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THEMES AND DEBATES

Theory of Communicative Action in Nutritional Counseling

Teoría de la acción comunicativa en la consulta nutricional

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Abstract

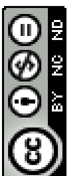
This essay addresses the importance of effective communication between nutrition professionals and patients as a fundamental basis for successful health interventions. It highlights the relationship between communicative action and instrumental action in nutritional counseling, where openness to dialogue, sincerity, and trust are key elements in establishing a strong therapeutic relationship. The need for authentic and respectful communication is emphasized, in which both the therapist and the patient are active participants in the health care process. The influence of Jürgen Habermas's theory on understanding communicative action in the health field is discussed, emphasizing the importance of negotiation and consensus in resolving community issues. Additionally, the risks of biased communication and the automation of treatment are highlighted, which may lead to the dehumanization of health care. In conclusion, the essay underscores the need for ethical and effective communication to ensure informed and collaborative decision-making in the field of nutrition and health.

Keywords: Communicative Action, Nutritional Counseling, Therapeutic Relationship

Resumen

Este ensayo aborda la importancia de la comunicación efectiva entre el profesional de la nutrición y el paciente como base fundamental para una intervención exitosa en la salud. Se destaca la relación entre la acción comunicativa y la acción instrumental en la consulta nutricional, donde la apertura al diálogo, la sinceridad y la confianza son elementos clave para establecer una relación terapéutica sólida. Se resalta la necesidad de una comunicación auténtica y respetuosa, en la que tanto el terapeuta como el paciente sean participantes activos en el proceso de cuidado de la salud. Se menciona la influencia de la teoría de Jürgen Habermas en la comprensión de la acción comunicativa en el ámbito de la salud, enfatizando la importancia de la negociación y el consenso en la resolución de asuntos de competencia comunitaria. Además, se alerta sobre los riesgos de una comunicación sesgada y la automatización del tratamiento, que pueden llevar a una deshumanización en la atención sanitaria. En conclusión, se subraya la necesidad de una comunicación ética y efectiva para una toma de decisiones informada y colaborativa en el ámbito de la nutrición y la salud.

Palabras clave: Acción comunicativa, Consulta nutricional, Relación terapéutica



Introduction

For German philosopher and sociologist Jürgen Habermas, the way humans relate to each other is grounded in the concept of "communicative action"; a social interaction among various subjects, coordinated through the exchange of communicative acts that use language to bring about understanding and comprehension. On the other hand, "instrumental action" is an action oriented towards success, considered under the observance of technical rules of action, where the effectiveness of the intervention in a physical state is evaluated. These are typically associated with social interactions.[1]

For Habermas, communicative (political) reason and instrumental reason have not developed simultaneously throughout human history, with the latter displacing the former. In the field of health, it is indisputable that scientific and technological advancements open new possibilities for the prevention and curing of disease, as well as for improving quality of life. However, they also create new contradictions and problems.[2]

Healthcare professionals have a large number of studies that allow them to understand, comprehend, and distinguish between different physiological and pathological conditions, as well as compare and recommend various physical, pharmacological, nutritional, and surgical treatments. This raises the question of how poor communication between healthcare staff and healthcare service users can lead to negative consequences for disease prognosis, the possibilities for healing, and the correct adherence to treatment.

An example of the above argument is a study published by the *Journal of Clinical Oncology* in 2013, conducted between 2003 and 2005. The study aimed to understand the expectations of 384 individuals diagnosed with incurable lung cancer regarding the effects of the radiation therapy treatment they were undergoing. The study found that almost two-thirds of the patients believed that the radiation therapy was intended to cure them, rather than to alleviate the symptoms of their condition. Given that these were terminally ill patients, these results seem to indicate that the doctors had not explained the purpose of the treatment clearly enough, and/or that the patients lacked the capacity to understand the doctors' words, since this was not an isolated case.[3]

