

Rhetoric in Italy

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Therapeutic advice: a rhetorical-argumentative perspective on doctor-patient communication

Abstract

The purpose of this work is to analyze the persuasion which characterizes therapeutic advice and its collaborative goal. It is observed that this type of advice seems to be more effective when it is not limited to a mere scientific demonstration, but it considers also all the interlocutor's subjective aspects. The study is supported by examples from a little corpus of transcribed real doctor-patient dialogues, collected and analyzed in a previous research work of the author. The research examines the principal arguments, argumentative figures and silences.

Key words

rhetorical-argumentative analysis, argumentation, doctor-patient communication, therapeutic advice, persuasive communication

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It is, then, established that rhetoric is not concerned with any single delimited kind of subject ... that its function is not persuasion. It is rather the detection of the persuasive aspects of each matter and this is in line with all other skills. (It is not the function of medicine to produce health but to bring the patient to the degree of well-being that is possible; for those that cannot attain to health can nevertheless be well looked after.)

Aristotle (*Rhetoric* 1355b 11-18)

1. Demonstration and argumentation in the doctor-patient relationship

The formulation of therapeutic advice is, in its tactful character, a daily practice of the physician and of the relation with his patient. It is the precious chance, for the expert, to use his/her competences to interact with the interlocutor's subjective world. The persuasive elements which enrich and empower scientific demonstration of this type of communication will be the subject of this paper.

First of all, we can find the origins of the deep relational – and thus discursive – change of doctor-patient relationship during the Enlightenment. This period brought rhetoric and medicine at the same time to be directed toward a common objective: the divulgation of information. This aim implies an increase in the typology of readers and in knowledge, which both characterized this time.

According to two Italian literary critics, Battistini and Raimondi (1990), on one hand rhetoric – after the seventeenth-century crisis, during which logic questioned its merely persuasive goal – became necessary again to the Enlightenment sciences and to a new audience. It was directed at the *miscere utile dulci* and to a new style: “*netto, chiaro, preciso, ma depurato della secchezza denotativa dei trattati scientifici, irti di formule algebriche e di figure sibilline*” [clean, clear, exact, but purified from the denotative dryness of the scientific treatises, bristling with algebraic formulas and sibylline figures] (Battistini and Raimondi 1990, 219-220).

On the other hand, for the first time medicine talks to an unqualified audience. In 1761 a doctor from the Montpellier school, S.A. Tissot, with his *Avis au peuple*

sur sa santé, needs to make people conscious of the most frequent contemporary illnesses, the symptoms through which to identify them and the advice about possible precautions to take. It's from works such as Tissot's and his colleague Venel's that the importance of the doctor-patient relationship begins to increase. The patient is suddenly provided with that basic knowledge, which was completely unknown to him before; therefore, from that time on, s/he sometimes feels up to discussing it with his/her doctor (Singy 2010). It follows that besides a scientific exactness, the physician needs now to consider the persuasive aspect of the dialogue, too.

Walton (1996) suggests different types of dialogue, considering that often an analysis can be understood only if "a dialectic shift, from one type of dialogue to another, is detected" (cited in Walton 1996). The doctor-patient dialogue may be considered at first an "expert consultation":

The expert consultation is a species of advice-giving dialogue. ... A familiar type of case is the type of physician-patient dialogue where a patient who is not very knowledgeable about medical matters goes to a physician for advice on how to deal with a particular problem in an area of medicine where this physician is a specialist. The physician bases his answers, and his questions, in this type of dialogue, on his knowledge base of the field, acquired from his studies and experience. Since the patient is not an expert, it may not be easy for him to extract the information he requires in order to make an intelligent decision about the best course of treatment for his special problem. And in fact the success of the treatment often depends significantly on the quality of the dialogue that takes place in this type of encounter. (Walton 1996, 192)

This type of dialogue has two main characteristics: it is asymmetric, since the expert's advice is based on specialized knowledge, offered to a layperson in that same field; secondly, it is collaborative (Walton 1996, 193). The assumed purpose is "decision for action" (Walton 1996, 190), which the doctor will express in the form of advice. This decision implies a "deliberation", i.e., a "long and careful consideration or discussion" (*Oxforddictionaries*, s.v. "deliberation", last cons. 05/12/2016). This deliberation needs to be expressed very frequently in persuasive form.

In fact, as Walton (1996, 188) says, persuasive dialogue should not be seen only as "eristic"; on the contrary, it can often be called "collaborative." As in political deliberation, the doctor needs thus the therapeutic power of persuasion. To assert that, we have now to mark the difference between demonstration and argumentation.

