



## Argumentative discourse in clinical dialogues: An interdisciplinary perspective

Sarah Bigi <sup>\*</sup> 

Dept. of Linguistic Sciences and Foreign Literatures, Catholic University of the Sacred Heart, Milano, Italy

### ARTICLE INFO

#### Keywords:

Clinical dialogues  
Deliberation  
Persuasion  
Argumentation  
Healthcare communication

### ABSTRACT

**Objective:** Building on existing literature, which has pointed out the acceptability of certain persuasive strategies used by specialists in clinical communication, the article aims to describe the forms and functions of argumentative discourse in clinical dialogues.

**Methods:** The article relies on classical definitions of argumentative discourse that describe argumentation as the communication process characterized by a standpoint and at least an expression of doubt, often also by the presence of arguments in favor or against the standpoint.

**Results:** Through examples from real-life cases, it is shown that besides the typical function of persuasion, argumentation in clinical dialogues may have also the function of finding agreement for the alignment of assessments and for deliberation.

**Discussion:** This implies that when analyzing argumentative discourse, wider stretches of dialogue should be taken into consideration, not limiting observations to single turns or adjacency pairs.

**Conclusion:** The article highlights the importance of correctly understanding the role argumentation can play in the medical context and offers some suggestions for the analysis of argumentative discourse in clinical dialogues, in view of study design and professionals' training.

**Practice implications:** The article offers insights for the development of training materials in view of improving HCPs' abilities to put forward reasons for clinical decisions.

### 1. Introduction

In a seminal paper, Street [1] highlighted a major issue in healthcare communication studies, i.e. the need to make explicit underlying assumptions and models in order to outline and justify the pathways that lead from specific communication processes to patient outcomes. Indeed, it is typically the case that communication processes have indirect effects on clinical outcomes, i.e. they impact on intermediate outcomes, which then play a role in bringing about the actual clinical outcome. For example, high-quality information giving can improve patients' understanding of their condition; this, in turn, can improve their commitment to treatment and, in the end, produce better quality of life (QoL), if not healing. In this sense, information giving (a communication process) does not impact *directly* on QoL or healing, but does so in a mediated way, i.e. by impacting on a proximal outcome, such as

understanding [1, p. 288]. Thus, the frequent assumption in studies on clinical communication that there is a direct relationship between good quality communication and patient outcomes is an oversimplification of a very complex process.

One implicit premise in Street's paper is that it should be possible to describe and identify different communication processes in order to be able to link them to clinical outcomes. This article aims to draw attention to argumentative discourse in clinical dialogues, understood as a communication process mainly used for persuasion, decision making, and patient education and counseling.<sup>1</sup> After discussing argumentative discourse in face-to-face interactions in the Methods section, in the Results section the forms and functions of argumentative discourse in clinical settings are described by relying on excerpts from real-life cases. The Discussion section points out implications for the analysis of argumentative discourse in clinical settings, followed by Concluding remarks

\* Correspondence to: Largo Gemelli 1, Milano 20123, Italy.

E-mail address: [sarah.biggi@unicatt.it](mailto:sarah.biggi@unicatt.it).

<sup>1</sup> The article intentionally avoids highly specialized technicalities from the disciplinary fields of linguistics and argumentation theory in order to favor readability and accessibility to a wider readership. A more technical discussion of topics related to argumentation in healthcare can be found in the thematic issue of the *Journal of Argumentation in Context*, 7/2, 2018.

and Implications for the clinical practice.

## 2. Methods

The use of argumentative discourse in everyday verbal interactions is pervasive and usually connected to the aim of persuasion. In this article, ‘persuasion’ is not understood in a negative sense: to argue in favor of or against a certain standpoint is one of the most typical human verbal behaviors; to aim at persuading other people into accepting (or refuting) certain ideas or actions is also a common and legitimate human activity. In healthcare communication studies, it is often the case that ‘persuasion’ is understood as a negative practice, meaning coercion and manipulation, but it has been argued that it is not necessarily so [2–5]. In addition, for the sake of the present discussion it is useful to keep a distinction between persuasion, understood as a function of discourse, and argumentative discourse, which is here considered as a form of discourse that can be used also for other functions. Indeed, argumentative discourse with a persuasive aim is something we cannot do without when we find that we have to deal with opinions that are different from our own and when we think *our* opinion is the right one. But it can also be used in situations in which a decision has to be made, and we are invited to (or want to) influence that decision: we cannot but argue in favor of our proposal.

