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The role of argumentative practices within advice-seeking activity types. The case of the medical consultation

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Abstract Advice seeking and advice giving have been studied both as speech acts and as complex discursive activities in various dialogical contexts. One particularly interesting aspect involved in the acts of seeking and giving advice is the negotiation of the epistemic status of the parties involved and it is interesting to observe the role played by argumentative practices in the achievement of this goal. In particular, it is argued that argumentation sequences may appear in advice-giving activities with two main functions: as the pivotal elements of pragmatic argumentation (i.e., providing reasons for supporting or refusing a certain proposal for action); and as dialogic tools for the alignment of assessment criteria for decision making. As a consequence, argumentation sequences emerge as decisive moments in the learning process leading to radical conceptual change. In this paper, the functions of argumentative practices within advice-giving activities are exemplified in relation to the goals of medical encounters, analyzed as instances of advice-seeking activity types. The analysis is based on excerpts from real-life interactions in different medical settings.

Keywords: activity types, advice giving, practical argumentation, medical consultation, health communication

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0. Introduction

Advice seeking and advice giving have been studied both as speech acts and as complex discursive activities in various dialogical contexts. Initially observed within institutional settings, such as the medical, legal or educational one, they have also been studied in non-institutional interactions, where it is less straightforward to determine who is entitled to the role of advice giver and why (among others, Locher 2006, Locher, Limberg 2012, Heritage 2013, Riccioni *et al.* 2014).

One particularly interesting aspect involved in the acts of seeking and giving advice is the negotiation of the epistemic status of the parties involved. Indeed, it is usually because of an epistemic imbalance, or asymmetry of knowledge, that advice is sought, both in institutional (e.g., legal, medical, financial domains) and everyday situations. At the same time, the epistemic imbalance at the origin of the advice-giving activity is the same factor that can cause a few challenges during the process of advice giving itself. If institutional contexts somehow predefine the social and communicative roles, determining in various ways who is supposed to be the advice giver, the advice seeker

and the knowledge domain about which the advice giver is supposed to know more, in non-institutional situations it is up to the parties to signal to each other their epistemic status and their entitlements to the 'ownership' of certain bits of information. As has been pointed out, knowledge is closely linked to the idea of Self and individuals seem to be extremely careful about representing themselves as knowledgeable with regard to certain domains depending on the interlocutor they are talking to (Heritage 2013).
In the study of advice giving activities, it is interesting to observe the role played by argumentative practices. The relationship between argumentation and the epistemic dimension has been studied in particular within the domain of science education, where argumentative practices are used as educational strategies to engage students and develop their critical thinking abilities (Erduran *et al.* 2015). In this context, argumentation has been shown to play a crucial role for achieving radical conceptual change, i.e. a situation in which individuals do not simply add knowledge incrementally, but are able to restructure the beliefs they have formed and reinterpret them (Asterhan, Schwartz 2009).
The relationship between argumentation and advice giving, on the other hand, is frequently touched upon in studies on the medical consultation, where argumentation is mostly observed as a means for the doctor to persuade the patient about the goodness of a certain therapeutic advice (Gambarelli 2017), or as the pivotal dialogical tool in the development of practical argumentation (Walton 1985, 1996).
In this paper, the role of argumentation in advice seeking activity types will be discussed, with a particular focus on the medical consultation as an example of advice seeking dialogue in which the epistemic imbalance between the parties constitutes a crucial and often problematic element.

