

# Part 10. Persuasion

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*Rhetoric is the art of persuasion.*  
Plato

In January 1860 the explorer Henri Mouhot parted palm fronds to lay eyes upon Cambodia's Angkor Wat. The Frenchman described the temple as "a rival to that of Solomon ... erected by some ancient Michelangelo." It's extraordinary that Angkor had been essentially lost for generations.

We physicians have largely lost something very important ourselves. Somehow our field has long omitted training in the central clinical skill of *persuasion*. Rhetorical training was an essential part of every respected Western education dating back to the fourth century BC. But starting in the late 19th century, it was slowly smothered by the science of molecules and moles.

Today we have gene therapy, technicolour positron emission tomographic scans, and marvelous machines that go "ping." But because we lack formal rhetorical training, we're far from optimally persuasive. Our frowning forebears would rightly declare us unfinished.

## Medical explorer parts palm leaves to rediscover the *Art of Rhetoric*



### Every appointment

For just one moment, please set aside your feelings about the word *persuasion*. Let's reflect upon the start of your upcoming day:

TIME	PATIENT	DIAGNOSIS	RHETORICAL CHALLENGE*
9:00 AM	Logan, a 39-year-old retired dermatologist	Dysthymia	Yes, life <i>can</i> indeed have meaning
9:15 AM	Ava, a 25-year-old opinion leader relationship manager	Body dysmorphic disorder	Yes, you <i>are</i> attractive just the way you are
9:30 AM	Sophia, a 33-year-old veterinary plastic surgeon	Health anxiety	No, MS is <i>not</i> very likely
9:45 AM	Owen, a 16-year-old tow-in surfer	PTSD	Yes, you <i>will</i> surf Peahi again
10:00 AM	Ethan, a 95-year-old media baron	Shame	Yes, you <i>can</i> make amends
10:15 AM	Stuart, a 55-year-old tar sands lobbyist	Medication non-adherence	Yes, you <i>do</i> need minoxidil

MS—multiple sclerosis, PTSD—posttraumatic stress disorder.  
\*Most appointments contain more than 1 rhetorical challenge.

### Fiduciary responsibility

You might find the term *persuasion* unsettling. If this is the case, please draw a sharper line between persuasion and coercion. And rest assured that persuasion is rarely possible without a solid doctor-patient relationship.

If visions of heavy-handed paternalism still haunt you, please invest in a good synonym for *persuasion*. But whether you'd prefer to impel, incline, induce, inspire, or inveigle, I hope you see yourself as a medical expert. And as such, I hope you agree you have a fiduciary responsibility to cogently present what science tells you are the preferred perspectives.

### What are your tools?

How do you meet your rhetorical challenges? In more modern terms, how do you persuade your patients to drop their pathogenic beliefs? What techniques do you use?

Assuming your compliance rates are cracking the double-digits, you are indeed using some rhetorical techniques. However, unless you've been formally trained, you're likely not using more than a dozen tools, and odds are you're using tools without knowing their names. Fortunately, a trained medical cognitive behavioural therapy (CBT) practitioner watching you from behind the mirror could identify your rhetorical tools one by one—and explain to you the subtleties of each. She would also likely have many new ones to teach you.

## The paradigm

My first psychotherapy mentor was the Viennese analyst Karl Enright. In 1982 Karl introduced me to the writings of Johns Hopkins psychiatrist Jerome Frank. In *Persuasion and Healing*,<sup>1</sup> Frank argues that persuasion is central to all clinical encounters. Somehow Frank persuaded me, and for nearly 30 years I've practised and experimented within his rhetorical paradigm.

Aristotle was among the first to catalog the tools of persuasion. His *Art of Rhetoric*<sup>2</sup> is one of CBT's founding texts, and we continue to use classical names for some of our tools (eg, *reductio ad absurdum* and *post hoc ergo propter hoc*). However, most modern tools have modern-sounding names like distortion identification, systematic desensitization, and exposure and response prevention. A selection of both classic and contemporary tools are being reviewed in this series.

As I have explained in a previous article, I define a *cognogen* as a "pathogenic belief"—a belief that contributes to psychological or physical pathology.<sup>3</sup> But unlike other pathogens, cognogens are usually treated with cognitive restructuring techniques rather than medication. Although the orthodox CBT literature uses the term *restructuring technique*, I prefer the more parsimonious expression "tool of persuasion" (or "rhetorical tool").


One rhetorical tool we all wish still worked begins with "Trust me, I'm a doctor..." Unfortunately, today

that expression is more often a set-up for a comedy club joke than a successful tool.

## Better igloos

Imagine the Inuit woman without words for snow. What are the odds her igloos will appear in *Architectural Digest*? And what of the keratotic surfer—could the dude tuck into the barrels of Teahupo'o if he spoke normal English? And our orthopod: how efficiently does he get his thingamajigs from the nurse with grunts and hand motions alone?

As the table in this article illustrates, we use rhetorical tools in almost every clinical encounter. To be maximally effective, we need to know which tool we're using when—and the subtleties of its application.

Please join medical CBT practitioners in arguing as persuasively as possible that rhetorical training be restored to our basic medical curriculum. 

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### References

1. Frank J. *Persuasion and healing*. Baltimore, MD: Johns Hopkins University Press; 1961.
2. Aristotle. *The art of rhetoric*. Freese JH, trans-ed. Cambridge, MA: Loeb Classical Library, Harvard University Press; 1924.
3. Dubord D. Part 7. Pathogenic beliefs. *Can Fam Physician* 2011;77:689.

Next month: **Viewpointing**

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