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Table of contents – Indice

ESSAYS – SAGGI

BOOK REVIEWS – RECENSIONI

The agency in language and the professionals' intercultural competences: A case study on the educators' "pivot move" in medical visits of unaccompanied minors

Letizia Caronia, Vittoria Colla, Federica Ranzani*

Abstract

The presence of unaccompanied minors (UAM) in the Italian health care system represents a recent phenomenon, not fully investigated from a pedagogical perspective. The article reports findings from an exploratory study on medical visits involving UAMs with low communicative competence in the language of interaction, and their accompanying educators. Adopting a Conversation Analysis-informed approach to a corpus of video-recorded visits, we analyze the "problem presentation" and "history taking" phases. We singled out two resources (the 'pivot move' and the 'oscillating addressivity') respectively used by the educator and the physician to 1) pursue the "incompatible goals" of their agendas and 2) manage the UAM's participation in the interaction by attributing him agency (or not). Focusing on the (inter)professional challenges of this triadic medical encounter, in the conclusion we advance that the awareness of the communicative details through which agency can be allocated or revoked is part of the intercultural competences of professionals working for UAM's inclusion in the host society.

Keywords: *triadic medical visit; interprofessional care; doctor-patient interaction; ethnography in health care settings; conversation analysis.*

1. Introduction

The article reports findings from an exploratory study on triadic medical visits involving unaccompanied minors (hereafter UAM). Focusing on the medical interaction as it unfolds in different phases of the visit (see Heritage & Maynard, 2006a), the article illustrates the discursive and multimodal practices through which the physician and the educator differently manage the inclusion of the UAM as an active participant in the visit. Following a phenomenologically oriented approach to the constitution of the crucial dimensions of everyday life (see Schutz 1967[1932]; Besoli & Caronia, 2018), we maintain that the ways in which the patients are conversationally treated (or not) as interactionally competent know-

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ing subjects, project (or not) a sense of agency and therefore participate in (de)constructing their locally relevant identity. Further, we consider that the ways the physician and the educator orient toward the UAM patients' agency display their respective institutional goals as well as their "professional vision" (see Goodwin, 1994) concerning the UAM's epistemic rights in the medical encounter.

The article is structured as follows. In the introductory sections, we delineate the crucial role of educators in the Italian foreigners' reception system, describe the overall structure of medical visits as an institutional event and then report extant studies on triadic medical interaction. In the analysis, we focus on the physician's contributions that acknowledge or deny the UAM patient's agency and illustrate a) their distribution in the different phases of the visit, and 2) the educators' alignment or resistance to these contributions. We then present a series of excerpts of video-recorded physician-UAM-educator interactions occurring during the first part of the visit. The excerpts are analyzed adopting an ethnographically nurtured Conversation Analysis-informed approach, which has proved to be well-suited for studying not only the agency *of* language, i.e. language as a social action (see Caronia & Orletti, 2019) but also, and more importantly, the agency *in* language (use), i.e. language as a tool for the ascription, recognition or denial of agency (see Duranti, 2004; Donzelli & Fasulo, 2007). The analysis illustrates what we call the "pivot move", i.e. a multimodal contribution through which the educator constructs the UAM as the physician's responder. In the discussion we advance that several interactional aspects appear to occasion the educator's "pivot move": namely, the phase-specific relevance of the patient's epistemic status, the degree of communicative competence necessary to make it "actionable through talk" (Heritage, 1997: 222), as well as the "oscillating addressivity" of the physician's preceding turn. Focusing on how the "pursuing understanding vs. allocating agency" dilemma is cooperatively managed by both professionals, in the conclusions we enlighten the "interactive vigilance" of the educators, i.e. their capability to restore the UAM's agency whenever appropriate. We propose considering the awareness of the power of language (see Caronia & Orletti, 2019) in constituting the UAM patient's agency and in managing the care professionals' "incompatible goals" as an essential component of their intercultural competences.

2. The (pedagogical) role of educators in the Italian reception system

The presence of UAM represents a new and challenging phenomenon for the Italian welfare and foreigners' reception systems: given their "unaccompanied" status as well as linguistic and cultural differences, UAM may experience serious difficulties in accessing health-care and social services (see Saglietti, 2019). The national law 47/2017 has

recently strengthen the UAM's rights and protection, establishing their reception in the SPRAR system (System of Protection for Asylum Seekers and Refugees) until they turn 18 and 6 months. Within these residential care structures, the UAM are supported by professional educators in the accomplishment of their everyday practices.

The educators' institutional mandate consists in mediating the encounter between the UAM and the host society, as well as promoting their active participation and empowerment. In compliance with this pedagogical mandate, the educators work to broaden the UAM's "spaces of possibility" (see Contini, 2014; Demozzi, 2017), supporting and accompanying them in their administrative, educational and health-care related accomplishments. Not surprisingly, the educator-UAM pedagogical relationship exemplifies the paradoxical dimension of any educational relationship (see Fabbri, 1996). In order to foster the UAM's autonomy and agency, educators should be, at the same time, present and distant: they should scaffold UAM enough to make them feel they can count on someone who cares yet, concurrently, they should pursue the UAM's autonomy and avoid establishing a dependency bond.

As data in our study reveal, the UAM triadic medical visits represent a challenging territory for the educators' professional "paradoxical injunctions" (see Fabbri, 2012, 2016): while they should ensure understanding throughout the process of "giving and taking" biomedical information characterizing the medical encounter, they are above all expected to maximize the UAM's empowerment and participation in any occasion of their daily life. If pursuing the former goal risks delegating to the educator the understanding of the UAM patients' condition and the management of their health care, pursuing only the latter risks serious misunderstanding about diagnosis and treatment.

3. The medical visit as an institutional event: phases, epistemic asymmetries and agency distribution

As any institutional interaction, medical encounters have an overall structure of phases (see Drew & Heritage, 1992; Orletti, 2000).