It could be claimed that interactions in medical settings are very special instances of the general situations just evoked: in medical interactions patients and healthcare professionals (HCPs) may have competing or even conflicting agendas, their points of view regarding a certain treatment or recommendation may differ, they may disagree on a specific course of action. What makes these disagreements ‘special’ and different from the ones occurring every day among friends, spouses, siblings, etc. is that they occur in an institutional setting, defined by predetermined goals, roles and structures, affording participants different rights and obligations. This setting is important to keep in mind when discussing any verbal event occurring within its boundaries, because it impacts on participants’ expectations and meaning-making abilities [6–8].

Classical argumentation theories will say that we have an argumentative text when there is a standpoint and arguments in favor or against it [9,10]. Typically, argumentation occurs with regard to opinions, which by nature are not objective, or to decisions that have to be made, so that, “an argument is a single unit of argumentation consisting of a claim and its support (its premises). This support comes from resting on something (such as facts or circumstances) that is already known so as to demonstrate the truth of an uncertain thesis.” [3, p. 297]. The ways in which premises and conclusions hold together can be different, and the kind of inference drawn from available premises can make an argument stronger or weaker. For example, compare the following cases:

A: You should eat vegetables, because they provide vitamins that are good for your body.

B: You should eat vegetables, because I say so.

In example A the case is made in a stronger way because an actual reason is provided that justifies the speaker’s standpoint. In example B, instead, the argument (“because I say so”) is strong only if the speaker’s authority is strong, or if the hearer has a lot of trust in him.

There is also an ongoing debate regarding the fallacious use of arguments that aims at finding criteria to determine when arguments are acceptable and when, instead, participants in a discussion are incurring in a fallacy, i.e. “an argument, a pattern of argumentation, or something that purports to be an argument, that falls short of some standard of correctness as used in a conversational context but that, for various reasons, has a semblance of correctness about it in context, and poses a serious obstacle to the realization of the goal of the dialog.” [11]. Imagine, for example, a person with obesity, diabetes, or hypertension

objecting to a recommendation for dieting in the following way: “Don’t tell me I should go on a diet, you are overweight yourself!”. This kind of personal attack is considered fallacious and, in spite of the fact that it often succeeds in silencing the interlocutor, it is not reasonable: it is a fact that being overweight is bad for anybody’s health; of course, dieting might not be the only way to reduce overweight, but then the discussion should focus on alternative options, and not on the proposer’s weight. Clearly, good example is the most persuasive of all strategies, so the frustration of our fictitious patient is understandable; still, his argument can be considered fallacious.<sup>2</sup>

The description of argumentation as the practice of supporting or refuting certain conclusions through premises (or arguments) tells us something about the forms and the general communicative goal argumentation serves, but more could be said about the specific functions that argumentative sequences can play in the development of a dialogue. The connections between the assertions that make up an argument are not always explicit; the same can be said about the connections between the argument and the rest of the dialogue. It is therefore not always easy to interpret the functions of argumentation, whether it is used to serve the primary function of supporting/refuting a standpoint, or it is used in a more complex dialogical activity. In the context of this general theoretical framework and based on the observation of real-life interactions, I propose that, besides the typical function of persuasion, argumentative discourse in clinical dialogues serves two other crucial functions: the alignment of assessments and the development of deliberative sequences. In both cases the aim is finding agreement, but this aim is pursued for different reasons: in the first case, agreement is sought in order to create a shared understanding of certain facts, which is necessary in order to achieve other aims, such as patient education and counseling or decision making; in the second, agreement is sought in order to find alignment on a course of action to pursue in view of a shared goal.

My claim regarding the functions of argumentative discourse in clinical dialogues is supported in the next sections through the analysis of excerpts from real-life cases recorded in Italy; the first two have been recorded in a hemophilia care setting, while the third one in a diabetes care outpatient clinic.

