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REASONABLE EMOTIONS AND ARGUMENTATION

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Using keywords to analyze conflicts in doctor-patient consultations*

Sarah Bigi

Introduction

The present paper tackles the challenge posed by conflicts emerging in doctor-patient consultations.

Communicative exchanges situated in the medical setting – consultations in particular – have been closely studied in the last thirty years from many points of view. One of the most important issues in the study of these communicative exchanges has been the asymmetry of roles between patients and doctors, which often causes misunderstandings, incomprehension, poor patient compliance and low satisfaction on both sides.

Such conflicts have often been studied from the point of view of the power relations generating them, more seldom looking at the communicative structure of the interaction itself and at its internal dynamics. The present paper focuses in particular on the argumentative structure of certain crucial parts of the consultation – namely the ones of patient education and counseling (Roter & Hall 2006) – in order to describe a heuristic strategy – keywords and key expressions – that can be used to understand the origin of the conflict[1].

The paper is structured as follows: the first paragraph presents a description of the communication context of doctor-patient consultations along the lines of the model of communication contexts proposed in Rigotti & Rocci (2006a). This is functional to the identification of the relevant factors influencing the communicative exchanges between doctors and patients during the consultation. The second paragraph focuses on the notion of conflict, describing the types of conflicts that can arise during a medical consultation. Building on the first two paragraphs, the third one discusses in which sense keywords and key expressions can be viewed as strategies of conflict detection and management. The fourth paragraph offers an example of analysis from a real life consultation. The last paragraph is devoted to some concluding remarks.

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[1] The concept of *conflict* in this context is not intended in the common sense of *argument*, but of difference of opinion, which is not disruptive *per se* but can become so if it is not properly managed (Greco-Morasso 2008).

1. *The communication context of doctor-patient consultations*

In order to better understand the strategies used in certain verbal interactions, it is most useful to view the interaction in its specific context.

The communication context of a medical consultation can be fruitfully described by following the model proposed in Rigotti & Rocci (2006a)[2]. This model foresees two main components in any context of communication: an institutional and an interpersonal one.

As for the institutional component, any interaction needs to be observed in its *interaction field*, "the place of *social reality* where the interaction takes place" (Rigotti & Rocci 2006a: 172).

An interaction field is defined by the goal the participants in the interaction share: in the medical setting, the main shared goals are to understand what kind of illness affects the patient, to find a solution for it, and to involve the patient in the therapeutic process[3]. The shared goal is also what defines commitments and social roles of both subjects. In the case of the medical setting: it is in order to achieve the shared goals that subjects "play the roles" of patients, doctors or other personnel. A role carries with it commitments which may be more or less codified. In the case of doctors, the basic commitments are often explicitly stated in a deontological code whereas patients' commitments are more implicit, the basic one being to cooperate with doctors, i.e. follow their lead. Whether this had better be a passive or active obedience is what is being discussed in the contemporary debate on doctor-patient relationship.

Within an interaction field, it is also relevant to identify the *interaction schemes*, which are more or less conventionalized "scripts" that need to be followed in order to interact in a specific field. These interaction schemes "select" the dialogue games relevant to the goal, they determine the speech acts chosen and their arrangement. The typical interaction schemes enacted during doctor-patient consultations are *problem-solving* and *decision making*, but also, among others, *advisory*, *negotiation*, *mediation*.

The description given so far of the communication context needs to be implemented by real subjects in order for it to generate actual roles and *communicative flows* connecting them. The literature on doctor-patient consultations has identified the main communicative flows present in this kind of interaction: question asking, information giving, suggest-

[2] On the relevance of this model for the description and analysis of interactions in the medical setting, see also Bigi (forthcoming).

