Shifting addressivity : In/Exclusionary practices in triadic medical interaction with unaccompanied foreign minors

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Abstract

In dealing with recent migration-related phenomena, inclusion has become an increasingly common normative ethical imperative in socio-political discourse. Considering inclusion as a situated interactive accomplishment, this article reports findings from a study on medical visits each one involving a physician, an unaccompanied foreign minor (UFM) and a professional educator. Adopting a Conversation Analysis-informed approach to a corpus of video-recorded visits, we analyze a) the physician's shifts in addressivity, which either foster or hinder UFM's inclusion during the history-taking phase, and b) *when* and *how* these shifts occur. We contend that, by shifting addressivity, the physician navigates the locally incompatible goals of gaining reliable information on UFM patients and fostering their active participation. We contend that the micro practice of shifting addressivity is consistent with the management of cultural-linguistic diversity proposed by the intercultural dialogue perspective.

Keywords: triadic medical interaction; interactive inclusion; unaccompanied foreign minors; addressivity; intercultural dialogue

1. Introduction

In dealing with recent migration-related phenomena, inclusion has increasingly become an ethical and normative imperative in EU socio-political discourse and agenda (see, for example, the "EU Action Plan on Integration and Inclusion 2021-2027"). Considering inclusion as a situated and interactive accomplishment occurring during everyday activities (for a similar approach, see Weiste, Stevanovic and Lindholm 2020; Finlay et al. 2008; Ochs et al. 2001), in this article we report findings from an exploratory case study on primary care medical visits, each one involving a general practitioner, an unaccompanied foreign minor (hereafter UFM) with low competence in the

language of the visit, and a professional educator[1] institutionally in charge of them. A fundamental structural element of this institutional encounter is that neither the physician nor the professional educator knows the UFM patient's L1; therefore, it is *not* a case of interpreter-mediated interaction. Compared to other triadic medical encounters (e.g., pediatric interactions, Stivers 2007, Tates and Meeuwesen 2001; interpreter-mediated visits, Bolden 2000, Baraldi and Gavioli 2014), visits with UFMs are characterized by participants' orientation not only to the specific cultural, linguistic, epistemic and social asymmetries at stake, but also to the institutional role and professional agenda of the third party, i.e. the professional educator (Caronia, Colla, and Ranzani 2020). Therefore, this case study constitutes a perspicuous case (Garfinkel and Wieder 1992) for observing not only how the UFM patient's in/exclusion and local identity are interactively accomplished, but also how these local constructions depend and impact on the achievement of the institutional goals of the medical encounter. Further, this study vividly illustrates a micro practice of talk-in-interaction that can be considered as a practical realization of the inclusion-oriented objectives of intercultural dialogue (ICD, Ganesh and Holmes 2011)[2].

The article is structured as follows. In section 2, we provide information concerning the inclusion-oriented Italian UFM reception system. We also stress how UFMs' inclusion is not only a principle staged by macro-structural frameworks but also a form of participation achieved (or not) in the course of situated social interactions, like those occurring during medical encounters. In section 3.1, we illustrate the specific asymmetries to which participants orient in medical visits involving UFMs, while in section 3.2 we describe the communicative challenges of the history-taking phase of the visit.

In section 5, the analysis focuses on the physician's interactional moves and linguistic practices that foster or hinder UFMs' inclusion in this phase. In particular, we present a series of excerpts where the physician carries out a shift in addressivity, i.e. he[3] changes his addressee by shifting from the UFM patient to the professional educator and vice versa. Adopting a Conversation Analysis-informed approach supplemented with ethnographic background knowledge (on the [limited] affinity between ethnography and CA, see Maynard 2006; Moerman 2010 [1988]), we analyze *how* and *when* the physician addresses the UFM patient *vs* the professional educator. In the

[1] We use the term 'professional educators' to refer to social workers working in UFMs' residential care structures and specialized in socio-educational interventions.

[2] As any normative definition of dialogue, the intercultural dialogue perspective (ICD) encompasses an *ideal* type of interaction that should orient ordinary as well as institutional interactions. However, as any normative stance, ICD also needs to be articulated into practical ways of behaving. This study inductively identifies one of them.

[3] We use the masculine form of the pronoun because the physician in our case study was a man.

conclusion, we contend that, by means of shifting his addressivity, the physician appears to be oriented to searching for a balance between gaining accurate and reliable information on the one hand, and maximizing the UFM patient's (interactive) inclusion on the other. Finally, we emphasize the crucial role that interactional practices play in accomplishing UFMs' inclusion as well as in defining their locally relevant identities in the medical encounter. In the conclusion, we delineate applied implications for practitioners' training in the area described in this study.

