Getting the vaccine now will protect you in the future! A pragma-dialectical analysis of strategic maneuvering with pragmatic argumentation in health brochures

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CHAPTER 2

Institutional preconditions for strategic maneuvering in health brochures

2.1 Introduction

In the extended pragma-dialectical theory, it is assumed that the type of interaction in which an argumentative exchange takes place influences the manner in which the argumentative discourse manifests itself (van Eemeren & Houtlosser 2005). The institutional conventions governing the type of interaction affect what strategic maneuvers are allowed and in what ways the maneuvers are performed. In this chapter, the focus is placed on the conventions applying to communication in the institutional context of advisory health brochures. The institutional context is described on the basis of the concept of the *argumentative activity type* (van Eemeren & Houtlosser 2005), which is a more or less institutionalized type of activity in which argumentation plays a crucial role. In order to explain the choices for pragmatic argumentation and a specific design of pragmatic argumentation in the context of advisory health brochures, the chapter examines how institutional preconditions affect the strategic maneuvering in this particular activity type.

Section 2.2 discusses the institutional point of advisory health brochures. In Section 2.3, a description is given of the institutional conventions governing the argumentative practice of advisory health brochures. Section 2.4 provides a characterization of advisory health brochures as a particular argumentative activity type. In Section 2.5, the focus moves to the preconditions for strategic maneuvering in the argumentation stage of health brochures. Section 2.6 provides the conclusion.

2.2 The institutional point of health brochures

To examine health brochures from an argumentative perspective, it is necessary to consider the macro context in which the communication takes place. According to van Eemeren and Houtlosser (2005), argumentative practices take place in settings that are more or less institutionalized, in the sense that specific conventions

apply, regulating argumentative exchanges in that context. Levinson (1992) used the term *activity type* to refer to rule-governed, institutionalized settings of communication. To be able to systematically describe the argumentative dimension of particular practices, van Eemeren and Houtlosser (2005) introduced the concept of *argumentative activity type*, to distinguish between particular institutionalized communicative practices in which argumentation plays a prominent role.

In the extended pragma-dialectical theory, it is assumed that arguers engaged in an argumentative discussion, in any argumentative practice, try to achieve both dialectical and rhetorical objectives. Accordingly, in all argumentative activity types, arguers maneuver strategically to reconcile their dialectical aim, that of resolving the difference of opinion in accordance with the dialectical norms of reasonableness, with their rhetorical aim of having the discussion decided in their favor (van Eemeren & Houtlosser 2002). The strategic maneuvering that takes place in argumentative reality is affected by the type of activity discussants are engaged in. The conventions pertaining to particular institutionalized activities constrain the argumentative discourse in that context. The constraints on the discourse establish preconditions for strategic maneuvering in the sense that they create particular opportunities for and limitations on strategic maneuvers. The type of interaction or activity influences what kind of standpoints may be under discussion, which arguers will participate in the discussion, which means they use to reach their dialectical and rhetorical goals, and what rules the arguers must comply with (van Eemeren & Houtlosser 2002, 2005; van Eemeren 2010). For example, in her account of strategic maneuvering in the activity type of Prime Minister's Question Time, Mohammed observes that the strategic maneuvering is shaped by the precondition that the exchange should take place in the form of a question-answer sequence (Mohammed 2009: 76).

Van Eemeren (2010: 129) argues that communicative practices, such as Prime Minister's Question time, a doctor's consultation or an advertisement, are usually associated with particular institutional contexts, or domains, and serve a specific purpose within that context in realizing the institutional point of the activity. Health brochures can be seen as a communicative practice taking place within the *medical* domain. Other domains are legal communication, political communication, interpersonal communication and commercial communication (van Eemeren 2010). Within each of these contexts, certain communicative practices have been developed that are conventionalized in accordance with the exigencies of the institution (van Eemeren 2010: 129-130).[1]

1 For example, in the political domain, the institutional point is to preserve a democratic political culture by means of deliberation. The institutional goal of the activity type of Prime Minister's Question time belonging to this domain is to hold the Prime Minister to account for his government's policies in accordance with the conventions and regulations such as the House of Commons Rulings from the Chair (van Eemeren 2010: 141).

The institutional point, or rationale, of the activities in the medical domain in general is to address and solve health problems that exist among the population. The World Health Organization (WHO), a leading authority in this field, describes its goals as follows: "To improve equity in health, reduce health risks, promote healthy lifestyles and settings, and respond to the underlying determinants of health" (WHO website; WHO 2007). Since the medical field attends to all aspects of both people's physical and mental wellbeing, the scope of medical communication is very broad and the parties involved comprise a wide variety of institutions, non-profit organizations, commercial players and individual consumers and patients. The US National Cancer Institute describes health communication as a tool for promoting or improving health. In its health program guide, the institute argues that health communication can effect change among individuals, groups and society as a whole. It can influence people's perceptions, beliefs, and attitudes that may change social norms, it can prompt action, reinforce knowledge, attitudes, or behavior, show the benefit of behavior change, and refute myths and misconceptions (NCI 2008: 3-4).

Within the medical domain, different communicative practices have been developed to realize the institutional point in a specific way. Beside the health brochure, examples of communicative activities in the medical domain include a visit to the doctor or the package leaflet. In each activity type in the medical domain, a specific *genre* is implemented in order to realize the relevant institutional point. A predominant genre that is instrumental in fulfilling the institutional needs in this domain is the genre of *consultation* (van Eemeren 2010: 143).[2] Advisory health brochures can be considered as a particular communicative activity type, in which the genre of consultation is implemented to address health issues. Other examples of activity types making use of the same genre include the doctor's consultation and a medical ad (van Eemeren 2010: 143). These types of activity all involve professional medical advice towards a lay person. In that sense, they differ from activity types that one could identify in the same domain in which other genres are implemented (e.g. talk between doctors in the surgery room). The concrete representations of these communicative activity types in reality are referred to as *speech events* (van Eemeren 2010: 139). For example, the British brochure that was introduced in Chapter 1 with advice about eating fruit, called '5 a day', is a particular speech event, which is an instantiation of the argumentative activity type of the advisory health brochure.

2 Other genres that can be implemented in communicative activity types are mediation, adjudication, negotiation, communion, and promotion (van Eemeren 2010: 139).

2.3 The institutional conventions of advisory health brochures

The advisory health brochure can be considered as a particular type of activity within the medical domain, which is governed by specific institutional conventions. One characteristic of advisory health brochures is that they are short texts distributed among the general public by official institutions to help lay people to make the necessary changes in their lives in order to minimize health risks. The messages are spread by governmental institutions and non-profit organizations and via various media, and they are usually part of a larger public campaign through which these institutions try to promote public health. Health promotion generally involves three areas of attention, which are the *prevention* of health problems, the *treatment* of health problems, and the *detection* of health problems.