[3] "Solution" is intended here in a broad sense, including the cases of chronic illnesses for which no cure is possible and a doctor's role is mainly to make the patient's life bearable. In the words of one of the first advocates of "patient-centered medicine": "In practical terms the doctor's tasks are, first, to find out *how* and *what* the patient is or has been feeling and experiencing; then to formulate explanations (hypotheses) for the patient's feelings and experiences (the "why" and the "what for"); to engage the patient's participation in further clinical and laboratory studies to test such hypotheses; and, finally, to elicit the patient's cooperation in activities aimed to alleviate distress and/or correct underlying derangements that may be contributing to distress or disability. The patient's tasks and responsibilities complement those of the physician." (Engel 1980: 536).

ing, giving opinion, showing solidarity (Roter & Hall 2006: 118). Once more it is the shared goal that contributes to the organization of the communicative flows in more or less institutionalized structures. The medical consultation has been shown to display certain recurrent phases, which are functional to the attainment of the shared goal. They are: the opening, the history, the physical examination, patient education and counseling, and the closing. The main purpose of the opening is the expression of the chief complaint and of the reason for the patient going to see the doctor. This phase is concluded when the doctor directs the patient toward the history segment. The physical examination phase is followed by the moment of patient education and counseling, in which explanation of the symptoms is given and suggestions for treatment are put forward. The closing has been shown to be the moment when patients tend to express more emotionally charged concerns, if they haven't been given time enough to express them during the opening. This phase appears to be revealing of the general quality of the interaction: if the physician has been responsive from the very beginning, no new concerns are brought up in the closing phase (Roter & Hall 2006: 113-116).

With regard to the interpersonal component of context, it is particularly relevant for doctor-patient consultations, as it can have a very strong influence on the attainment of the shared goal. Numerous studies claim that there exists a direct relation between the quality of the relationship between doctor and patient and patients' outcomes and satisfaction. The construction of a good relationship is also acknowledged among the aims of the medical consultation (Moja & Vegni 2000). The ways through which this good relationship should be constructed are often made to coincide with various communication skills, aimed at putting the patient at ease, making them feel cared for and listened to. In Rigotti & Rocci (2006a) this level of the interaction is described within the interpersonal dimension of the context and referred to as *solidarity*, which can be of two types. One type is the solidarity achieved within personal relations, the other is the one obtained in goal-oriented interactions, and which is functional to achieving the shared goal of the interagents. A feature that characterizes medical consultations is the intertwining of the two types of solidarity: actual trust between doctors and patients has been shown to deeply affect the quality of the goal-oriented level of their relationship.

One of the most effective ways of achieving both types of solidarity is the sharing of a *common ground*. Following Clark (1996), common ground corresponds to what is thought to be shared knowledge by two or more participants in a joint activity. This approach to common ground is embedded within a theory of joint activities and joint actions, in which one crucial point is the achievement of coordination among the expectations of the participants in the interaction. The participants assume the existence of a certain common ground between them on the grounds of certain shared bases; of course, if their assumptions are wrong and there is no actual common ground between them, coordination problems may arise. In other words, the expectations of the participants regarding the actions that will be taken by the others are not coordinated (Clark 1996: 62-81).

A medical consultation may well be considered a joint activity composed of single joint actions, which need to be coordinated in order to attain the final shared goal. Generally, there is one participant (the doctor) who is leading the interaction as for the phases it is composed of. The patient usually follows the doctor's lead regarding "what to do next" in terms of opening, history, physical examination, patient education and counselling, closing (Roter & Hall 2006: 112)[4]. In this sense, the medical consultation is a quite conventionalised joint activity.

Still, it is often the case that during a consultation there happen to be no shared bases, i.e. the participants have different assumptions on what is common ground between them. The patient may not be expecting the doctor to formulate a certain diagnosis or to suggest a certain kind of therapy; the patient may also be scared or worried by what the doctor tells him and imagine a scenario that is distant both from actual reality and from what the doctor had in mind. The doctor may expect the patient to know things he actually doesn't know (Levenstein *et al.* 1986).

If these situations occur, the consequences are most generally misunderstandings, poor compliance, low patient satisfaction, and, in the worst cases, the interruption of the relationship[5].

2. *Conflicts in doctor-patient consultations*

As shown in Greco-Morasso (2008), conflicts can be of two types. Conflicts of the first type (C1) occur when the struggle between two or more human subjects is characterized by hostility and by the attempt to eliminate one's adversary. Conflicts of the second type instead (C2) are defined as propositional incompatibilities, i.e. as incompatibilities of positions or goals.