Perelman and Olbrechts-Tyteca ([1958] 2013, 14), authors of the famous *The New Rhetoric: A Treatise on Argumentation*, distinguished clearly the two processes at the beginning of their work:

When the demonstration of a proposition is in question, it is sufficient to indicate the processes by means of which the proposition can be obtained as the final expression of a deductive series,

which had its first elements provided by the constructor of the axiomatic system within which the demonstration is accomplished. ... But when it is a question of arguing, of using discourse to influence the intensity of an audience's adherence to certain theses, it is no longer possible to neglect completely, as irrelevancies, the psychological and social conditions in the absence of which argumentation would be pointless and without result. For all argumentation aims at gaining the adherence of minds, and, by this very fact, assumes the existence of an intellectual contact.

So doctor-patient dialogue cannot be based only on scientific demonstration, even though it is indisputable. The doctor with his words will certainly pay a constant attention to the audience in front of him. Let's suppose an exemplifying situation: a patient needs a certain medicine, but he does not want to take it because he is afraid of its side effects. Demonstrating the curative properties of the medicine won't be enough for the expert, in order to persuade the patient to change his idea; he will have to consider the patient's assumptions, if he wants to achieve an effective result. The argumentation then needs to be built starting from elements not organized in logical and linking sequences, but "*a fascio*" [as beam of light]: in this way, each element, independently, runs towards the same goal (Reboul [1991] 2013, 105). This is the basis of the persuasive effect and it's of primary importance for whoever is concerned with the result and, in this field, with healing, because "persuading surpasses convincing, since conviction is merely the first stage in progression toward action" (Perelman and Olbrechts-Tyteca [1958] 2013, 27). Actually persuasion, which since antiquity was the final aim of sectorial languages such as the political one, "*fidem facere et animos impellere*", i.e., beyond the rational conviction, moves the audience's or interlocutor's disposition (Desideri, 2011).

Argumentation and the importance of its effectiveness, to aid the therapeutic pathway projected by the doctor, must follow a first anamnesis phase. This first type of dialogue moment is in many cases reserved for the patient's narration. These stories would deserve a long specific description, since they are full of figurative language: metaphors, similes, personifications help the patient to describe to his interlocutor the terrible symptoms of the illness not yet identified. The literature about analysis of the medical narrations is currently abundantly reachable: in particular, there are recent studies linked to the American conceptual model of the Narrative-Based Medicine (NBM), developed by the medical anthropologist B. Good from the Harvard Medical School and R. Charon, director of the NBM Programme at the Columbia University. They see the narration moment and the linguistic characters of patients' stories as a way to enter in their own subjective world (Good 2006), as a chance "for respectful, empathic, and nourishing medical care" (Charon 2001).

In this first dialogue moment, the only rhetorical device which can be useful to the expert is the question, the principle instrument to cross the threshold of the mentally different and very delicate worlds of patients (Bert and Quadrino 2006, 151). Talking about this, two French linguists Anscombe and Ducrot (1981) observed how the question form could have an argumentative significance itself. In fact, different from the argumentative act, it may simply consist in directing the dialogue toward determined conclusions, excluding other ones at the same time. In these terms, the physician can select and examine the most necessary elements to his diagnosis and construction of therapeutic pathway. The collected elements will be added to the “beam” of arguments defined by Reboul ([1991] 2013, 105) and will give the opportunity to the expert to know, study and explore the interlocutor’s subjectivity, in order to be able to carry out the most apt argumentative strategy to persuade him, above and beyond the conviction to face his illness and his treatment.

Therefore, the arguments, more than *ad humanitatem*, i.e., oriented to an extended audience and to the research of a collective validity and agreement, will be overall *ad hominem*, i.e., grounded on a specific interlocutor’s point of view (Capaci e Licheri 2014, 58-59; cfr. Perelman and Olbrechts-Tyteca [1958] 2013, 119-120).

2. The rhetoric of therapeutic advice: the arguments

The observations reported here are based on a rhetorical-argumentative analysis of real consultations between two family doctors from Torino and their patients. Subject to agreement of the parties concerned, in 2005 some consultations were recorded. Recently, the author transcribed, respecting anonymity, a part of the collected material, selected in a random way. Every time doctor-patient dialogue is reported, it will refer to these consultations¹.

