A pragma-dialectical perspective on obstacles to shared decision making

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Shared medical decision-making has been analyzed as a particular kind of argumentative discussion. In the pragma-dialectical argumentation theory, different types of conditions and rules are formulated for the ideal of a reasonable argumentative discussion. In this paper, we shall first show how making use of the distinctions made in the pragma-dialectical theory between different types of conditions for reasonable discussion can help to give a more systematic account of the obstacles that need to be overcome for shared decision-making to be successful. Next, by referring to the rules for critical discussion, we shall provide a more detailed explanation than can be found in the literature on health communication of why certain types of conduct of the participants in the medical encounter can be analyzed as obstacles to the goal of shared decision-making.

Keywords: discussion rules, fallacies, higher order conditions, obstacles to shared decision-making, pragma-dialectical argumentation theory

1. Introduction

Shared decision-making is an ideal model for making decisions about medical treatments in which both the doctor and the patient participate (Charles et al. 1997). In the last two decades, this model has come to be regarded more and more as the preferred way of arriving at decisions in consultations (Stiggelbout et al. 2015). At the same time, there has been much debate about whether this type of decision-making is feasible in practice.[1] Various types of obstacles to shared

1. Even though there is also still some discussion as to whether shared decision-making is the right ideal for medical consultation (see for instance McNutt 2004: 2516, who believes the ideal should rather be 'informed medical decision-making'), the majority of authors on medical communication seems to consider shared decision-making as the preferred model for consultation (see for instance the Salzburg Statement on Shared Decision Making, 2010). In many countries,

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decision-making have been mentioned in the health communication literature, ranging from the problem that there is no real decision to be made since there are no real options, to doctors putting pressure on their patient to accept a specific kind of treatment (Engelhardt et al. 2016; Karnieli-Millier and Eisikovits 2009; Ziebland et al. 2014).

By argumentation theorists, shared medical decision-making has been analyzed as a particular kind of argumentative discussion (Goodnight 2006; Labrie 2014; Snoeck Henkemans and Mohammed 2012). The aim of this type of discussion is, according to Snoeck Henkemans and Mohammed (2012), compatible with that of a critical discussion, which is to resolve a difference of opinion by critically testing the acceptability of a point of view. For this ideal type of argumentative discussion, different types of conditions and rules have been formulated in the pragma-dialectical theory of argumentation (Van Eemeren and Grootendorst 1984, 2004).

Making use of the pragma-dialectical framework in analyzing the obstacles to shared decision-making mentioned in the literature on medical communication enables giving a more systematic overview of the types of conditions that need to be fulfilled in order to realize the ideal of shared decision-making than has been offered until now in the medical communication literature.

In this paper, we shall first present a pragma-dialectical analysis of the various kinds of conditions that need to be fulfilled in order for shared medical decision-making to be possible. Next, we shall use the pragma-dialectical code of conduct for reasonable discussants as a starting-point for giving a more detailed explanation of why certain types of conduct during the process of shared decision-making can be regarded as non-conducive to the goal of reasonable decision-making. Such an argumentation based approach to shared decision-making can help analyzing in a more precise and systematic way the diversity of barriers to shared decision-making that have been discussed in the extant literature. Moreover, this approach also provides insights in how to overcome such barriers.

2. An argumentative analysis of the conditions for shared decision-making

Shared decision-making has been presented as an alternative to the informed decision-making model (Charles et al. 1997). In the latter model, according to Charles et al. (1999: 652), doctors communicate the technical knowledge about

this ideal also functions as an official benchmark for good health care. In this paper, we will not call into question the ideal of shared decision-making itself, but only pay attention to obstacles to applying the ideal in practice.

treatment benefits to patients, who will then use this knowledge in combination with their own values and preferences to arrive at a decision. By contrast, in the shared decision-making model, "both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences." (Charles et al. 1999: 652).

Even though the ideal model of medical shared decision-making and the ideal model of a critical discussion are designed to further two different goals, following the rules of a critical discussion can be seen as instrumental to the process of shared decision-making: by having a reasonable discussion about what would be the best treatment option, a well-founded decision can be made (Snoeck Henkemans and Mohammed 2012: 29).