2. Unaccompanied Foreign Minors in an inclusion-oriented society

The presence of UFMs is a new and challenging phenomenon for the Italian welfare and foreigner reception systems. Given their 'unaccompanied' status as well as different linguistic and cultural backgrounds, UFMs may experience serious difficulties in accessing social and health-care services (Lynch 2001; Saglietti 2019). In line with the increasing orientation toward migrants' inclusion as set forth in European recommendations, the Italian law 47/2017 has strengthened UFMs' rights and protection by establishing their reception in the System of Protection for International Protection Holders and Unaccompanied Foreign Minors (SIPROIMI) until they turn 18 years and 6 months of age. Within the SIPROIMI residential care structures, UFMs are supported by professional educators, whose institutional mandate consists in mediating the encounters between UFMs and the host society as well as promoting their empowerment and inclusion.

The orientation toward fostering migrants' inclusion is particularly evident in UFMs' medical visits, where the presence of a professional educator is normatively required to support UFM patients throughout the encounter and to make patient-physician communication as smooth as possible. Importantly, professional educators are not cultural linguistic interpreters: they do not know UFMs' L1s and are not supposed to speak on their behalf, unless it turns out to be unavoidable[4]. Rather, according to their professional mandate and expertise, professional educators are expected to foster UFMs' active participation in medical interaction by maximizing their chances to speak for themselves.

While the normatively established presence of professional educators during UFMs' medical visits is an evident case of implementation of the national policies' orientation toward 'inclusion-as-a-principle', it is in and through the interaction that this principle is practically accomplished (or

[4] For economic reasons, the SIPROIMI system relies on cultural linguistic interpreters only for very serious conditions and for UFM psychiatric patients.

not) as a situated and co-constructed structure of participation. Adopting such an interactional approach to inclusion, we consider UFMs' inclusion in triadic medical visits as something that participants *do* in and through the unfolding of the interaction. In this article, we focus on the physician's interactional moves and linguistic practices, illustrating how they either foster or hinder UFM patients' (interactive) inclusion in primary care visits (for a study focused more on the professional educators' interactional moves, see Caronia, Colla, and Ranzani 2020). From a theoretical perspective, these practices can be inductively considered as (not necessarily conscious) ways to position oneself with respect to the ICD main issue, i.e. how "to develop a deeper understanding of diverse perspectives and practices; to increase participation […] and ability to make choices" (Council of Europe, 2008: 10, quoted in Ganesh & Holmes 2011: 81).

In the next section we outline the epistemic imbalance and interactional structures at stake in medical visits as pointed out by 40 years of research on doctor-patient communication, and then make a case of the specific asymmetries characterizing triadic medical encounters with UFMs.

3. Epistemic asymmetries and agency distribution in medical encounters

As research on medical visits as institutional events has illustrated, medical encounters are structured into phases (see among others Byrne and Long 1976; ten Have 1989; Heath 1992; Heritage and Maynard 2006a). Each phase is characterized by a specific goal, a typical structure of participation and boundaries to which participants orient with 'considerable exactness' (Heritage and Maynard 2006b: 363). In addition, medical visits are characterized by an epistemic tension between two different types of knowledge: the physician's biomedical expert knowledge ('the voice of medicine', Mishler 1984), and the patient's experiential lay knowledge ('voice of the life-world', Mishler 1984; on the recent phenomenon of hybridization of these epistemic territories, see Stivers 2007). The relevant type of knowledge and related distribution of epistemic rights between participants vary across the different phases of the medical encounter (see among others Heritage and Maynard 2006a, b; Stivers 2007). In the first part of the visit (i.e. problem presentation, history taking and physical examination), the patient is typically constructed as the 'epistemic authority' (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). Conversely, the physician emerges as the epistemic authority in the second part of the visit, where diagnosis and treatment recommendations are at stake and the professional voice is the most relevant.