Each phase is characterized by a specific goal, a typical structure of participation and discernable boundaries, to which the participants are socialized and orient with "considerable exactness" (Heritage & Maynard, 2006b: 363). Research concurs in identifying six phases of the medical encounter. The "opening sequence" is generally followed by the "problem presentation" phase aimed at identifying the reasons for the visit. In the "history taking" phase, patients are asked information concerning their medical history (e.g. previous medical conditions, current medications, family and social background). During the "physical examination", which routinely follows the history-taking phase, the physician inspects and assesses the patient's body in order to acquire objective information on the

patient's status. The visit typically progresses with the delivery of the diagnosis and the treatment recommendations. The encounter ends with pleasantries that signal the "closing sequence", i.e. greetings.

The phases differ in the locally relevant types of knowledge and the related distribution of epistemic rights among participants (see Heritage, 2010; Heritage & Raymond, 2005; Raymond & Heritage, 2006; Stivers *et al.*, 2011; Orletti, 2000; Pasquandrea, 2013). In the first part of the visit (i.e. problem presentation, history taking and physical examination) the patient is typically and consistently treated by the physician as the "epistemic authority" (see Heritage, 2012), i.e. the most knowledgeable participant having "first-hand" access to the locally relevant type of knowledge (his subjective status, symptoms and medical history). The patients' epistemic authority in the domain of experiential knowledge ("the voice of the life-world", see Mishler, 1984) is displayed by the participants' ways of engaging in the questioning activity during the problem presentation, the history taking, and the physical examination (see Heritage, 2010). Conversely, the physician emerges as the most knowledgeable participant in the second part of the visit, where diagnosis and treatment recommendations are at stake and "the voice of medicine" (i.e. the expert knowledge implied in assessing and prescribing, see Mishler, 1984) is the most relevant one.

The linguistic and interactional practices adopted in the phases of the medical visit crucially impact the construction of the patient's agency, i.e. their competence in making the difference in the unfolding of the visit.[1] It is indeed *in and through* the interaction that patient and physician locally manage their agentivity and, in particular, their "interactional agency", i.e. "the right to speak and to actively participate in conversation" (Bazzanella, 2009: 253, see also the notion of "enunciative agency", Fasulo, 2007: 217).

Stressing the importance of acknowledging the patients' (interactional) agency, several studies converge toward the suitability of what has been called the "patient-centered approach" (see Mishler, 1984; Heritage & Maynard, 2006b; Mead & Bower, 2000; Baraldi & Gavioli, 2013; Orletti & Iovino, 2018). Within this approach, the acknowledgement of the patient's agency is not only an ethical issue (see the Italian law 219/17), but also and above all a means for maximizing the patients' compliance, i.e. their adherence to the therapy.

Involving the patients in the medical interaction can be a challenging task when they do not possess a good enough communicative competence in the language of the visit. This is typically the case of most triadic medical encounters.

1 Although the notion of "agency" has been diversely conceived and defined by different scholars (see Giddens, 1984; Duranti, 2004; Cooren, 2004, 2010; for a review see Ahearn, 2001), all the definitions share a core meaning (i.e. the power of making a difference) and scholars commonly acknowledge the central role played by language and social interaction in the construction of the participants' (local) agency (see among others Duranti, 1997, 2004).

3.1 Triadic medical interactions

Once the cruciality of the patient's active participation in the medical encounter is acknowledged, a question arises as to how to deal with patients having minimal (or no) communicative competence in the language of the medical institution. In this case, a third participant is needed in order to support the patient in pursuing a full understanding of the interaction. Research on triadic medical visit typically concerns medical encounters involving native parents and children (see among others Stivers, 2005a, 2005b, 2007; Tates & Meeuwesen, 2001; Tates *et al.*, 2002) as well as interpreters and non-native patients (see Baraldi & Gavioli, 2012, 2013).

Conversation analytic research on parent-mediated pediatric visits has highlighted the physician's tendency to exhibit different behaviors according to the intended recipient of their contributions. When interacting with parents, the practitioners perform an instrumental (cure oriented) behavior, characterized by the delivery or request of medical information. On the contrary, when addressing children, they are more likely to use an affective (care oriented) behavior (see Hall *et al.*, 1987; Ong *et al.*, 1995). As for the recipient selection by the physician, research is not consistent. Some studies report that the participants orient to the child's participation as an exceptional event (see Tates & Meeuwesen, 2001; Aronsson & Rundstrom, 1988; Freemon *et al.*, 1971; van Dulmen, 1998). On the contrary, Stivers (2001) illustrates quite a different pattern: the physician selects the child as the next speaker in the majority of the problem presentation questions and the parents provide an answer only when the child demonstrates some inability to respond. The "parental speaking for the child" activity (see Tates *et al.*, 2002) emerges as a negotiated contingent product of the interaction among the physician, the child, and the parent(s) (see Stivers, 2001).

Conversation analytic research has also shown the active role played by cultural-linguistic mediators in interpreter mediated medical interactions (see Wadenjsö, 1998; Bolden, 2000; Davidson, 2002). Being institutionally in charge of "speaking for" the patient, i.e. giving voice to participants' talk in another language (see Amato, 2009), not surprisingly interpreters often substitute to patients within this interactional frame. Not only do they translate the participants' turns, but they also contribute to constituting the medical information by negotiating and building new meanings (see Mason, 2006; Cronin, 2006). Furthermore, interpreters' verbal and multimodal actions contribute to foster or hinder the patients' agency and epistemic authority (see Baraldi & Gavioli, 2013).

To our knowledge at least, no research has ever addressed the specific type of interaction occurring when an educator participates in physician-UAM medical encounters, even if their role is quite specific with respect to other accompanying adults involved in triadic medical visits.