According to the pragma-dialectical theory of argumentation, there are ten rules for critical discussion that are instrumental in resolving a dispute on the merits: each of these rules represents an indispensable component of a code of conduct for resolving differences of opinion (van Eemeren and Grootendorst 1992: 104–105, 2004: 190–195). The rules for critical discussion are regarded by van Eemeren and Grootendorst (2004: 36–37) as *first-order conditions* for a reasonable resolution of a difference of opinion. Van Eemeren et al. (1994: 31–32) give the following description of the function of the first-order conditions:

> the first-order conditions provide certain guarantees against things that could go wrong in the search for a resolution to a disagreement. For example, the first order conditions assure that both parties to a dispute will have unlimited opportunity to cast doubt on standpoints and that both parties to a dispute will be obliged to respond to such doubts.

In addition to these discussion rules that function as first order conditions, van Eemeren and Grootendorst (2004: 189–190) distinguish *higher order conditions*. Higher order conditions concern factors beyond the control of the arguers that hinder these arguers in their attempt to follow the rules for critical discussion and, thus, have a reasonable discussion. These higher order conditions can be divided into *second* and *third* order conditions. Second order conditions refer to the state of mind of the participants in the discussion, that is, their attitudes, skills, and competence. Ideally, participants should, for instance, have no stake in the outcome of the discussion, have sufficient argumentation skills, and be competent in the subject matter under discussion (van Eemeren et al. 1994: 32). Third order conditions have to do with the external circumstances or social reality (van Eemeren and Grootendorst 2004: 189). Such third order conditions pertain, for instance, to the power or authority relationships between the participants and to special features of the situation in which the discussion takes place, such as the amount of time available for discussion (van Eemeren and Grootendorst 2004: 189).

In addition to the first, second, and third order conditions for reasonable discussion, there are also conditions that van Eemeren and Grootendorst suggest might be considered as *fourth* order conditions. These conditions, however, are not confined to argumentative discussions, but need to be fulfilled in order for *any* successful communication to take place (van Eemeren and Grootendorst 2004:189, n. 8). Such conditions are, for example, that the interactants should be able to understand each other, and that they should not be unconscious, drunk, or deaf (van Eemeren and Grootendorst 1984:151–152).

Clear parallels can be drawn between the kinds of obstacles discussed in the literature on medical shared decision-making and the non-fulfillment of different types of higher order conditions for critical discussion. The non-fulfillment of second order conditions is seen as an important obstacle to shared decision-making. In particular, the epistemic asymmetry between doctor and patient is mentioned as a serious barrier to shared decision-making. According to Landmark, Gulbrandsen and Svennivig (2015:55), there are two forms of asymmetry involved in the medical consultation:

> Within medicine, patients' and physicians' epistemic domains are complementary, or even constitute a knowledge gap. Patients have primary epistemic rights to knowledge about their experience of symptoms, preferences and life-world circumstances, while physicians have primary epistemic rights to knowledge about diagnoses, treatments etc.

Third order conditions are also often mentioned as obstacles to shared medical decision-making. A first example of the non-fulfillment of such an external condition for shared decision-making is when there is an emergency situation in which there is no time for shared decision-making. In such emergency situations, according to Charles et al. (1997:683), the paternalistic model of doctor-patient communication is still the preferred model.

Another example of an external condition is that the type of decision should be such that there is a real choice to be made. The decision concerned should be preference sensitive, or, in other words, be one of "professional equipoise", which according to Elwyn et al. (2000:895) means that on the basis of the medical evidence alone the doctor can have no clear preference about the treatment choice to make, so that legitimate choices exist. If the external circumstances are such that there are no equivalent alternative treatments, then shared decision-making is seen as less feasible (Elwyn et al. 2000:895) or not applicable at all (McNutt 2004:2516).[2]

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2. One could argue that there is always a choice to be made, since the patient always has the right to opt for no treatment at all. In some cases, this may not be a legitimate medical choice,

Fourth order conditions, that is, general conditions for communication, may not be fulfilled, because the patient is unconscious or too ill. In such cases, communication is not possible, let alone shared decision-making. As Probst et al. (2017: 690) point out, "in the case of a patient who is unable or unwilling to participate in decision-making, and there is no access to surrogates, shared decision-making is not appropriate and care should proceed based on physician-directed decision-making."