Grounded in epistemics is the 'interactional asymmetry', i.e. the socially ratified power to establish who speaks, when and about what (see Linell, Gustavsson, and Juvonen 1988). Assuming that the physician typically acts as the 'director' of the medical interaction (Orletti 2000), the amount of interactional space allocated to patients significantly varies throughout the visit (see Ten Have 1991; Robinson 2001, 2003). In the first part, the physician engages in questioning the patients, thus requiring a considerable amount of contribution from them (see Robinson 1998; Stivers 2002a; Heritage and Robinson 2006; Heritage 2010), while in the second part of the visit, the prevalence of the physician's talk reflects their epistemic dominance (see Peräkylä 1998, 2002; Stivers et al. 2018; Heritage 2018).

The interactional practices adopted in the different phases of the medical encounter have a crucial impact on the patient's active participation, which is considered an essential achievement of the visit. Indeed, and as emphasized in the so-called 'patient-centered care' (see among others Castro et al. 2016; Mead and Bower 2000), fostering patients' active participation is more than an ethical issue: it is a means to maximize their agentivity in the healing process and their compliance with therapies. However, when patients have low competence in the language of the visit and/or experience extremely fragile socio-psychological conditions, including them as active participants can be difficult. This is often the case with UFMs.

3.1. Triadic medical visits with UFMs: The multiple asymmetries at stake

Triadic encounters with UFMs are characterized by further types of asymmetry with respect to both dyadic primary care visits (see above, section 3) and other kinds of triadic visits (e.g., pediatric and interpreter-mediated medical encounters, see among others, Stivers 2002a, b, 2005, 2007; Tates and Meeuwesen 2001; Bolden 2000; Baraldi and Gavioli 2014). The most evident is the linguistic asymmetry: neither the professional educator nor the physician knows UFM patients' L1, and, conversely, UFMs' competence in the language of the visit is very low. In addition, these encounters are characterized by the socially sanctioned hierarchy of professional expertise, i.e. the primacy of the physician's voice over the professional educator's, and the consequent stratification of professionals' interactional rights (see Caronia, Colla, and Ranzani 2020; Colla, Ranzani, and Caronia 2020). Last but not least, the encounter can be characterized by socio-psychological asymmetry, as UFM patients live in extremely fragile conditions due to their migratory paths and post-traumatic state (Taurino et al. 2012; Crowley 2009; Derluyn and Broekaert 2008).

Given these specific asymmetries, some goals which in most medical visits are synergic (e.g., ensuring understanding of medical information and maximizing patients' active participation) become 'incompatible' in the context described: the more the physician pursues understanding, the more he has to exclude the UFM as the intended recipient of his talk; conversely, the more the physician strives for UFM patient's inclusion by talking to him[5], the more he risks missing the information gathering and, in turn, may fail to fully understand the UFM patient's health condition[6]. This dilemma and the system of intertwined asymmetries from which it originates are particularly binding in the history taking.

3.2. The history-taking phase in triadic medical visits with UFMs

The history taking represents a core part of the visit, characterized by a series of question-answer sequences typically initiated by the doctor (Boyd and Heritage 2006; Zucchermaglio, Alby, and Fatigante 2016). The institutional goal of this phase consists in both collecting information on the patient's medical history (e.g., present and past problems, family and social background as well as previous treatments) and initiating the 'differential diagnosis'[7] (Athreya and Silverman 1985; Stivers 2007).

In triadic medical interactions with UFMs, the history taking can be particularly complex and challenging for a series of reasons. First, linguistic asymmetry makes it very difficult for the physician to pursue the specific goal of this phase, i.e. obtaining from the patient a report of the symptoms, diagnoses and treatments concerning his/her past medical problems. Second, relevant information concerning the UFM patient's present and past clinical conditions is distributed among the different people and artifacts present on the scene (see Sterponi et al. 2017; Berg 1996). These include the UFM patient (who has first-hand knowledge of his/her own medical history), the

[5] We use the masculine form of the pronoun because the UFMs in our case study were males.

[6] We do not claim that this dilemma is specific to UFM medical visits. Arguably it is also at stake in other kinds of medical interactions involving communicatively (and/or cognitively) impaired patients. However, and despite some analogies, we do not generalize our findings and claims beyond this single case, as it is characterized by a specific inter-professional structure and related knowledge and competence imbalances (see Caronia, Colla, Ranzani 2020). On ways of gaining and providing information in medical visits involving communicatively impaired patients, see among others, Garcia (2012), Muntigl, Hödl and Ransmayr (2014).