C2 conflicts are the ones that may arise within any interaction, due to the differences and asymmetries which lie at the origin of any communicative interaction. In doctor-patient consultations, conflicts of this kind may occur especially because of the relevant asymmetry characterizing the relationship between the two. This asymmetry can be of two types:

[4] It is necessary to draw a distinction between *communicative flows* and *phases* of the consultation. Whereas the communicative flows depend on "what the speaker wants to do to the addressee with his/her utterances" according to the different roles of the participants in the interaction and consist in the verbal side of the joint actions which are building up to form the joint activity, the phases of the consultation correspond to the conventional steps taken together by doctor and patient in order to achieve the shared goal (which is not communicative in nature, but consists of an action). So phases include communicative flows, but not vice versa. Byrne & Long's (1976) famous classification used to distinguish six main phases: 1. relating to the patient; 2. discovering the reason for attendance; 3. conducting a verbal or physical examination or both; 4. consideration of the patient's condition; 5. detailing treatment or further investigation; 6. terminating.

[5] With regard to the issue of knowledge and power asymmetry in the medical consultation as the cause of conflicts and misunderstandings, see among others: Todd (1989); Beisecker (1990); Beisecker & Beisecker (1993); Ainsworth-Vaugh (1998); Thesen (2005); Irwin & Richardson (2006) and the references therein cited.

of knowledge or of skills and competences. The most recent literature on doctor-patient consultations tends to consider this asymmetry both from the point of view of the doctor and of the patient. In other words, while the doctor is the expert in the medical field and has the skills to solve health problems, patients are considered to be experts "of themselves", i.e. they are the only ones to know their own feelings, perceptions, fears regarding the illness (Stewart *et al.* 2003)[6].

Within the consultation, conflicts tend to arise basically for two reasons: doctor and patient do not agree on the diagnosis, i.e. they do not share the same beliefs regarding a certain part of reality; doctor and patient do not agree on the therapy, i.e. they do not share the same opinion on the course of action to take. The assumption regarding doctor-patient consultations is that in any case the participants share at least the main goal, i.e. to agree on a solution to the patient's health problem.

Table I shows the basic types of conflicts that can arise during doctor-patient consultations, related to the diagnosis or to the therapy.

Diagnosis-related conflicts (conflicting beliefs regarding a certain part of reality)	1. incompatibility of beliefs (lay diagnosis: patients' beliefs derive from non-expert ideas on the disease and may be incompatible with doctors' beliefs); 2. difference of beliefs (alternative diagnosis: patients' beliefs derive from their personal experience and may be integrated with doctors' beliefs); 3. no coordination of expectations (patients do not accept the diagnosis).
Therapy-related conflicts (conflicting beliefs regarding the course of action to take)	1. patients put forward an alternative therapy because of: a) distrust for certain treatments (health (il)literacy); b) personal history of negative side-effects (patient "expert of himself"); 2. non acceptance of therapy (non compliance).

Table I: *Basic types of conflicts in doctor-patient interactions*

In order for conflicts not to escalate and reach the point of jeopardizing the existence of the relationship itself, the participants are faced with the problem of coordinating their mutual expectations. Expectations reside in the common ground, i.e. they depend on the participants' knowledge of reality, and are influenced by a subject's interests and desires. In order to coordinate them and prevent them from clashing, there is the need for a coordination device able to operate at these different levels: interpersonal and institutional.

[6] This reading of the situation solves the problem only partially as the challenges posed by asymmetry are set momentarily aside. The idea of an encounter between peers though may entail a risk, i.e. to overlook the fact that the asymmetry derives not only from doctors' competences, but also from the social role "designed" for them by the institutional structure in which the encounter is set. From this point of view, the patient can hardly be considered the doctor's peer, and in order to level this asymmetry the creation of a whole new institutional framework should be considered. An alternative way might be to reconsider the assumption that interpersonal or social asymmetry is intrinsically negative.