It is clear that part of the obstacles mentioned in the literature on medical communication can be explained as having to do with the non-fulfillment of one of the higher order conditions that are distinguished in argumentation theory. Even though the fulfillment of such higher order conditions is a precondition for a reasonable discussion about a treatment decision, and thus for shared decision-making, this is not to say that the model of critical discussion loses its purpose when these conditions are not fulfilled in practice. As van Eemeren et al. (1994: 118) point out:

> For the ordinary arguer, a model of critical discussion is not so much a set of prescriptions for engaging in actual argumentative conduct as it is a set of standards against which actual practice is to be compared. How to bridge the gap between the real and the ideal can be seen as a kind of "engineering" problem. "Realizing" an ideal procedure requires comparison of actual conditions with normative assumptions and, wherever a mismatch is found, the creation of a structure or a technique that will alter the conditions or compensate for them.

In the literature on shared decision-making, examples can be found both of solutions aimed at compensating the non-fulfillment of conditions and of altering the circumstances in such a way that the conditions are fulfilled. An example of the first solution is the proposal to compensate for the epistemic asymmetry between doctor and patient by advocating a division of labor between doctor and patient: the doctor should have the burden of proof for what are the best treatments medically speaking, and for what benefits and risks they bring, while it is the patients' task to weigh these possibilities by taking into account their own preferences and values (McNutt 2004). By giving the doctor a specific institutional burden of proof for claims concerning risks and benefits of treatment options and giving patients the role of taking a decision based on their own preferences and values, some

but then, as Bickenbach (2012: 8) points out, respecting patients' autonomy also means that patients have the right to be wrong. And in some cases, patients' circumstances may be such that the best medical choice is not the best personal choice for them.

of the obstacles can be compensated for (Snoeck Henkemans and Mohammed 2012: 21).[3]

For the problem of epistemic asymmetry, sometimes a solution that is aimed at altering the conditions is proposed: patients should be offered education and decision aids to enable them to participate more fully in the decision-making process. Doctors should be educated to become more patient-centered. By doing so, the asymmetry between doctor and patient could be reduced. Such a solution is for instance proposed by Barry and Edgman-Levitan (2012: 781):

> Patients should be educated about the essential role they play in decision making and be given effective tools to help them understand their options and the consequences of their decisions. They should also receive the emotional support they need to express their values and preferences and be able to ask questions without censure from their clinicians. Clinicians, in turn, need to relinquish their role as the single, paternalistic authority and train to become more effective coaches or partners – learning, in other words, how to ask, "What matters to you?" as well as "What is the matter?"

Even if all higher order conditions would be fulfilled so that both parties are, in principle, able to participate optimally in the shared decision-making process, obstacles to shared decision-making may still arise due to the non-fulfillment of the first order conditions. This means that the conduct of one or more of the parties constitutes a violation of the rules for reasonable discussion. If this is the case, reasonable discussion of the treatment and thus the ideal of shared decision-making may still be endangered. In the next section, we will discuss those discussion rules that are the most relevant for the communicative activity of medical consultation and show how a large part of the obstacles mentioned in the literature on medical communication can be analyzed as violations of such first order rules.

3. Violations of discussion rules

The ideal of shared decision-making can only be reached if patients are offered sufficient opportunity to question or oppose doctors' treatment proposals. Doctors might nevertheless not always fully provide patients with the opportunity to do so during medical consultation. It could, for example, be the case that a doctor expects the patient in question to raise unfounded objections to treatment options.

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3. Snoeck Henkemans and Wagemans (2012) investigate to what extent Dutch laws, guidelines, and professional conventions within the medical domain can function as institutional safeguards for the quality of medical decisions by compensating for the non-fulfillment of particular higher order conditions.

Within the treatment discussion itself, doctors can – consciously or unconsciously – try to limit patients' possibilities to ask questions or raise objections in two distinct ways: doctors can attempt to limit patients' room to participate in the decision-making process, and doctors can try to present fewer or no arguments to ask questions about or raise objections to. These ways can be particularly effective in medical consultation because of the asymmetry between doctors and patients. After all, institutionally speaking, doctors have a leading role in the consultation and can therefore more or less decide to what extent patients can partake in the decision-making process. Additionally, patients might not feel comfortable about questioning doctors' information or ideas. What is more, patients typically do not have enough medical background to know when exactly a doctor's argumentation is incomplete.

At the same time, the two ways by means of which doctors can try to limit patient participation in shared decision-making can hamper a critical discussion of the treatment options. Indeed, the aforementioned first order rules lay down that discussion parties should not prevent each other from discussing each other's positions and that they should always provide sufficient support for what they claim.