The term “consultation”, used for the doctor-patient consultation (in Latin, *consultatio*, *-onis*) suggests, from its intrinsic meaning, a request for an opinion, for advice. The physician, making a diagnosis and consequently giving advice on the best way to act for healing, often uses a powerful, argumentative dialectic.

If we analyze the *dispositio* dominant in the doctor-patient communication during therapeutic advice, we could suppose a *climax* order. Metaphorically a staircase, where the addition of elements and the contact with the patient’s world allow the doctor to persuade the latter gradually to follow the most convenient course of action.

1. The corpus is composed of 22 transcriptions, with a rhetorical-argumentative analysis and it was the main subject of the author’s degree thesis’ work, finished in 2016 (“La retorica dello iatros. Analisi retorico-argomentativa del dialogo medico-paziente”, Degree Thesis, supervisor Prof. Bruno Capaci, Bologna University).

Very often, after an initial phase of strengthening and clarification of the information received during the anamnesis moment, an action proposal follows. Such a proposal should be shared and accepted before any other suggestion. If the expert advice goes against the patient's idea, the dialogue and its order become a sort of negotiation (Walton 1996, 192; Bert and Quadrino 2006, 92-93), in which the physician is forced to climb the ladder very prudently.

In one example analyzed in the transcripts, a young man tells the doctor that, after many years, he is having panic attacks and fits of depression. He describes to the doctor his situation with difficulty and hesitancy. He declares he absolutely does not want to resort to medicines or consult a psychologist for help. On the contrary, he is convincing himself to make it on his own. At the beginning the family doctor pretends to agree with the patient's idea and he suggests trying to apply the same strategies the patient used during the last crisis, years before.

At the second step of argumentation the doctor says that if making it by oneself proves hard, there are still pharmacological supports or, with an attenuative litotes, "*persone che non necessariamente debbono deluderti*" [people who should not necessarily disappoint you], therefore neither should be excluded. The negotiation consists in placing, by the physician, an intermediate step between the patient's idea and the doctor's solution: the young man could feel free to talk to him about his problem, any time he needs to. This way of proceeding is defined by Perelman and Olbrechts-Tyteca ([1958] 2013, 282) "device of stages", which answer the question "What are you driving at?". They observe how usually it's better

[...] not to confront the interlocutor with the whole interval separating the existing situation from the ultimate end, but to divide the interval into sections, with stopping points along the way indicating partial ends whose realization does not provoke such a strong opposition. (Perelman and Olbrechts-Tyteca ([1958] 2013, 282)

In this particular situation the argumentation actually is successful: consequently, the patient lets himself go and he places confidence in his doctor, declaring himself at that point to be "*disarmato*" [unarmed] and unable indeed to manage it on his own.

The physician concludes the well-made communication, showing himself to be sympathetic toward the young man's embarrassment in talking about his problem, with an argument of reciprocity: even if this kind of problems may breed prejudice, it is so diffused that anyone could suffer from it like him ("*abbiamo tutti naturalmente*" [certainly we all have]).

In therapeutic advice, this argument of direction can become the so-called slippery slope argument, when – because of the importance of the situation and of the refusal by the patient to collaborate with his healing process – the doctor could

have no choice but to show a bleak future in order to persuade him. Assuming a gastroscopy was necessary for the patient, but that he wouldn't agree to it, he could be persuaded by the description of the serious risks he could face, if the condition was severe and not diagnosed in time.

As with the argument of direction, another type of argument directed toward action and frequently observed is the pragmatic one. The pragmatic argument, as Capaci and Licheri assert in *Non sia retorico!* (2014, 66), answers the question “*cui prodest*” and makes explicit the advantageous or otherwise scope of every action. It's important to be subjected to a certain medical examination, because only that can lead to the identification of the possible problem. In that case, it is obvious that this type of argumentation will be based on the interlocutors' agreement with the significance of the consequences (Perelman and Olbrechts-Tyteca [1958] 2013, 268).

As we observed, the search for agreement and discussion, from the Enlightenment on, brought about a shift from a categorical order, issued by the physician as holder of knowledge, to the consultation in the form of therapeutic advice. This no longer implies a unique and undisputed assertion by the doctor of his *auctoritas*. It is rather “conflict between *authorities*” (Perelman and Olbrechts-Tyteca [1958] 2013, 309), involving doctor's authority and other (usually fallacious) authorities.

