Pragma-Dialectics and Self-Advocacy in Physician-Patient Interactions

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PRAGMA-DIALECTICS AND THE IDEAL MODEL OF CRITICAL DISCUSSION

The pragma-dialectical theory of argumentation presents an ideal model of critical discussion in which a proponent advances a standpoint and defends it against the challenges of an opponent (van Eemeren & Grootendorst, 1992). Van Eemeren, Grootendorst, Jackson, and Jacobs (1993) elaborated the theory with a method for reconstructing and improving argumentative discourse. They described higher-order conditions needed to achieve a “correct, justified, and rational” (p. 25) conclusion. First-order conditions are the basis for resolution-oriented interactions and include rules of the discussion (e.g., “Parties must not prevent each other from advancing standpoints or casting doubt on standpoints.” “A party that advances a standpoint is obliged to defend it if the other party asks him to do so.” “A party may defend his standpoint only by advancing argumentation relating to the standpoint.”) see van Eemeren & Grootendorst, 1992, p. 208). Violations of the first-order conditions lead to fallacious moves in the argument: Shifting or evading the burden of proof is a failure to meet one’s obligation to defend a standpoint that has been challenged (van Eemeren & Houtlosser, 2002). Second-order conditions “correspond, roughly, to the psychological makeup of the arguer” (van Eemeren et al., 1993, p. 32) and include requirements such that the participants (a) are disinterested in the outcome (i.e., willing to change positions); (b) are able to offer valid reasoning and to account for multiple lines of argument; and (c) are skilled and competent in the subject matter under...
discussion. Third-order conditions “stress the importance of political ideals such as non-violence, freedom of speech, and intellectual pluralism as well as practical constraints and resources for empowering critical discussion” (van Eemeren et al., 1993, p. 33). These conditions reflect the assumed “symmetry in the status of participants; neither party can be dependent, subordinate, or inferior” (p. 33).

The model of critical discussion presented by van Eemeren and colleagues, however, represents an ideal or a normative standard by which arguments can be judged—not a description of real argument practice. As Jackson (2002) noted, “highly theorized models of ideal argumentative practice such as the pragma-dialectical model of critical discussion depend on competencies and conditions that are almost never satisfied in actual interaction” (p. 116). However, it is both interesting and important to understand how actual practice deviates from the ideal model. Interactions can be examined to determine to what degree deviations from the ideal harm disagreement resolution and how to improve practice when they do, what Jackson (2002) described as the “engineering of argument” (p. 105). Building a normative theory of practice can help us understand how communication behaviors are evaluated and how communicators can achieve desired outcomes (Goldsmith, 2001). This process includes identifying dilemmas of interaction, and options for responding to those dilemmas (Brashers, Neidig, & Goldsmith, 2004).

One case in which deliberative interactions might vary from the ideals of critical discussion is self-advocacy (Janoff-Bulman & Wade, 1996). People often face the task of persuading others for something they need or want for themselves. Self-advocacy is a unique argumentative task that is defined by self-interest in advancing a standpoint, such as writing a letter of application for employment or asking for a raise in salary. People who need to advocate for themselves may or may not be skilled in situation-specific rules of deliberation (e.g., self-represented litigants in court proceedings) and may not be recognized as experts in the subject matter being discussed (e.g., patients in healthcare settings). These deficiencies may need to be overcome or adjusted for in discussion.

Healthcare interactions are a particularly interesting context in which individuals might need to advocate for themselves. A great deal of research indicates that people managing illnesses desire more input into healthcare decision making, yet it is often difficult for them to enact (Brashers, Haas, Kingle, & Neidig, 2000). There are disparities in expertise and status that signal power differences, physicians often are trained to take control of decision making, and patients often do not assert themselves in the healthcare setting. There is evidence, however, that patients are becoming increasingly consumerist and likely to claim power for themselves (Ainsworth-Vaughn, 1998). It is important to understand more fully how and why patients promote their own interests, and what outcomes are associated with self-advocacy (Brashers, Haas, & Neidig, 1999; Brashers, Haas, Neidig, & Rintamaki, 2002). The following section describes patient self-advocacy and outlines some challenges.
changes needed to take the medication?""). These are the normal expectations of pro-argumentation: The protagonist must establish the grounds for accepting a standpoint. In the ideal model of critical discussion, advancing and casting doubt on a standpoint represent the confrontation stage, clarifying common ground and resolution mindedness occurs in the opening stage, advancing and reacting to arguments is the argumentation stage, and resolving the disagreement (accepting or rejecting the standpoint) is the concluding stage (van Eemeren & Grootendorst, 1992).

