The stereotypicality of symptomatic and pragmatic argumentation in consultations about palliative systemic treatment for advanced cancer

Kunneman, M.; Gartner, F.R.; Hargraves, I.G.; Montori, V.M.

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Commentary by

Marleen Kunneman, PhD[1,2]

Fania R. Gärtner, PhD[2]

Ian G. Hargraves, PhD[1]

Victor M. Montori, MD, MSc[1]

[1]Knowledge and Evaluation Research Unit, Mayo Clinic, Rochester MN, USA

[2]Medical Decision Making, Department of Biomedical Data Sciences, Leiden University Medical Center, Leiden, the Netherlands

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To address a patient’s problematic situation, patients and clinicians must work together to figure out a way forward that maximally supports meeting the patient’s goals, such as cure or better quality of life, while minimally disrupting their lives and loves, such as family life, work, or leisure. This work takes place in a conversation in which patients and clinicians test, or ‘try on’, the available options as ‘hypotheses’ until they identify one that fits best. The option that ‘fits best’ is the one that makes the most intellectual, emotional, and practical sense. This means that not only do patients and clinicians *know and understand* that it is the best option at hand, it also *feels right* and *can be implemented* in the life of the patient. The conversational dance between the patient and clinician (Kunneman et al. 2016:1320-1324) and the trying out of different options and making sense of these options is sometimes called shared decision making or SDM (Charles et al. 1997:681-692; Kunneman et al. 2016:1320-1324). SDM shifts the focus of healthcare from care for ‘patients like this’ to care for ‘this patient’.

In this issue of *Journal of Argumentation in Context*, Akkermans and colleagues explore argumentative aspects of the conversational dance seeking to connect the fields of argumentation and SDM (Akkermans et al. 2018). In describing stereotypical argumentation types in SDM encounters about palliative cancer care, they commonly found symptomatic and pragmatic argumentation while authority argumentation was less common. Because of this distribution, the authors conclude that, when using an SDM approach, clinicians should be aware of the structure of symptomatic and pragmatic argumentation, and of their associated weaknesses and pitfalls.

Before endorsing this recommendation, some questions remain. Was the extent of SDM present in the encounters studied sufficiently to draw these conclusions? If these were typical encounters, SDM would be rare or present in a very limited way (Montori et al. 2017:617-618; Stacey et al. 2017:CD001431). If so, then the authors’ conclusion would relate less to stereotypicality of SDM encounters and more to the stereotypicality of argumentation in encounters suitable for SDM. Also, it would be valuable to learn whether the arguments and argumentative structures used are phrased *in* the SDM process, i.e., during the dance, or are used to justify a decision, thus appearing at the conclusion of the decision-making process. In addition, is the content of the arguments warranted in the sense that they are based on reliable evidence and therefore capable of invoking and involving the values and preferences of well-informed patients? Finally, in clinical situations, a well-formed argument for how to proceed goes beyond making symptomatic, authoritative, or consequential (pragmatic) sense. It also has to make sense emotionally and practically in the patient's life. A focus on structures of intellectual argument risks missing these other important factors in argument.

Another concern has to do with the difficulty of assessing the extent to which the conversational dance between the patient and clinician develops care for *this patient* by drawing from both research and patient evidence. In other words, focusing on learning and using correct communication (or techniques or steps of SDM) only makes sense if using these techniques and structures advances the situation of the patient. Similarly, the presence and use of types of arguments in conversation only make sense if they allow us to be appropriately persuaded of the idea that our way forward makes sense for *this patient*, *this situation*.

Since the emergence of SDM, research and implementation has primarily focused on getting the structure of SDM right: to take the right steps at the right time. It suggests that there is a technically correct sequence of steps, one that is best able to lead to identifying the best option, the best care for this patient. At a high level, this 'mechanical' approach is comprised of three steps: 1) fostering choice awareness, 2) providing information, and 3) discussing patient preferences (Elwyn et al. 2017:j4891; Stiggelbout et al. 2015:1172-9). In judging the quality of SDM, some experts assess the presence or absence of these technical steps. In part, this research has been valuable: it has shown that 'technically correct SDM' is still rare in routine practice, even when experimentally induced (Montori et al. 2017:617-618; Stacey et al. 2017:CD001431). For example, research in routine practice showed limited presence of behaviors to 1) foster choice awareness (Kunneman et al. 2018:60-68), 2) provide balanced information (Engelhardt et al. 2016:55-66), and 3) discuss patient preferences (Henselmans et al. 2017:625-633). Akkermans and colleagues take a similar technical approach in their paper, focusing on the argumentative structures used in the SDM process.

To our knowledge, the relation between having a technically correct structure of the SDM process – at a high level or by looking at the argumentative structures present – and the likelihood that care decisions made will fit *this patient* well remains unclear. Can focusing on meeting these technical requirements have unintended effects? Can this approach encourage clinicians, who are under pressure of productivity and efficiency, to ‘go through the motions’ or ‘check the boxes’, following a rote? Or is it instead possible that building the right structure can enable professionals to sincerely bring the patient into the conversation, to engage in a moment of deep human connection? Is it possible to dance well, responding to the music and to the partner, by first learning the dance steps without music or partner? When assessing the occurrence of SDM and its quality by evaluating the technical steps of SDM, or outcomes such as knowledge (Stacey et al. 2017:CD001431), we assume that the technical structure we see stands for a caring SDM conversation. However, to this caring aspect of the SDM conversation, we remain blind. In this way, current SDM evaluations may lack validity, overestimate the occurrence of SDM as a caring process, and, to the extent that the conversation is necessary for SDM to exert its salutary effects, may underestimate the impact SDM could have on patient outcomes when applied in its caring form. Downstream, the focus on structural evidence supports policies and practices that implement a mechanical form of SDM that, while technically correct, may ultimately fail to care for patients and their situation.

The way forward may need to focus on responding to each patient’s problematic situation, and then explore the structures necessary, of SDM and argumentation, to achieve this response. We believe that in shifting this focus, we will look beyond what is technically correct, to uncover humanistic SDM and caring conversations.

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Author information:

Marleen Kunneman, PhD
Kunneman.Marleen@mayo.edu
Mayo Clinic
Knowledge and Evaluation Research Unit
200 First St SW
Rochester MN 55905, USA

and

Leiden University Medical Center
Medical Decision Making, Department of Biomedical Data Sciences,
P.O.Box 9600
2300 RC Leiden, the Netherlands

Fania R. Gärtner, PhD
F.R.Gaertner@lumc.nl
Leiden University Medical Center
Medical Decision Making, Department of Biomedical Data Sciences,
P.O.Box 9600
2300 RC Leiden, the Netherlands

Ian G. Hargraves, PhD
Hargraves.Ian@mayo.edu
Mayo Clinic
Knowledge and Evaluation Research Unit
200 First St SW
Rochester MN 55905, USA

Victor M. Montori, MD, MSc
Montori.Victor@mayo.edu
Mayo Clinic
Knowledge and Evaluation Research Unit
200 First St SW
Rochester MN 55905, USA