1. Advice seeking activity types

The studies on advice giving consistently describe it as a sequential speech activity, featuring the interplay of different discursive moves (Locher 2006, Riccioni *et al.* 2014), rather than a single speech act expressing an imperative for action. In particular, Locher (2006) recalls Searle (1969) to stress the difference between the speech act of request and that of advice, which is not aimed at getting the interlocutor to do something with the same force of a request: «advice is more like telling you what is best for you» (Searle 1969: 67). Moreover, Locher (2006) characterizes advice-giving as a combination of assessing, judging and directing that regards a future action assumed to be positive for the advisee.
In relation to the dimension of assessment and judgment involved in advice-giving, Heritage, Sefi (1992) point out the potentially threatening or judgmental function of advice-giving acts in a healthcare related context. In relation to this aspect, Locher, Limberg (2012) stress the relevance of the wider speech event and of the norms of the practice in question for the interpretation of the advice-giving acts' force: individuals are likely to enter the dialogic activity with certain presupposed knowledge regarding who should provide the advice, how they should do it and about which topics. Such presupposed knowledge triggers the specific expectations interlocutors have when entering an advice-seeking activity type, which will impact on the way single speech acts are interpreted. It is likely that within an advice-seeking activity type individuals will interpret speech acts as advice even when they were not intended as such (Locher, Limberg 2012: 5).
The interpretation of an advice-giving speech act may impact also on the conversational outcomes of the exchange: Riccioni *et al.* (2014) show that mitigating an advice-giving speech act is not really necessary in cases where the advice had been solicited in the first

place. On the other hand, if the advice has been given without being solicited, even if mitigated, it is often followed by misalignment. This is an additional confirmation of how relevant it is for the parties to correctly negotiate their epistemic positions in order to achieve alignment, or agreement.

Locher, Limberg (2012) also list the main factors that should be taken into account when studying advice: practice (speech activity or practice); ideologies and culture (cultural contexts); hierarchical differences and role of expertise (relational work); solicited versus unsolicited advice; fuzziness of the concept: (i.e., interlocutors can construe utterances as advice even without clear markers that signal their function. In the most dubious cases, the way the other party responds to an apparent advice can provide hints as to how the utterance was interpreted); advice-giving in different kinds of discourse (not only institutional, but also every-day, non-institutional and peer-to-peer interactions).

1.1. Epistemic imbalance and the problem of assessing facts

One particular feature that characterizes advice-seeking activity types is the role of the epistemic dimension. When someone seeks advice, it is usually because they are uncertain as to what course of action they should follow in relation to certain facts or situations. In other words, an advice seeker is usually unable to assess a certain situation, to interpret it to the extent that they are able to decide on the most appropriate things to do. This is true, for example, of medical conditions, legal situations, but also of interpersonal relationships, as Riccioni *et al.* (2014) nicely show by reporting the case of two friends, Eleonora and Marta, who are discussing the relationship between Eleonora and her boyfriend: Eleonora feels that her involvement in the situation is too deep to allow her a clear understanding and a sensible decision. Therefore, she turns to her friend for advice and says, "Listen, in your opinion, you see it from the outside, I mean that you are not directly involved and maybe you can be more objective […]" (Riccioni *et al.* 2014: 56). In this case, the situation is known to both, there is no asymmetry of information as to the facts; instead, there is an imbalance in the ability of the two girls to *assess* the facts and derive from the assessment a decision for action.

At other times, the epistemic imbalance may appear as related to the facts, i.e. the difficulty of the advice seeker derives from lacking a piece of information that is crucial to the decision.

Depending on the kind of epistemic imbalance, the provision of advice may include narrative parts, in which the advice giver spends time reframing the situation for the advisee in order for him/her to understand the advice. A useful example is provided by Locher (2006), who reports and analyzes cases of online advice giving. In one of these cases, a man writes to an online column reporting his habit of talking to himself, even in public, and wondering whether this is a healthy behavior and if he should try and restrain himself. The person providing the advice takes up the man's narrative, analyzes the problem and only at the end proceeds to give the advice. As Locher notes, the core piece of advice occurs only in the very last sentence. However, it could also be argued that

> the entire answer constitutes advice since the final suggestion largely obtains its full scope from being embedded in its context. The pieces of information delivered reassure the advice-seeker that the fears expressed in his or her question (*Is this healthy?*) are unwarranted. *In many instances, offering advice is therefore not a matter of giving straightforward imperatives for instruction, but a complex interplay of linguistic realizations of different discursive moves* (Locher 2006: 2, italics added).

Thus, advice giving is a complex discursive activity, which stretches further than the single advice-giving speech act. As stated previously, the discursive context that frames the single speech act expressing the advice is very important for the correct interpretation of the speech act itself, especially in non-institutional contexts.
In the next section, attention will be placed in particular on the role of argumentative moves within advice giving.