According to Brashers, Haas, and Neidig (2002), the patient also may need to address the circumstances of the argument at a second level (e.g., "Is the patient competent to make a decision about treatments?" “Do political concerns prevent a fair and accurate representation of the data?”). These second-level requirements of self-advocacy are derived from the idealization of discussion procedures; that is, the higher-order conditions described by van Eemeren et al. (1993). Realizing these higher-order conditions in practice can be difficult (Jacobs, 1999, 2000). In physician-patient interactions, social and personal barriers to normative discussion exist. Self-advocacy reveals a rhetorical dimension to argumentation: “people who take part in argumentative discourse try to resolve the difference of opinion in their own favor, and their use of language and other aspects of their behavior are designed to achieve precisely this effect” (van Eemeren & Houtlosser, 1997, p. 52). Patients who want to persuade their physicians to prescribe a treatment are not likely to be “disinterested” in the outcome, particularly if they come to the interaction with a personal decision preference. Moreover, physicians and patients may have motivations other than resolution seeking (e.g., maintaining or challenging existing power structures, managing identity, or maintaining relationships). Patients may lack appropriate expertise, or they may be perceived to lack appropriate expertise, in the subject matter (i.e., medicine, virology, and so on) needed to debate issues. Patients may feel pressured to reach a decision quickly due to the severity of the consequences of not finding an effective treatment. Physician-patient relationships often are asymmetrical in power, time constraints of the medical interview can decrease the patient’s ability to develop arguments, and patients may choose to discontinue relationships with their physicians rather than continue debate.

Deviations from the ideal provide a starting point for examining the unique argumentative requirements of patient self-advocacy. If there are real or imagined violations of the ideal model, discussants may need to deal with them explicitly. For example, self-advocating patients must establish self-interest without appearing selfish. By this, we mean that the patient needs to be willing to develop arguments that advance a position other than “desire” (i.e., “I want this medication” is insufficient argumentation). Although some claim that all behavior is self-interested (Elster, 1990), some interests obviously are more self-serving than others. Self-advocacy also requires establishing sufficient competence to advance a position. Competence includes expertise in the subject matter, ability to argue effectively, and mental competence and freedom from emotional duress. Finally, self-advocacy may require impartiality. Evidence may need to be externally verifiable to prevent the patient from serving as his or her own witness.

To determine how patients might advocate for themselves, Brashers, Haas, and Neidig (2002) presented a hypothetical scenario to participants living with HIV. They were asked to describe how they would request a medication that they believed their physician would be reluctant to prescribe. Table 3.1 presents the 11 strategies for self-advocacy that were identified in those data. Participants sometimes crafted messages with multiple strategies, as in this example from Brashers, Haas, and Neidig (2002):

I have researched it to the best ability that anyone could have, and I understand the possible side effects. This is something I really want to do that could have a positive effect on my health. If this treatment has a negative effect on my health, I am ready for this and hold my self responsible (not the physician) for the effects. This should be my decision, what the doctor should do is let me know all consequences and positive contributions this treatment could have on my overall health. (p. 302)

In addition, some participants described "opting out"—not challenging the authority of the physician by accepting his or her decision.