In the following sections, it will be discussed in more detail how important barriers to shared decision-making that are discussed in the medical communication literature can be analyzed in terms of the pragma-dialectical first order rules. More precisely, we will analyze a number of distinctive barriers to shared decision-making that are mentioned in Engelhardt et al. (2016), Karnieli-Miller and Eisikovits, (2009), and Ziebland, Chapple and Evans (2014). We will show that, underlying these barriers, there are violations of the pragma-dialectical *freedom rule*, *starting point rule*, *relevance rule*, *burden-of-proof rule*, *argument scheme rule* or a combination of these rules.[4]

3.1 Patients' participation

To be able to reasonably resolve a difference of opinion, discussion parties should be free to present any doubts, criticisms, alternative standpoints, or arguments. Without this freedom, parties cannot fully participate in the discussion. According to the pragma-dialectical theory, discussion parties should therefore observe the *freedom rule*: "Discussants must not prevent each other from advancing standpoints or from calling standpoints into question." (Van Eemeren and Grootendorst, 2004: 190).

4. An overview of the pragma-dialectical rules for critical discussion is provided in Van Eemeren and Grootendorst (2004, pp. 190–195).

Barriers to shared decision-making can result from violations of the pragma-dialectical *freedom rule*. Shared decision-making is, after all, impossible if doctors simply disallow patients to question their treatment proposal during the decision-making process ("Of course, you don't know this, but it's best to take some rest for now").

A blatant violation of the *freedom rule* occurs when doctors attempt to exclude patients from contributing to the decision-making process. Example (1), taken from Karnieli-Miller and Eisikovits (2009: 5), illustrates how this can happen. In this example, a doctor tries to exclude the patient's mother from a discussion about whether her son, who suffers from Crohn's disease, should undergo an additional endoscopy.

Example 1. Excerpt of a discussion between a doctor (Dr) and mother (M) of a patient suffering from Crohn's disease

1 M: So if they found the inflammation and give treatment, what difference does it make if they know it is an inch longer or not?
2 Dr: We need to know the depth of the inflammation.
3 M: But you saw it on the CT – why does it matter?
4 Dr: *Are you done? Can I answer? Thanks.*
5 M: We are here to ask questions, I'm sorry if that is bothering you.
6 Dr: *You are here to ask questions. We can't meet twice a day for that. In our clinic, we perform an endoscopy on every adolescent with suspected Crohn's, unless you want to find another clinic.*
[Mom looks scared.]

(taken from Karnieli-Miller and Eisikovits 2009: 5; our emphasis)

In this example, the mother questions the necessity of the doctor's treatment proposal of performing another endoscopy on her son (turn 1). At first, the doctor provides a reason why such an endoscopy (turn 2) is necessary, but the mother is not satisfied with this argumentation and continues her questioning of the doctor's treatment advice (turn 3). Subsequently, the doctor makes a first attempt to prevent the mother from contributing any further to the discussion: by rhetorically asking whether the mother is done and whether he can answer her question (and sarcastically thanking her for that), the doctor suggests that the mother does not contribute to the consultation in a constructive way, thereby indicating that she had better stop doing so (turn 4). The mother indeed understands the doctor's reaction in this way, but, in line with the pragma-dialectical *freedom rule*, emphasizes her right to ask questions, even if the doctor dislikes that (turn 5). Subsequently, the doctor echoes the mother's words and indicates that the mother cannot continue asking questions because that would take too much time and "We can't meet twice a day for that" (turn 6). Indeed, he continues by forcefully restat-

ing that the endoscopy will be performed and threatens the mother by saying that if she does not agree to it, she will have to find another clinic (turn 6).

The doctor's contributions in turns 4 and 6 thus aim at preventing the mother from casting doubt on his standpoint, a blatant violation of the pragma-dialectical *freedom rule*. More precisely, the doctor's threat in this last turn is known as an *ad baculum*-fallacy (a fallacy of the stick). This fallacy is a *freedom rule* violation in which discussion parties are (physically) threatened in order to make them accept an opposing standpoint (Van Eemeren and Grootendorst 2004: 179–180).

Barriers to shared decision-making can also be the result of less obvious attempts to limit the patient's room for participating in the shared decision-making process. Example (2), taken from Ziebland, Chapple and Evans (2014: 3305), shows how such an attempt can occur. In this example, a patient with pancreatic cancer describes how her doctors proposed surgery to her.

