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Key components of effective collaborative goal setting in the chronic care encounter

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Abstract

Collaborative goal setting in patient–provider communication with chronic patients is the phase in which – after collecting the data regarding the patient's health – it is necessary to make a decision regarding the best therapy and behaviors the patient should adopt until the next encounter. Although it is considered a pivotal phase of shared decision-making, there remain a few open questions regarding its components and its efficacy: What are the factors that improve or impede agreement on treatment goals and strategies?; What are the 'success conditions' of collaborative goal setting?; How can physicians effectively help patients make their preferences explicit and then co-construct with them informed preferences to help them reach their therapeutic goals? Using the theoretical framework of dialogue types, an approach developed in the field of Argumentation Theory, it will be possible to formulate hypotheses on the 'success conditions' and effects on patient commitment of collaborative goal setting.

Keywords: argumentation schemes; chronic care; decision-making; deliberation dialogue; doctor–patient communication; presumptive reasoning

1. Introduction

Focusing on the process of collaborative goal setting, considered to be a crucial part of shared decision-making in the medical encounter, in this contribution I will propose a theoretical and interdisciplinary perspective aimed at answering some of the questions that are still open regarding the relationship between communication styles between doctors and patients and outcomes. As Street (2013) points out, it is important that observations regarding communication in the medical setting are set within a clear theoretical background, and that the assumptions and implications that derive from the theory are also explained.

In particular, some of the existing models on decision-making in the medical encounter – for example, the shared decision-making model outlined by Charles *et al.* (1997, 1999) and that describing the formation and development of patient preferences in Street *et al.* (2012) – have reached a very advanced level of descriptive power, but still lack the capacity to explain *why* certain features are more preferable than others. Such capacity could be achieved by integrating these existing models with more complex models of communication, which will make it possible to explain the complexity of dialogical interactions and instances of 'pragmatic ambiguity'; i.e. cases in which it is hard to define what kind of communicative 'actions' the interlocutors are performing (Charles *et al.* 1997: 689).

Various complex models of this kind are available in the fields of Pragmatics and of Argumentation Theory, offering the opportunity for a fruitful interdisciplinary merging of research questions and theoretical approaches. In particular, in this contribution I will propose adapting an abstract model developed within the field of

Argumentation Theory – the model of deliberation dialogue (Walton and Krabbe 1995; Walton 2006; Walton *et al.* 2010; Walton 2010; Walton *et al.* 2014) – for the description and understanding of the dialogical components of the process of collaborative goal setting in the chronic care consultation. This will make it possible to identify its 'success conditions' and formulate hypotheses on which of its components are more likely to impact positively on patient commitment, thus fostering adherence to healthy lifestyles.

The paper is structured as follows: in Sections 1 and 2 I discuss the main literature on the process of shared decision-making in the medical encounter, suggesting that collaborative goal setting should be considered as a part of this process – which, however, leaves a few open questions. In order to provide answers to these questions, in Section 3 I introduce the deliberation dialogue model, along with its characteristic features. In Sections 4 and 5, I discuss two crucial features of deliberation which both play a role in collaborative goal setting: the speech act of 'proposal' as a key to understanding the success conditions of collaboratively setting goals, and the challenge posed by preferences and values for practical reasoning in the chronic care encounter. The final section is devoted to discussion and implications for further research.

2. Making decisions cooperatively in the medical encounter

In the rich literature on effective consultation and communication in the medical encounter (among many others: Street *et al.* 1993; Coupland *et al.* 1994; Beach and Dixson 2001; Roter and Hall 2006; Heritage *et al.* 2007; Labrie 2012; Pilgram 2012), a topic that stands out is that of decision-making, with its corollary of how to improve patient adherence to treatment and to healthy behaviors. These are aims that are particularly relevant in chronic care (among others: Charles *et al.* 1997, 1999; Elwyn *et al.* 2000, 2012; Emmons and Rollnick 2001; Entwistle *et al.* 2004; Taylor 2009; Politi and Street 2011; Epstein and Street 2011; Street *et al.* 2012).