3.2 Triadic medical visits with UAM: the multiple asymmetries at stake

Compared to medical visits mediated by parents or cultural-linguistic interpreters, triadic encounters with UAM are characterized by further levels of complexity and therefore challenge the professionals involved in taking care of these patients. There are at least four types of asymmetry that can be made "actionable through talk" (Heritage, 1997: 222) during the visit (see Caronia *et al*., 2019). First, what is at stake is the institutional epistemic asymmetry governing the medical visit, i.e. the socially sanctioned privilege of the expert knowledge over the experiential knowledge and the correspondent asymmetrical status of those who embody those epistemic positions. Second, the linguistic asymmetry: the UAM patients have little or no competence in the language of the visit and neither the educator nor the physician know their L1. Third, the interaction is also characterized by a strong social asymmetry as the UAM patients live in an extremely fragile condition given their migratory paths and post-traumatic status. Last but not least, these interactions are characterized by the socially sanctioned hierarchy of professional expertise and the consequent stratification of the professional's interactional rights. Despite the pressure for a flat hierarchy in interprofessional collaboration (see Machin *et al*., 2019), participants in the medical visit still orient to the primacy of the physician's knowledge over the educator's professional knowledge: not surprisingly the educators systematically align with the physician's actions and cooperate in maintaining his interactional dominance (i.e. the socially approved power to establish who speaks, when and about what, see Orletti, 2000; Orletti & Iovino, 2018). Despite these characteristics, the goals of the professionals' agendas remain the same: while for the educators the promotion of agency constitutes the main goal, for the physician the acknowledgement of agency is assumed to be functional to pursuing the understanding of medical information, and ensuring healing by maximizing the patient's compliance to the therapy.

Given the system of intertwined asymmetries of UAM triadic medical visits, some goals that in most medical visits are synergic (e.g. ensuring understanding of the medical information and pursuing the patients' agency) become "incompatible": the more professionals pursue understanding, the more they have to exclude the UAM as the intended recipient of their talk; the more they pursue the UAM patient's agency by addressing him, the more they risk to miss the full comprehension of his health conditions and even more of the diagnosis and the treatment recommendations.

How do the professionals manage to recognize the UAM as active agents of their own healing while, at the same time, ensuring full understanding of the medical information?

In the next sections we present data from an exploratory study aimed at describing the communicative resources adopted by the physicians and the educators when copying with this practical dilemma. Particularly, we focus on the communicative construction of the UAM's *interactional* agency.

4. Data, corpus and procedures

The excerpts presented in this article are drawn from a corpus of three video-recorded medical visits totaling 88,72 minutes. Each medical visit involved an Italian family physician, one UAM patient and the educator. The researcher was also present during the medical visits as the responsible for positioning and switching on/off the video camera. The UAM participating in the research were aged between 16 and 18 and had a minimal competence in Italian or didn't master it at all, despite having been in Italy for one or two years at the time of the video recordings (i.e. June-July 2018). The participants were recruited by the third author through her work connections and their consent was obtained according to the Italian laws regulating the handling of personal and sensitive data. For the sake of anonymity, all names have been fictionalized. The excerpts presented here have been transcribed using Conversation Analysis conventions (see Jefferson, 2004). In line with the multimodal approach to social interaction (see Goodwin, 2000; Mondada, 2007), transcriptions have been enriched with notations for gaze, gestures, body movements and orientations when ostensibly relevant for participants as a means to unfold the interaction. Original conversations in Italian have been almost literally translated in English.

5. When and how professionals (de)construct the UAM as an interlocutor

For the purpose of this study, we firstly scrutinized the video recordings focusing on the constitution of the UAM's interactional agency. As the participation framework is constituted, negotiated and even challenged through a multitude of semiotic resources (see Duranti, 1997), we paid particular attention to the multimodal means employed by the participants to select their interlocutor, namely: 1) linguistic and morpho-syntactic elements of turn design (see Drew, 2013); 2) turn-taking procedures, e.g. self vs. other next speaker selection procedures and overlapping talk (see Hayashi, 2013; Lerner, 2003); 3) embodied resources, e.g. gaze direction, gestures and body orientations (see Goodwin, 1981; Kendon, 1972; Mondada, 2007).

Focusing on the physician's interactional moves, we considered:

1. occurrences of *attribution* of interactional agency, those contributions where the physician addresses the UAM;

2. occurrences of *denial*, those contributions where, *despite talking about the UAM*, the physician addresses the educator as the recipient of his turn and/or as the next speaker.

According to these definitions, we singled out 279 occurrences of attribution and/or denial of the UAM's interactional agency and measured their distribution in the different phases of the visit (see Table 1).

Table 1 – Addressivity in physician's contributions in the different phases of the visit.

		Physician addresses		Total (100%)
Phases of the visit:		UAM	Educator	
First part of the visit	Problem presentation	26	2	28
	History taking	63 (60%)	42 (40%)	105
	Physical examination	26	0	26
Total		115 (72%)	44 (28%)	159
Second part of the visit	Diagnosis	0	14	14
	Treatment recommendations	15	62	77
Total		15 (16.5%)	76(83.5%)	91
Opening and closing greetings		10	19	29

In the first part of the visit (see Table 1), the physician appears mostly oriented to acknowledging the UAM's epistemic authority resulting from his first-hand experience of the illness (72%). However, he also appears oriented to the communicative asymmetry: in the history taking phase where a higher degree of linguistic competence is required, the physician addresses the patient in 60% of cases, adopting question formats that presuppose little communicative competence of the interlocutor. In the second part of the visit (see Table 1), the physician mostly selects the educator as his interlocutor (83,5%), despite talking about the co-present patient and/or his illness. We assume that, in doing so, he prioritizes ensuring the understanding of the diagnosis and treatment recommendations over acknowledging the patient's agency. In other words, during these phases, he enacts the so-called "medical agenda" focused on the biomedical evaluation and treatment (see Mishler, 1984).

Performing agency allocation in the first part of the visit and revoking it in the second part of the visit by selecting the educator as the intended recipient, is the way the physician deals with the "pursuing understanding vs. allocating agency" dilemma. But how does the educator, i.e. the other co-present professional, confront with this double bind?

5.1 The educators' orientation toward the "pursuing understanding vs. allocating agency" dilemma in UAM medical visit

We identified the educators' orientation to the physician's addressing forms, distinguishing the cases where the educator aligned with or resisted to the agency projected by the physician's turns addressivity.