A common obstacle in the present doctor-patient relationship is created by the fact that the patient, easily getting information from different sources, feels entitled to a self-diagnosis. How many times does a patient come into the surgery already worried about his health, because – as result of a careful research of his suspected disease on the Web or of a TV debate – he came to superficial yet catastrophic conclusions?

A real example from the corpus concerns a patient refusing to take a certain medicine, because he is frightened of the contraindications listed in the information leaflet. However, the media's rhetoric is totally different from the physician's, who has a personal relationship with his patient. It would be worth analyzing more deeply drug information leaflets (which often are characterized by terrifying *occupatio*).

The analyzed transcripts illustrate a dialectical progress of argumentation in such situations. In addition to his knowledge, the doctor needs to affirm his *ethos*, because he is the only one who really knows the patient's specific condition. In one of the analyzed dialogues, the doctor, to affirm his *ethos*, uses a popularization argument, which is nothing more than one of the forms that the argument of direction can take. In the discussed case, a patient comes to the doctor, because – having heard on the TV about the importance of the test concerning the prostate cancer risk – he wants to do it. The physician answers undermining the propagation

of this sort of information by the media. The matter of this test, he says, “*non è la storia che dicono e raccontano in televisione ... la televisione è il mondo delle ballerine*” [it is not the story said and told on television... the TV is the dancers’ world]. What is being contested is not the value of the test claimed by the patient, but the authority of the source.

In another example, a patient had heard, from the media again, an expert advising ex-smokers to do a specific radiological lung cancer examination. The doctor answers once more with slippery slope arguments. The aim is to alert the patient about the risk of the uncertain interpretation that this sort of test can offer. In this particular case, the physician uses an argument by comparison too, comparing the distant world of the media to an immediate first-hand experience, with a real example: he talks about the story of another patient of his, who did the same examination, which showed a “*macchiolina*” [speckle]. Since then he must repeat the test every six months and, reporting the hyperbolic doctor’s expression, “*ha smesso di vivere*” [he stopped living]. The subjectivity (for an in-depth discussion of the issue in the doctor-patient dialogue cfr. Bernabé, Benincasa and Danti 1998) typical of the therapeutic communication, changes the direction of argumentation from a more general perspective activated by the patient, to the one relevant for this individual patient himself. This is what the expert does, using the aforementioned expression: “*quindi a lei ... che già è una persona che ha diversi problemi ... se io faccio fare una TAC spirale ... ha smesso di vivere anche lei*” [so you ... who already are a person with a lot of problems ... if I prescribe a CT scan you stop living too].

Other frequent types of argumentation brought by patients are the fallacious ones, found in the so called apparent enthymeme. The enthymemes, or “the flesh and blood of proof,” quoting Aristotle (*Rhetoric* 1354a 16-17), are apparent when they present fallacious deductions, as we can see from one of the Greek philosopher’s examples: “And that since twice as much is unhealthy, not even the single amount is healthy” (Aristotle, *Rhetoric* 1401a 28-29).

Finally, another form of the argument from direction, very frequent in the analyzed texts, is the consolidation argument. It drives toward a very prudent acquisition of statement not already certain (Capaci e Licheri 2014, 63). According to what Cattani (2001, 182-187) writes in *Botta e risposta*, this argument may actually be a refusal to answer, based on the lack of elements; then it may often be used to protect patients from potentially useless alarms or worries.

2.1 The argumentative figures

The so called rhetorical figures are essential in argumentation, too. Perelman and Olbrechts-Tyteca ([1958] 2013) are interested in studying them not as a mere

stylistic ornament, but as a real persuasive instrument. From antiquity they have been recognized as “modes of expression which are different from the ordinary” (Perelman and Olbrechts-Tyteca [1958] 2013, 167). A figure may be defined “of style” only if integrated in a speech whose goal is the audience’s adherence; on the other hand “we consider a figure to be argumentative, if it brings about a change of perspective, and its use seems normal in relation to this new situation” (Perelman and Olbrechts-Tyteca [1958] 2013, 169).

Frequently the physician needs to be closer to the patient and for this reason he uses communion figures, such as the enallage of person. There are, in fact, many examples where the doctor supposes an action plan with his patient, where he’s acting with him, replacing the use of the second singular person with the first plural one. Expressions from the corpus such as “*andiamo a prenotare la TAC*” [let’s go to reserve CT scan] or “*non abbiamo lesioni vascolari di quelle importanti*” [we do not have serious vascular lesions] become somehow a “we can make it”, the arm which goes up the steps of the treatment with the patient. If we described the therapeutic pathway as a fight against the disease, the doctor then plays the role of his ally².