Example 2. A patient's report of communication with her doctors about the possibility of undergoing a Whipple's operation

> I was taken into the specialist hospital to have keyhole to see if it had spread. They said, "If it's not spread you'll have the big operation," which involves all these different things. It sounds like rewiring your insides […]. It was a Whipple's operation. I looked it up on the internet and it's sort of wow it's massive. It was a nine hour operation it turned out. So he said, "*If it's not spread you'll go for the big one*." I said, "Okay." I was only under anesthetic for about half an hour. So as soon as I was coming round and I could stand up and everything they said, "Right, you're fine to go. But your doctor just wants to have a word with you." So this other doctor comes who's off this team, he come and he said, "*Right you're going for the big one, we'll let you know when it is, in about two or three weeks*." I said, "Okay fine. So that's good isn't it?" He said, "Oh yes, very good. Can't see any cancer on the outside." I says, "Okay."
>
> (taken from Ziebland, Chapple and Evans 2014: 3305; our emphasis)

As Ziebland, Chapple and Evans (2014: 3305) observe, the doctors presented the Whipple's operation in the example as a foregone conclusion: if the patient's cancer would be confined to her pancreas, she was "going for the big one" – as opposed to deciding whether she wanted to undergo this serious surgery. By presupposing agreement on this starting point, the doctors do not seem to leave much room for questioning this procedure, let alone challenging it. What is more, the patient's use of the particle "okay" is interpreted by the doctors as a token of the patient's agreement, while, in its first and last use, it is in fact rather unclear whether the patient indeed meant it as such; she might have merely been backchanneling, using "okay" as a conversation continuer. The interpretation by the doctors, while eventually perhaps justified, does limit the patient's room to participate in the shared decision-making process.

This attempt to limit patient participation in Example (2) nonetheless occurs in a less obvious manner than the one in Example (1); rather than blatantly trying to exclude the patient (or the patient's representative), the doctors in Example (2) make it seem as if common ground has already been reached on which treatment (a Whipple's operation) should be carried out. Such common ground is, however, questionable, as the patient is not explicitly asked for this agreement and her contributions to the discussion do not necessarily indicate it. In fact, this introduction of a starting point as though it is shared amounts to a violation of the pragma-dialectical *starting point rule*: "Discussants may not falsely present something as an accepted starting point or falsely deny that something is an accepted starting point." (Van Eemeren and Grootendorst 2004: 193).

Other barriers to shared decision-making described in the extant literature also result from a violation of the *starting point rule*. For instance, the barrier that Engelhardt et al. (2016: 59) describe as the implicit persuasion behavior of "having one treatment implicitly tag along with another", and the barrier that results from what Karnieli-Miller and Eisikovits (2009: 5) call "the illusionary power to decide" with "a focus to timing" both come down to unjustifying presenting particular propositions as common starting points; similar to Example (2), these behaviors limit the patient's possibilities to discuss the proposed treatment, since the doctor presents part of the treatment as though it has already been accepted.[5]

3.2 Doctors' argumentation

Even if patients are entirely free to question or criticize a treatment proposal, shared decision-making might be frustrated or even hindered if doctors represent the risks and benefits of the proposed treatment in a biased way. Due to the characteristic asymmetry in medical knowledge and expertise (Landmark, Gulbrandsen and Svennivig 2015: 55), patients depend to a certain extent on the doctor's presentation of the advantages and disadvantages of the proposed treatment. A skewed representation of the proposed treatment can therefore effectively limit patients' possibilities to critically discuss this treatment.

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5. It should be noted that not just violations of the pragma-dialectical *freedom rule* and *starting point rule* can hinder shared decision-making by limiting the patient's room for participating in this process; doctors might also "frighten patients about non-compliance" by unduly emphasizing the risks of not complying with the recommended treatment (Engelhardt et al. 2016: 58, Karnieli-Miller and Eisikovits 2009: 5–6). By such undue emphasis, doctors, in fact, restrict discussion about the advantages and disadvantages of the proposed treatment itself. Such a play on emotions indeed violates the pragma-dialectical *relevance rule*, which stipulates that "Standpoints may not be defended by non-argumentation or argumentation that is not relevant to the standpoint." (Van Eemeren and Grootendorst 2004: 192).