Albeit having sometimes a high descriptive strength, none of these models and approaches are able to explain *why* certain communication styles impact positively on patient satisfaction or outcomes. Paradigms such as the paternalistic model, informed decision-making model, and the professional-as-agent model (described in Charles *et al.* 1997) all assume an 'information-plus-choice' pattern for the realization of decision-making, in which decisions seem to 'flow' directly from the information the patient receives. However, for this to be true, we would have to assume that patients and physicians share the same criteria for the interpretation of information, but this does not seem to be always the case (Charles *et al.* 1997: 688; Epstein and Street 2011: 458; Elwyn *et al.* 2012). Moreover, these models are often only aimed at providing practical indications on how to realize certain communication styles, such as a successful shared decision-making (for example, Elwyn *et al.* 2012). The fact of not being based on a theory of dialogue, however, weakens their potential for improving clinical practice, because they are not able to provide more general criteria and explanations for how things should happen in a certain way.

3. Collaborative goal setting as part of the process of shared decision-making

A 'sub-category' of the studies on decision-making focuses in particular on collaborative goal setting, a term more specifically referring to the discussion that arises between patient and physician, when – after collecting the data regarding the patient's health – it is necessary to make a decision regarding the best therapy and/or behaviors the patient should adopt until the next encounter. In this sense, collaborative goal setting is the part of the decision-making process taking place in a medical encounter (typically, in a collaborative one; see Politi and Street 2011: 580), in which preferences emerge or are co-constructed (Street *et al.* 2012). Another feature that distinguishes shared decision-making and collaborative goal setting (and the main reason

for choosing to address the latter rather than the former in the present article) is that 'shared decision-making' is often used as a term referring to a specific paradigm of patient–physician communication. My interest in this contribution is to consider a dialogical process rather than a model; moreover, I am interested in decision-making regarding behavior change, and the concept of 'collaborative goal setting' seems both appropriate and intuitive enough to be used without fear of misunderstandings.

Collaboratively setting goals is seen to feature among the strategies that build self-management support, together with assessment, action planning, problem-solving, and follow-up (Langford *et al.* 2007: 140S). Self-management support, in turn, is one of six key components in the Chronic Care Model, an approach presented as a way of improving chronic care delivery (Wagner 1998). Albeit having been acknowledged as a crucial phase, there remain a few open questions regarding its components and its efficacy: What are the factors that improve or impede agreement on treatment goals and strategies (Heisler *et al.* 2003)?; What are the 'success conditions' of collaborative goal setting (Lafata *et al.* 2013)?; How can physicians effectively help patients make their preferences explicit and then co-construct with them informed preferences to help them reach their therapeutic goals (Epstein and Gramling 2013)?

3.1. What do we know about collaborative goal setting in chronic care?

The literature addressing the features of communication in the chronic care medical encounter stresses the importance of proactive, participatory patient–provider communication (Naik *et al.* 2008), providing evidence to show that active patient participation increases health outcomes (Lafata *et al.* 2013). Indeed, studies in diabetes care settings have shown negative correlations between exertive or dominant communicative behaviors on the part of physicians and outcomes such as patients' satisfaction, adherence, and health (Street *et al.* 1993). Indeed, effective chronic care happens when self-patient care and medical care are combined and attuned, which can only be achieved when there is good collaboration between physicians, on the one hand, and patients and their families, on the other (von Korff *et al.* 1997). Good patient–provider collaboration, in turn, is constructed and realized during the encounter and by means of communication.

Studies suggest that the most relevant moments in the process of constructing effective patient–provider collaboration are the collaborative definition of problems, targeting, goal setting, and planning (von Korff *et al.* 1997; Heisler *et al.* 2002). However, it is not clear how patient–provider communication styles impact positively on patient outcomes. In particular, it remains to be understood which aspects inherent in shared decision-making are most effective in promoting patient self-management. There is evidence to show that patient self-efficacy – i.e. patients' understanding of their condition and treatment, and patients' self-confidence in their own self-care abilities – is positively related to treatment adherence (Heisler *et al.* 2002). So, do collaborative communication styles impact directly on the self-management abilities, or via self-efficacy? Provisional results suggest that the provision of information is an important part of this process (Heisler *et al.* 2002), but others stress the fact that information alone cannot be sufficient to foster the necessary motivation for patients to maintain long-term treatment adherence (Epstein and Gramling 2013). Heisler *et al.* (2003) show that patients who shared in treatment decision-making and discussed the relevant content areas with their physicians were more likely to display agreement with the physicians, something which is positively correlated with health outcomes.