Also the phase of the consultation in which conflicts are more likely to emerge is important. Following the classification of phases within the consultation in Roter & Hall (2006), "patient education and counseling" is the moment when conflicts that are most difficult to manage generally arise. In fact, it is in this phase that doctors express their opinion both on diagnosis and therapy, and the moment when different expectations or gaps in the participants' common ground are more likely to come to light.

It is important to keep in mind the essentially argumentative nature of this phase of the consultation: any strategy devised to cope with conflicts at this stage of the interaction will have to be attuned to the persuasive dynamics underlying the discourse.

3. *Keywords and key expressions as conflict indicators*

In what could be defined as the core description of keywords and key expressions, they are considered as *relevant* and *pivotal* words within texts, words that reveal certain ideas, values, ways of thinking, and that are emotionally *loaded* (Firth 1958; Williams 1985; Wierzbicka 1997; Bennet et al. 2005; Bigi 2006).

The first two features – relevance and the property of being pivotal – usually indicate words that occupy a central position within the lexical fields present in the text. The latter features – the property of being revealing and loaded – are suggestive of words carrying particular connotations.

In the context of the present paper, the notion of connotation can be understood as the property of triggering inferences linked to premises (values or ideas) that are relevant for the participants in the interaction[7].

The idea of *relevant premises* refers to sets of information present in the common ground that are felt as *interesting* by the subjects involved in the communication. The dimension of interest involves both the personal common ground of the interagents (*interesting*, in the sense of something that has to do with one's life and that can influence it), and the attainment of the shared goal that defines the joint activity in which the subjects are participants (*interesting*, in the sense of something that allows someone to attain the goal that led them into the interaction in the first place).

The ability to *trigger inferences* means that, by referring to relevant premises in the interagents' common ground, keywords and key expressions evoke certain scenarios or frames, which can be considered as cognitive resources through which people interpret and organise reality (Fillmore 2006). They are also the structures through which the interagents' deepest premises are categorized (Greco-Morasso, forthcoming).

In this context, it is possible to understand keywords as words or expressions having the main property of triggering inferences from sets of information present in the common ground that 1. interest the subjects involved in the communication and 2. are relevant for

[7] On connotation, see Rigotti & Rocci (2005).

the achievement of the shared goal that defines the joint activity in which the subjects are participants.

It is in this sense that they can become *conflict-indicators*: by their identification it is possible to outline the frame or scenario they evoke. When the outlined scenarios appear to be incompatible, then it will be easier to understand the origin of the conflict.

4. *An example from a real life consultation*

In this paragraph, the hypothesis outlined this far is tested on a consultation in the oncological setting[8]. The chosen medical consultation takes place in the oncologist's office, set within the structure of an Italian public hospital. The participants in the consultation are two women doctors, and a married couple. The patient is the husband and both he and his wife – who is accompanying him – are in their seventies.

The patient has come to see the doctor three months after undergoing a biopsy to ascertain the nature of a lump growing close to his lungs. What he needs to discuss with the doctors are the results of the new exams he has had, which were supposed to show more clearly the nature of the lump. Unfortunately it is still unclear whether the lump is a malignant tumor or not. However it has grown a little and the doctors argue in favour of doing more exams at once instead of waiting another three months.

The *shared goal* between the participants in the interaction is to understand precisely what the patient is affected by in order to suggest a proper treatment. Accordingly, the main *interaction scheme* is problem solving, which is argumentative in nature. A subordinate interaction scheme is decision making.

The analysis focuses on the part of the consultation in which the doctor argues for the necessity of having more exams done immediately.

The coordination problem the doctor is faced with is to obtain the patient's agreement on this course of action without scaring him and making it acceptable to him that the diagnosis is still not clear.

First of all, the relevant extract from the analyzed consultation is presented[9]:

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[8] This consultation was taken from the Archive of Videorecordings of Medical Consultations of the Università degli Studi in Milan.

[9] M = doctor; P1 = husband (the patient); P2 = the wife. The conventions for the transcription follow Traverso (1999):
[interruption and overlapping;
= turns following one another with no interruption;
(.) pause of one second or less;
↑ rising intonation (questions);
/ slightly rising intonation (suspension);
↓ falling intonation (exclamations).