[7] The 'differential diagnosis' is the clinical method whereby physicians consider various possible causes of the patient's illness by rejecting a series of hypotheses before making the final diagnosis.

professional educator (who has second-hand knowledge of the patient's conditions), the electronic health records (EHR), and the paper health records handled by the professional educator. Yet, despite this distribution and the linguistic gap, the physicians' institutional mandate still prompts them to get information directly from the patient, not only because the patient is the one having primary access to their own entire clinical history, but also because including the patient as an active participant is considered a crucial means to maximize therapeutic compliance. In this complex epistemic and communicative landscape, the (interactive) inclusion of UFM patients in the history-taking phase is constantly negotiated and revised.

In the next section we present the data and analytical procedures of our study, which aims at illustrating *when* and *how* the physician includes or excludes the UFM patient in the history taking, thus, respectively, facilitating or impeding ICD.

4. Data and analytical procedures

The data presented in this article are drawn from a corpus of three video-recorded medical visits totaling 88.72 minutes. Each medical visit involves a general practitioner, a UFM patient and a professional educator institutionally responsible for him. The UFMs participating in the study are aged between 16 and 18 and have minimal competence in the language of the visit (i.e. Italian). The participants were recruited by the second author through her work connections. Consent was obtained according to the Italian laws regulating the handling of personal and sensitive data. The excerpts presented here have been transcribed and analyzed using Conversation Analysis conventions (Sacks, Schegloff, and Jefferson 1974; Jefferson 2004; for transcripts conventions, see the Appendix). In line with the multimodal approach to social interaction (Goodwin 2000; Mondada 2016), transcriptions have been enriched with notations for gaze directions, gestures and body positions and orientations when visibly relevant for the participants. Transcriptions are presented in two lines: the original Italian transcript is followed by an idiomatic translation in American English.

5. Addressing the patient *vs* the professional educator: The physician's *in*/*ex*clusionary practices

In the aim of identifying the physician's including and excluding practices, we considered the 'addressivity' of his contributions: we assume that addressing a participant (i.e. constituting him/her

as a ratified listener and/or a candidate next speaker) is the basic dimension of interactive inclusion. In particular, we considered as occurrences of *inclusion* of the UFM patient those contributions where the physician addresses the UFM, and as occurrences of *exclusion* those contributions where, despite talking about the UFM, the physician addresses only the professional educator. To trace the physician's addressivity, we paid special attention to the multimodal resources deployed by the physician to select his interlocutor, namely: 1) linguistic and morpho-syntactic elements of turn design (Drew 2013); 2) turn-taking procedures (see Hayashi 2013; Lerner 2003); 3) embodied resources, e.g., gaze direction, gestures and body orientations (see Mondada 2016; Rossano and Stivers 2010; Auer 2017).

In the next sections, we focus on the physician's shifts in addressivity, i.e. his changes of addressee by shifting from the UFM patient to the professional educator and vice versa. We contend that shifting addressivity is a practice that fosters or hinders the UFM patient's inclusion during the history taking.

5.1. Inclusionary shift: From the professional educator to the patient

In the following example (1), the physician performs an inclusionary shift, that is he first addresses the professional educator and then the UFM patient. In this excerpt, the physician is collecting information about the patient's medical history in order to create his electronic health record (EHR). Note that it is the professional educator who handles the patient's paper health records.

Ex. 1 – Mahdi (5.23 - 5.52)

D = Physician

P = Patient (Mahdi, 16 years old)

E = Professional Educator

D ha fatto:: altri test? (.) Mantoux?
did he do:: other tests? (.) Mantoux?
((looking at the paper health records on the desk and then directly at E)) **[fig.1a and 1b]**

(1.0) *((D looks at E, E starts leafing through the folder))*

E [°( )°]

D [radiografia del torace?]
[chest x-ray?] *((looking at the folder and then directly at E))*

D [>non ha fatto niente<

[>he did nothing< ((looking at E))

E [tutte le parti di:: profilassi penso che le abbia fatte prima,=
[all the parts o::f prophylaxis I think he did them before,=
((leafing through the folder))

D =°no°.
=°no°.

E io qui non ce l'ho (.) (però,)
I don't have it here (.) (though,) ((E keeps looking through the folder))

D allora (.) ^<TU TI RICORDI>- lo capisci l'italiano?
well (.) ^<DO YOU REMEMBER>- do you understand Italian?
D ^*((turns to P and starts looking at him))* [fig.1c]

P °sì (un po')°
°yes (a bit)° ((lowering his head))

D sì. (.) TU TI RICORDI: CHE PROBLEMI-,
yes. (.) DO YOU REMEMBER: WHAT PROBLEMS-, ((looking at P))

D SE HAI AVUTO QUALCHE PROBLEMA DI SALUTE?
IF YOU HAD ANY HEALTH PROBLEMS? ((looking at P))

D hai avuto dei:: ^vedo che c'hai una ferita lì
did you have any:: ^I see you have a wound there ((looking at P))

D ^*((points at P's right arm))*

P sì.
yes.