Table 2 – The educators' alignment or disalignment to the physician's addressivity in the different phases of the visit.

Phases:	A Physician Selects UAM	A1 Educator *aligns*	A2 Educator *resists*	B Physician Selects Educator	B1 Educator *aligns*	B2 Educator *resists*
Problem presentation	26	26	0	2	0	2
History taking	63	61	2	42	41	1
Physical examination	26	26	0	0	0	0
Diagnosis	0	0	0	14	14	0
Treatment recommendations	15	14	1	62	62	0
Opening and closing greetings	10	10	0	19	19	0
TOTAL:	140	137 (97,8%)	3 (2,2%)	139	136 (97,9 %)	3 (2,1%)

As Table 2 shows, the educator basically aligns with the physician's turns addressivity. This comes as no surprise as aligning or disaligning with the previous turn addressivity are not equivalent alternatives. While alignment is functional to the smooth progression of talk and is therefore in line with the preference for progressivity in interaction (see Stivers & Robinson, 2006; on the notion of preference in conversation analysis see Pomerantz & Heritage, 2013), resisting to the physician's interlocutor selection violates this preference and is commonly treated as an accountable action. Alignment can also be considered as displaying the educator's orientation towards the physician's interactional dominance (see Orletti, 2000).

The cases where the educators resist to the physician's recipient selection are just 2% of the total. Despite being few, these "deviant cases" (see Schegloff, 1968; Perakyla, 1997; Ten Have, 1999) are extremely insightful precisely because they are atypical: they illustrate when and how the educator changes the interactional structure projected by the physician's turns. For the purposes of this study, we focus only on the cases where the educators resist to their having been selected by the physician as the intended recipient in the first part of the visit (column B2, Table 2): they do this by carrying out a particular type of repair (Schegloff *et al.*, 1977), which we call a "pivot move". In the next section we qualitatively analyze this phenomenon.

5.2 Reallocating the interactional agency to the UAM: the educators' "pivot move"

The next example illustrates an occurrence of the "pivot move", i.e. an interactional move through which the educator, who has been selected by the physician as an interlocutor, multimodally passes his turn to the UAM. In repairing the physician's move, the educator withholds the answer to the physician's question and, after making a brief eye contact with him, visibly turns his head and gaze toward the patient. Through this move, the educator makes sequentially relevant for the physician to address the minor as his interlocutor and for the minor to start talking. Therefore, the "pivot move" appears to be effective in reorienting the participants towards the attribution of interactional agency to the UAM.

Ex. 1 – Malik (03.14 – 03.18)
D = Physician
E = Educator
P = Patient (Malik, 18 years old)

This excerpt marks the beginning of the problem presentation phase: after reconstructing with P his medical history, the physician asks the reason for the visit.

1	D	adesso ^sei qui per un altro ^^proble^^^ma? *now are ^you here for another ^^proble^^^m?*
2	D	^*((looks at the documents E's holding))*[fig. 1a]
3	D	^^*((looks at E))*[fig. 1b]
4	E	^^*((looks at D))*[fig. 1b]
5	E	^^^*((visibly turns towards P))*[fig. 1c]
6	D	*((stops looking at E and looks at P))*[fig. 1d]
7	P	sì e:: il mio occhio che °mi brucia° *yes e:: my eye that °itches° ((looking at D))*

Figure 1a

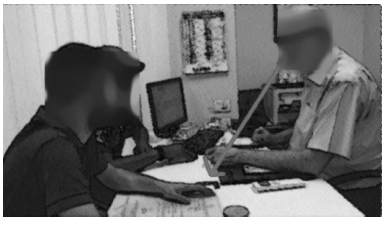


Figure 1b

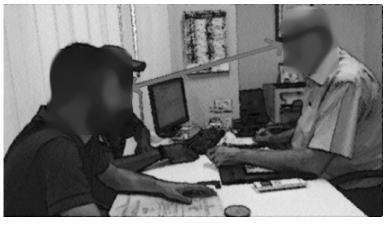


Figure 1c

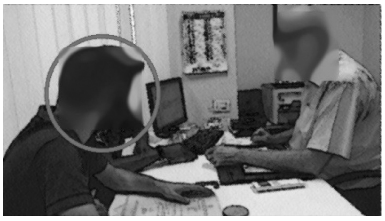
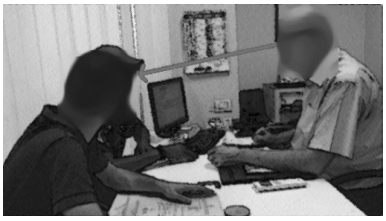


Figure 1d



In the turn at line 1, D asks for the reasons for the visit by means of a polar question favoring a positive answer (see Heritage, 2002, 2010). The turn is opened by the temporal deictic "now", which signals the end of the "history taking" and introduces the next phase, which, in this case, concerns the UAM's current conditions (i.e. the problem presentation phase). Despite using the second person singular in the question ("are you", line 1), D addresses E as his main interlocutor by looking at the documents he is holding (line 2, fig. 1a) and then, while pronouncing the word "problem", by directly selecting him with the gaze (line 3, fig. 1b, on next speaker selection through gaze see Lerner, 2003). Through this multimodal move, the physician manages to address the educator as his interlocutor while also verbally acknowledging the UAM as his patient.

E does not provide an answer to D's question and, after making a brief eye contact with him (line 4, fig. 1b), he visibly turns his head towards P (line 5, fig. 1c). Thus doing, E carries out a "pivot move": he passes his turn to P, selecting him as the next speaker. In other words, by withholding the answer and turning his head, E interactionally constructs P as the appropriate addressee of D's question. D aligns to E's multimodal selection of the next speaker: he looks at P too, thus constituting him as his interlocutor (line 6, fig. 1d). Then, P (who has been looking at D from the beginning of the excerpt, thus demonstrating his readiness to respond) positively answers to D's polar question ("yes") and discloses the reason for his visit ("my eye itches", line 7).