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<th>TABLE 3.1 Argument Strategies for Self-Advocacy (Brashers, Haas, &amp; Neidig 2002)</th>
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<tr>
<td>1. Establish facts (e.g., “I would offer all available information on the drug to my physician and ask that he recommend it for me.”)</td>
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<td>2. Establish expertise (e.g., “I would let my physician know that I have taken the time to research the treatment.”)</td>
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<td>3. Make conditional threats (e.g., “I would say to the physician, ‘I’m going to insist that you enroll me in this treatment. If you cannot in good conscience do so, I understand, but I will find another physician who will.’”)</td>
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<td>4. Appeal to relationship (e.g., “I would state how important it is that he and I work together as a team.”)</td>
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<td>5. Establish obligation (e.g., “I hire my doctor to provide services for me. If they want to remain my employee they will read on my disease.”)</td>
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<td>6. Describe other benefits (e.g., “It is better to have tried than not to have tried at all. My life should be used to help prolong the lives of others in the future. This is the importance of experimental drugs.”)</td>
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<td>7. Accept responsibility (e.g., “I would say that I realize that experimental treatments are no guarantee and may be harmful, rather than the desired effect; but I am willing to take responsibility for my healthcare.”)</td>
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<td>8. Describe the severity of the consequences (e.g., “I think I have the right to choose experimental treatments because of my prognosis.”)</td>
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<td>9. Establish self-interest (e.g., “We are discussing my body, I have the right to decide what to do with it, what constitutes quality of life, etc.”)</td>
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<td>10. Promise to exercise caution (e.g., “I might argue that, since I monitor my own health closely and try to stick to my treatment regimens, I would be a good candidate to obtain information about the effectiveness of this treatment.”)</td>
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<td>11. Elicit and respond to counterarguments (e.g., “First I would want to know why he would be so reluctant to prescribe the medication in the first place.”).</td>
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As Brashers, Haas, and Neidig (2002) hypothesized, participants described strategies that are a normal part of critical discussion (e.g., establishing the facts), but they also described explicit strategies for addressing the higher-order conditions (e.g., establishing their own expertise). They also, as Hitchcock (2003) noted, described strategies that appear to be more like negotiation tactics than components of critical discussion (e.g., making conditional threats). Brashers, Haas, and Neidig (2002) noted that those latter strategies might be considered fallacies in a critical discussion. Those moves, however, may be aimed at resolving discrepancies between self-advocacy and the conditions for an ideal model of critical discussion, or designed to argue the irrelevance of certain conditions. For example, making conditional threats and establishing obligation might be an attempt to balance an asymmetrical relationship in which the physician is perceived to have more power than the patient. Describing other benefits might be used to demonstrate that the attempt at self-advocacy is not solely motivated by self-interest. On the other hand, establishing self-interest may be a strategy for denying the appropriateness of the higher-order condition that individuals should be disinterested in the outcome of a critical discussion. Therefore the “negotiation” strategies may be deemed acceptable as violations of critical discussion rules because they serve to move the discussion forward.

Much more needs to be done to understand how and why people advocate for themselves. The remainder of this chapter considers data from two samples of people living with HIV or AIDS: A set of focus group interviews with 32 participants and a set of one-on-one interviews with 72 participants. Transcripts were reviewed for comments associated with self-advocacy. Two related themes are examined here: (a) the subjectivity of the illness experience leads to a need for self-advocacy and (b) negotiation and critical discussion occur together in self-advocacy situations. Selected examples are presented in the following sections to elaborate these themes.

**ILLNESS AS A SUBJECTIVE EXPERIENCE**

Participants emphasized that self-advocacy often is appropriate because illness is a subjective experience. For participants in our studies, illness-related information includes more than the objective medical knowledge. Randy explained the difficulties of finding the right authority for patients’ illness experiences:

> We all react to these drugs differently. Our body reacts to HIV in different ways. The physicians look at HIV in a specific way ... I mean, there’s so many different things and no one’s an expert on all of these so we don’t have a choice but to draw from all these sources and to pick and choose what we feel is right for us specifically. We can’t draw blanket generalities from one source.

Randy’s comment highlights the differences between the knowledge of objective medical information and the knowledge of subjective experiences. Adam described the need to conference with peers (i.e., others with the illness) because of their ability to empathize:

> “The best, the BEST resource though are other people who are going through what you are going through . . . I go to medical professionals more for the treatment issues.”

Daniel similarly explained,

> [Other patients'] personal experiences may be a lot better to rely upon than the statistics. You know, the medications made them sick and they can tell you how they made them sick or how bad they made them sick, you know versus reading it in a text.

Often, individuals’ subjective illness experience is beyond the scope of a healthcare provider’s understanding of medical knowledge and medical terminology. Adam described his frustration in explaining his illness experience to the healthcare providers:

> There’s a fuzzy feeling. And the doctor looks at you and goes, “So what do you mean?” It’s like a whoosh. “Describe whoosh.” And I told her, “I feel poopy.” I mean, that’s how I feel but what’s the medical terminology for that?

If the patients do connect their subjective illness experience with their physicians, using language that is shared by both, healthcare providers still would not be able to claim authority over the knowledge of illness experiences. Such experiences and knowledge are only accessible to other patients who are going through or have gone through the illness event. In other words, healthcare providers could not be a reliable source in their understanding and interpretation of the patients’ illness experiences.