[...]

46 M: vediamo un attimo questa TAC perché lei avrà letto il referto: magari non ha capito perché
let's have a look at this CAT scan because you may have read the report. Maybe you didn't understand it because
47 c'erano delle parole un po' difficili (.) però: quello che si vede: sa che [dovevamo ricontrollare
there were some difficult terms. Anyway what can be seen... you know we had to check again
48 P2: [sì sì
yes, yes
49 M: quel chiamiamolo nodulino che c'era qui in mezzo nello spazio [tra i due polmoni
that, let's call it a little lump, that was here in the middle in between... between the lungs
50 P2: [sì quello me lo ricordo/
yes I do remember that
51 M: e dove non abbiam/ non si è mai capito bene: da che cosa è fatto quel nodulo tant'è che ha
and where we didn't... we never really understood what that lump was made of and that's why you
52 provato a fare anche la broncoscopia per prenderne un pezzo e [farlo analizzare
had to undergo bronchoscopy to take a sample from it and have it analyzed
53 P1: [sì sì
yes, yes
54 M: però quel campione lì tirato via non ha trovato cellule cattive non ha trovato cellule tumorali
but that sample didn't show any bad guys, didn't show any cancer cells
55 per cui anche d'accordo con i chirurghi toracici cioè quelli che tagliano s'era detto facciamo un
so in agreement with our thoracic surgeons, the people who operate, we said let's have
56 controllo della TAC a tre mesi [e vediamo/
a look at the CAT scan after three months and we'll see
57 P1, P2: [sì sì
yes, yes
58 M: visto anche il suo impegno con il cuore queste cose: se è indispensabile fare altri
considered your heart condition, these things... if it's really necessary to have other
59 accertamenti [o basta
exams or if it's enough
60 P1, P2: [sì sì
yes, yes
61 M: questa TAC fa vedere che **è un po' cresciuto** quel nodulo lì (.) non tantissimo: vuol dire che
this CAT scan shows that lump ***has grown a bit****. Not that much, which means*
62 prima misurava due centimetri e mezzo per un centimetro e mezzo (.) adesso è due centimetri e
it used to be 2.5 by 1.5 centimetres, now it's 2.5,
63 mezzo è sempre uguale per tre (.) cioè nell'altra dimensione **è un po' cresciuto** (.) questa è una
the same, by 3... that it ***has grown a bit*** *on one side... this is something*
64 cosa che tanto tanto tranquilli non ci lascia il fatto che **sia cresciuto un po'** [...] è questa pallina
slightly bothering for us... the fact that it ***has grown a little*** *[...] it's this little*
65 grigia qua vede↑
grey spot here see?
66 P1: sì
yes

67 M: questo nodulino qua più grigio rispetto a=
this little lump here a little darker than...
68 P1: =vicino a dov'è↑
and it is close to what?
69 M: è vicino: al [cuore
it's close to the heart
70 P1: [ah/
oh
71 M: non non così non è attaccato al cuore però come zona è qua in mezzo vicino a dove ci sono le
not, not that very close to the heart, but the area is the one close to the
72 arterie che vanno ai polmoni (.) che poi hanno fatto anche qua: l'ingrandimento
arteries going to the lungs. You see, they also made an enlargement here...
73 (*i medici parlano tra loro sottovoce*)
(doctors whisper something to each other)
74 M: stiamo [ragionando perché
we are thinking about it because...
75 P1, P2: [sì sì sì
yes yes
76 M: così come non abbiam capito l'altra volta che cos'era questo tessuto non è che adesso: sia
same as last time when we didn't understand what this tissue was, this time it still isn't
77 chiaro=
clear
78 P2: =non è chiaro ancora↑
it's not clear yet?
79 M: no (.) però quello che è più chiaro rispetto a prima è che è una cosa che **è cresciuta** e che
no, but it is clear that since last time this thing ***has grown*** *and this*
80 quindi ci motiva di più nel fare altri accertamenti (.) che **se fosse rimasto uguale** uno avrebbe
gives us more reasons to further examine it. ***If it had been the same*** *we would*
81 detto/ [va bè
have said... well...
82 P2: [sì
yes
83 M: lo ricontrolliamo tra sei mesi: niente/ siccome **è ulteriormente cresciuto** rispetto a novembre
we can check it in six months, ok. since ***it's grown*** *since November,*
84 **non cose catastrofiche** eh: per carità però: **è comunque un po' cresciuto** (.) per cui questo
nothing alarming, *I mean... but* ***anyway it has grown a little****... so this*
85 merita di fare qualche piccolo accertamentino in più (.)
deserves some little examination still