The following example illustrates another occurrence of the "pivot move" as a means employed by the educator to reallocate the turn, and therefore the interactional agency, to the minor.

Ex. 2 – Mahdi (10.23 – 10.35)
D = Physician
E = Educator
P = Patient (Mahdi, 16 years old)

We join the conversation when D asks P the reasons for the visit, thus opening the problem presentation phase.

1	D	^adesso ^^c'è un motivo ^^^per cui venite qui? ^*now* ^^*is there a motive* ^^^*why you come here?*
2	D	^*((looks at the documents E's keeping on the desk))*
3	D	^^*((looks at E))*[fig. 2a]
4	E	^^*((looks at D))*[fig. 2a]
5	E	^^^*((looks at P))*[fig. 2b]
6	D	*((stops looking at E and looks at P))*[fig. 2c]
7	P	*((looks down))*
8		(1)
9	D	qual è?= *what is it?= ((looking at P))*
10	P	*((looks at D))*
11	E	=come mai Mahdi? (.)sei voluto venire qua dal dottore? =*why Mahdi?* (.) *you wanted to come here to the physician?*

Figure 2a

Figure 2b

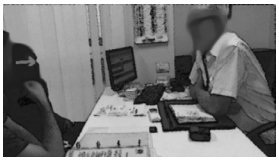
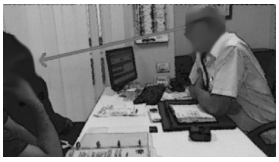


Figure 2c



As in the previously analyzed excerpt (ex.1), D introduces a new phase of the visit through the temporal deictic "now", which signals the end of the "history taking" phase (line 1). He then verbally addresses both E and P by using the second person plural, however, while pronouncing "is there a motive" he selects E as his main interlocutor through the gaze direction (see lines 2 and 3, fig. 2a). After making an eye contact with D (line 4, fig. 2a), E turns his head toward P (line 5, fig. 2b). In this way, E carries out a "pivot move": he passes the turn to P, selecting him as the expected answerer of D's question. D aligns to E's selection of P thus participating in constituting him as the intended respondent (line 6, fig. 2c).

Despite having been multimodally ratified as the next speaker by both E and D, P doesn't answer and looks down for a second (lines 7 and 8). At this point, D asks P (see the direction of D's gaze, line 9) the reason for the visit by means of an interrogative open question ("what is it?", line 9). He intervenes by formulating the physician's question by means of implementing its deictic references and using the personal name next speaker selection (see Sacks *et al.*, 1974; Lerner, 2003) (line 11). In making explicit

and narrowing the reference, the educator treats the physician's question as repairable and – at the same time – orients to the low communicative competence of the UAM patient. The use of the personal name further allocates interactional agency to the minor.

The following example illustrates an occurrence of the educator's "pivot move" during the "history taking" phase.

Ex. 3 – Aamir (03.06 – 03.14)
D = Physician
E = Educator
P = Patient (Amir, 18 years old)

This excerpt marks the beginning of the history taking phase. E and P are sitting side by side and D is sitting in front of them.

1	D	tu avevi avuto un altro problema? a parte *did you have another problem? a part from*
2	D	il discorso delle labbra che mi ricordo= *the lips that I remember= ((looking at P and touching his own lips))*[fig.3a]
3	D	= >aveva un altro problema anche<? = >*had he another problem too<? ((looking at E))*[fig.3b]
4	E	*((looks at D))*
5	E	*((assumes a thoughtful facial expression))* (1)
6	E	*((looks at P))*[fig. 3c]
7	P	questo *this one ((touching his lips and looking at E))*
8	D	eh quello lì. solo quello lì eh that one there. only that one there ((looking at P))

Figure 3a

Figure 3b

Figure 3c

D opens the history taking phase by asking about P's previous disease (lines 1 and 2). In his opening turn, D directly addresses P by multiple means: 1) he uses the second person singular ("avevi" in Italian, line 1), and the subject pronoun "you", which is marked in Italian; 2) he looks at P (see the direction of D's gaze, line 2, fig. 3a); 3) he touches

his own lips, thus making visible and explicit the referent of his utterance (line 2, fig. 3a). Through this "pointing" (see Kendon, 2009), D uses the semiotic resources available (i.e. his own body) to maximize the understanding of his words. Through this recipient designed utterance, he displays he is taking into account the UAM patient's low communicative competence in the language of the visit, while engaging him as a candidate interlocutor.

However, immediately after (see the latching), D formulates his question: by means of talking about P at the third person singular ("had he", line 3) and looking at E (line 3, fig. 3b), D now addresses E as his responder. After making a brief eye contact with D (line 4), E withholds the answer for one second (she does this by assuming a thoughtful facial expression, line 5), then turns her gaze toward P (line 6, fig. 3c). Once selected as the next speaker by the educator's "pivot move", P answers D's question (line 7). Finally, D confirms P's answer (line 8), thus ratifying him as an interlocutor.

6. Discussion

As our data show, in the first phases of the visit, both professionals appear to be mostly oriented to the UAM patient as the most knowledgeable participant while also orienting to his (known or assumed) low communicative competence in the language of the medical interaction. The physician selects the UAM as his intended recipient three times out of four, yet the ways he performs addressing (e.g. using mostly yes/no questions, see ex.1, 2, 3, line 1; multimodally indicating the referents of his talk, see ex. 3, line 2) display he is taking into account the UAM's low communicative competence. The physician typically selects the educator as his ratified recipient when a high communicative competence is required for understanding the medical information. As we mentioned above, most of the time the educators align with the physician's turns addressivity, thus contributing to acknowledging the physician's interactional authority and ratifying the oscillating positioning of the UAM patient as an agentive interlocutor.

However, there are few, yet remarkable, exceptions. Whenever the physician selects the educator as his intended recipient *during the problem presentation phase* (ex. 1 and 2), and in one occasion during the history-taking phase (ex. 3), the educator visibly re-directs the turn to the UAM by carrying out a "pivot move" (see ex. 1 and 2, lines 4 and 5, ex. 3, lines 4-6). Through this dispreferred action, the educator manages to reallocate the interactional agency to the UAM by making sequentially relevant for the physician to address him and for the minor to start speaking.