## 3. Results

### 3.1. The alignment of assessments

During verbal interactions, exchange of information, views, beliefs, emotions, etc. brings about the creation of emergent common ground [12,13], which is defined as “knowledge that is aroused, co-constructed and/or involved as shared enterprises in the particular situational context that pertains to the interlocutors exclusively” [13, p. 308]. This kind of common ground provides the basis on which to build assertions or modify previous assumptions and beliefs. In clinical discourse, an important part of this emergent common ground has to do with assessments of events, symptoms or decisions that have to do with the condition at issue and that often are not aligned. Consider the following excerpt from a hemophilia setting, in which doctor (D) and patient (P) discuss the necessity for P to quit smoking<sup>3</sup>:

<sup>2</sup> Actually, the definition quoted here is not the only one. Indeed, the debate on what is fallacious argumentation and how it can be identified and assessed is open and rich, but impossible to summarize here and beyond the scope of this article. For the sake of the present discussion, the selected definition is arbitrarily chosen and used to exemplify the fact that not any kind of argument can be acceptable.

<sup>3</sup> This case and the next are part of a larger dataset, collected between 2012 and 2014 in two hospital-based Hemophilia Treatment centers in Milan and Naples (Italy) [14]. They have been commented on also in [15–17]. The original dialogues are in Italian.

## CASE 1

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!

In this excerpt, doctor and patient disagree on how a certain amount of smoking – three cigarettes a day – should be assessed. The doctor thinks that three cigarettes a day amounts to being a regular smoker, while the patient has declared to smoke only “now and then”. Hemophilia patients should not smoke and both participants are aware of this; indeed, in the discussion that follows the patient supports his assessment by using a comparison: “compared to people who smoke a packet a day...”. The doctor takes up this comparison and uses it to support her own assessment: for people who smoke twenty cigarettes a day smoke is a real addiction (thus it would be *really* difficult for them to quit), while three cigarettes a day can easily be avoided. The conclusion is that the patient should quit smoking: “you can do without them”. The patient reacts by protesting that he cannot quit because smoke for him is a pleasure. In this excerpt, a failed alignment of assessments makes it harder to find agreement on a decision, i.e. if and how to quit smoking. The participants' disagreement develops mainly around the definition of certain terms: how much is three cigarettes a day? Is it “regularly” or “now and then”? And, consequently, if twenty cigarettes a day is an addiction, what is three cigarettes a day? Also values come into play in relation to the definitions chosen by the two participants: the doctor seems to imply that smoking ‘only’ three cigarettes a day is a whim and can be avoided, but the patient claims it is a “pleasure” and cannot be given up. Clearly, finding agreement on ‘how to name’ a certain event and on how to consider it (whether positively or negatively) is an important precondition for finding agreement on decisions regarding the same circumstance [18].

The next excerpt shows a successful attempt at assessment alignment in a different dialogue, again between a doctor and a hemophilia patient:

## CASE 2

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

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 three thousand units three times a week, we could do three thousand 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 this: three thousand units twice a week

[participants talk about other issues]

D: Ok, then. Shall we try to do the prophylaxis twice a week?

P: I'll try it, Doc

In this excerpt, what becomes relevant in the emergent common ground is the fact that the patient has stopped doing his prophylaxis. He puts forward a reasonable argument for this decision, but the doctor provides a different perspective. Thanks to the doctor's argumentation, the patient understands the risks of his decision and is able to autonomously come up with a compromise that is considered acceptable by the doctor. The alignment of assessments here regards the way prophylaxis is valued, not only in relation to the disease, but also to the patient's life. In other words, prophylaxis is not useful ‘just’ because it provides the body with an element it is not able to produce by itself, but also because it allows the patient to live an active life, something which he not only wishes but also needs (“I need to go to work”). In this case, the argumentation relies mostly on the consideration of consequences, so that the positive/negative value assigned to a consequence is transferred to its cause: from the excerpt, “...as you are not protected by the drug, then you'll end up moving less and less and you'll give up doing things...”. To stop having an active life is considered negative, thus the cause of this – not doing the prophylaxis – is considered negative as well and argued against by the doctor.

Both examples show that the alignment of assessments can be considered as an intermediate outcome that is necessary for successful decision making: if the participants assess the same symptom, situation, treatment, behavior, etc. in different or even incompatible ways, it will be more difficult to find agreement on what to do. Such alignment is achieved through argumentative discourse, and it is important that all participants have their chance to express their point of view.

This brings us to the second important function of argumentative discourse, i.e. finding agreement on a decision through deliberation.

### 3.2. The development of deliberative sequences

Deliberation is a kind of verbal activity aimed at finding agreement on a course of action to pursue in relation to a problem. A problem could be, “where could we have dinner tonight?”, “should we go on vacation by car or by train?”, but also “how can we slow down climate change?”, “what could be the best treatment in this particular circumstance?”, etc. In all these cases, an action, or a chain of actions, needs to be agreed upon. However, starting points may be complex and the circumstances uncertain, as is often the case when making decisions about health.