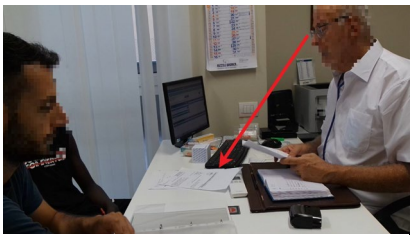

Fig. 1a.
D looks at the documents

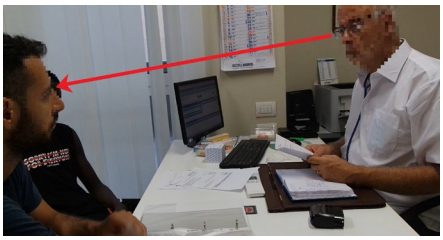

Fig. 1b.
D looks at E

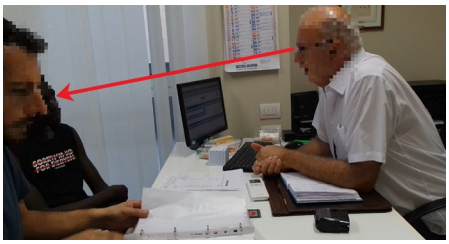

Fig. 1c.
D looks at P

In line 1, D inquiries about P's past medical examinations. In delivering the question, he clearly and unambiguously addresses E: he looks at the paper health records (Fig. 1a) and then directly at E (Fig. 1b). In addition, D treats P as a non-ratified participant by talking about him in the third person (*ha fatto* 'did *he* do', line 1) and using the specialized medical term "Mantoux" (line 1), which selects the more linguistically competent professional educator as the physician's addressee.

After D's question, E starts looking for P's paper health records in the folder, while D keeps looking only at E (line 2). In overlapping with E's inaudible turn (line 3), D inquiries about another

medical examination (*radiografia del torace?* 'chest x-ray?', line 4). Here, D addresses E again by looking at the folder, and then directly at E (line 4). Receiving no answer, D quickly states *non ha fatto niente* 'he did nothing' (line 5), as to suggest the absence of paper health records attesting P's prophylaxis. Note that D continues excluding P from the medical interaction (see D's gaze direction toward E and the use of the third person referring to P, line 5).

In line 6, E aligns with D's addressivity by replying to D's statement: E explains that P may have taken preventive care examinations "before" being hosted in the residential care structure. Note that the epistemic stance-marker *penso* 'I think' presents E's answer as tentative, thus conveying the lack of paper health records attesting P's prophylaxis. The absence of records is ratified by D (see the token *no* 'no' uttered with a falling intonation, line 7) and again by E (*io qui non ce l'ho* 'I don't have *it* here', line 8).

In the absence of E's certain knowledge and documented information, D carries out a shift in his addressivity (lines 9 and 10): he begins a new conversational sequence (note the use of *allora* 'well', line 9, see Bazzanella et al. 2007), and unequivocally addresses P through a series of multimodal resources. First, he turns toward P, looks at him and adopts a body posture conveying his readiness to listen to him (see line 10, and Fig. 1c). Second, D uses the marked second person singular pronoun *tu*, thus selecting only P as his addressee (line 9). Third, D adopts a metacommunicative practice verifying the state of inter-comprehension (*lo capisci l'italiano?* 'do you understand Italian?', line 9), which is clearly oriented to P's low linguistic competence, and which again constructs P as D's main interlocutor in this phase of the visit.

After P's confirmation of understanding (line 11), D asks him a series of questions about his past health problems (lines 12-14). Throughout the turn, D appears oriented to gaining information despite P's scarce competence in the language of the visit. Specifically, D uses a close-ended question (line 12), that is a question format requiring only little contribution on the part of P. Then D narrows the object of the question by reformulating "problems" into "*health* problems" (line 13); finally, D makes a scar on P's arm multimodally relevant (lines 14 and 15), thus locating a trace of past health issues on his body. As we suggested in a previous work (Caronia, Ranzani, and Colla 2020), this multimodal practice (which we call 'making the body speak') constructs P's body as an intersubjectively shared clinical object, facilitating the establishment of a 'common ground' between P and D (see Galatolo and Cirillo 2017). This practice works: in the following slot, P provides an answer to D's question (*sì* 'yes', line 16).