Even acknowledging the agentivity of the educator's "pivot move" in constituting the minor as an active participant, it is worth noting that it

does not occur in a sequential vacuum. Rather, as any interactional turn, it depends on the discursive environment where it occurs as well as on the immediately preceding turn (on the CA core analytic principle of "next-ness" see among others Schegloff, 1984). As to the discursive environment, the "pivot move" in our corpus occurs only during the first part of the visit, i.e. where the patient is typically treated as the most knowledgeable party (see Heritage & Raymond, 2005; Raymond & Heritage, 2006; Stivers *et al.*, 2011). The educator's contribution therefore appears to be phase-aligned: despite the UAM patient's low competence in the language of the visit, the educator treats him as the one having primary access to the relevant knowledge at stake "right here right now".

Additionally, we observed that the "pivot move" appears to consistently follow an occurrence of what we call "oscillating addressivity" by the physician. By this category we indicate the simultaneous or in-quick-succession use of different, not coherent nor stable resources as a means to *ambiguously* select the candidate next speaker. For example, while the physician acknowledges the UAM as a ratified participant by using the second person singular (ex. 1, line 1), he concurrently multimodally addresses the educator (see lines 2 and 3; for a similar pattern see ex. 3), or he uses the second person plural form while clearly addressing the educator with the gaze and the body direction (see ex. 2) as if he distributed next-speakership. By projecting the acknowledgement of the UAM's interactional agency while addressing the educator, the physician's "oscillating addressivity" paves the way to the educator's "pivot move".

7. Interprofessionality and the educator's interactional vigilance: concluding remarks

In this study we analyzed the ways in which the physician and the educator cope with the "pursuing understanding vs. allocating agency" dilemma. A first general finding concerns the phase-dependent distribution of "the agency-acknowledgment" activity: professionals do not engage in this activity in a generic way as if they were merely concerned with the moral obligation of the "patient-centered approach". On the contrary, they acknowledge the UAM's agency in ways and moments that are both consistent with the specific phase of the visit and sensitive to the communicative competence implied in actively interacting within each phase: the UAM patient's agency is recognized the most when he can contribute to the unfolding of the visit with a few words.

A second finding concerns the communicative resources deployed by the educator to redirect the agency to the UAM patient whenever possible. Focusing on the first part of the visit, we singled out the "pivot move". Through this move the educators display and accomplish their professional mandate (maximizing the minor's active participation in the host society): "speaking for" the patient therefore emerges not as an expected

and taken-for-granted practice, but rather as a negotiated form of participation. However, this move does not occur in a *vacuum* or in ways that are deaf to the institutional goals of the encounter. On the contrary, the educator appears to enact this move always after what we identified as the physician's "oscillating addressivity".

To summarize our findings: both the professionals constitute the minor as a ratified participant whenever they 1) assume he is knowledgeable about the matter at stake (e.g. his symptoms) and 2) assess the phase-relevant knowledge as deliverable even with minimal communicative resources (such as answering yes/no questions). The attribution of the interactional agency to the minor therefore appears to be a phase-consistent phenomenon, distributed and co-constructed by the participants in the sequential unfolding of the interaction: whenever the physician provides the possibility for the reallocation of agency, the educator grasps this opportunity and openly engages the UAM. Although we cannot demonstrate it, we advance that it is precisely the educators' professional mind-set and training that enables them to contribute in this interprofessional achievement by performing "interactional vigilance".

7.1 Limitations, direction for future research and implication for policies and practices

Like any exploratory single case study, our study's main contribution consists in singling out types of phenomena that become inspectable for the analysis and therefore a grounded empirical bases to orient the practices. More research is needed to analyze the professionals' communicative practices in the other phases of the visit as well as the systematic occurrence of the "pivot move" structural organization.

By illustrating how and when the educator engages in shifting the physician's addressivity, and the micro interactional practices (e.g. gaze direction, use of addressing terms, oscillating addressivity and pivot move) through which the professionals manage their "incompatible goals", data from this study can support professional training centered on reflexive thought (see Schön, 1983; Mortari, 2003). We contend that the awareness of the power of language (see Duranti, 1997, 2004) in the making of locally relevant identities (e.g. the UAM as an active patient) as well as the knowledge of the communicative details through which this occurs in ways that are compatible with the institutional goals of the encounter, are an essential component of the intercultural competences of the professionals working for the UAM's inclusion in the host society[2].

2 The article reports findings from a larger research project. It has been conceived and discussed by the three co-authors who shared the analysis and the conclusion. However, for all practical purposes, we owe to Letizia Caronia the paragraphs One, Six and Seven; to Vittoria Colla the paragraphs Four and Five; to Federica Ranzani the paragraphs Two and Three.

Bibliography

Ahearn, L.M. (2001), "Language and agency", in *Annual review of anthropology*, vol. 30, n. 1, pp. 109-137.

Amato, A.A.M. (2009), "L'orientamento dell'interprete ai parlanti nell'interazione mediata", in *La mediazione linguistico-culturale: una prospettiva interazionista*, Perugia: Guerra Edizioni, pp. 111-150.

Aronsson, K., & Rundström, B. (1988), "Child discourse and parental control in pediatric consultations", in *Text*, vol. 8, n. 3, pp. 159-189.

Baraldi, C., & Gavioli, L. (eds.) (2012), *Coordinating Participation in Dialogue Interpreting*, Amsterdam and Philadelphia: John Benjamins.

Idd. (2013), "La mediazione nell'interazione centrata sul paziente: il caso delle domande del medico", in *Salute e Società*, vol. XII, n. 1, pp. 94-109.

Bazzanella, C. (2009), "Agency e interazione: quando l'agency altrui è negata o assunta nella conversazione", in *Attanti, Attori, Agenti–Lexia (New Series)*, 03-04, pp. 249-270.