1.2. The role of argumentation in advice giving activities

In institutional settings where the epistemic imbalance regards specific knowledge domains, explanations may precede or follow the advice, because they provide the criteria for the correct understanding of the recommendation provided through the advice. Alongside explanations, another important part of advice-giving are argumentative sequences, which may appear with two main functions: as the pivotal instruments of pragmatic argumentation (i.e., providing reasons for supporting or refusing a certain proposal for action); and as dialogic tools for the alignment of the assessment criteria that surface in the emergent common ground.
Pragmatic argumentation happens when the parties need to agree on the solution to a problem, and discuss the validity of a course of action based primarily on its consequences (Perelman 1959). In this use of argumentation, the positive or negative evaluation of the consequences is transferred to the causes, which are accordingly accepted or rejected. Going back to the example proposed in Locher (2006), the advice offered to the young man who talks to himself is to stop doing it in public only if he thinks he cannot bear the social consequences of his habit. In this argument, the non-acceptability of the consequences, social exclusion, is transferred to the cause, talking to himself in public, and used as a criterion to decide on the acceptability of a decision.
However, a preliminary and indispensable part of making decisions is to agree not only on the problem at issue, but also on the criteria that determine why certain consequences are acceptable while others are not. Such criteria are usually presupposed by the parties and do not always become the object of the discussion themselves. Argumentation can, again, be a crucial instrument to turn the presupposed assessment criteria of the parties into actual topics of a critical discussion. In other words, if narrative sequences can serve the purpose of introducing the parties' assessment criteria into the emergent common ground (Kecskes 2014), it is only through argumentation that the parties can scrutinize the relevance of such criteria for the problem at issue and find alignment.
These two functions of argumentation in advice-giving – pragmatic argumentation and the alignment of assessment criteria – can be considered as crucial moments in the learning process leading to radical conceptual change. Indeed, as mentioned above, advice-seeking happens in a situation of epistemic imbalance, where one party is supposed to know more than the other and therefore is entitled to give advice. The epistemic imbalance implies the opportunity for advice seekers to access knowledge they did not have before. This is always true, but particularly significant in the cases of advice seeking in institutional settings, where the epistemic imbalance concerns very specialized domains of knowledge. In these cases, advice seekers have the opportunity to actually learn from the interaction, and this may happen in an effective way when argumentation is used as a dialogical means to support the learning process leading to the construction of new knowledge. Studies in the field of science education place particular emphasis on the use of argumentation as one of the tasks that exercise understanding. It is argued that learning is closely related to discourse and talking, is a highly relational activity and argumentation plays a crucial part in it because students learn to present and criticize ideas, thus acting like scientists (De Vries, Lund, Baker

2002). Working on the notion of conceptual understanding, Asterhan & Schwartz (2009) study in particular a specific form of learning, called conceptual change, which involves transforming prior misconceived knowledge into correct knowledge. There are at least two kinds of conceptual change: incremental and radical. In the former, correct knowledge is 'inserted' to replace or repair prior misconceived knowledge; in the latter, a substantive reorganization of the knowledge structure allows repairing certain misconceptions which are resistant to the previous kind of change. It is in this latter case that argumentation can play an important role, as it forces the parties to make explicit and consider critically their beliefs regarding certain knowledge domains. When the advice giver uses argumentation as a means to support a learning process in the advice seeker, this may start a virtuous circle in which the latter acquires knowledge and criteria to more appropriately face similar situations in the future. This kind of result is particularly significant in the case of the medical encounter, which is discussed in the next section as a relevant example of advice-seeking activity type.

2. The case of the medical encounter

A dialogic interaction between health care professionals and patients can be viewed as an activity type, intended as the characterization of an interactional setting (Levinson, 1992: 69, Sarangi 1988, 2000, 2013). This section and the following ones aim to propose and discuss the description of the medical encounter as an instance of advice-seeking activity type.