However, it is not clear what the factors are that favor or impede patient–provider agreement on treatment goals and strategies. Shared goal setting has also been found to improve patients' perceptions of ownership and accountability, which are key components in effective diabetes self-management (Langford *et al.* 2007). Other studies agree on the fact that patients involved in collaborative goal setting reported a higher perception of self-management competence and of having a trusting relationship with their physician

(Naik *et al.* 2008; Lafata *et al.* 2013). However, it also looks like collaborative goal setting is not equally beneficial under certain conditions: if, for example, the communication exchanges do not facilitate a positive patient–clinician rapport or patients' confidence to achieve any goals set during the exchange (Lafata *et al.* 2013).

Addressing more specifically the components of decision-making, Epstein and Gramling (2013) highlight the crucial role of preferences, 'statements by individuals regarding the relative desirability of a range of health experiences, treatment options and health states' (Brennan and Strombom 1998: 259, cited in Epstein and Gramling 2013), which in the clinical practice are often contextual, conditional, and provisional.

To sum up the findings and insights regarding collaborative goal setting: it is a process that involves providing information and making shared decisions; evidence shows that it correlates positively with patient self-management, treatment adherence, and trust in the patient–provider relationship; and its effectiveness is tightly bound with the parties' ability to construct a shared set of preferences, which will support shared decisions, provide motivation, and favor rapport building. Based on this summary, the 'pathways' from communication styles to patient outcomes in the chronic care encounter are mapped out in Figure 1, where the elements to the left of the arrows are considered to be the best conditions for the elements to the right of the arrows to come about.

However, the arrows – it can be said – hide the inner dialogical and behavioral mechanisms that lead from one box to the next. Awareness of these would make it possible to map out the inherent elements that build the process of collaborative goal setting within decision-making. This would lead to a better understanding of the factors that favor agreement between physicians and their patients (Heisler *et al.* 2003). It would also make it possible to highlight the conditions under which collaborative goal setting is beneficial (Lafata *et al.* 2013). Finally, we would be able to answer the question of how to manage implicit preferences in the process of decision-making during the medical encounter (Epstein and Gramling 2013).

In the following sections, I propose to use the model of deliberation dialogue (Walton and Krabbe 1995; Walton 2006; Walton *et al.* 2010; Walton 2010; Walton *et al.* 2014) as a tool to uncover the inner mechanisms involved in the process of collaboratively setting goals during the chronic care medical encounter.