The first type of advisory brochure is the one aimed at preventing health problems. Many governmental institutions and non-profit organizations try to advocate behavior that ideally prevents serious health problems from occurring. The most institutionalized form of prevention is immunization programs intended to prevent infectious diseases such as tetanus, diphtheria, measles, hepatitis, polio, and, more recently, the flu and the human papillomavirus (HPV). The main objective of such brochures is to promote the vaccination of children and adolescents. In the last decades, the focus of public health in Western countries has shifted more and more from (infectious) diseases to the prevention of (chronic) diseases (Buchanan 2008: 15). To reduce health risks, health messages address the behavior that usually causes chronic diseases, such as tobacco use, alcohol consumption, a bad diet and/or a lack of physical activity.[3] By making different lifestyle choices many modern-day health risks can be avoided or diminished.

The second type of brochure that is directed, at least partly, at the treatment health problems is the patient information leaflet, which is circulated by general practitioners, hospitals, and health departments. They provide online and printed leaflets and brochures with information about a wide range of illnesses and conditions, such as hay fever, arthritis, bladder infection, sprained ankles, and weight problems. These brochures mainly consist of information on the subject, but they also contain advice on how to recover from the illness or how to alleviate the symptoms caused by one of these illnesses or conditions. These types of brochures contain advice, for instance, to drink a lot of water (bladder infection),

3 The main causes of death in the industrialized world, such as cardiovascular diseases, cancer and diabetes, are illnesses that are often related to lifestyle choices such as smoking, drinking, unhealthy eating habits and a lack of exercise. People are becoming more inactive, because they use more motorized transportation, they spend more of their free time in front of the computer or the television, and professions require less physical work. People's diets are negatively affected by the rising consumption of foods that are high in fat and salt, and in developing countries, alcohol consumption and tobacco use are expected to rise in the near future as well (WHO, *World Health Statistics*, 2008).

to wear sunglasses (hay fever), or to be physically active (arthritis). As all written communication, discourse in such brochures is constrained in the sense that these texts can only address a generalized audience member. Therefore, a brochure writer can merely provide general instructions on what people should or should not do, while in face-to-face communication a health professional can provide personal medical advice.

A third category of advisory brochures is concerned with detecting health problems. Brochures aimed at detection consist of advice to go to screenings, for example to detect breast cancer or cervical cancer, or to conduct self-examination to improve early diagnosis. An example of advice about both of these acts can be found in the brochure 'Be breast aware' (2006), published by the British National Health Service. The main advice for the female reader is to "be breast aware", which is further explained as "a process of getting to know your own breasts and becoming familiar with their appearance" by "looking and feeling in any way that is best for you (e.g. in the bath, shower, when dressing)." Self-examination may help to detect abnormalities which might point to (an early stage of) cancer and thus increase the chances of a successful treatment. The brochure is intended for all women, but the same brochure also offers advice to a sub-set of the audience, namely women *over* 50. They are advised to get screened: "If you are aged 50 or over it is strongly recommended that you take advantage of the National Health Service Breast Screening Programme which offers three-yearly mammography."

All of these brochures have in common that they provide professional health advice to laypeople with respect to a certain course of action that should positively influence their wellbeing. Depending on the topic they address, the brochures can be very diverse in appearance and style: some are formal, others informal, some are very factual, others are illustrated with visual images. The appearance and style is also adapted to the intended audience: brochures are designed to appeal to a specific target group with specific preferences that need to be taken into account. Since brochures are meant to reach a large amount of people at relatively low cost, they must be designed in such a way that they appeal to all people belonging to the target group at the same time (Klaassen 2004).

Even though there are no fixed rules with respect to the appearance of health brochures, due to their shared goal and topic some conventions can be identified. The front page usually contains an image and a slogan to draw attention to the brochure. The brochure further introduces a potential health problem, proposes a course of action as a solution to the problem, and lists advantages and disadvantages of the course of action. It can also provide practical information on how to proceed and further information on the campaign or the institution, for example, an address or a website.

Brochures do not lend themselves to addressing just any health problem. Only those which have been well researched, against which people can undertake action themselves, and which fit in the policy of the institution concerned, are apt for

health promotion. A brochure is only of use when it raises a problem that the reader could actually solve, for example because the problem or risk is (partly) caused by their own behavior (Wapenaar, Röling & van den Ban 1989: 88-91; Klaassen 2004: 153). People who make the effort to read the brochure will then examine whether it indeed serves them well to follow up the advice. A writer thus has the difficult task to essentially criticize someone's behavior without seeming to interfere and limit the reader's freedom to choose an unhealthy lifestyle.

Characteristic of all forms of communication in the medical domain between a professional or institution and a layperson, is that there is a disparity in knowledge, experience and power between the sender of the message (the professional or institution) and the receiver. The sender has access to research results about the problems under address, such as the causes and consequences of chronic diseases, while the receiver does not. Laypersons often do not have the knowledge or ability that is required to make a decision on health issues. This is in fact the very reason why they seek help from a professional. The power relation between professionals and individuals is also unequal, for example because health professionals have the authority and the facilities to offer (and revoke) health care and are in the position to impose laws and regulations (for example concerning prices of medicine, what treatments are to be covered by insurance, etcetera) (Gostin & Javitt 2001: 547). Directly or indirectly, this particular position of institutions will always be of influence in (the reception of) health messages to the public.

Governments play an especially important role in promoting public health (Gostin & Javitt 2001: 547). They have the responsibility to employ all means available to diminish health risks and protect people's health and wellbeing (Childress et.al. 2002: 170). Most health institutions are also tied to or financed by governmental institutions and share the institutional aim of guarding the public's wellbeing. As public health institutions are principally concerned with the wellbeing of the population as a whole, instead of the individual, measures or policies to improve the welfare of the population may conflict with individual rights, such as privacy and the freedom to choose (Childress et. al. 2002; Buchanan 2008). For example, while prohibiting smoking in public areas benefits the general population, individual smokers are limited in what they wish to do. In the case of health messages, these conflicting interests can also play a role: messages merely telling people to stop smoking or to exercise more might be considered as overly paternalistic and thus as interfering with the autonomy of the individual. In addition, whereas health institutions obviously have the public's health as their priority, governmental institutions might also have other aims, such as improving the population's productivity, cutting down on health care costs and reducing unemployment.

The unequal division of power and knowledge may also affect communication itself. Laypeople may not be able to understand the claims that are made or they may be hesitant to express doubt with respect to a professional's opinion. To protect citizens and to help them in making decisions with respect to their health, various

national and international rules and laws have been enacted which regulate communication in the medical domain.