By addressing P through these interactional practices, D visibly orients to P's scarce linguistic competence in the language of the visit and draws upon the first-hand knowledge of his

own medical history after the other sources of reliable information (i.e. E and the paper health records) turn out to be uncertain and lacking.

Example 2 in section 5.2 below shows the opposite case: the physician locally excludes the UFM patient from the medical interaction.

5.2. Exclusionary shift: From the patient to the professional educator

In Example 2, the physician shifts his addressivity by firstly selecting the UFM and then, immediately after, the professional educator. In the part of the conversation transcribed, the physician is reading the patient's EHR on the computer to gather information on his previous skin problems. While reading, the physician asks about a visit which had been prescribed to the patient.

Ex. 2 - Amir v.3 (3.42 – 3.56)

D = Physician

P = Patient (Amir, 18 years old)

E = Professional Educator

1 D io ho una visita dermatologica che ho scritto in giugno.
I have a dermatological visit that I prescribed in June.
((looking at the computer screen))

2 D ^tu l'avevi fatta ^^di nuovo o dovete farla?
^did you[SG] have it ^^again or do you[PL] still have to have it?

3 D *^((looks at P))*[fig.2a]

4 D *^^((looks at E))*[fig.2b]

5 (1.0) *((E and D look at each other))*

6 D ^la visita dermatologica che ^^scrissi in giu[gno.]
^the dermatological visit that ^^I prescribed in [June.]

7 D *^((looks at E))*

8 E *^((starts leafing through P's folder))*

9 D *^^((turns toward the computer))*

10 E [esatto] quella:
[correct] that o:ne

11 D ne ha fatte due.
he had two of them. ((looking at the screen))

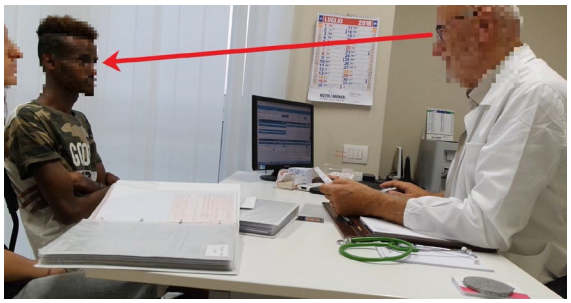

Fig. 1a.
D looks at P

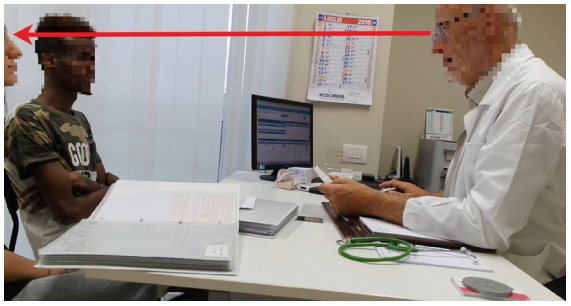

Fig. 2b.
D looks at E

While looking at the screen, D reports a dermatological visit prescribed to the patient the previous month and asks whether he has had it yet (lines 1 and 2). D's turn is composed of two complete and distinct questions (i.e. *tu l'avevi fatta di nuovo* 'did you [sing.] have it again' and *o dovete farla?* 'or do you [plur.] still have to go?', line 2) produced as a unique turn, with no gaps in between. While asking the first question (*tu l'avevi fatta?* 'did you have it?'), D clearly selects P as his addressee through his gaze direction (see line 3, Fig. 2a) and the use of the second person singular form of the subject pronoun and the verb. Yet, while uttering the second question (*o dovete farla?* 'or do you still have to go?'), D performs a shift in his addressivity: he uses the second person plural form of the verb *dovete* 'have to', and concurrently looks only at E (see line 4, Fig. 2b). In other words, in the course of the very same turn, D first addresses P and then E. By gazing at E at the end of the turn, D appears oriented to soliciting an answer more from E than from P (see Auer 2017). This shift can be interpreted as a self-repair by the physician following his use of a technical term (*visita dermatologica* 'dermatological visit', line 1) as if he understood that the term was beyond the UFM's reach.