Walton (1985) describes medical consultations as instances of «intelligently planned and directed activities» insofar as their goal is to provide treatment for a medical problem. In his discussion, Walton goes on to describe the «basic logical structure of goal-seeking action» in terms of practical reasoning, i.e. «a process of answering questions to decide on courses of action to carry out a goal or intention» (Walton 1985: xi). A pivotal part of this is the assessment process involved in the definition of the criteria that link commitments to goals; this usually remains implicit, but it plays a significant role and is often at the origin of misunderstandings and misalignments (Macagno forthcoming, Bigi 2016, Macagno, Bigi 2017b).

In this perspective, the medical consultation is originated by an individual who seeks the advice of an expert in relation to a specific health problem. As such, it can be described as an *advice seeking* activity type. In order for this implicit intention to be fulfilled, the core speech activity within the interaction is that of *advice giving*. This characterization slightly differs from previous ones, in which the medical consultation is described as an advice-*giving* activity type (Walton 1996), or more loosely as an activity type in which seeking and giving advice are the consultation's main aim (Pilgram 2009). Here, it is proposed to describe the *activity type* in terms of 'advice seeking', since it is originated by the intention of the patient to seek advice in relation to a health problem. Within this activity type, 'advice giving' is intended as a *discourse type*, i.e. as a form of talk (other examples are, medical history taking, promotional talk, interrogation, etc.) (Sarangi 2000). It is the typical and most relevant form of talk within the medical consultation, because it is the one that is indispensable for the realization of the activity type's implicit institutional goal.

2.1. Epistemic imbalance in medical consultations

The characterization of the medical consultation as an advice seeking activity type turns out to be particularly useful to describe and understand one of the most relevant and disputed features of this kind of interaction, i.e. the epistemic imbalance it is grounded upon. A significant number of studies have approached the issue from a sociological

perspective, discussing it in terms of a power struggle, usually unfavorable for patients (Todd 1989, Ainsworth-Vaugh 1998, Thesen 2005). This approach focuses on the imbalance between the social roles predefined by the system for interaction within the medical domain, grounding the definition of the roles in the knowledge disparity between the expert and the lay person. As an attempt to overcome the negative effects deriving from an analysis in terms of asymmetry, in some cases the consultation is described as an interaction between peers, albeit of a different nature: the clinician as an expert in medicine, the patient as an expert 'of himself' (Moja, Vegni 2000). Studies in the field of discourse analysis, instead, show how the asymmetry of roles is often enacted and reinforced by *both* participants in the interaction, thus finding indicators that the parties are actually accepting the roles predefined for them by the context (Ten Have 1991, Maynard 1991).

Whichever approach is followed, the different epistemic status between clinicians and patients is an observable fact and cannot be eliminated. However, it can be described more specifically and perhaps better understood in its complexity.

According to Kamio (1997) it is possible to describe *territories of information*, i.e. domains of knowledge or information, to which the participants to an interaction are more or less close, relative to others. A patient's knowledge about his blood tests can be limited to what he reads on the report: in this case, this information is situated at the periphery of this person's territory of information. On the other hand, if the clinician is able to make sense of the values related to the patient's blood tests to the extent that he can suggest action to take in order to improve the situation, this means that this information is more central in the clinician's territory of information. Kamio further develops this notion by including not only who knows what and in what way, but also who has rights to know it and express it (Kamio 1997: 6-7). A common example from the medical context is when patients attempt to put forward their own interpretation of their symptoms (lay diagnosis) and use mitigating strategies to signal that they know they are not entitled to that kind of information, nor it is their right to express it.

The notion of *territories of information* is useful not only to describe the interplay between the epistemic status of the interlocutors in relation to specific domains of knowledge, but also to note that in the context of the medical consultation clinicians can be considered as 'knowing' (Heritage 2013) *only relative to the domain of medical knowledge*. When it comes to information regarding 'the world', either the clinician or the patient could be 'knowing' or 'unknowing'. This aspect is not predefined by the implicit definition of the institutional roles and it needs to be negotiated every time. However, the social roles may interfere and make it difficult, for example, for patients to be heard when they contribute pieces of information about which they are more 'knowing' than the clinicians. A nice example is provided by Sbisà (1996) in her discussion about women's point of view regarding childbirth, as opposed to the 'institutional', male-determined, representation of this event.