One of these laws is the doctrine of *informed consent*, which defines what health professionals should communicate to patients who seek their help (Goodnight 2006; Schulz & Rubinelli 2008). In most developed countries, the law prescribes that medical professionals should always fully inform their patients of the possibilities, risks and prospects of treatment, that they should always ask the patient's permission for any treatment and for the disclosing of any medical information to others, and that patients have the right to see their medical records.[4]

Besides certain rules obliging doctors to fully inform their patients, laws have been enacted to regulate the kinds of health claims that may be in the medical domain. One of these laws is the US Food and Drug Administration Modernization Act of 1997 (FDAMA), which stipulates that manufacturers may only use health claims that are based on scientific, current, published, authoritative statements. Since this law considers governmental institutions as authoritative sources, it can be assumed that any publication issued by these institutions is designed in accordance with the same principles. Not only advertisements for health products, but also health campaign materials are thus restricted by the FDAMA. In the Netherlands, rules have been formulated to regulate all communication aimed at influencing people's behavior. According to the Dutch *Voorlichtingsraad* (Information Council), for instance, public campaigns should be accessible and understandable (Klaassen 2004: 44). In addition, all persuasive messages by the government and non-profit organizations have to comply with the Dutch Code of Advertising Practice. This means that they cannot spread incorrect, misleading, frightening or aggressive messages (Stichting Reclame Code 2008). The communication through advisory health brochures is thus, to a greater or lesser degree, affected by institutional conventions.

2.4 Advisory health brochures as an argumentative activity type

2.4.1 Reconstructing advisory health brochures as an argumentative discussion

Advisory health brochures are meant to serve the institutional goal of improving people's health by advising them on health-related behavior. In a brochure writer's attempts to influence people's attitude and/or behavior, argumentation plays a crucial role in this type of activity. At first sight, brochures may seem merely informative, but information about, for example, the advantages of certain

4 Source: 'Wet op de geneeskundige behandelingsovereenkomst (WGBO)', Dutch Ministry of Public Health, Welfare and Sport. Similar laws exist in other countries.

vaccinations or the disadvantages of being obese is not merely directed at adding to the knowledge of the reader about vaccinations or obesity. Instead, the brochure contains these facts to convince the reader that they should get vaccinated and that they should not be overweight. Some readers may be skeptical towards the content of the brochure and doubt the acceptability of (part of) the piece of advice, such as its necessity or its effectiveness. Other readers may doubt that the advice really applies to them or that the situation is serious enough to warrant the effort required to follow the advice. Therefore, the advising institution presupposes that advice will not be accepted by the addressees at face value and thus offers pieces of information that might convince the audience. The institution assumes that a difference of opinion might arise between herself and the reader about the acceptability of the piece of advice. To get her advice accepted by the reader, the institution engages in what can be reconstructed as an argumentative discussion in which she attempts to convince the reader on the basis of argumentation. The advisory health brochure can therefore be considered as an argumentative activity type in which a writer tries to convince the reader of the acceptability of a piece of advice.

To identify the institutional constraints imposed on strategic maneuvering in advisory health brochures, the activity type is to be characterized from an argumentative point of view. This can be done by comparing the argumentative practice in this activity type with the ideal model of a critical discussion (van Eemeren & Houtlosser 2005, 2006; van Eemeren 2010: 146). According to the pragma-dialectical model of a critical discussion, a discussion ideally goes through four stages in which the standpoint is critically tested (van Eemeren & Grootendorst 1984, 1992). To give an argumentative characterization of advisory health brochures, one needs to take into account how the resolution process develops in that particular communicative practice, and compare this with the ideal model. In this comparison, the following four focal points are taken into account, which correspond with the four stages of a critical discussion: the initial situation (confrontation stage), the procedural and material starting points (opening stage), the argumentative means (argumentation stage), and the outcome of the discussion (concluding stage) (van Eemeren & Houtlosser 2005, 2006; van Eemeren 2010: 146). Based on these four points, the argumentative discourse in advisory health brochures can be systematically analyzed.

2.4.2 The initial situation

In the confrontation stage of a critical discussion, discussants externalize the difference of opinion, which entails that at least one party expresses his standpoint with respect to a proposition and another language user expresses at least doubt towards this standpoint. Discussants can then determine what the difference of opinion is about (van Eemeren & Grootendorst 1992: 17). In the argumentative

activity type of advisory health brochures, the initial situation is that an authoritative institution has identified a health problem among (parts of) the population and consequently spreads advice on this topic on her own initiative. The advice concerns particular behavior that affects the reader's health. As the reader may not find the given piece of advice (completely) acceptable, the institution presupposes that a difference of opinion over the acceptability of the piece of advice may arise. The standpoint expressed by the writer is thus a *prescriptive* standpoint. Contrary to evaluative and descriptive standpoints, a prescriptive standpoint is ultimately meant to make the reader perform or refrain from performing a particular action. The given advice can be positive, in the sense that a particular course of action is recommended ('you should do X'), or negative, if a course of action is discouraged ('you should not do X').

The piece of advice can concern issues similar to those a physician may address in a consultation with a patient. In doctor-patient interaction, however, it is the patient, and not the physician, who presents a problem for which he needs advice. The difficulty in presenting such a standpoint is making sure that there is no misunderstanding over the purpose of the advice, while at the same time preventing the reader from feeling offended by the attempt to influence their behavior.[5]

Contrary to face-to-face communication, the audience to which brochures are directed consists of an anonymous, heterogeneous group of readers, consisting of persons of different age, sex, background, etcetera. Even if a brochure is specifically targeted at a particular subgroup (such as teenagers or women over 50), the advice is meant to address a *composite* audience. This means that the audience consists of individuals or subgroups holding different positions or starting points in the discussion (van Eemeren 2010: 110). In addition, given that every person decides for themselves whether they want to read the brochure or not, the advice will not reach all those it is meant for, and will also reach people for whom the advice is not meant. In health brochures, no direct interaction is possible and thus the difference of opinion cannot be made fully explicit: the writer conveys his view while the reader cannot explicitly express any doubt, criticism or an opposing standpoint to the writer. As a consequence, a writer can only anticipate potential doubt of the other party.

In the absence of an explicit antagonist, the writer may interpret the difference of opinion in the way that suits him best, be it single, multiple, non-mixed or

5 Since advising is an intrinsic face-threatening act (Brown & Levinson 1987: 65-66), it is to be expected that a brochure writer will attempt to minimize damage to the reader's face and thereby make the advice more acceptable to him. A writer can do this by employing certain linguistic means to present a piece of advice in a way that does not hinder the hearer's freedom to act (see also Brown and Levinson 1987: 129).

mixed.[6] For example, the writer may deem it wise to introduce a fictitious reader and ascribe a standpoint to him. In the brochure "Is what you know about smoking wrong?" (2010), the standpoint 'An occasional cigarette is no big deal' is ascribed to the reader and then challenged by the writer by calling the statement a 'myth' (see Chapter 5).