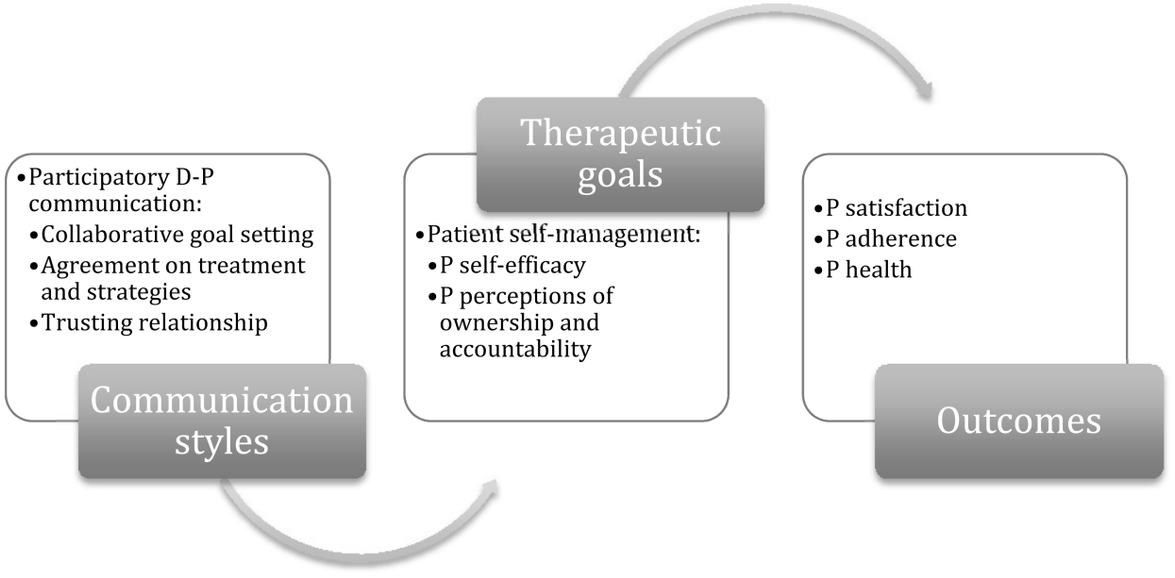

Figure 1. *'Pathways' from communication styles to patient outcomes*

4. Dialogue types and the deliberation dialogue

The deliberation dialogue is one of seven basic types of dialogue, described by Walton and Krabbe (1995). Dialogue types are ideal models of different kinds of interaction (McBurney *et al.* 2007) and have been outlined by looking at different dialogical contexts – i.e. by considering the different aims that people have when they interact in different situations (Walton and Krabbe 1995). Figure 2 represents the types of dialogue as described in McBurney //check// and Parsons (2001):

Each dialogue type has specific rules for the management of commitments and often, within longer sequences, dialogues shift from one type to another.

4.1. Deliberation dialogues and their characteristic features

Deliberation dialogues are abstract patterns that outline the most effective dialogical moves aimed at finding an acceptable course of action to achieve a certain goal (Walton and Krabbe 1995; Walton *et al.* 2010; Walton 2010).[1] Parties in deliberation dialogues are out to reach a *collective* goal, which can be contrary to or different from the individuals' personal goals; in the medical encounter, the patient's health can be construed as a collective goal because it is the only reason for physician and patient to come together in the interaction field of the hospital or out-patient clinic (Bigi 2012).

Deliberation dialogues result from the combination of the information-seeking dialogue and the persuasion dialogue: on the one hand, the development of the deliberation dialogue involves the ability of the participants to share information that is relevant in view of the collective goal and to adapt to new information (Walton *et al.* 2014). On the other hand, however, the core feature of deliberation dialogues is the discussion of the proposals that are put forward by each of the participants in the dialogue, who may also decide to support or criticize the proposals by putting forward arguments in favor or against them. This is the crucial point in which the deliberation and persuasion dialogues are combined and work together towards the definition of the best course of action in the given circumstances; indeed, it is often the case that, in view of new information introduced by any one of the participants, the proposal accepted in the end is very different from the ones put forward at the beginning (Walton 2006).

Deliberation dialogues develop in three stages: the opening stage, the argumentation stage, and the closing stage. In the case of the medical consultation, these stages correspond to the process of shared decision-making. The opening stage is where the parties share information and preferences and formulate the governing question (McBurney *et al.* 2007) – i.e., the question regarding the actions to take. In the argumentation stage, proposals are put forward and possibly changed if new information comes in, modifying the initial scenario. At this stage, parties may want to argue in favor of or against

TYPE OF DIALOGUE	INITIAL SITUATION	PARTICIPANT'S GOAL	GOAL OF DIALOGUE
Persuasion	Conflict of opinions	Persuade other Party	Resolve or clarify issue
Inquiry	Need to have proof	Find and verify evidence	Prove (disprove) hypothesis
Discovery	Need to find an explanation of facts	Find and defend a suitable hypothesis	Choose best hypothesis for testing
Negotiation	Conflict of interests	Get what you most want	Reasonable settlement both can live with
Information-Seeking	Need information	Acquire or give information	Exchange information
Deliberation	Dilemma or practical choice	Co-ordinate goals and actions	Decide best available course of action
Eristic	Personal conflict	Verbally hit out at opponent	Reveal deeper basis of conflict