In clinical dialogues, deliberation can be considered as the crucial component of decision making [19], and it is easy to understand how important argumentation can be in this process. Besides, the possibility for all participants to put forward proposals for action and appropriate reasons for doing or not doing something is what makes a decision-making process a *shared* one. At an analytical level, aspects that can be considered are: the presence or absence of all the phases that should be present in a deliberation [16,20]; the kinds of arguments proposed by the participants [21]; the practice of deliberation in relation to certain psychological factors involved in decision making, such as e.

g., reactance [22]. The following is an excerpt in which a deliberation sequence is conducted by a diabetologist in a way that leads the patient to suggesting a course of action she can accept and (hopefully) put into practice<sup>4</sup>:

#### CASE 3

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

Daughter: 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?

In the opening of the excerpt the doctor presents the options available to address the problem of rising diabetes values. In so doing, she performs her professional task of providing a piece of 'advice', or 'expert opinion'. The way the doctor presents the issue involves argumentative discourse:

Premise 1: "the three levels of the treatment are physical activity, diet and drug"

Premise 2: "the quantity of drug prescribed is already very high"

Conclusion: "we should work on the other two levels"

The conclusion sets the goal of the deliberation sequence: the participants need to decide which strategy to put in place in order to decrease the diabetes values. It is interesting in this example that the doctor does not put forward her proposal first but opens the floor to suggestions from the patient. In so doing she shows a high awareness of the correct distribution of tasks: it is up to the doctor to put forward suggestions regarding the more strictly clinical side of the matter, but it is the patient who should then speak up regarding aspects that involve lifestyle and habits. Initially this particular patient does not seem to be able to suggest anything. Again, this doctor is particularly effective in orienting the patient to what she thinks she is able to do, realistically. At this point the patient's daughter puts forward the first concrete suggestion by means of an interrogative sentence that has the function of an

invitation, "would you like to go to the gym with me for three months?". The patient accepts this option, and the doctor confirms that it is a good idea also from her point of view. She then adds a second suggestion that relates to eating habits, "we could add a free diet but a very careful monitoring of sweets". After some further discussion, the patient accepts to have limitations to sweets but not to fruit. The action plan is thus settled: three months at the gym, no sweets, but free to have fruit.

In this deliberation sequence all participants had the opportunity to contribute and the distribution of tasks respected the competencies of each, so that the patient was offered a useful professional advice in deciding how best to proceed in order to achieve wellbeing. One interesting aspect is the use of interrogative structures, which in this case had the function of opening up room for participants' contribution.

## 4. Discussion

The preceding sections have shown two additional functions of argumentative discourse in clinical settings besides the typical function of persuasion. When attempting to find agreement on assessments, discussions are typically about definitions and values; when argumentation is used for deliberation in view of decision making, the (non) acceptability of certain consequences is usually at issue. This points to a certain complexity in the ways in which argumentative discourse is embedded in clinical dialogues, which brings us to a few final considerations regarding the challenges of analyzing argumentative sequences in these dialogues.

Certainly, limiting observations to single turns or adjacency pairs is not sufficient to account for the role that argumentative discourse plays in a dialogue. This indication is supported also by elements we know about face-to-face dialogues: they are built 'as they go' [7,24]; the language used by participants is vague on purpose, in order to allow for faster interpretation by relying on contextual information [25]; turn organization is fundamental to understand how meanings are constructed and roles allocated [26–28]; if the sequential organization of interactions is overlooked, understanding of the interaction is lost [29].

An additional challenge may derive from the fact that we hardly ever find standpoints and arguments neatly organized and spelled out. In many cases, standpoints can remain implicit and have to be inferred; other times, arguments appear before standpoints. More often than not, in spoken face-to-face dialogues, participants use all sorts of intertextual references to build their argumentation so that it becomes very difficult for an external observer (such as an analyst, for example) to understand what is going on.

It should also be considered that many of the linguistic structures that typically appear in argumentative discourse also appear in explanations. Let us compare:

Lucy said she is not eating *because* she is feeling sick.

Lucy is sick, *because* she is not eating.