[...]

The argumentation stage (van Eemeren & Grootendorst 2004), in which arguments are put forward supporting or casting doubt on a standpoint, begins at line 61, when the doctor puts forward her first and strongest argument: the lump has grown a bit (*il nodulo è un po' cresciuto*). This argument is repeated at lines 63, 64, 79, 80, 83, 84.

The doctor's standpoint appears at lines 80 and 85: we have reasons to further analyze this lump (*ci motiva di più nel fare altri accertamenti; questo merita qualche altro accertamentino in più*). Only once does the doctor express the second reason for having further exams: we still don't know what the lump is (*non è che adesso sia chiaro*) (lines 76-77).

The conflict the doctor needs to prevent is at the same time on the level of the interpersonal relation and related to the achievement of the shared goal. On the one hand, the fact of not being able to formulate a precise diagnosis could diminish the patient's trust in the doctor's abilities. The patient could begin to feel unsure, not trust the doctor anymore and perhaps not follow her therapeutic suggestions. What is more, the patient could start focusing on the uncertainty of the situation, which would be likely to induce him to think of the terrible implications of a cancer diagnosis. In such a context, an uncertain diagnosis is more likely to leave room for despair than for hope. On the other hand, it is necessary for the patient to agree with the doctor's suggestion to have further exams, thus he must somehow perceive the urgency of the situation.

In the previous paragraph keywords have been described as words or expressions having the main property of triggering inferences from sets of information present in the common ground that 1. interest the subjects involved in the communication and 2. are relevant for the achievement of the shared goal that defines the joint activity in which the subjects are participants.

The key expressions (in bold in the text) reword in different ways the fact that the lump has grown, at the same time mitigating this information by the use of adverbs (*ulteriormente*), adverbial phrases (*un po'*) and a diminutive (*accertamentino*) (Caffi 2007). According to the description given in the previous paragraph, the ones in bold can be considered as key expressions for the relevance of the inferences they trigger – or of the scenarios they evoke – both at the interpersonal and institutional level. The scenario evoked by the doctor is one in which an (unknown) object has unexpectedly grown. This image is implicitly linked to the following argument: tumors generally grow, this lump has grown, this could be a tumor. In order to prevent the patient from panicking (coordination at the institutional level: to achieve the shared goal the patient's cooperation is needed), the doctor's words merely evoke this reasoning focusing only on the concept of *unexpected growth*. For the same reason this concept is expressed with mitigated forms. The second, but more relevant, reason for doing more exams is that the nature of the lump is still unknown. Stressing this could impinge on the patient's perception of the doctor's authority, thus affecting the interpersonal level of the interaction. For this reason the doctor only briefly mentions the fact once and does not come back to it during the course of the whole consultation.

This strategy aims at coordinating the patient's expectations with the doctor's, by finding a balance between the need to tell the truth and the need to prevent the patient from panicking. Also, it is likely that the patient would have come to the doctor expecting to have a diagnosis and a therapy. This expectation needs to be adjusted to the fact that no certain diagnosis is possible yet.

The chosen keywords evoke a scenario in which something unknown is growing and this is referred to as a risk, thus the nature of the growing object must be ascertained. This scenario is likely to belong to the common ground of both doctor and patient, to interest both doctor and patient and to be relevant for the achievement of the shared goal of finding a solution for the patient's illness[10].