Figure 2. *The seven basic dialogue types (McBurney and Parsons 2001)*

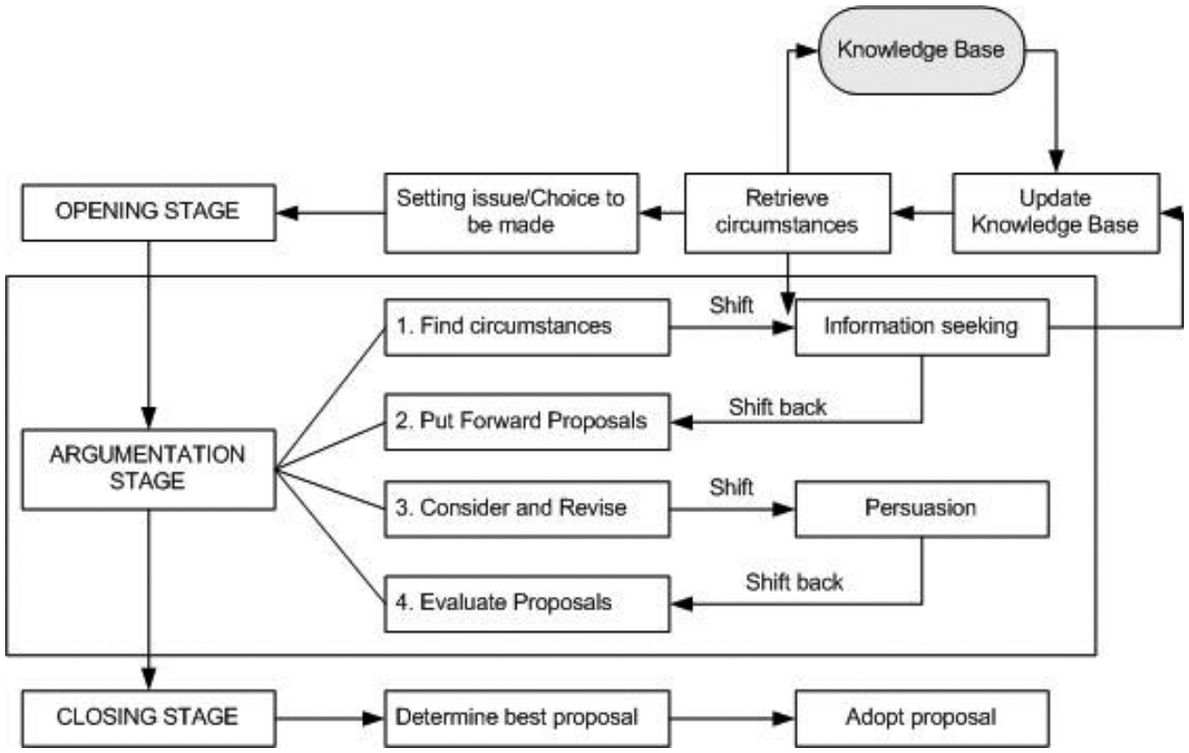

Figure 3. *The three stages in deliberation dialogues (Walton* et al. *forthcoming)*

a proposal, thereby shifting to a persuasion dialogue. In the closing stage the parties agree on a course of action, thus committing to jointly perform it in order to achieve the collective goal.[2]

Figure 3 represents the structure of deliberation dialogues, highlighting in particular the interaction between the information-seeking and persuasion dialogues within the argumentation stage (Walton *et al.* 2014: 9):

If the model of deliberation dialogue in Figure 3 can be considered as a representation of the process of shared decision-making within the chronic care consultation, its argumentation stage could be considered as the phase of collaborative goal setting, in which – after collecting the data regarding the patient's health (opening stage) – it is necessary to make a decision regarding the best therapy and behaviors the patient should adopt until the next encounter. On the backdrop of this new perspective on collaborative goal setting, in the following sections I will propose initial answers to the open questions described in Section 2.

5. Proposals and the 'success conditions' of collaborative goal setting

According to Lafata,

> not all 'collaborative goal setting' is equal in its ability to improve patient outcomes. […], while our findings, on the one hand, support previously demonstrated benefits of active patient participation during office visits, they also continue to illustrate *the challenges in understanding the mechanisms through which active participation leads to these benefits* and how best to foster productive participation processes during clinical encounters as well as how to do so in a timely, proactive fashion. (Lafata *et al.* 2013: 98; italics added)

Viewed within the larger framework of the deliberation dialogue, collaboratively setting a goal is a process that develops around the pivotal 'action' of making proposals and discussing them, together. However, it still needs to be considered how this is achieved in a 'timely, proactive fashion'.

According to Walton (2006), 'making a proposal' within the deliberation dialogue is

the pivotal dialogical move and is defined as a 'speech act'. A speech act is the combination of a proposition (e.g. 'you have gained weight') with an illocutionary force (e.g. a reprimand, or worry). In order to reach their intended communicative goal, speech acts have to be performed by respecting certain 'felicity conditions'. If they do not, the risk is for a failed communication (Austin 1962). In the case of the proposal within a deliberation dialogue, Walton indicates three different types of conditions that must be realized in order for the proposal to be a valid speech act.

