Education, University and Research (Program MIUR-FIR 2013, Grant n. RBFR13FQ5J, PI: Sarah Bigi).

Analyzing a case study from the context of Assisted Reproductive Technology (ART), we underline the highly ethical relevance of this medical context and stress the importance of an appropriate use of argumentative and communicative strategies to protect patients' values and decisions.

Keywords: doctor-patient communication; dialogical relevance; non-neutral communication; patient-centered medicine; Assisted Reproductive Technology.

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