In summary, participants in our research demonstrate a complicated understanding of bodies of knowledge and their corresponding authorities. Although most participants would agree knowledge is power in their illness events, providers and patients have access to different types of knowledge. Participants in this study suggested that they do not perceive healthcare providers as credible authorities for their understanding of subjective illness experiences. In addition, the objective medical knowledge that allowed medical professionals to assume the role of credible authorities is subject to challenge. Other healthcare providers and patients may be able to access more or better medical information that allows them to become competing authorities.

**NEGOTIATION OF DECISIONS AND CRITICAL DISCUSSION RULES**

To account for the subjectivity of the illness experience, patients may have to find ways in which to incorporate evidence from their own experiences into the discussion of treatment options. Participants in our studies described healthcare interactions as sites of negotiation (also see Ratzen, 1993)—both about healthcare decisions as well as rules of discussion. For example, Charles noted that his doctor developed contingent plans and offered advice, but he still allowed Charles to feel in charge of the decision making:
The doctor I’ve got, other than throwing me on anti-depressants at first—which I didn’t need, I walked around kind of stoned out of my mind for a while—basically with all of the antiretrovirals, and protease inhibitors, and all that good stuff, it was like “This isn’t working. Let’s try this. This had this potency. This didn’t do this.” He was explanatory about it: “We’ll do it this way, if that doesn’t work, then we’ll try this.” And stuff like that. If you don’t agree with something, he’ll say, “this is a risk, but if you still want to do it, we can give it a try.” So he’s willing to do whatever, but he also gives you all the information that goes with it. Which is good.

Charles revealed that discussion of treatment options was an ongoing deliberation and a form of critical discussion aimed at problem solving (see van Rees, 2002). Another important point revealed by Charles is that the “science” of medicine is an inexact or uncertain enterprise (Fielding, 1999). Medications may or may not work, there may or may not be extensive side effects. This again highlights the subjective nature of the illness experience, but it also highlights uncertainty about HIV illness and treatments that patients may not initially expect (Brashers & Haas, 1999).

Participants also noted that they placed boundary conditions on their decisions, which might limit their options from the outset. For example, Marcos stated that his experience with neuropathy (a potentially debilitating form of chronic pain that is associated with many HIV medications) led him to exclude treatments that might exacerbate his condition:

At this point we sort of ruled out a lot of things because of their potential side effect of neuropathy. I’m really scared to start taking something that I know could make my neuropathy worse. My discussion with my doctor has been, “I’d rather live a shorter amount of time but have the quality better than live a long time and be miserable.” That’s sort of the way we approach things.

Marcos noted that his decision might ultimately shorten his life, but that his preference toward living a good quality of life (versus a long life in extreme pain) was a choice he made consciously.

Similarly, Beau’s experience with protease inhibitors led to lipodystrophy, a condition with visible fat redistribution that can cause a thin face, large abdomen, and lump on the upper back. Beau’s discomfort with this side effect prompted a renegotiation of his medicine regimen with his physician. He noted,

When I was on those protease inhibitors, one of the things they cause are those huge bellies. I went in and hiked up my shirt and said, “look at me, I look like I’m pregnant,” and I said, “Fuck this. I am not going to walk around looking like some damn elephant.” I was adamant about that. I realize I am getting older and being a man you get the proverbial “pot belly.” That’s when he said, “Well, let’s switch you to Sustiva.” I just think it’s my personality.

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I guess I’m very lucky in that I have a very supportive physician and the nursing staff up here in the ID clinic is extremely supportive.

Beau, as did many participants, described support from his physician in his decision making. Carson similarly described a collaborative relationship with his physician, one in which his expertise was recognized:

I am kind of a resource person for my doctor—he asks me questions about how I am doing and things like that. We are able to talk about it even though he is not an Infectious Disease doctor. He’s very supportive, he’s always there, and tells me to do whatever I need to do. I can go to him and tell him I need a prescription for Bactrim and a prescription of this, this, and this. He says, “why do you need it?” Obviously I need it and he says, “okay.” In fact I can say I love my doctor and I wouldn’t want another doctor.

Strategies for negotiation also might include behaviors with less productive outcomes. For example, Luke noted that his friend engaged in frequent “doctor shopping” to find a physician to agree with his preferred options:

I had one friend who’s changed a doctor like twice a year and somebody else was saying “Why are you doing this?” Are you just trying to find someone to agree with you? I don’t know what they’re looking for, basically—cause some of them have had, in the course of using so many doctors, they have actually had some good ones that have given them good advice and things that seemed reasonable as far as treatments and things like that; but they just didn’t want to do that, they didn’t want to hear it so—“I’m going to use someone else.”