2.4.3 The starting points

In the opening stage of a critical discussion, arguers distribute the burden of proof and explore whether they share enough starting points to make an effort to solve the difference of opinion (van Eemeren & Grootendorst 1992: 82). The starting points consist of *procedural* and *material* starting points. Procedural starting points refer to the discussion rules and the distribution of roles in the discussion. Material starting points are a collection of propositions about facts and values that can be used in the argumentation. The fact that the discussion in health brochures is implicit also has implications for the opening stage: the discussants cannot explicitly agree on common starting points or on the roles they take upon themselves. The explicit exploration of common ground is necessary to determine whether the "zone of agreement" is broad enough to be able to properly defend a standpoint (van Eemeren & Grootendorst 2004: 60).

The distribution of the burden of proof is in principle determined by the type of dispute that is central to the discussion. In the case of a non-mixed difference of opinion, the burden of proof is *one-sided*: only one of the discussants carries a burden of proof for one or more standpoints, while the other discussant has no burden of proof. If the dispute is mixed, the burden of proof is *two-sided*: each of the parties has a burden of proof for one or more standpoints that are opposite to the other party's standpoints.[7] In health brochures, the format of the brochure also determines the strict distribution of roles in the implicit discussion: the writer is the initiator and takes the role of protagonist of a standpoint about health advice upon himself, while the reader is presumed to play the role of antagonist

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6 In the simplest case, only one party expresses a standpoint involving a single proposition and the other party only casts doubt on the standpoint. In this case, the dispute is considered single non-mixed (van Eemeren & Grootendorst 1992: 17). The dispute can be more or less complex: the dispute could involve more than one proposition (resulting in a multiple dispute) and the dispute could involve more than one standpoint (resulting in a mixed dispute). In case of a mixed dispute, the one party not only expresses doubt with respect to the other party's standpoint, but also adopts an opposing standpoint of his own. The type of dispute that gives rise to the discussion has implications for the way the discussion is to be conducted, because every party who expressed a standpoint has a burden of proof (van Eemeren & Grootendorst 1992: 17).

7 The burden of proof can also be *distributed*, which means that each of the parties carries a burden of proof for a standpoint that is not opposite to the other party's standpoints. This is the case when the difference of opinion is non-mixed and multiple (van Eemeren, Houtlosser and Snoeck Henkemans 2007: 64).

who cannot actively engage in the discussion. In some cases, brochures refer to a discussion party adopting an opposing standpoint. In those cases, this fictitious reader is acting as a protagonist of his own standpoint in a mixed difference of opinion with the writer.

In health brochures, the procedural starting points are formalized to some extent and consist of externally established rules, internal rules, and practical restrictions. First, the externally established rules for health communication are those that were mentioned in Section 2.3. These formalized rules, such as the Code of Advertising Practice and the Food and Drug Administration Modernization Act, explicitly codify what information may be used and how it may be presented. They restrict the kind of claims that can be made in the context of health brochures, for example in the sense that all claims should be scientifically justified and may not be misleading or manipulating.

Second, health institutions may also adopt special internal rules with respect to the form and content of advisory brochures that affect the discussion. They may, for instance, apply guidelines concerning the format of the brochure, such as the length and the use of visual elements. Third, there are also practical restrictions: the fact that a brochure is a written text with limited space is crucial, since this restricts the amount of argument that can be advanced and the amount of attention a reader gives to its content.

Material starting points can be divided into descriptive, normative and pragmatic starting points or commitments. Descriptive commitments include facts, truths and presumptions, normative ones include values, value hierarchies and *topoi*, or conventional rhetorical topics (van Eemeren 2010: 83). Besides the descriptive and normative commitments, which are ideally obtained as concessions in the opening stage of the discussion, an arguer can also exploit so-called 'pragmatic' commitments, which relate to the argumentative situation. Pragmatic commitments refer to the commitments a discussant has undertaken by performing particular moves in earlier stages of the discussion and are linked to the speech acts by which the discussant performed those argumentative moves. For example, the fact that a health institution provides health advice on a particular issue implies that the institution deems the problem serious enough to devote a campaign to it and does find the recommended course of action an effective solution to deal with it. These pragmatic commitments will be further specified in Chapter 3.

For an institution that publishes a health brochure it is predictable, to a large extent, to which values and facts they attach importance. For example, a health institution can be held committed to the belief that living a long, healthy life is desirable. Another commitment that can be ascribed to them is that they have great trust in medical science and only consider propositions as facts if they are based on research carried out by authoritative institutes (see the FDAMA in Section 2.3), excluding statements based on alternative medicine, superstition or religion.

To get his advice accepted, a brochure writer needs to establish a zone of agreement with the reader. A lack of common ground complicates the brochure writer's task of solving the anticipated difference of opinion *ex concessis*, i.e. on the basis of shared starting points. Since brochure readers form a heterogeneous group consisting of individuals that each have their own beliefs, values and value hierarchies, it is difficult to establish common ground. Many readers may consider statements based on medical science as facts and may want to live a long and healthy life, while others may prefer the joy of smoking or eating fatty foods whenever they choose to do so. Therefore, brochures are commonly directed at specific target groups. These target groups need to be well investigated to enable adaptation of the brochure to the preferences of that intended audience (Klaassen 2004).

In order to create common ground, starting points can also be elicited from the reader, for instance by posing questions. An example of this is the following excerpt from a brochure about drinking: 'Ever been so drunk that you're not sure how you got home? Or woken up the morning after and regretted making a fool of yourself?' ('How much is too much? under 25s', NHS 2007). The answer that a reader (implicitly) provides is added to the shared set of commitments and serves as a starting point for the discussion. Similarly, many brochures contain health tests which enable the reader to check whether they are overweight or belong to a particular risk group. The result of the test, for example a score in a table, serves as a starting point, too (for a discussion of an example of such a brochure, see van Poppel (2010)).

2.4.4 Argumentative means

In the argumentation stage of a critical discussion, the protagonist advances argumentation to overcome the antagonist's doubts. The antagonist determines to what extent he deems the argumentation acceptable and, if necessary, provides critical reactions (van Eemeren & Grootendorst 2004: 61). In the argumentation the protagonist will make use of starting points agreed upon by the parties in the opening stage to show that the questioned proposition is actually part of the antagonist's set of commitments (van Eemeren & Grootendorst 1984: 165-166). Ideally, the discussant that acts as antagonist expresses his doubt and criticism towards the standpoint and argumentation of the protagonist, and the protagonist responds with an exchange of moves and countermoves.