Another study conducted with patients with type 2 diabetes, whose objective was to identify the general satisfaction with the doctor-patient relationship based on accessibility and communication between individuals, found that such satisfaction was linked to adherence to treatment for the patient's glycemic control.[4]

Nutritional Consultation Based on Communicative and Instrumental Action

Nutritional consultation is commonly based on communicative action, meaning it revolves around the proper interaction between the nutritionist and the patient, as a necessary element for addressing the patient's needs and actions. This communicative foundation supports the use of instrumental action.[5]

During the nutritional consultation, communicative or political action takes this direction and moves towards the opening of dialogue between the participating subjects, facilitating their expression of reasons aimed at negotiation, criticism, and consent. This process makes it possible to justify the use of instrumental action, whether through a diagnostic technique, treatment, or monitoring the patient's health condition.

According to Habermas' proposal, political reason is the human activity aimed at resolving issues of community competence through the search for agreements where negotiation, and thus communication, are indispensable. The greater the communicative power of a society to organize the exercise of power, the greater the possibility of achieving the pursued goals.[6] However, this phenomenon is complex and can lead in two completely opposite directions: to either improve, or to cause harm (iatrogenesis) to the health condition.

It is important to emphasize that the nutritionist may be knowledgeable about the best techniques and treatments for patient care, but if they ignore how to communicate that knowledge to the patient, or fail to gather the necessary information for

proper decision-making, and if the patient is also unable to express their own reasons, then there is a risk of implementing the wrong instrumental reasoning, which could jeopardize the physical and emotional well-being of the patient.

As Habermas suggests, rationality does not refer to the possession of knowledge, but to the way subjects endowed with speech and action acquire and use it. Rationality resides in how people (the first element) use knowledge and in how symbolic expressions (the second element) are used.[7]

This understanding of rationality is crucial for understanding the communicative interactions that allow individuals to share and validate their experiences and knowledge.

Invasion of the Lifeworld in the Practice of Human Nutrition as a Profession

The concept of "lifeworld," according to Habermas, constitutes a complementary concept to communicative action; that is, the existence of this lifeworld is based on the assumption that by telling others what we think and perceive about the world, we will achieve mutual understanding and have it accepted as true, while also preventing any questioning. This is why we talk about a world free of communicative problems that seeks consensus among individuals in society.[2]

This context is, so to speak, the transcendental space where the speaker and the listener meet; a space where they can mutually claim that their utterances align with the world (the objective, the subjective, and the social); and where they can critique and expose the foundations of these claims of validity, resolve their disagreements, and come to an agreement.[2]

The problematization of this environment between two individuals who operate with significantly different languages— in our case, the nutrition professional who uses specialized language and the patient who does not, although they may be somewhat familiar with it— can be detrimental to the resolution of any clinical case of type 2 diabetes. To achieve a positive outcome in this case, dynamic interaction between the involved parties is required.

For instance, during the inquiry aimed at identifying the patient's general conditions and eating habits, it is common to use some of the following specialized expressions that are likely not part of this social subject's everyday experience unless a prior explanation is provided:

> *Please mention the number of grams of carbohydrates you consume over the course of a week,*
> *What is your approximate consumption of oils rich in omega-3, 6, and 9 fatty acids?*
> *Have you received your glycosylated hemoglobin results from the lab?*
> *When was the last time you experienced exacerbated polyuria, polydipsia, and polyphagia?*
> *Did you experience morning preprandial hyperglycemia?*
> *Have you noticed any proteinuria in your urine?*

This excessive use of specialized medical language, aimed at demonstrating knowledge and professionalism, not only creates a distancing effect between the participants in the consultation, but it also leads to a limited understanding of the disease and the treatment on the part of the patient.