Of course, the legal requirement of *informed consent* aims to prevent misinforming patients about their health problem, the nature and character of the proposed treatment, the expected treatment results, possible alternatives, and the risks and benefits of this treatment (Murray 2012: 564). According to Pilgram (2015: 70–71), this means that, in a treatment discussion, doctors should first of all make acceptable that, given the effects and risks of the proposed treatment, the treatment can be expected to be beneficial to the patient and, second, that the proposed treatment is more beneficial than relevant alternative treatments or non-treatment in view of the patient's particular condition and situation. These obligations can be regarded as the doctor's 'burden of proof'.

Nevertheless, some of the barriers to shared decision-making that are mentioned in the literature seem to arise from issues with doctors' fulfilment of their burden of proof. Engelhardt et al. (2016: 58–59), for instance, mention "presenting the side-effects after the final treatment decision has been made" as an unbalanced presentation of the proposed treatment. In terms of the pragma-dialectical discussion rules, this could be regarded as a direct violation of the *burden-of-proof rule* ("A party who puts forward a standpoint is obliged to defend it if asked to do so"),[6] a fallacy of evading the burden of proof (Van Eemeren and Grootendorst 1992: 117–120). After all, doctors do not fully fulfil their burden of proof if they present side-effects only after the treatment discussion has ended.

An example of a barrier resulting from a violation of the *burden-of-proof rule* and another first order rule is what Engelhardt et al. (2016: 58) and Karnieli-Miller and Eisikovits (2009: 3) call "dramatizing the evil". This strategy, by means of which doctors can emphasize the seriousness of the diagnosis before presenting possible treatments, effectively excludes non-treatment as a viable possibility from the treatment discussion: if the patient's health problem is extremely bad, something has to be done about it; this is a given and does not require further justification. It can therefore be seen as a violation of the *burden-of-proof rule*.

A doctor's argumentation can also be limited by assuming that the patient already agrees on a particular starting point. In Example (3), taken from Ziebland, Chapple and Evans (2014: 3307), the doctors that the patient talks about indeed seem to have violated the *starting point rule*.

Example 3. Excerpt of an interview between an interviewer (I) and patient (P) who suffers from pancreatic cancer

1 I: Did they [the doctors] give you the option [of refusing chemotherapy]?
2 P: No, well actually, it is a question that didn't come up, you know.
3 I: Didn't come up?

6. Pilgram (2015, pp. 19–70) specifies what "asking to do so" amounts to in discussions between a doctor and patient in light of the legal requirement of *informed consent*.

4 P: No, no, I mean I think I'd have been very stupid to say I didn't want it, but having said that I know one particular person who has refused to have chemo.

(taken from Ziebland, Chapple and Evans 2014:3307)

From the interview excerpt in Example (3), it appears that the doctors that the patient talks about never presented him with the option of refraining from undergoing chemotherapy. Even though turn 4 shows that the patient realizes that he could have refused chemotherapy and he did not want to do so, the doctors in question should have listed non-treatment as a possibility if only to show why chemotherapy is the preferred treatment (and thereby fulfilling their burden of proof). It seems that the doctors assumed the patient shares with them the starting point that refraining from treatment is undesirable, while they cannot know this for sure, since it was not discussed in the consultation (turns 3–4). Falsely assuming a starting point to be shared amounts to a violation of the *starting point rule* (see also Section 3.1). By such an assumption, the doctor effectively limits the patient's possibility to discuss non-treatment, which goes against the ideal of shared decision-making.

3.3 Authority argumentation

The aforementioned characteristic asymmetry in medical knowledge and expertise between doctors and patients actually pervades all the barriers to shared decision-making that have been discussed so far. The attempts of doctors to limit the patient's room to participate in the decision-making process are a way to reinforce this asymmetry, and doctors rely on this asymmetry when providing limited argumentation. In the literature, several other barriers to shared decision-making are mentioned that result from issues with medical authority. As these barriers essentially combine violations of both the pragma-dialectical freedom rule and the burden-of-proof rule, they will be discussed separately in this section.

One barrier that underpins the knowledge gap between doctors and patients results from the use of the pronoun "we" when proposing a treatment ("*We* are in favor of hospitalization") (Engelhardt et al. 2016:59; Karnieli-Miller and Eisikovic 2009:5). As Karnieli-Miller and Eisikovic (2009:5) argue: "plurals are used to enhance credibility and lend authority to more threatening interventions". The use of "we" in treatment proposals suggests that not just the doctor who proposes the treatment is in favor of it, but also the entire medical team surrounding him or her. Even if the doctor does not have such a team or has not discussed the treatment with the team (and the "we" in question is, in fact, an instantiation of the

royal "we"), the suggestion is that the doctor's treatment proposal is the one that other medical professionals would give.