In the implicit discussion of health brochures it is up to the writer to decide whether he should make explicit any possible doubt or criticism from the other party with regard to the standpoint or the argumentation. This means that a writer has the choice to present the difference of opinion as non-mixed or as mixed and he is free to explicitly present potential countermoves of the audience or not. Since no explicit agreement on starting points can be reached, a writer will have to choose what propositions can be regarded as belonging to the shared commitments and can thus be used in the argumentation, and which propositions will be found

unacceptable. Even if he expects doubt or criticism towards the argumentation, a brochure writer can still choose to attend to potential countermoves or not, whereas in an explicit mixed discussion he would have to address all criticism that is expressed towards his case to fully comply with his dialectical obligations (van Eemeren & Grootendorst 1984).

In health brochures, the argumentative means that are used by the protagonist to justify the health advice can consist of any type of argumentation. A prototypical argumentative means used is pragmatic argumentation based on the results of scientific research about the effects of the advised or discouraged behavior and the (un)desirability of these effects. Another prototypical argumentative means is referring to statistical information about the probability that the predicted effects do indeed occur. Such figures may be presented in percentages but may also be described. To guarantee the trustworthiness of the facts provided in the brochure, the authority of the source of the facts (either the institution itself or some other scientific institute) is explicitly emphasized. An example is the following fragment: "The advice in this leaflet is based on research from some of the world's leading experts, including the World Health Organization" ('5 a day. Just eat more fruit & veg', NHS 2008).

In the argumentation, the protagonist may also refer to values and value hierarchies of the intended audience, for example to demonstrate the (un) desirability of the recommended or the discouraged action. As it is necessary in some cases to make readers aware that they belong to the intended audience, the argumentation can also involve references to symptoms of a disease which people may recognize. Another means to create awareness is by introducing a health test or checklist to demonstrate that a reader belongs to a risk group.

Due to the implicitness of the discussion, a writer cannot determine whether the reader found the arguments acceptable, and therefore needs to anticipate the critical reactions that the reader might have. For each type of argumentation, different critical reactions can be expected. This entails that each type of argumentation demands different supporting arguments to successfully address different critical reactions. In anticipation of doubt or criticism, the protagonist may provide further argumentation for his arguments, resulting in a complex argumentation structure. Complex argumentation does not consist of single argumentation, but of a constellation of multiple, coordinative, and/or subordinative arguments (van Eemeren & Grootendorst 1992: 86).

To hide the protagonist's intention, the persuasive message may be disguised as merely information. It may be useful to hide the intention to influence the reader's behavior, because people do not always appreciate the interference of governmental institutions in their personal life. Moreover, people may not like to be directly confronted with their possible flaws. In order to prevent people from being offended, in other words, to protect their *face* (Goffman 1967; Brown & Levinson 1987), health messages are generally formulated indirectly. For example, the effects of the advocated or discouraged behavior are then presented as facts meant to

inform the reader, for instance by introducing those facts with a sentence such as 'Did you know that'. In this way, people might be more open to accept the message.

2.4.5 The possible outcome

In the concluding stage of the discussion, the discussants determine whether the difference of opinion is solved and, if so, in whose favor (van Eemeren & Grootendorst 1992). In health brochures, the outcome of the discussion remains implicit. All readers determine for themselves whether the argumentation is convincing or not and whether they will accept the advice and even adjust their behavior accordingly. In the end, the institution might reach agreement with some of the readers but this agreement is not explicitly expressed.[8] The implicitness of the discussion thus puts great constraints on the possible moves in advisory health brochures. Although the addressees of the brochure cannot make their doubt or disagreement explicit, the institution offers argumentation nonetheless in order to remove any obstacles people may have to accepting the advice. The characteristics of the communicative activity type of health brochures are summarized in Table 1.

Table 1 Argumentative characterization of the health brochure

Communicative activity type	initial situation	starting points (rules, concessions)	argumentative means	outcome
advisory health brochure	Anticipated difference of opinion between health institution and reader over the acceptability of advice to follow or stop a particular course of action in order to prevent, detect or treat a health problem.	Partly codified rules regulating the argumentative means. Practical restrictions on space and time. Institution is authority on health issues; institution is primarily concerned with improving public health. Institution fulfills role of protagonist; reader implicitly fulfills role of antagonist.	Argumentation for the proposed or discouraged course of action based on scientific facts in monological brochure. Argumentation to show the need for and the (dis) advantages of (not) following the proposed course of action. Response to anticipated critical reactions by the reader.	Implicit resolution by the reader's implicit act of accepting the advice (and possibly following up the advice). Possible return to initial situation for alternative advice.

8 To contrast this with a different activity type within the medical domain, namely doctor-patient interaction: in consultation, the outcome of the discussion is determined within the conversation and the doctor will also be able to retract or modify his standpoint when his starting points appear to deviate too much from those of the patient.

2.5 Institutional preconditions for strategic maneuvering in the argumentation stage

2.5.1 Strategic maneuvering in the argumentation stage

Now that the advisory health brochure is described from an argumentative perspective, the consequences the characteristics of this activity type have for the possibilities to maneuver strategically, especially in the argumentation stage, are specified. As stated in Section 2.4.4, pragmatic argumentation is a prototypical argumentative means used in health brochures. The choice for this type of argumentation should be seen as a maneuver to reach the dialectical and rhetorical goals that a brochure writer tries to reach. A writer attempts to resolve an anticipated dispute over some piece of health advice in a reasonable way, and, simultaneously, he intends to make the message as effective as possible within the boundaries imposed upon the discourse by the conventions of the activity type. By maneuvering strategically, he will try to reconcile the dialectical goal of solving the anticipated difference of opinion on the merits and his rhetorical goal of getting the advice accepted (van Eemeren & Houtlosser 2005).

In an argumentative discussion, strategic maneuvering happens on the level of the discussion as a whole, on the level of the discussion stage, and on the level of each individual move. On the level of the discussion stage, discussants attempt to build the strongest case by giving (a combination of) arguments to remove all (anticipated) doubt from the antagonist by choosing the argument schemes deemed most effective in that particular context. Depending on the kind of critical reactions expected from the antagonist, the protagonist puts forward multiple, coordinative and/or subordinative argumentation (van Eemeren 2010: 39). On the level of the discussion move, they try to design every move in the most effective way by making an opportune choice from the available topics, by making use of attractive presentational techniques and by adapting the move to the preferences of the intended audience.