On the flip side, there are linguistic expressions that the patient uses to describe their illness, which may be unknown and/or rejected by the nutritionist, but which also affect and alter the course of the consultation. Some examples include:

> *Yes, doctor, my sister also had sugar issues, and in fact, that's what she died of.*
> *Last night, I ate a whole turkey.*
> *I thought it could be cured.*
> *I'm afraid they might cut off my leg.*
> *My friend told me that taking those things you're talking about (referring to insulin) might make me blind.*

The above examples are worth mentioning, because the lack of knowledge about the components of the patient's lifeworld (culture, society, and personality), which shape how people behave in the face of a chronic degenerative illness, is very likely to make actions aimed at improving their quality of life ineffective.

Another way the lifeworld is problematized in these cases is through the colonization imposed by

the system. While the lifeworld is built on a normative agreement supported by consensus, with a symbolic structure encompassing three spheres of action—culture, society, and personality—the system, by contrast, operates through non-normative control over individual decisions and is expressed in a material structure.[6]

Therefore, we believe that this is a serious issue in any health practice, as it assumes individuals are driven by the search for their own success, and whose interests apparently cannot be questioned through communicative actions. The system invades them with a logic of money and power, which replaces the language that supported the lifeworld, without the need to persuade or refute understanding, ultimately reducing the motivation for exchange.

In these cases, the reasons can vary, from the desire to impose authority over the patient due to the need for legitimacy, to the possible pursuit of profit, and even the desire to reaffirm academic and professional prestige, or the seduction or pleasure of performing a new clinical procedure. This leads us to the idea of the nutrition professional who abandons communicative reasoning and follows the system's thought, which can be reflected in the following situations.

First, the care protocol directed at people with type 2 diabetes commonly fails because patients do not feel understood by the nutrition professional. They are often stripped of their need to participate, as their reasons are ignored by the nutritionist, who attempts to exercise unilateral control. This allows instrumental reasoning to prevail during the consultation, when dialogue is avoided and communication becomes dominated by the nutritionist, meaning messages are almost exclusively transmitted in an instructional manner. For example:

> *Your fasting capillary glucose result is 140 mg/dL, you must have diabetes.*
> *The scale shows you've gained weight this month, you're probably not following the diet properly.*
> *I don't need you to explain your condition to me.*
> *Are you going to listen to your friend or to me?*
> *I'm not going to ask you about your personal life, it's none of my business.*
> *I forbid you from eating bread.*
> *What are you thinking? Don't eat tortillas.*
> *Take the medication.*
> *Don't get upset.*
> *Don't listen to other remedies.*
> *Don't question the treatment.*
> *Don't eat chocolate.*
> *Take off your clothes.*
> *Get up early and exercise.*

But the unjustified use of instrumental reasoning can have more severe consequences, as the lack of dialogue that would allow the exchange of reasons to arrive at a better diagnosis opens the risk of avoiding a more collaborative approach to choosing the best treatment for the patient through strategic rationality—this is, the success-oriented rationality typical of political action.

Secondly, the lack of wisdom derived from the dialogue between the nutrition professional and the patient is responsible for the inability to choose the appropriate instruments for the various purposes of the consultation. The mere availability of a technique does not necessarily mean it should be applied, especially if resources are scarce and require restricted use.

On the other hand, imposing a dietetic treatment for all patients with a common problem (in this case, type 2 diabetes) without thoroughly understanding the patient's experience with their illness will also cause harm. This is because such a treatment may have characteristics that prevent it from being differentiated from other similar therapeutic approaches, that is, the overuse and unjustified distribution of a dietary regimen that appears successful on subjects who share similar characteristics. In other words, the nutrition professional falls into the mistaken belief that all individuals are the same, and therefore, all will respond in the same way to the same solution.

Moreover, this process of treatment automation is driven by the increased use of specialized software for nutritional therapy, which allows for providing care to more patients in less time. The main issue with this is that reliance on these tools promotes a high output of treatments (or the same treatment multiple times) in a shorter period, while simultaneously reducing the time spent with the

patient, thus increasing the process of dehumanization.