Besoli, S., & Caronia, L. (a cura di) (2018), *Il senso della realtà. L'orizzonte della fenomenologia nello studio del mondo sociale*, Macerata: Quodlibet.

Bolden, G. (2000), "Toward understanding practices of medical interpreting: Interpreters' involvement in history taking", in *Discourse Studies*, vol. 2, n. 4, pp. 387-419.

Caronia, L., & Orletti, F. (2019), "The agency of language in institutional talk: An introduction", in *Language and Dialogue*, vol. 9, pp. 1-27.

Caronia, L., Ranzani, F., & Colla, V. (2019), "Quando 'il parlar chiaro' non basta. Il lavoro di attribuzione di agency nelle visite triadiche a minori stranieri non accompagnati", *La comunicazione medica. Ciclo di seminari "Un Lessico per le Scienze Umane"*. Centro Internazionale di Studi Umanistici "Umberto Eco" – Università di Bologna.

Contini, M. (2014), *Deontologia pedagogica. Riflessività e pratiche di resistenza*, Milano: FrancoAngeli.

Cooren, F. (2004), "Textual Agency: How texts do things in organizational settings", in *Organization*, vol. 11, n. 3, pp. 373-393.

Id. (2010), *Action and Agency in Dialogue: Passion, Incarnation and Ventriloquism*, Amsterdam: John Benjamins.

Cronin, M. (2006), *Translation and identity*, London: Routledge.

Davidson, B. (2002), "A model for the construction of conversational common ground in interpreted discourse", in *Journal of Pragmatics*, vol. 34, pp. 1273-1300.

Demozzi, S. (2017), "Elogio della cura. Una riflessione sull'incontro tra pedagogia e medicina", in G.M. Anselmi & P. Fughelli (a cura di), *Narrare la medicina*, Bologna: Dipartimento di Filologia Classica e Italianistica, pp. 91-100.

Donzelli, A., & Fasulo A. (a cura di) (2007), *Linguaggio e Agency. Etnoteorie della soggettività e della responsabilità nell'azione sociale*, Roma: Meltemi.

Drew, P. (2013), "Turn Design", in J. Sidnell & T. Stivers (eds.), *The Handbook of Conversation Analysis*, Hoboken, NJ: Wiley-Blackwell, pp. 131-149.

Drew, P., & Heritage, J. (eds.) (1992), *Talk at Work: Interaction in Institutional Settings,* Cambridge, UK: Cambridge University Press.

Duranti, A. (1997), *Linguistic Anthropology,* Cambridge: Cambridge University Press.
Id. (ed.) (2004), *A Companion to Linguistic Anthropology*, Malden: Blackwell.
Fabbri, M. (1996), *La competenza pedagogica. Il lavoro educativo fra paradosso e intenzionalità*, Bologna: Clueb.
Id. (2012), *Il transfert, il dono, la cura*, Milano: FrancoAngeli.
Id. (2016), "Sciogliere i nodi del tempo. Ingiunzioni e predizioni paradossali fra esperienze personali e realtà storica", in *Rassegna di Pedagogia*, vol. LXXIV, n. 1-2, pp. 55-72.
Fasulo, A. (2007), "Cosa ha veramente detto X: due casi di agency contesa", in A. Donzelli & A. Fasulo (a cura di), *Linguaggio e Agency. Etnoteorie della soggettività e della responsabilità nell'azione sociale*, Roma: Meltemi, pp. 215-236.
Freemon, B., Negrete, V., Davis, M., & Korsch, B. (1971), "Gaps in doctor-patient communication: Doctor-patient interaction analysis", in *Pediatric Research,* n. 5, 298-311.
Giddens, A. (1984), *The Constitution of Society: Outline of the Theory of Structuration*, Berkeley: University of California Press.
Goodwin, C. (1981), *Conversational Organization: Interaction between Speakers and Hearers*. New York: Academic Press.
Id. (1994), "Professional vision", in *American Anthropologist*, vol. 96, n. 3, pp. 606-633.
Id. (2000), "Action and Embodiment within Situated Human Interaction", in *Journal of Pragmatics*, n. 32, pp. 1489-1522.
Hall, J.A., Roter, D.L., & Katz, N.R. (1987), "Task versus socio-emotional behaviors in physicians", in *Medical Care*, n. 25, pp. 399-412.
Hayashi, M. (2013), "Turn allocation and turn sharing", in J. Sidnell & T. Stivers (eds.), *The Handbook of Conversation Analysis*, Hoboken, NJ: Wiley Blackwell, pp. 167-190.
Heritage, J. (1997), "Conversation Analysis and Institutional Talk: Analyzing Data", in D. Silverman (ed.), *Qualitative Research: Theory, Method and Practice*, London: Sage Publications, pp. 222-245.
Id. (2002), "Ad hoc inquiries: Two preferences in the design of 'routine' questions in an open context", in D. Maynard, H. Houtkoop-Steenstra, N.K. Schaeffer, & H. van der Zouwen (eds.), *Standardization and Tacit Knowledge: Interaction and Practice in the Survey Interview*, New York: Wiley Interscience, pp. 313-333.
Id. (2010), "Questioning in medicine", in A.F. Freed & S. Ehrlich (eds.), "*Why do you ask?": The function of questions in institutional discourse,* New York: Oxford University Press, pp. 42-68.
Id. (2012), "Epistemics in Action: Action Formation and Territories of Knowledge", in *Research on Language and Social Interaction*, vol. 45, n. 1, pp. 1-29.
Heritage, J., & Maynard, D.W. (eds.) (2006a), *Communication in Medical Care: Interactions between Primary Care Physicians and Patients*, Cambridge: Cambridge University Press.
Idd. (2006b), "Problems and Prospects in the Study of Physician-Patient Interaction: 30 years of research", in *Annual Review of Sociology*, n. 32, pp. 351-374.
Heritage, J., & Raymond, G. (2005), "The terms of agreement: indexing epistemic authority and subordination in talk-in-interaction", in *Social Psychology Quarterly*, vol. 68, n. 1, pp. 15-38.