The choice for pragmatic argumentation can be seen as a maneuver on the level of the discussion stage and the choice of design of the argumentation as a maneuver on the level of the discussion move. This specific maneuver takes place in the argumentation stage, which has its particular dialectical objective with a rhetorical counterpart. Van Eemeren (2010: 45) describes the dialectical aim of the argumentation stage as follows: "To achieve clarity concerning the protagonist's argumentation in defense of the standpoints at issue and the antagonist's doubts concerning these standpoints and the argumentation in their defense". The rhetorical analogue to this aim is the following: "To establish argumentation that constitutes an optimal defense of the standpoints at issue (by the protagonist) or to establish critical doubts that constitute an optimal attack on the standpoints and the argumentation (by the antagonist)" (van Eemeren 2010: 45). Strategic maneuvers

by the protagonist in the argumentation stage thus come down to providing the most optimal defense of the standpoint at issue by removing all of the antagonist's expressed or anticipated doubts.

Every maneuver involves choices with respect to three aspects: *topical potential*; making a choice from the available topics, *audience demand*; adapting the move to the preferences of the intended audience, and *presentational choices*; presenting the move in the most appealing way. The three aspects of strategic maneuvering all hang together: a topical choice always entails a presentational choice and a choice with respect to audience adaptation. The strategic choices thus cannot be seen as completely separate, but they can be analytically distinguished. The following section explains possible choices with respect to each of the aspects of strategic maneuvering in the argumentation stage in health brochures.

2.5.2 Making a choice from the topical potential

In pragma-dialectics, the topical potential is seen as a collection of topical options at a particular point in the discussion. According to van Eemeren (2010: 100), the topical options are reminiscent of the topical systems (providing *topoi* or *loci*) in the classical rhetorical tradition. In the argumentation stage, selecting an option from the topical potential comes down to choosing the most suitable line of defense in the dialectical situation concerned by using a particular argument scheme. From all of the available arguments they could put forward, i.e. all variants and subtypes of causal, symptomatic or comparison argumentation, they choose those arguments that suit them best to defend the standpoint (van Eemeren & Houtlosser 1999: 165; van Eemeren 2010: 100).

To indicate what specific moves the discussants have at their disposal at a particular point in the discussion, we can make use of the dialectical profile of that stage. A dialectical profile represents a sequence of moves and countermoves that are all analytically relevant for the discussion, meaning that they are instrumentally capable of reaching the dialectical goal of that stage (van Eemeren 2010: 98).[9] The type of standpoint that is put forward in the confrontation stage determines to some extent the topical potential available in the argumentation stage. At the level of the discussion move, the topical potential consists of the choices a discussant has at his disposal in concretizing the argument scheme. For example, if the protagonist chooses to base his argumentation on the causal argument scheme, he has to choose which effects to refer to in one of the premises.

In health brochures, the topical choices in the argumentation stage are constrained by the type of standpoint that is expressed in the confrontation

9 A simplified dialectical profile of the argumentation stage, providing an overview of the available options, is presented in Chapter 4.

stage. Since the standpoint in health brochures is prescriptive, not all types of argumentation are appropriate: the argumentation in defense of a prescriptive standpoint should justify why something should be done, while argumentation in defense of a factual standpoint should justify why something is the case. A prescriptive standpoint will generally not be defended by merely pointing at facts, but involves a normative aspect as well: why would someone start eating vegetables, for example, if doing so did not lead to some advantages? An institutional precondition therefore is that the prescriptive standpoint is defended by means of pragmatic argumentation, which points at the desirable consequences of an advocated action (or undesirable consequences of a discouraged action). This intrinsic relation between the type of standpoint at issue in health brochures and the type of argumentation is further discussed in Chapter 3.

In principle, a prescriptive standpoint could, for example, also be supported with authority argumentation. Considering the context of health brochures, in which the relation between a reader and an authoritative brochure writer is asymmetrical, providing only authority argumentation would not be very appropriate. Such a selection from the topical potential would not be in line with the idea that advice from health institutions should be in the reader's best interest and that a reader should be free in making up his mind about whether to adhere to the advice or not. The fact that the standpoint in health brochures is an advisory standpoint is thus an institutional precondition for strategic maneuvering.

Another precondition for the maneuvering is that the discussion between writer and reader is implicit. The implicitness affects the strategic maneuvering in the sense that a reader cannot directly express criticism and a brochure writer can only anticipate critical reactions to the argumentation that he advances. To reach the institutional point of the brochure, a writer must enable the reader to make a well-considered decision regarding the piece of advice and therefore he must address potential doubts and criticism of the reader. At the same time, the brochure offers limited space and therefore the amount of additional arguments a writer can advance to address potential criticism is restricted. A writer can deal with this conventional constraint by including a reference to other sources, for example a campaign website, where the argumentation is further elaborated.

Topical selection on the level of the discussion move is affected by institutional conventions as well. Actual instances of argumentation always entail topical choices. The topical potential when advancing pragmatic argumentation consists of all the actions and all of the effects one could refer to in the argument. The topical potential in health brochures is affected by the institutional context in the sense that the arguments in defense of the advisory standpoint should all mainly concern (the effects on) the reader's health. Even though changes in behavior may also have consequences for other areas of interest (e.g. finances, love life), these are of minor importance in health brochures. The advantages or disadvantages referred to in the argumentation are also constrained to those affecting the reader

himself, thereby excluding the effects of an individual's change of behavior for the population as a whole (e.g. lower health care costs).[10] The effectiveness of these choices depends on the way they are adapted to the audience.

2.5.3 Adapting to audience demand

The second aspect of strategic maneuvering, the adaptation to audience demand, refers to the attempt of discussants to take the preferences of the intended audience into account in the choice and design of the moves in each discussion stage (van Eemeren 2010: 108). To reach rhetorical success in the argumentation stage, a discussant will orient his moves towards the views and preferences of the audience he is trying to convince. In order to get the arguments and standpoint accepted, a protagonist needs to make use of the commitments of the audience to create a shared zone of agreement. In the argumentation stage, this means that he tries to base his arguments on the starting points he expects to have in common with the targeted audience. For example, the protagonist can adapt pragmatic argumentation to the audience by referring to a consequence which he assumes that the audience considers as a positive. Another way of adapting arguments to the audience is by referring to characteristics that are familiar to them. For example, by referring to customs, traditions or slang of a particular (sub)group.[11]

In health brochures, there are two main preconditions that constrain the adaptation to audience demand. The first is that the discussion is implicit, so a brochure writer cannot know for sure what commitments can be ascribed to the reader. A brochure writer then can only resort to general ideas and values that the target group can be expected to adhere to. The other complicating factor is that the audience is usually composite: it consists of a large heterogeneous group of people from very different backgrounds with diverging convictions, values and value hierarchies.[12] These differences may be reflected in the kinds of arguments they will and will not appreciate. It is important to identify the relevant views and preferences of the audience correctly, because the rhetorical success of argumentative moves depends on whether a brochure writer manages to utilize the commitments of the audience correctly. One way to deal with composite audiences is to advance multiple

10 Exceptions to this convention are health brochures that intend to discourage the use of antibiotics for colds or flu. These brochures tend to refer to collective interests such as preventing bacteria from becoming antibiotic- resistant. However, they still connect this collective interest to the individual's interest by emphasizing that even if you do not ask your doctor for antibiotics to treat a cold, you will still get well soon and will prevent you from needing stronger treatment (see, e.g. 'Get well soon without antibiotics', NHS 2008, 2010; 'Get smart. Know when antibiotics work', CDC).