It is important to note that a biased communicative reason can create an environment prone to misinformation, manipulation, and self-justifications, which in turn reduces the credibility of the information provided. This lack of transparency may lead to the unjustified use of expensive technologies, such as continuous glucose monitoring devices, which require a significant investment for both acquisition and maintenance. Additionally, these devices typically require frequent consultations with the nutrition professional, further increasing consultation costs. In contrast, it would be more beneficial to recommend more accessible methods, such as conventional glucometers, which do not require constant monitoring and are more cost-effective, thus enabling a more sustainable and equitable approach to managing the patient's health.

Application of Communicative Action in Nutritional Consultation

To avoid poor communication between a nutrition professional and the patient, as well as the consequences arising from it, it is necessary to carry out effective communicative action during the consultation and follow-up, strongly supported by a theory of meaning.

The theory of meaning is about understanding what is being said or, in other words, how to comprehend the meaning of a linguistic expression and under which contexts that expression can be accepted as valid. This is why Habermas emphasizes that, in language, the dimension of meaning and the dimension of validity are internally connected to each other.[8]

Therefore, in human nutrition practice, statements must contain two dimensions: one of meaning and one of validity, which are deeply intertwined; thus, validity can be equated with truth. Moreover, all statements can be critiqued in terms of truth, correctness, and veracity, but considering that intelligibility or the expository function is the only universal claim (inseparably satisfied by language) that participants in communication can demand from a grammatically correct sentence that satisfies the claim of intelligibility.[9]

Additionally, the speaker's communicative intention includes: a) performing a speech act that is correct in relation to the given normative context (which reflects something belonging to the world), to establish an interpersonal relationship with the listener that can be considered legitimate; b) making a true statement (or assumptions of existence adjusted to reality) so that the listener can assume and share the speaker's knowledge; and c) truthfully expressing opinions, intentions, feelings, desires, etc., so that the listener can trust what they hear.[9]
Thus, if the patient follows the nutritional recommendation, they must accept the offer of the three claims of validity that are being argued, which are subject to criticism, and this even involves the patient's own understanding of the language in which the nutritionist speaks. Below is an example of this assumption from the dialogue between the two subjects referred to in this essay: The Nutrition Professional (NP) and the Patient (Px):

> ***(NP)**: Sir, I am going to provide you with the nightly snack that you should have every night at 12 a.m., which consists of half a cup of natural oatmeal mixed with 1 cup of warm skim milk, or, as another option, a banana.*
> ***(Px)**: Why should I eat something at that time?*
> ***(NP)**: Because, as you have mentioned throughout our conversation, when you wake up in the mornings, you suffer from excessive hunger, you don't feel like you've rested even though you've slept 8 or more hours straight, you experience headaches, irritability, palpitations in your chest, difficulty seeing clearly, sweating more than usual, tingling in your hands and feet, and you mentioned that this week you almost fainted twice right after getting out of bed. What this means is that around 3 or 4 a.m., your stomach has finished digesting the food you ate during dinner, and unconsciously, even though you're asleep, it releases chemicals that take the sugar reserves from your liver and muscles so that you can keep breathing, your heart can beat, and your brain can function. In other words, your body uses sugar as fuel, and what we want to achieve with the nighttime snack is to provide you with a reserve of fuel so that when you wake*

> *up, you don't feel the excessive need to eat something, and you avoid all those discomforts.*

In this case, the patient accepts the three claims of validity, as they are true: the therapist intends to explain the needs of the nighttime snack; it is correct because the benefit for the patient is being sought; and it is truthful because the patient had mentioned those discomforts earlier. All of this was understood and accepted by the patient. This example demonstrates the close relationship between meaning and validity.