It is not by accident that in this passage the keywords and key expressions coincide with the wording of the argument used to support the doctor's standpoint. This is due to the persuasive aim and argumentative structure of the passage. The way keywords and key expressions evoke scenarios or frames is closely linked to the kind of text they appear in. In a persuasive text, this will happen in accordance with the text's argumentative structure, which originates from the relations between a standpoint and the arguments used to support (or cast doubt on) it. The arguments are generated by corresponding argumentative *loci*, "templates" providing the general inferential structure of which each specific argument is an instantiation (Rigotti 2006). Each *locus* predefines certain possible inferential relations between standpoints and arguments. Thus each *locus* can be seen as representing reality in a certain way. In other words, *loci* can be considered too as frames, of an inferential kind. It is likely that keywords in a persuasive text, as is the passage analyzed in this paper, will coincide with the words evoking these frames, i.e. with the words referring to the *locus* the argument is generated by.

5. *Concluding remarks*

This paper addressed the issue of the analysis of conflicts in doctor-patient consultations by means of the identification of keywords and key expressions. This perspective seems to offer insights at various levels.

The description of the types of conflicts that can arise during doctor-patient interactions, merely drafted in the second paragraph, surely deserves further study. Indeed among the most problematic issues regarding doctor-patient interactions, noncompliance remains one of the most difficult to clarify. To interpret it as a latent conflict of beliefs opens up new possible lines of research that can be followed in order to understand this phenomenon. One of these lines is the one adopted in this paper, where keywords are used as conflict indicators pointing at implicit conceptual frames. The analysis proposed here is simply meant to exemplify this hypothesis; a larger research project is underway to test it on a much bigger number of consultations.

The use of keywords and key expressions is not a matter of lexical choice simply at a stylistic level: rather it has to do with the choice of particular lexical items that closely relate

[10] It is also interesting to observe here that the use of keywords as coordinating devices in the argumentative phase of the consultation leads to an explicit agreement in the concluding phase, thus constituting an example of synergy between different coordination devices (Clark 1996).

to the institutional setting of the interaction, to the common ground between the participants, to their mutual commitments and expectations, and to the shared goal in the interaction. If considered in a cognitive perspective, a further line of research could inquire more deeply into the connections between keywords and semantic frames (Fillmore 2006); the same could be done from an argumentative perspective, verifying the possibility to consider keywords and key expressions as cases of strategic manoeuvering (van Eemeren & Houtlosser 2006).

The description of the communication context along the lines of the model designed in Rigotti & Rocci (2006a) allows to account for features described in studies conducted within the medical sciences. Thus it appears to be a sufficiently flexible model, and one that could be fruitfully employed to integrate in a coherent framework the various features characterizing interactions in the medical setting.

Also the connection between keywords and argumentative *loci* deserves to be further pursued. Explaining its dynamics in more detail could benefit current research on keywords by providing an objective method for the identification of keywords at the textual level. Moreover, it could yield useful observations for the training of clinicians: which are the most adequate *loci* to use in relation to certain typical issues emerging during a consultation? is there any correlation between certain *loci* and the phases of consultations? which are the margins for non-institutionalized talk in doctor-patient interactions? can the use of keywords be turned into a tool that can be taught to clinicians during their training?

These questions also pave the way for issues of a completely different nature: should clinicians' training in communication only be focused on skills, or should communication skills be set within a broader perspective on doctor-patient relationship? This leads to the problem of asymmetry, briefly touched upon in this paper, but deserving to be discussed more thoroughly: is it possible (or necessary) to balance social asymmetry? is it possible to do so merely by exploiting certain abilities in verbal communication? Teaching clinicians to give patients the impression of being empathic with them, but not training them to consider their social role properly hides a very dangerous risk: that clinicians will learn the 'tricks' of empathic communication, but maintain the asymmetric attitude in their behavior. This is sure to jeopardize the construction of solidarity between doctors and patients, as the latter realize the lack of consistency between clinicians' words and their actions. Therefore, a further point on which communication sciences could integrate research on communication in the medical setting is the construction of *ethos* in discourse.

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