11 The use of slang is obviously a stylistic choice as well. Here, it is considered also as a means to adapt an argument (or other move) to the intended audience: the choice to use slang that is commonly spoken among the intended audience may create a sense of communion between writer and reader.

12 Van Eemeren (2010: 110) calls this a *composite* audience.

argumentation aimed at several (groups of) people. Another method is to design different brochures with the same message for different audiences, often ethnic groups or age groups (e.g. an HPV-brochure for Alaskans, a weight brochure for African-Americans, an alcohol brochure for teenagers).

2.5.4 Exploiting presentational devices

The third aspect of strategic maneuvering, exploiting presentational devices, refers to the choices arguers make with respect to the linguistic presentation of their argumentative moves.[13] A different choice from the topical potential always implies a different presentation, and every specific audience-directed topical choice can be designed in a stylistically different way. Van Eemeren (2010: 120) argues that even when no obvious stylistic devices, such as a rhetorical question or a metaphor, are employed choices have been made with respect to the stylistic presentation.

In the argumentation stage in health brochures, presentational devices are exploited in order to represent the chosen arguments in the most appealing manner for the targeted audience. There are two main institutional preconditions constraining the exploitation of presentational devices. The first is that the message should not come across as too paternalistic and too interfering, so that a reader feels free to make his own decision and is not deterred. The second precondition is that the message is as effective as possible: to realize the institutional point of the activity type, the message should be formulated in such a way that it is most likely that the reader accepts the piece of advice.

In order to prevent the message from seeming paternalistic and interfering, a brochure writer typically presents his arguments *implicitly* and/or *indirectly*. In order to systematically determine the function of presentational variations in strategic maneuvers, van Eemeren (2010: 120) proposes to differentiate between an explicit and an implicit presentation of moves. An arguer can explicitly express what function a particular move has, e.g. 'my argument for that is that quitting smoking reduces the chance of lung cancer', or leave it implicit, e.g. 'quitting smoking reduces the chance of lung cancer'. The implicit presentation of the argument makes the argument appear as information, rather than an attempt to influence the reader. An implicit presentation of the argumentation gives the impression that the brochure writer is not attempting to change the reader's beliefs or behavior and is only providing objective information to enable the reader to make up his own mind.

13 In health brochures, visual elements play an important role. In contrast with other activity types, such as advertising, their role is to merely illustrate the textual message and not to express a message of their own. In this dissertation, the focus lies on textual elements and the visual ones are left out of the discussion.

A similar effect can be achieved by presenting the argumentation *indirectly*. Van Eemeren (2010: 120) argues that an implicit move is indirect when the function or content of the literal speech act by which the move is realized is only secondary and the primary function or content must be inferred from the context. For example, the following move can only be interpreted as an argument when considering that the literal speech act, a question, is not the primary function of the statement in the context of a health brochure: 'did you know that quitting smoking reduces the chance of lung cancer?' The reader will understand that the writer does not really want to ask whether the reader knows about the effect of quitting smoking, but rather wants to state that this is a fact. By expressing the argument in an indirect way, the writer again gives the impression of being concerned merely with providing information, rather than with attempting to convince the reader.

In order to present the message as strongly as possible, discussants have a large amount of stylistic devices at their disposal, which in rhetorical approaches have been labeled *figures of speech* and *figures of thought*. Figures of speech, like repetition or change in word order, are schemes used to arrange words in an unusual pattern or order. Figures of thought concern a deviation from the usual way of expressing thoughts, ideas or reasoning, such as a paradox, which involves a contradiction, or a *praeteritio*, a figure in which the speaker raises an issue by saying that the issue should not be raised. A figure of speech disappears when words are changed or replaced, while a figure of thought remains the same and can be expressed by means of various figures of speech. Quintilian (1856/2006) also describes a third category: the tropes, such as metaphor and metonymy, in which "some words are substituted for others" (9.1.5), thus transforming the actual meaning of the words. All of these devices can be exploited to reinforce the argumentation. For example, the use of a metaphor may evoke particular associations in a very subtle way. The metaphor of war, or military metaphor, for instance, is a very common metaphor to help to understand other concepts (see Lakoff & Johnson 1980). Reisfield and Wilson (2004: 4025) explain that even in medicine, and specifically in oncology, the war metaphor is used by patients, physicians, and pharmaceutical companies (see also Chapter 6). Another presentational device that is particularly relevant for the context of health campaigns is what in communication studies is usually referred to as *message framing*. Since framing encompasses not only presentational choices, but also choices with respect to the other two aspects of strategic maneuvering, this device is described separately.

2.5.5 Goal-framing argumentation in health brochures

The concept of *framing* is particularly relevant for this study as it involves the way in which the argumentation in favor of an advisory standpoint is designed. The concept of framing, a common notion in discourse analysis and in the social sciences, refers to a communicative technique that is meant to place a particular thing or event in

a specific (positive or negative) perspective. The notion is applied in various ways,[14] but in this study the focus lies on a specific kind of framing that is usually called *goal framing* (see e.g. Levin, Schneider & Gaeth 1998). Goal framing refers to the way the consequences of an advocated action are presented.[15] This type of framing is relevant for discussing choices in the design of argumentation in advisory health brochures, because the message in this context typically revolves around trying to influence people's behavior on the basis of the effects of that behavior. Research on goal framing mainly involves the effect of a public health message that is either *gain-framed* or *loss-framed*. A gain-framed message emphasizes the positive consequence (or gain) of complying with the advised behavior, while a loss-framed message emphasizes the negative consequence (or loss) of not complying with the recommended behavior (see e.g. Block & Keller 1995; Rothman & Salovey 1997). Meyerowitz and Chaiken (1987) provide an example of a gain-framed message (in (2)) and a loss-framed message (in (3)) about breast self-examination (BSE). In the examples, the standpoint 'You should do BSE' is added to emphasize the argumentative nature of the messages:

(2) You should do BSE. Research shows that women who do BSE have an increased chance of finding a tumor in the early, more treatable stages of the disease.
(3) You should do BSE. Research shows that women who do not BSE have a decreased chance of finding a tumor in the early, more treatable stages of the disease.