Jefferson, G. (2004), "Glossary of Transcript Symbols with an Introduction", in G. Lerner (ed.), *Conversation Analysis: Studies from the First Generation*, Amsterdam: John Benjamins, pp. 13-31.

Kendon, A. (1972), "Some Relationships between Body Motion and Speech. An Analysis of an Example", in A. Siegman & B. Pope (eds.), *Studies in Dyadic Communication*, Elmsford (NY): Pergamon Press, pp. 177-210.

Id. (2009), "Kinesic Components of the Multimodal Utterances", in *Berkeley Linguistics Society Proceedings,* Berkeley: Berkeley Linguistics Society, pp 36-53.

Lerner, G. (2003), "Selecting next speaker: The context-sensitive operation of a context-free organization", in *Language in Society*, n. 32, pp. 177-201.

Machin, L.L., Bellis, K.M., Dixon, C., Morgan, H., Pye, J., Spencer, P., & Williams, R.A. (2019), "Interprofessional education and practice guide: Designing ethics-orientated interprofessional education for health and social care students", in *Journal of Interprofessional Care*, n. 33, pp. 608-618.

Mason, I. (2006), "On mutual accessibility of contextual assumptions in dialogue interpreting", in *Journal of Pragmatics*, vol. 8, n. 3, pp. 359-373.

Mead, N., & Bower, P. (2000), "Patient-centredness: A conceptual framework and review of the empirical literature", in *Social Science & Medicine*, vol. 51, n. 7, pp. 1087-1110.

Mishler, E.G. (1984), *The discourse of medicine: dialectics of medical interview,* Norwood: Ablex Publishing.

Mondada, L. (2007), "Multimodal resources for turn-taking: Pointing and the emergence of possible next speakers", in *Discourse studies*, vol. 9, n. 2, pp. 194-225.

Mortari, L. (2003), *Apprendere dall'esperienza*, Roma: Carocci.

Ong, L.M., De Haes, J.C., Hoos, A.M., & Lammes, F.B. (1995), "Doctor-patient communication: A review of the literature", in *Social Science & Medicine*, vol. 40, n. 7, pp. 903-918.

Orletti, F. (2000), *La conversazione diseguale. Potere e interazione*, Roma: Carocci.

Orletti, F., & Iovino, R. (2018), *Il parlar chiaro nella comunicazione medica. Tra etica e linguistica*, Roma: Carocci.

Pasquandrea, S. (2013), "Uso del linguaggio tecnico e rapporto medico-paziente: un'analisi in contesti interculturali", in *Salute e società*, n. 1, pp. 76-93.

Perakyla, A. (1997), "Reliability and validity in research based on naturally occurring social interaction", in D. Silverman (ed.), *Qualitative Research. Theory, Method and Practice*, London: Sage.

Pomerantz, A., & Heritage, J. (2013) "Preference", in J. Sidnell & T. Stivers (eds.), *The Handbook of Conversation Analysis*, Hoboken, NJ: Wiley Blackwell, pp. 210-228.

Raymond, G., & Heritage, J. (2006), "The epistemics of social relations: Owning grandchildren", in *Language in Society*, n. 35, pp. 677-705.

Sacks, H., Schegloff, E.A., & Jefferson, G. (1974), "A simplest systematics for the organization of turn-taking for conversation", in *Language*, n. 50, pp. 696-735.

Saglietti, M. (2019), "'Inevitable distinctions': The discursive construction of unaccompanied minors' agency in Italian residential care", in *Language and Dialogue,* vol. 9, n. 1, pp. 172-190.

Schegloff, E.A. (1968), "Sequencing in Conversational Openings", in *American Anthropologist*, n. 70, pp. 1075-1095.

Id. (1984), "On some questions and ambiguities in conversation", in J. Atkinson & Heritage (eds.), *Structures of Social Action: Studies in Conversation Analysis*, Cambridge: Cambridge University Press, pp. 28-52.

Schegloff, E.A., Jefferson, G., & Sacks, H. (1977), "The preference for self-correction in the organization of repair in conversation", in *Language*, vol. 53, n. 2, pp. 361-382.

Schön, D. (1983), *Il professionista riflessivo. Per una nuova epistemologia della pratica professionale*, Bari: Dedalo.

Schutz, A. (1967[1932]), *The phenomenology of the social world*, Evanston, IL: Northwestern University Press.

Stivers, T. (2001), "Negotiating who presents the problem: Next speaker selection in pediatric encounters", in *Journal of Communication*, vol. 51, n. 2, pp. 252-282.

Ead. (2005a), "Non-antibiotic treatment recommendations: Delivery formats and implications for parent resistance", in *Social Science & Medicine*, n. 60, pp. 949-964.

Ead. (2005b), "Parent resistance to physicians' treatment recommendations: One resource for initiating a negotiation of the treatment decision", in *Health Communication*, n. 18, pp. 41-74.

Ead. (2007), *Prescribing Under Pressure. Parents-Physician Conversations and Antibiotics*, Oxford: Oxford University Press.

Stivers, T., & Robinson, J.D. (2006), "A preference for progressivity in interaction", in *Language in Society*, n. 35, pp. 367–392.

Stivers, T., Mondada, L., & Steensig, J., (eds.) (2011), *The morality of knowledge in conversation*, Cambridge: Cambridge University Press.

Tates, K., & Meeuwesen, L. (2001), "Doctor-parent-child communication. A (re)view of the literature", in *Social Science and Medicine*, n. 52, pp. 839-851.

Tates, K., Elbers, E., Meeuwesen, L., & Bensing, J. (2002), "Doctor-parent-child relationships: a 'pas de trois'", in *Patient Education and Counseling*, n. 48, pp. 5-14.

ten Have, P. (1999), *Doing Conversation Analysis. A Practical Guide*. London: Sage.

van Dulmen, A.M. (1998), "Children's contributions to pediatric outpatient encounters", in *Pediatrics,* 102(3 Pt 1), pp. 563-568.

Wandensjö, C. (1998), *Interpreting as interaction*, London & New York: Longman.

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