Pre-conditions define the characteristics of the dialogical situation in which 'making a proposal' can be considered a speech act: a proponent and a respondent are engaged in a deliberation dialogue (a doctor and a patient are engaged in collaborative goal setting), there is a governing question of the dialogue ('what can be done about your weight gain?'), the proponent puts forward a proposition saying s/he *proposes* it (the doctor or patient proposes a treatment or behavior change, e.g. the patient could propose to exercise more), and the proposal is an appropriate answer to it (either party suggests actions that are relevant for the problem, e.g. if weight loss is the problem, eating less pasta or exercising more would be relevant actions).

Defining conditions set the function and structure of proposals by positing that when a proposition describing an action is put forward in the argumentation phase, it is a speech act. Therefore, by performing it, the proponent is advocating that both parties commit to carrying out the action proposed. For example: the doctor suggests an action that will help the patient lose weight. The problem that may arise in relation to defining conditions is referred to as 'pragmatic ambiguity'; i.e., it is not always very clear which dialogical activities the participants are performing (for example, is the doctor *explaining* the mechanisms that favor high levels of sugar in the blood, or is she *arguing* in favor of healthier eating habits?).[3]

Post-conditions define the conditions of validity for commitment and response. The proponent's commitment to the action is assumed as soon as s/he proposes it. So, for example, if the patient proposes to cut down on pasta, the doctor may assume that s/he is committing to this course of action and may consider the patient responsible for acting or not on this proposal in the future. Of course, in the context of the chronic care relationship 'considering someone responsible for their actions' should be considered in the perspective of patient empowerment, whereby holding patients accountable is done as a way of letting them progressively develop a sense of ownership and responsibility, which will increase the perception of self-efficacy and lead to the goal of self-management. The post-conditions also describe the ways in which the respondent can criticize a proposal. This can be done in various ways, basically by objecting that the proposal does not represent an appropriate way to reach a solution to the problem agreed upon at the beginning of the discussion (Walton 2006: 33).

The three sets of conditions describe the validity conditions of making proposals, and we may argue that validly putting forward proposals is a success condition for collaboratively setting goals. More specifically, in order for proposals to be validly performed, an effective process of collaborative goal setting should feature the following elements for both parties:

(1) awareness that there is room for putting forward proposals that have to do with what the patient should perform in order to improve his/her own health conditions, e.g. a 'trigger' from the doctor such as: 'So, Mr. Smith, what do you think you could do until our next meeting to lose at least two kilos?';
(2) awareness that doing something is necessary and unavoidable if the higher values of better health, satisfaction, and adherence are to be achieved; e.g. if the patient does not seem convinced about the necessity for taking action, the doctor should explicitly address this issue before moving on to the phase of putting forward proposals (argumentation stage); and
(3) the possibility to comment on or express doubt about the proposals that are being

put forward, e.g. if the patient does not propose anything, immediately accepts the doctor's proposal or remains silent, s/he should be stimulated by the doctor to comment or express any perplexities regarding the proposal at issue.

In all cases, if proposals are put forward when the validity conditions have not been fulfilled, they are not valid speech acts, i.e. they cannot have the same force of 'changing reality'. And in this context, 'reality' would correspond to patients' commitments.

6. The problem of preferences and values in practical reasoning

I now turn to the other open questions regarding collaborative goal setting: what are the factors that improve or impede agreement on treatment goals and strategies (Heisler *et al.* 2003)?, and how can physicians effectively help patients make their preferences explicit and then co-construct with them informed preferences to help them reach their therapeutic goals (Epstein and Gramling 2013)? To answer these questions we must turn to the structure of the reasoning that is embedded in the deliberation dialogue and to the problem of preferences and values.

Preferences and values come into play in two crucial moments for decision-making: the definition of the goal, and the choice of the means to bring about the goal. These two evaluative steps are presupposed by the pattern of practical reasoning, in which deliberation is rooted and which can be represented as follows:

> I have a goal G.
> Bringing about A is necessary (or sufficient) for me to bring about G.
> Therefore, I should (practically ought to) bring about A.