In goal framing, BSE is portrayed as a good thing with positive consequences in both frames. The goal is framed differently: in the positive frame, the goal is framed as obtaining potential gain (an increased chance of finding a tumor early) and in the negative frame as avoiding potential loss (a decreased chance of finding a tumor early). The arguments in these examples are instances of pragmatic argumentation supporting the prescriptive standpoint 'You should do BSE'.

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14 The notion of frame was introduced by Goffman (1974) as referring to the activity in which people take part, with particular conventions and role distribution, shaping an individual's understanding of events and experiences. In linguistics, frames are seen as frameworks or scenarios that evoke associations and contextual knowledge and can be used to explain the working of language (Fillmore 1976; Fillmore & Atkins 1992).

15 Levin, Schneider and Gaeth (1998) distinguish, besides goal framing, two other types of framing: *risky choice framing* and *attribute framing*. Risky choice framing involves the framing of an option as either a risky option or a secure option (Tversky & Kahneman 1981). Attribute framing involves the framing of only a single object or event in one way or the other. Contrary to risky choice framing, it does not involve a comparison between two options, but just the evaluation of one attribute, and risk perception is not a factor in attribute framing (Levin, Schneider & Gaeth 1998: 159). In several studies it is argued that positive attribute framing results in a positive evaluation (Marteau 1989; Wilson, Kaplan & Schneiderman 1987).

Pragmatic argumentation in which *negative* advice is supported can both be gain-framed and loss-framed as well. Based on the examples provided by Meyerowitz and Chaiken (1987), two examples of framing with the negative advice 'you should not drink more than the recommended amount of alcohol' can be formulated (based on the advice from the brochure 'How much is too much? under 25s', NHS 2007). In (4), the message is gain-framed and in (5) the message is loss-framed:

(4) You should not drink more than the recommended amount of alcohol, because if you do not drink more than the recommended amount of alcohol, then you have greater control over what happens during a night out.
(5) You should not drink more than the recommended amount of alcohol, because if you drink more than the recommended amount of alcohol, then you don't have control over what happens during a night out.

The framing of a message is often seen as merely a matter of presentation without any implication for the meaning of the message. Seen from the perspective of the extended pragma-dialectical theory, framing can be seen as a combination of choices regarding all three aspects of strategic maneuvering.[16] The difference between the gain-frame and the loss-frame can first of all be described in terms of topical choices, because the gain-frame entails a choice to refer to a different consequence than the loss-frame, namely to the consequence of adhering to the advice and to the consequence of *not* adhering to the advice, respectively. The framing of the pragmatic argument does not only come down to choosing one of the available consequences to refer to, but also entails a presentational choice. Using a loss-frame instead of a gain-frame requires different linguistic means and places the action in a different perspective. The choice for a gain or a loss-frame is also a choice to orient the message towards different intended readers.

In terms of strategic maneuvering, framing can thus be seen as a way to appeal to a specific audience via a combination of particular choices from the topical potential, namely referring to a desirable effect to be gained or a desirable effect to be lost, and certain presentational devices evoking either a positive or a negative association. The concept of framing can help to demonstrate how choices with respect to each of the three aspects of strategic maneuvering are connected to each other and can even reinforce each other: choices in the design of pragmatic argumentation in health brochures can be explained as the choice for a particular

16 In principle, framing does not necessarily take place only in argumentative discourse: also in informative discourse the effects of a course of action could be described either in terms of gain or in terms of loss. Nevertheless, goal framing is usually discussed in a context in which a deliberate attempt is made to convince someone, and I will also limit the discussion to the argumentative use of framing.

frame. The strategic function of framing in pragmatic argumentation is further described in Chapter 6.

2.6 Conclusion

To gain insight into the influence of institutional conventions on the argumentative discourse in advisory health brochures, these brochures are characterized as an argumentative activity type in the medical domain. Communicative practices in this domain set out to realize the institutional aim of addressing and solving health problems existing among (parts of) the population and are generally regulated by explicit and implicit rules concerning the format and the content of the brochures. Advisory health brochures provide advice on preventing, treating or detecting health problems. In all of these brochures, the writer anticipates a difference of opinion and adopts a standpoint with respect to the acceptability of a piece of health advice, encouraging the reader to adopt certain behavior or refrain from certain behavior. The writer maneuvers strategically to solve the anticipated difference of opinion on the merits and to solve it in his favor.

By comparing the development of the resolution process in health brochures with the ideal model of a critical discussion, it is determined how the institutional conventions of the activity type affect the strategic maneuvering. The main institutional preconditions for strategic maneuvering are that the dispute concerns a piece of health advice, that the relation between the health institution and the reader is asymmetrical, and that the discussion is implicit. For each of the three aspects of strategic maneuvering, it is further specified how brochure writers maneuver strategically in the argumentation stage in accordance with these institutional preconditions.

First, the choices from the topical potential are constrained in three respects. Because brochures are meant to provide health advice, the strategic maneuvering should be aimed at demonstrating that adhering to the advice indeed has beneficial effects for the reader. Therefore, a brochure writer typically advances pragmatic argumentation. The fact that the discussion is implicit constrains the maneuvering because a writer can only anticipate possible criticism from the reader. The topical potential is also restricted by the topic of the brochure: a writer should advance argumentation that relates to (the effects on) the reader's health.

Second, the audience adaptation is constrained in two respects. Since the discussion is implicit, a brochure writer cannot be sure what starting points about values and facts to base his arguments on. The second institutional precondition is that the audience is usually composite, which means that a brochure writer needs to take into account various possible starting points.

Third, the selection from the available presentational means is constrained in two ways as well. The presentation is constrained in the sense that a brochure writer should respect the reader's right to make his own informed decision on the basis

of the brochure. Another presentational precondition is that the message should contribute to realizing the institutional point of convincing people to follow up on the piece of health advice. A writer's presentational maneuvering thus involves avoiding appearing as too paternalistic while also presenting the argumentation as strong as possible.

The institutional conventions influence the possibilities for strategic maneuvering in the argumentation stage with respect to the selection from the topical potential, the adaptation to audience demand and the use of presentational devices on the level of the discussion stage and on the level of the discussion move. A writer selects arguments that indicate the benefits of adhering to the advice and that are based on scientifically established facts. He adjusts these arguments to the preferences of the intended audience by taking into account their beliefs with respect to science and health. The arguments are presented in a way that sheds a positive light on the recommended action (or a negative light on the discouraged action), without imposing too much on the reader. In this context, strategic maneuvering typically involves the use of pragmatic argumentation, either gain-framed or loss-framed, designed in the way that serves the writers best in getting the advice accepted.