From the previous quotes, we understand that the therapist-patient relationship must be based on sincerity and trust in communicating health-related facts. Furthermore, the therapist must attend to the patient's constant requests for information, as this will generate trust, security, and hope. The fact that the nutrition professional speaks the truth is accepted by patients, as long as the potential reactions the patient may have to hearing the truth are taken into account. It is important that the therapist conveys the information with conviction so that the therapist maintains a degree of legitimacy, and for this, the health professional must be able to demonstrate the truthfulness of their opinions, feelings, and desires in order to avoid uncontrollable reactions from the patient.

Lastly, health care is a mutual task between the therapist and the patient, where both parties must be communicative, trusting, respectful, and committed to each other. This allows both the patient and the healthcare professional to enrich one another.

Conclusion

It is very difficult to criticize the system when it is already embedded in the lifeworld. The practice of nutrition as a profession encompasses a multitude of concepts and actions that are often difficult to recognize within the lifeworld of both the professional and the patient, as well as within the practice itself. Critiquing this system can only be accomplished through ethics, which will guide communicative action for making informed decisions about health.

Communicative action should not be taken lightly nor as an impossible or utopian goal in the field of health, because through its action, the correct use of instrumental reason can be achieved.

The fact that, initially, the two communicative subjects do not understand each other is not necessarily negative, as it can lead to criticism and questioning of the reasons presented during the dialogue, which can ultimately lead to a better understanding of what the other person is trying to convey.

On the other hand, a seemingly problematic conversation between therapist and patient may conceal the complacency of thinking that one fully understands what the other is saying. In this case, numerous errors can arise that may be costly for the patient. It is, therefore, important for both parties to question their reasoning.

Disagreements that arise from a lack of understanding between the nutritionist and the patient, as they each try to defend their reasoning, are not necessarily negative. Such disagreements do not mean abandoning communication or, even less, understanding. In fact, it is precisely for this reason that discourse plays such a crucial role in political practice.

References

1. Espigares, J. (2009) 'Jürgen Habermas: la acción comunicativa', Temas para la educación, 48(3), pp. 1–13.
2. Habermas, J. (1990) Teoría de la Acción Comunicativa II. 1st edn. Editorial Aguilar.
3. Chen, A. et al. (2013) 'Expectations About the Effectiveness of Radiation Therapy Among Patients With Incurable Lung Cancer', Journal of Clinical Oncology, 31(21), pp. 2730–2735. https://ascopubs.org/doi/10.1200/JCO.2012.48.5748?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed
4. Ríos, M., Acevedo, Ó. y Gónzalez, A. (2011) 'Satisfacción de la relación médico-paciente y su asociación con el control metabólico en el paciente con diabetes tipo 2', Revista de Endocrinología y Nutrición, 19(4), pp. 149–153. https://www.medigraphic.com/pdfs/endoc/er-2011/er114d.pdf

5. Sánchez, D. y Contreras, Y. (2014) 'La relación médico-paciente y su importancia en la práctica médica', Revista Cubana de Medicina Militar, 43(4), pp. 4528–533. http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0138-65572014000400011
6. Santillana, A. (2011) 'Del mundo de la vida al sistema: el poder integrador del poder', Andamios, 8(16), pp. 161–185. https://www.scielo.org.mx/scielo.php?pid=S1870-00632011000200011&script=sci_abstract&tlng=es
7. Grondin, J. (1990) 'Racionalidad y acción comunicativa', Ideas y valores, 6(23), pp. 16–33. https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://revistas.unal.edu.co/index.php/idval/article/download/18540/19450&ved=2ahUKEwiS88fH4YuPAxX6kmoFHRYdKd4QFnoECB4QAQ&usg=AOvVaw12ZKu6oq4b2Y5-BuUBMADr
8. Garrido, L. (2011) 'Habermas y la teoría de la acción comunicativa', Razón y palabra, 75, p. 19. https://www.researchgate.net/publication/277270449_Habermas_y_la_teoria_de_la_accion_comunicativa
9. Habermas, J. (2011) Teoría de la acción comunicativa: complementos y estudios previos. Ediciones Cátedra.

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