This pattern sets the relationship between something that is desirable (G) and the means to achieve it (A). But how do agents determine what is desirable (the goal)? As explained in Macagno (forthcoming), the evaluative process leading to the identification of what can be defined 'good' and 'better' is complex and rooted in two subsequent logical steps: the argument from classification and the argument from values.[4] The argument from classification describes the process through which an entity is classified as desirable or not.[5] The link between this judgment and the commitment to a goal is made through the argument from values,[6] in which the value judgment that caused a state of affairs to be defined as desirable (e.g. my health) becomes the premise for the evaluation of a goal to be considered acceptable (e.g. lose weight), which in turn causes the commitment of the agent to this goal (e.g. starting to eat less pasta).

It is at this point that practical reasoning is called into play, by connecting a commitment to a goal with the means that are necessary for the goal to be achieved:

> I have the goal of losing weight.
> Eating less pasta is necessary (or sufficient) for me to lose weight.
> Therefore, I should (practically ought to) start eating less pasta.

In everyday dialogues, the arguments from classification and from values that lead to practical reasoning usually remain implicit: the classificatory criteria and the values (in other words, the preferences) that substantiate the acceptability of the goal indicated in practical reasoning are assumed, depending on the context of the interaction, based on social conventions and the knowledge shared between the interlocutors. It is quite clear that, especially in contexts where there is a considerable amount of unshared knowledge between the interlocutors, the parties often do not share the evaluations behind practical reasoning. In these cases, parties involved in a deliberation dialogue merely assume a shared goal and discuss certain means to achieve it, but serious misunderstandings may occur and failure to arrive at a shared solution is frequent.

Connected to this is the issue of the evaluation of what actions to pursue in order to reach the intended goal. In this case, it is fundamental to assess the consequences of the different options for action. This is done by using the argument from positive/negative consequences;

for example: 'if I take these pills, I will feel better'/'if I take these pills, I will suffer from side effects'. When this argument is used within a dialogue, the assumption is made that there are common standards between the parties for what can be considered 'good' and 'bad' values. It would be interesting to collect systematic evidence to observe how frequently the argument from consequences is used in chronic care encounters, by whom, and based on what values.

At the heart of the reasoning behind both the definition of a goal and of the choice of the means to reach a goal, we find preferences and values. However, in both cases these remain 'hidden' in the implicit (presupposed) part of the reasoning. This indicates that one factor that could surely improve agreement on treatment goals and strategies (Heisler *et al.* 2003) would be to make sure the values and preferences that guide decisions are shared.

The model of the deliberation dialogue offers a realistic blueprint for doing this, by indicating that the knowledge base from which the deliberation starts should be 'reopened' during the argumentation stage, to allow for new circumstances and criteria for the evaluation of proposals. In other words, the model indicates that the most effective way of finding agreement is to avoid taking for granted the knowledge base, which includes the preferences and values that drive decisions and that may have changed over the course of time. This leads us to the final question: how can physicians effectively help patients make their preferences explicit and then co-construct with them informed preferences to help them reach their therapeutic goals (Epstein and Gramling 2013)? Again the model of the deliberation dialogue indicates that the preferred path leading to the co-construction of informed preferences resides in the close interaction between the information-seeking dialogue and the persuasion dialogue.[7] By allowing for the knowledge base to be 'reopened' during the argumentation stage, the parties will allow for new information to be addressed, evaluated and – if it is the case – integrated in the knowledge base, which amounts to the process of 'making preferences explicit', 'co-constructing preferences' and 'making informed decisions'. For example, the argumentation stage may begin based on the patient's decision to refuse a certain pill due to his/her preference for avoiding side effects; but the doctor may inform the patient about the existence of a new pill with lesser side effects, thereby updating the patient's knowledge base and bringing him/her to a modification of his/her preferences. Of course the issues are not always so simple and the model will need to be applied to various chronic care settings in order for its functioning to be discussed in more detail, but I believe its explanatory and normative potential can be understood even from such a simple example.[8]

7. Discussion and implications for further research

To sum up, it is possible to say that an optimal collaborative goal setting in the chronic care encounter should feature:

(1) an opening phase in which it is clear to both parties that 'something has to be done'. Doctors should therefore make sure that the urgency for action is clear also to their patients;
(2) a complete argumentation stage, in which both parties have the chance to put forward proposals and to comment on all of them;
(3) an explicit closing stage, in which both parties agree on one proposal, thus committing to it: the patient committing to carrying it out, the doctor guaranteeing for its relevance to the attainment of the collective goal and committing to checking its effects during the next encounter.