2.2. The role of argumentation in advice-giving practices within medical consultations

As mentioned previously, argumentation sequences may appear in advice-giving activities with two main functions: as the pivotal instruments of pragmatic argumentation (i.e., providing reasons for supporting or refusing a certain proposal for action); and as dialogic tools for the alignment of the assessment criteria that surface in the emergent common ground.

The case of pragmatic argumentation is well represented by the following excerpt[1]:

[1] This example has been commented also in Bigi (2016: 68-69).

D: Ok. So, from my point of view I do not have much to suggest, mainly because I do not have enough room for therapy, madam. You are already undergoing a very significant therapy, so if the three levels of the treatment are physical activity, diet and drug, the quantity of drug prescribed is already very high; therefore, we should work on the other two levels. If only one of them, both or a little of both is something you need to tell me. How do you think you could manage it?
P: I would like to…
D: Not I would like to
P: No, I would really like to
D: Ok, what we would like to do, that's the ideal model, it's perfection, but what you can manage to do now, in this period
P: I don't know what I can manage to do
Daugh.: Mom, would you like to go to the gym with me for three months?
P: Let's go; let's try it, yes.
D: Three months at the gym, ok good. So, three months at the gym plus we could add a free diet but a very careful monitoring of sweets
[…]
P: You know what? I can give up sweets but not fruit
D: I'm telling you, let's negotiate. Let's choose two things, three months at the gym and no sweets. I'm leaving you the fruit, we try for three months and see what happens, ok?

The advice here concerns weight control: the patient is affected with diabetes and needs to lose weight in order to keep her glycaemia levels down. The doctor's first turn opens with a description of the situation that helps framing the advice. The doctor frames herself as someone who can only give therapy-related advice ("I do not have much to suggest, mainly because I do not have enough room for therapy"); she then does offer advice on the set of possible options (diet and physical activity) but shifts the decision on the patient, because dieting and physical activity are decisions only the patient can make for herself. The question, "How do you think you could manage it?" opens up the sequence devoted to pragmatic argumentation, which happens when the parties need to agree on the solution to a problem, and discuss the validity of a course of action based primarily on its consequences (Perelman 1959).
It is interesting to observe that the patient's first move is a mitigated one ("I would like to"): is she framing herself as someone who cannot – or should not – make a decision? Or is she really having difficulties advancing a proposal? We do not know, but the doctor does not accept this reply and almost seems to 'force' on the patient a 'knowing' epistemic status, which the patient herself refuses, "I don't know what I can manage to do". The proposal put forward by the daughter saves the situation by offering an acceptable option for the mother.
The patient's attitude regarding the dieting part of the discussion is quite different. She accepts her 'knowing' epistemic status and expresses her preference regarding what to diet from. This corresponds to putting forward a proposal for action, which sounds acceptable to the doctor, who takes it up and frames it as a recommendation.
This example nicely shows the role played by preferences in the shared definition of advice. The fact that the patient expresses her preference for fruit makes it possible for the doctor to come up with a final recommendation that is clinically acceptable and aligned with what the patient can do and likes doing.

The following case (Bigi, Lamiani 2016), briefly mentioned at the beginning of the paper, is less straightforward[2]:

D: Do you smoke?
P: Something now and then
D: How much?
P: Three cigarettes a day
D: Well, this is not "now and then", it is regularly
P: Well, compared to people who smoke a packet a day, for me it is now and then …. Yeah, well, you are right though...
D: You know, I am almost more sympathetic with people who smoke twenty cigarettes a day because it is really an addiction and it's difficult to quit… three cigarettes, you can do without them
P: No because it is a pleasure!
D: Yes, but you can do without them
P: Yes, yes, I mean, if I do without them I don't die...I agree…but it's a pleasure!
D: Did you take your pill for the blood pressure today? (taking blood pressure)

This excerpt shows what happens when the parties do not share the same assessment of the situation. Argumentation is used here, but not to its full potential. In this case, the parties fail to find agreement on a solution to the problem at issue and, more importantly, the doctor fails to provide effective advice to his patient, because their preferences as to which criteria should be used to evaluate smoking as a negative habit are not aligned. In this example, argumentation is used by the participants only to support their own point of view, but not as a means to discuss the different criteria that motivate such different standpoints: the assessment criteria remain presupposed and do not become the topic of discussion (why is smoking a pleasure? why is three cigarettes a day not an addiction?). This makes it impossible to develop a dialogue-relevant emergent common ground between the two, where 'dialogue-relevant' means that the emergent common ground between the parties is relevant for the achievement of the shared dialogical goals determined by the institutional context within which the interaction is taking place (the doctor's office)[3]. As a consequence, the doctor is not able to elaborate the knowledge about the patient's smoking habits in a way that it can be included in the activity of advice-giving.