In the first case, Lucy is explaining why she is not eating, she is making explicit the causal link between two phenomena, the fact of being sick and the fact of not eating. The second case is a conjecture: someone is making the hypothesis that Lucy is sick and the reason to believe this is that she is not eating. In the second case, "because she is not eating" is the premise supporting the conclusion "Lucy is sick". In both cases the conjunction "because" is used, but in the first example it marks the connection between cause and effect, while in the second case it connects a standpoint to an argument. This means that relying only on the observation of linguistic indicators to identify argumentation can be misleading. The collocation of the argumentative sequence within the dialogue should instead be the first thing to consider.

Finally, as mentioned in Section 2, it is important that the wider interactional context is taken into consideration. Clinical dialogues happen within the boundaries of a precise institutional context: it might be the hospital, the outpatient clinic, or another kind of situation, but it

<sup>4</sup> This example has been commented also in [16]. The excerpt is taken from a collection of transcripts of videorecordings of consultations in a diabetes care setting, completed between 2012 and 2014 at a diabetes outpatient clinic in Italy [21,23].

is always a circumstance that has boundaries set by social structures. The roles of participants are predefined and so are their rights and obligations. Keeping these elements in mind when analyzing argumentative discourse in clinical dialogues means that, for example, HCPs' recommendations should be analyzed as instances of providing expert opinion on a problem, not always and by default paternalistic acts of authority that limit patients: this assessment should be made in view of patients' replies and of the overarching goal the interaction is aiming to achieve.

## 5. Concluding remarks

This contribution has discussed the relevance of argumentative discourse in the general organization of clinical dialogues, in particular in view of two main functions: the alignment of assessments and the development of deliberation sequences.

Careful consideration of the forms and functions of argumentation in clinical settings has the potential to offer relevant insights into the verbal structure of decision making, offering dialogue-specific criteria for its assessment. It can also allow a reconsideration of the issue of the asymmetry of roles in clinical dialogues: indeed, any interaction is always generated by some kind of asymmetry, which is what makes communication interesting.

Finally, the relevance of argumentative discourse does not rest on its potential for direct impact on clinical outcomes. Argumentative discourse can be expected to impact on intermediate goals, e.g. motivation, trust, understanding, commitment to treatment, which can foster the achievement of clinical outcomes such as improved parameters, pain control, cure, less suffering [1].

## 6. Practice implications

The considerations presented in this article can be indirectly relevant to the clinical practice via professionals' training. Indeed, mastering argumentative practices offers the opportunity to 'use' asymmetry with awareness of its potential, both negative and positive. In this sense, practicing the forms and functions of argumentative discourse should be included in HCPs' training.

In consideration of increasing aggressions to HCPs in hospitals, the ability to provide reasons for certain clinical choices could be considered as a strategy to prevent misunderstandings, frustration and ultimately open conflict between HCPs, patients and their families.

## Funding sources

Project *B-Hu-Well. Boosting Human Wellbeing with Behavioural Insights*, financed by the European Union, Next Generation EU, Mission 4 Component 2C, CUP B53D23030060001 (Research Unit Università Cattolica del Sacro Cuore, Milano, CUP J53D23017130001).

## Declaration of Competing Interest

The author declares that she has no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## References