The analysis of the deliberation process through the lens of the deliberation dialogue shows that it develops through the uncovering of relevant information and a shared discussion about what to do (opening and argumentation stages). Both these factors can be expected to enhance patients' self-efficacy, which is a hypothesis that

should be verified through empirical studies. If this were confirmed, however, we would be able to answer the question formulated by Heisler *et al.* (2002) through showing that collaborative goal setting does not impact directly on the self-management abilities, but via self-efficacy.

Moreover, the requirements of the model of deliberation confirm that information alone is not sufficient to foster the necessary motivation for patients to maintain long-term treatment adherence (Heisler *et al.* 2002; Epstein and Gramling 2013). As has been argued, commitment is generated by a process of definition (argument from classification), which qualifies a certain state of affairs as desirable, or 'good'. Through the argument from values, this judgment is then connected to a commitment, i.e. a decision to act in view of the desirable goal. In order to enhance patients' commitment towards the collective goal of their improved health, the provision of information needs to be accompanied by an explicit process of value and preference sharing.

In conclusion, the biggest advantage of the approach described in this paper is that it moves from a theoretical model rather than from empirical data, allowing the outline of an overarching framework that can include all particular cases and offering a normative perspective on the issue of optimal communication styles in chronic care. This approach goes in the direction of addressing the problem of the lack of an 'overarching theory for why things happen as they do between doctors and patients' (Roter and Hall 2006: 40), an issue addressed by many researchers who have observed the proliferation of empirical studies on communication between doctors and patients that are not systematic, rely on very diverse theoretical models, have often not been validated and produce results that are not comparable (among many others, Heritage and Maynard 2006; Wirtz *et al.* 2006; Street 2013). The approach outlined in this paper also allows the formulation of hypotheses that can be tested on real-life cases, in contrast to starting from patient outcomes (a complex notion in itself) and trying to empirically reconstruct the factors that influence them.

Notes

1. Dialogue types, along with argumentation schemes, have been applied especially in the field of Artificial Intelligence, in particular in computer-assisted argument mapping technology, which has very interesting applications – e.g. in the field of e-democracy (Atkinson *et al.* 2005; Walton 2005) and intelligence analysis (Atkinson *et al.* 2012; Toniolo *et al.* 2013).
2. It is necessary to note that in the case of the medical encounter the collective goal will not be achieved by a *joint action* of the parties. Only the patient will act, so the deliberation is about an action that both parties need *to agree* on. The doctor's agreement is necessary because of his counseling role in the interaction; on the other hand, only the patient knows which actions are possible for him in the specific circumstances of his life at that moment in time.
3. On this issue, see Bigi and Labrie (in preparation).
4. According to Walton and Reed (2002), argumentation schemes are argument forms that represent inferential structures of arguments used in everyday discourse.
5. Argument from classification (Macagno, forthcoming):

Premise 1:	If some particular thing *a* can be classified as falling under verbal category *C*, then *a* has property *P* (in virtue of such classification)
Premise 2:	*a* can be classified as falling under verbal category *C*
Conclusion:	*a* has property *P*

6. Argument from values (Macagno, forthcoming):

Premise 1:	The state of affairs *x* is *positive/negative* as judged by agent *A* according to Value *V* (value judgment)
Premise 2:	The fact that *x* is *positive/negative* affects the interpretation and therefore the evaluation of goal *G* of agent *A* (If *x* is *good*, it supports commitment to goal *G*)
Conclusion:	The evaluation of *x* according to value *V* is a reason for retaining/retracting commitment to goal *G*

7. In the literature on patient–physician encounters, persuasion is usually considered a form of manipulation. Rubinelli (2013) distinguishes four

forms of persuasion and argues that 'rational persuasion' can actually be beneficial in the medical encounter, as it aims at changing the patients' beliefs in order to change their attitude and behaviors by proposing various reasons in support of a certain point of view. This leaves the patient in the position to object or refuse the proposed persuasion, thus distinguishing it from manipulation and proposing a communication style that is actually quite inclusive and participatory. See also the contributions by Milos Jenicek on the role and use of reasoning in medicine (Jenicek and Hitchcock 2005; Jenicek 2009).

8. A paper is in preparation in which the model of the deliberation dialogue, which is here described on a theoretical level, will be applied as an analytical tool to real-life consultations in haemophilia.

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