Interestingly, this barrier limits patients' room for presenting any doubts about or opposition to the proposal, and can simultaneously be used by doctors to evade the burden of proof. As Snoeck Henkemans and Mohammed (2012: 27) point out, the use of authorized "we" in treatment proposals limits patients' freedom to question or criticize the proposed treatment, as they seemingly go against the medical profession if they would.

At the same time, emphasizing that the treatment proposal has been made by several medical professionals by means of an authorized "we" can be regarded as an authority argument ("This treatment proposal is acceptable, because several medical professionals are of the opinion that it is"). Doctors could use the reference to all these medical professionals to avoid going into details about the reasons for the proposed treatment, alternative treatments, and possible consequences of refraining from treatment altogether. In argumentation theoretical terms, this could be regarded as a 'fallacy of authority' or '*argumentum ad verecundiam*' if those medical professionals, in fact, are not actually present or have not indicated their agreement with the claims of the doctor in question. This fallacy results from an incorrect application of the argument scheme of authority argumentation, constituting a violation of the pragma-dialectical *argument scheme rule* ("Standpoints may not be regarded as conclusively defended by argumentation that is not presented as based on formally conclusive reasoning if the defense does not take place by means of appropriate argument schemes that are applied correctly" (Van Eemeren and Grootendorst 2004: 194)).[7]

4. Conclusion

In the literature on medical communication, various obstacles to shared decision-making are discussed. Shared medical decision-making requires that doctors and patients deliberate on what would be the best treatment choice. Since such a deliberation requires that the parties discuss the pros and cons of the treatment

7. Other examples of barriers emphasizing the asymmetry in knowledge and expertise between doctors and patients are "presenting treatment as an authorized decision based on 'the guideline'" and "giving the impression that undergoing or foregoing treatment is quite unusual" (Engelhardt et al. 2016: 59). In both these cases, patients' room for discussion is limited (because they would go against the guidelines or against normal behavior) and doctors can avoid partially or fully fulfilling their burden of proof (because the reference to guidelines or what is normal might be deemed authoritative enough to undergo treatment).

options, in argumentation theoretical terms, such a deliberation amounts to having a reasonable discussion. In this paper, we have investigated the relation between the obstacles to shared decision-making and the ideal of critical discussion. By doing so, it has become possible to make a distinction between obstacles that concern the non-fulfilment of preconditions or higher order conditions for shared decision-making and obstacles that are caused by the fact that the contributions of the participants to the shared decision-making procedure are not in accordance with the reasonableness standards of this type of discussion.

Obstacles created by the conduct of the participants in the decision-making process have recently received much attention in the medical literature, where in particular the persuasive behavior of the doctor is often seen as non-conducive to shared decision-making.[8] It is interesting to see that the types of persuasive techniques that are mentioned in the literature as threatening the ideal of shared decision-making can also be seen as violations of the rules for reasonable discussion, in particular of the pragma-dialectical *freedom rule*, *starting point rule*, *relevance rule*, *burden-of-proof rule*, and *argument scheme rule*; doctors can hinder shared decision-making by limiting patients' room to discuss the proposed treatment, or by misrepresenting the advantages and disadvantages of the proposed treatment. Underlying such barriers to shared decision-making are fallacies in the argumentation (for instance, the *ad baculum*-fallacy and the fallacy of evading the burden of proof).

In this paper, we hope to have shown that looking at the phenomenon of shared medical decision-making from the perspective of argumentation theory enables to explain in a systematic way why certain types of conduct by doctors or by patients can be seen as unreasonable and therefore also as a hindrance to shared decision-making. Additionally, distinguishing between different types of obstacles based on argumentation theoretical insights gives ideas about how to overcome these obstacles: the non-fulfilment of higher order conditions (conditions concerning the state of mind of the doctor and patient, and the consultation situation) requires compensation or alteration of the circumstances in which shared decision-making is taking place, while the non-fulfilment of first order conditions (the discussion rules) requires increasing doctors' awareness of the rules for critical discussion.

8. See, for instance, Karnieli-Miller and Eisikovits (2009) and Engelhardt et al. (2016).

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