This may be a counterproductive strategy by which participants fail to balance their desires with their expectations for assistance from healthcare providers. And it would seem to be a fallacious move in a critical discussion. Although it may be a strategy for avoiding confrontation or gaining access to a preferred treatment, it may also forestall resolution of problem solving.

CONCLUSION

Self-advocacy is a form of persuasive communication that defies many traditional assumptions about argumentative discourse. In the healthcare decision-making context, self-advocacy may be particularly problematic, perhaps because (a) patients may be thought to lack appropriate expertise needed to support arguments in favor of a treatment or plan of action, (b) there are often power differences between patients and their healthcare providers, and (c) the time in which to develop arguments for a position may be limited. This may be particularly salient because of the need to encourage treatment adherence, which is typically a concern across a variety of illnesses.
The theory of pragma-dialectics provides a starting point for understanding judgments about the effectiveness and appropriateness of patient self-advocacy. Patients may use a variety of strategies for advocating for a treatment or medical procedure, including establishing credibility by demonstrating their expertise, attempting to minimize power differences by invoking the commercial nature of the relationship, or signaling urgency to reach a conclusion by highlighting the severity of the consequences of the illness. These strategies may help move self-advocacy attempts closer to the ideals of critical discussion, or they may move them farther away. Future research on naturally occurring interactions is needed to determine to what extent people use the strategies described by participants in the study by Brashers, Haas, and Neidig (2000). Research, including experimental and quasi-experimental studies, is needed to determine the effect of various strategies on the quality of deliberation and on the outcomes of interactions.

The current chapter added to understanding of patient self-advocacy by investigating more of the underlying mechanisms that might lead to participants advocating for themselves. Because the illness experience is often thought to be a subjective experience, participants noted that they felt healthcare providers could not fully understand or appreciate their individual needs. Therefore, they felt that their individual experiences with illness needed to be considered as evidence in decision-making discussions. They also noted that decision-making interactions involved negotiation strategies. They see healthcare interactions, including negotiation about treatments, as a collaborative enterprise. Their experiences also revealed that physicians and patients might both be open to persuasion.

There is a great deal of theoretical and practical benefit to better understanding patient self-advocacy. Theoretically, it is important to understand how context-specific variations in argumentation practice influence outcomes such as effective decision making and problem solving. Investigations into self-advocacy can further define how argumentation can be adapted for the special circumstances in which a person must argue for his or her own needs. Practically, studies of self-advocacy can lead to better designs for patient education and training. Current training programs aimed at enhancing health care for individuals with chronic illnesses tend to focus on providing information. Patient education programs that facilitate the development of communication skills may empower patients to engage in self-advocacy within a context of critical discussion, ultimately leading to better decisions and better healthcare for those individuals. Argumentation theorists can help promote self-advocacy and patient empowerment through continued research in this area.

REFERENCES

Evaluating Analogy: Toward a Descriptive Approach to Argumentative Norms

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Argumentation studies throughout the academic world present a remarkable diversity as regards the scientific disciplines they belong to (e.g., psychology, philosophy, linguistics, logic, literature) as well as the methodology they rely upon or the objects they try to account for. Nevertheless, it is possible to identify some strong theoretical or methodological commitments which contribute to structuring roughly this field of research. It is the case for the tension between descriptive and normative approaches to argumentation. In descriptive approaches attention is paid mainly to the way in which people actually do conduct arguments, while normative approaches focus on the way people ought to conduct arguments. The alternative between a normative or a descriptive perspective corresponds globally to the demarcation line between Anglo-Saxon research, inspired by studies about fallacies and informal logic (in particular by Hamblin, 1970), and research in the Romance area, directly connected with ancient rhetoric (Perelman & Olbrechts-Tyteca, 1968; Breton, 1996) or linguistics (Anscombre & Ducrot, 1983).

Nevertheless, such an alternative should not be thought of as entailing an exclusive focus on one of the two poles. Adopting a normative perspective does not mean that the way speakers actually argue is considered as irrelevant; for example, the analyst may be interested in the way the theoretical normative model of argumentation he elaborates does or does not echo the “naive” argumentative norms used in practice by ordinary speakers. Indeed, such a question is central to pragma-dialectics, as it claims that the norms ruling a critical discussion make sense insofar as they are intersubjectively approved, or conventionally valid—hence the recent studies aiming at evaluating the intersubjective acceptability of the academic argumentation categories (see Garssen, 2002).

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