Very often some figures are used by the expert to supply the asymmetry typical of this dialogue, as we said before. The *commoratio*, for example, defined by Mortara Garavelli ([1988] 2012, 238-239) as a figure of amplification through addition, may clarify the meanings of some scientific terms, obscure to the patient. Through paraphrases, but also metaphors and similes the physician tries to bring the person in care closer to his own world, starting from the albeit incorrect and imaginative world of the patient and avoiding equivocations and misunderstandings (Bert e Quadrino 2006, 172). We can notice how often the expert sacrifices his more specific terminology for expressions used by his patient. So the neurinoma becomes “*l’affare*” [*the thing*], which “*continua ad aumentare di volume*” [keeps growing] and that “*a un certo punto ... tende a bloccare il liquido che sta dentro il cervello e dentro il midollo spinale che si chiama liquido cefalorachidiano*” [somehow ... may block the liquid inside the brain and inside the spinal cord, called cerebrospinal fluid].

3. Persuasion and silence during consultation

There is a further kind of communication, different from argumentation: one based on the unsaid, on gaps, on silence. Bice Mortara Garavelli (2015) in *Silenzi d’autore* shows us an *excursus* of silence in some Italian literature works, as does

2. Talking about the military language, in the disease narration it occurs not rarely the use of this type of metaphor, where the illness represents the enemy above all others. To Galvagni (2007) it is one of the most common, with the born-out metaphor. Sontag ([1979] 1992) underlines that too, even though she draws a moralistic-social reflection.

Gardini with other examples in *Lacuna* (2014). The latter asserts that in poetry usually “*la lacunosità spinge il lettore ... a dare fiducia al poeta*” [Deficiency induces the reader ... to trust the poet] (Gardini 2014, 54).

Starting from this statement, we can wonder if and when it could be true for the physician and if it could be beneficial or necessary to adopt some forms of silence in doctor-patient communication. In general, in therapeutic advice, the observation reports a predilection for *perspicuitas*, which aims at a totally clear and transparent discourse (Capaci and Licheri 2014, 149). In fact, the clearness of the conversation is one of the four conversational maxims of the British philosopher of language Paul Grice, who asserts that in a successful dialogue the interlocutors should cooperate: in quality, offering true information; in quantity, avoiding useless reticent or excessive forms; in relation, respecting the discursive relevance; and finally in manner, not being obscure or ambiguous (Serianni and Antonelli 2011, 100). Even Aristotle dealing with *perspicuitas*, said that persuading is “speaking not artificially but naturally” (Aristotle, *Rhetoric* 1404b 21).

It's often the patient himself who goes to the doctor and encourages him to be clear. In most cases, he is terrified of the idea of not identifying his pain with a precise name. Good (2006), who carried out research in Indonesia, studying the importance of subjectivity in doctor-patient communication, writes that giving a name to the origin of pain is the first step in patient world reconstruction and it holds the power to relieve it (Good 2006, 198). In other words, the patient feels more confident if the doctor shows himself to be sincere, or at least he dissimulates to be so.

The elocutionary clarity (to which, as we saw, other amplification figures, like *commoratio*, may contribute) does not exclude in fact the possibility of hiding silences, through dissimulation, without appearing obscure. Since silences and reticences may already be present in patients' narrations, because of their sense of shame or because they are unable to identify the key information for a diagnosis or to describe them, the *dissimulatio* may play a role even before the therapeutic advice moment. In this case, we could talk about a Socratic dissimulation: the doctor's pretense not to have the slightest idea about diagnosis yet, in order to increase the number of useful elements during this first listening moment or simply to examine more deeply the interlocutor's point of view. During the advice phase this process can be analyzed as a support of the consolidation arguments, for example when the doctor, although quite sure about his own diagnosis, wants to verify this hypothesis before worrying the patient without reason. It can be in the worst cases also the basis for the so-called “*bugie pietose*” [merciful lies] (Capaci 2014, 71), which spare the patient too cruel truths, according to the *detractio* principle.

In this sense, we can pay attention to the *loci* of quality, thinking of the hypothetical situation, where persons, who received a cancer diagnosis, must be subjected to rounds of chemotherapy. When they want to know what they would go through and their expectations, the doctor could decide not to tell them the whole truth, for example, replacing the *loci* of quantity (like the question: “Doctor, how long do I have?”) with the *loci* of quality (like the answer: “Now we have to think about the quality of life, Madame”). Talking about *loci* as “premises of a very general nature” (Perelman e Olbrechts-Tyteca [1958] 2013, 83), in doctor-patient dialogue we have to consider the existence of the *loci* of quantity, too.