- [1] Street R. How clinician-patient communication contributes to health improvement: modeling pathways from talk to outcome. *Patient Educ Couns* 2013;92:286–91.
- [2] Cameron KA. A practitioner's guide to persuasion: an overview of 15 selected persuasion theories, models and frameworks. *Patient Educ Couns* 2009;74:309–17.
- [3] Rubinelli S. Rational versus unreasonable persuasion in doctor-patient communication: a normative account. *Patient Educ Couns* 2013;92:296–301.
- [4] Labrie N, Schulz PJ. Does Argumentation matter? A systematic literature review on the role of argumentation in doctor-patient communication. *Health Commun* 2014;29:996–1008.
- [5] Salmon P. Argumentation and persuasion in patient-centred communication. *Patient Educ Couns* 2015;98:543–4.
- [6] Levinson S. Activity types and language. *Linguistics* 1979;17:365–99.
- [7] Linell P. *Approaching dialogue: Talk, interaction and contexts in dialogical perspectives*. Amsterdam/Philadelphia: John Benjamins Publishing; 1998.
- [8] Culpeper J, Crawshaw R, Harrison J. Activity types' and 'discourse types': Mediating 'advice' in interactions between foreign language assistants and their supervisors in schools in France and England. *Multilingua* 2008;27:297–324.
- [9] Walton D. *Fundamentals of Critical Argumentation*. Cambridge: Cambridge University Press; 2006.
- [10] van Eemeren FH, Henkemans AFS. *Argumentation: Analysis and evaluation*. New York: Routledge; 2016.
- [11] Walton D. Defeasible reasoning and informal fallacies. *Synthese* 2011;179:377–407.
- [12] Kecskes I, Zhang F. Activating, seeking, and creating common ground: A socio-cognitive approach. *Pragmat Cogn* 2009;17:331–55.
- [13] Kecskes I, Zhang F. On the dynamic relations between common ground and presupposition. In Capone A., Lo Piparo F., Carapezza M. editors. *Perspectives on Linguistic Pragmatics. Perspectives in Pragmatics, Philosophy & Psychology*, vol 2. Cham: Springer; 2013. pp. 375–395.
- [14] Lamiani G, Strada I, Mancuso ME, Coppola A, Vegni E, Moja EA. Pro-Adherence Study Group. Factors influencing illness representations and perceived adherence in haemophilic patients: a pilot study. *Haemophilia* 2015;21:598–604.
- [15] Bigi S., Lamiani G. The Power of Words: Deliberation Dialogue as a Model to Favor Patient Engagement in Chronic Care. In Graffigna G. editor. *Promoting Patient Engagement and Participation for Effective Healthcare Reform*. Hershey, PA: IGI Global; 2016. pp. 66–92.
- [16] Bigi S. *Communicating (with) Care*. Amsterdam: IOS Press; 2016.
- [17] Bigi S. The role of argumentative practices within advice-seeking activity types. The case of the medical consultation. *Riv Ital Filos Ling* 2018;12:42–52.
- [18] Macagno F, Walton D. *Emotive Language in Argumentation*. Cambridge: Cambridge University Press; 2014.
- [19] Elwyn G, Miron Shatz T. Deliberation before determination: the definition and evaluation of good decision making. *Health Expect* 2010;13:139–47.
- [20] Lamiani G, Bigi S, Mancuso ME, Coppola A, Vegni E. Applying a deliberation model to the analysis of consultations in haemophilia: Implications for doctor-patient communication. *Patient Educ Couns* 2017;100:690–5.
- [21] Bigi S. Can argumentation skills become a therapeutic resource? In van Eemeren F., Garssen B. editors. *Scrutinizing Argumentation in Practice*. Amsterdam/Philadelphia: John Benjamins; 2015. pp. 281–296.
- [22] Bigi S. Communication skills for patient engagement: argumentation competencies as means to prevent or limit reactance arousal, with an example from the Italian healthcare system. *Front Psychol* 2016;7:1472.
- [23] Bigi S. Healthy Reasoning: The Role of Effective Argumentation for Enhancing Elderly Patients' Self-Management Abilities in Chronic Care. In Riva G., Ajmone Marsan P., Grassi C. editors. *Active Ageing and Healthy Living: A Human Centered Approach in Research and Innovation as Source of Quality of Life*. Amsterdam: IOS Press; 2014. pp. 193–203.
- [24] Linell P. Towards a dialogical linguistics. In *The XII International Bakhtin Conference: Proceedings*. Jyväskylä, Finland: Department of Languages; 2006. p. 52–167.
- [25] Voghera M. *Dal parlato alla grammatica. Costruzione e forma dei testi spontanei. [From spoken language to grammar. Production and form of spontaneous texts]*. Roma: Carocci Editore; 2017.
- [26] Drew P. Turn design. In Stivers T., Sidnell J. editors. *The Handbook of Conversation Analysis*. Malden, MA: Wiley-Blackwell; 2013. pp. 131–149.
- [27] Clayman S.E. Turn-constructional units and the transition-relevance place. In Stivers T., Sidnell J. editors. *The Handbook of Conversation Analysis*. Malden, MA: Wiley-Blackwell; 2013. pp. 151–166.
- [28] Hayashi M. Turn allocation and turn sharing. In Stivers T., Sidnell J. editors. *The Handbook of Conversation Analysis*. Malden, MA: Wiley-Blackwell; 2013. pp. 167–190.
- [29] Stivers T. Sequence Organization. In Stivers T., Sidnell J. editors. *The Handbook of Conversation Analysis*. Malden, MA: Wiley-Blackwell; 2013. pp. 191–209.