The two functions of pragmatic argumentation and alignment of the assessment criteria that surface in the emergent common ground have been previously considered as fundamental steps in a learning process potentially leading to radical conceptual change. Such virtuous dynamic can be observed in the following last excerpt:

D: The medicine intake is good? Do you have any problems?
P: Yes, it is good but... Doc, I am not doing the prophylaxis anymore…
D: Why? is the prophylaxis not going well?
P: The problem is that I have few venous accesses left, so I try to preserve those I've left for when I really need them. When I see I have some bruises, then I understand that that is the time for treatment
D: So, let's say that you are doing a "customized" prophylaxis

[2] This case and the next have also been commented in Bigi (forthcoming).

[3] See Macagno & Bigi (2017a) for a discussion of this concept in relation to the analysis of dialogue moves in interaction.

P: You got it...
D: Yes, I understand that you are adjusting your prophylaxis. However, you have to keep in mind that as you are not protected by the drug, then you'll end up moving less and less and you'll give up doing things. You won't feel confident to be doing anything more than what you feel sure about… So, I am not saying you must do the prophylaxis three times a week, because now we know that every patient reaches his optimal regimen… however, this does not mean that the patient gives up doing the prophylaxis altogether.
P: So, Doc, instead of doing 3000 units three times a week, we could do 3000 units twice a week.
D: I think this is the bare minimum for a person like you who still has an active lifestyle.
P: Yes, absolutely, I need to go to work. So, ok we can do like that: 3000 units twice a week
[…]
D: Ok, then. Shall we try to do the prophylaxis twice a week?
P: I'll try it, Doc

Here the patient is affected with hemophilia, a condition that requires patients to frequently inject a missing clotting factor in the blood. This sequence is again a case of pragmatic argumentation, because a problem emerges ("I am not doing the prophylaxis anymore") and the parties put forward proposals and arguments for its solution. What is interesting is the fact that the doctor does not simply oppose to the patient his alternative proposal ('you should not give up prophylaxis altogether') with a generic argument (e.g., it's not good for you). The arguments he brings in support of his standpoint actually foreground the criteria that should guide the decision to adjust the prophylaxis. This means focusing on the criteria that explain why stopping the prophylaxis is bad and proposing to the patient a different outlook on his condition; it actually means changing the value hierarchy by which he has been making decisions: an active life is more important than preserving veins and, in perspective, it can be much more dangerous for the patient to quit living his life with confidence. The end of the sequence is successful, as the patient manages to put forward his own solution, which is considered acceptable by the doctor.

3. Conclusions

This paper has focused on advice-seeking activity types by considering the role played by argumentative strategies in relation to the epistemic imbalance these activity types are grounded upon. The main discursive activity within advice-seeking activity types is advice giving, which cannot be reduced to a single speech act, but appears as a sequential activity, involving different functions, such as judging, assessing and directing. In particular, argumentation sequences may appear in advice-giving activities with two main functions: as the pivotal instruments of pragmatic argumentation (i.e., providing reasons for supporting or refusing a certain proposal for action); and as dialogic tools for the alignment of the assessment criteria that surface in the emergent common ground.

Argumentation is a constitutive part of advice-giving because it is the dialogical tool through which the parties' different competences can be called into play and merged, thus triggering the learning process that unveils the relevant criteria for decisions in relation to specific issues. It is in the light of this learning process, or at least of its potential existence, that institutional interactions grounded on an epistemic imbalance should be considered: not merely as occasions for prevarication and abuse, but first of

all as opportunities to integrate different knowledge domains in order to arrive at a clearer understanding of a problem.

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