For this reason, allow me a parenthesis about medical statistics, on which arguments are generally based. Given that the *loci* of quantity predicts the triumph of the collective consensus over minority opinions (Capaci e Licheri 2014, 124), in this sense statistics can be interpreted as a potential revision of this type of *loci*.

Another type of allusive expression is the euphemistic one. The euphemism recalls in an indirect manner the expressions of discourse or objects which the speaker does not want to make explicit and, for this reason, rhetorical figures as litotes or metaphorical circumlocution will help in that (Capaci 2016, 119-120). In the example analyzed before – that of the young man with panic attacks – we can observe that the physician calls (with a circumlocution) the psychologists, whose assistance the young man refuses, as persons who can help him. Risky operations are thus euphemistically defined as “*importanti*” [important] or “*impegnativi*” [heavy]. Interestingly, if we search for the word “*malattia*” [disease] in the little corpus of analysed transcriptions, it results paradoxically not very frequent, while “*problema*” [problem] is more used: “to solve a problem” appears instead of “to treat an illness”. Actually, the “disease” could be felt as identification, as a part of the patient himself, while “problem” could be conceived as something outside of him. “Illness” is an anomalous condition of our organism; conversely “problem” implies that it is just a query one has to answer. The doctor, who prefers to avoid repeating the name of the illness from which the patient is suffering (depression and panic attacks), uses the circumlocution “*questo genere di problemi*” [this kind of problems], as we can see in an example. It is obvious that this sort of described silence is allusive, words not so bitter, but in any case, both the interlocutors are aware of it.

At the same time, it could be analyzed how conversational gaps risk going against persuasion and efficacy of dialogue, when silences actually mean a lack of therapeutic advice because the physician’s opinion is hidden or not clearly expressed. For example, we can observe a *contrefision* used by the expert to a patient determined to undergo check-ups which the doctor does not deem necessary. Pretending to agree with the patient, he does not start to climb the ladder, as we saw at the

beginning, but, even if his opinion is quite clear, he fully gives to his interlocutor the possibility to demolish the created barrier so as to not to change his steps.

Francesca Piazza (2000) in *Il corpo della persuasione*, studying a passage from the *Rhetoric* by Aristotle, writes that the ways to be persuasive to the interlocutor and to interest him are not restricted to argumentation: outside of the discourse, there are other incisive elements, such as the way of acting (Piazza 2000, 143). So a part of the result of the dialogue may derive from the doctor's *action*. It may also depend on his way of observing, his attention towards patients telling their stories, substantially from how much his attitude will coincide or not with the words spoken.

To conclude, it is interesting to observe that Piazza (2000, 30-34) also writes about the way to proceed in medicine and rhetoric, studying a passage from the Hippocratic *De Aere aquis et locis* and the Aristotelian *Rhetoric*. She notices how both authors use the same Greek term indicating "single case." The first refers it to "every single case." from which the empirical scientific observation starts. The second one applies it to "every argument", i.e., "every argument", around which rhetoric detects the persuasive aspects, as main function of this art. Starting from this observation, Piazza (2000, 33) states that "*retorica e medicina condividono dunque, da un lato, la necessità di riferirsi al caso singolo ... e, dall'altro, il carattere congetturale della conoscenza su cui si basano, carattere che le espone al rischio del fallimento*" [so rhetoric and medicine share on one hand the necessity to treat a single case ... and, on the other hand, the conjectural character on which they are both based, a character which exposes them to a risk of failure].

4. Conclusions

This work aims to show that scientific demonstration needs argumentation, when the patient, as interlocutor in the dialogue, is involved in the decision-taking which concerns the proposed therapeutic pathway. Analyzing some examples of real transcribed dialogues, this paper highlights the most persuasive aspects in doctor-patient communication. In particular, the moment of the expert's advice is emphasized, when the physician talks. For space reasons, the patient's narrations, even if equally interesting, are not studied in detail. The analysis concerns arguments and argumentative figures, especially those used by the expert, which may create or not an efficacious therapeutic advice. Additionally, silence is examined in its persuasive form and in relation to its influence in this peculiar communicative context. In spite of the asymmetrical character of the doctor-patient dialogue, the studied corpus persuasion invites a collaborative way of taking decisions.

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