Getting no answer from E (line 5), D repeats his question (line 6). By using the specialized medical term *dermatologica* 'dermatological' again and by looking only at E (see line 7), D ratifies E as the only selected addressee. In the meantime, E starts leafing through the paper health records, inferably to find the document attesting P's dermatological visit (line 8). Through this action, E demonstrates her orientation toward finding and providing an answer to D's question, thus achieving an early self-selection as the next speaker (on multimodal resources for turn-taking, see Mondada 2007; Deppermann 2013). While D is finishing his turn, E completes her early-initiated self-selection as the next speaker: she starts talking and demonstrates that common understanding about the inquired visit has been reached (*esatto quella* 'correct that one', line 10). D then provides additional information concerning P's past dermatological visits (*ne ha fatte due* 'he had two of

them', line 11): here again, D unambiguously selects E as his unique addressee by means of talking about P in the third person.

In shifting his addressivity from P to E, D appears to be taking into account P's scarce competence in the language of the visit: answering a question about past dermatological examinations can be quite a challenging task for the UFM who did not master the Italian language. In other words, in this case where P's limited linguistic competence is not sufficient to provide an answer, D privileges the second-hand knowledge of the patient's medical history accessed by E and/or inscribed in the paper health records over P's first-hand knowledge of his own medical history.

Finally, Example 3 presented in the next section further shows how and when the UFM patient is in/excluded in the medical interaction: it illustrates both an exclusionary and an inclusionary shift in the physician's addressivity.

5.3. Ex/Inclusionary shifts: From the patient to the professional educator and back

The following excerpt (3) illustrates a double shift in the physician's addressivity: from the UFM patient to the professional educator and then back to the patient. In the example, the patient presents his current problem and the physician asks for his paper medical records (which are contained in the folder handled by the professional educator).

Ex. 3 – Amir v. 3 (02.40 – 02.58)

D = Physician

P = Patient (Amir, 18 years old)

E = Professional Educator

1	P	mi fa male:: *it hu::rts ((looking at D and touching his own leg))*
2	D	al ginocchio? *your knee? ((turning to the computer and moving the mouse))*
3	P	no brufolo. *no pimple.*
4	**D**	**alora 'spett- ^(.) eh:: il::** ***well wait- ^(.) eh:: the::***
5	**D**	**^*((looks and points at the folder handled by E))*** [fig.3a]

6	**D**	**un: documento suo così lo trovo prima,** ***a: document of his so that I can find him faster*** ***((looking at the folder handled by E and pointing at P))***
7	E	sì::, *ye::s, ((opening and starting leafing through the folder))*
8		(2.0) *((E leafs through the folder))*
9	**D**	**^tu eri già venuto per ^^i problemi di infezione no?** ***^you already came here for ^^the problems of infection, didn't you?***
10	**D**	***^((starts looking and points at P))*** [fig.3b]
11	**D**	**^^** ***((touches his own lips))*** [fig.3c]
12	P	°sì (tante volte)° °*yes (many times)*°

Fig. 3a.
D points and looks at the documents

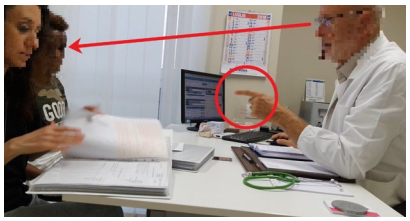

Fig. 2b.
D points and looks at P

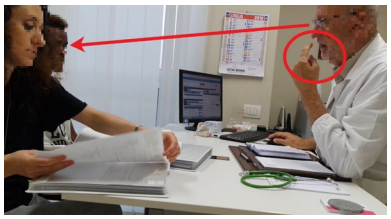

Fig. 3c.
D looks at P and touches his own lips

Through the turn in line 1, P presents the reason for his visit by using very few words (*mi fa male* 'it hurts') and multimodally indicating the painful part of his body (i.e. he touches his own leg). D then formulates his understanding of P's turn and asks for confirmation (*al ginocchio?* 'your knee?', line 2). Concurrently, D turns to the computer (line 2), probably looking for information about the patient on his EHR (note that he moves the mouse). In his reply, P negatively answers D's question and corrects the physician's candidate understanding (*no brufolo* 'no pimple', line 3).

At this point, D carries out a shift in his addressivity: he puts P on hold (*alora 'spett* 'well wait', line 4) and multimodally addresses E. Specifically, D starts looking and pointing at the folder controlled by E (line 5, see Fig. 3a), then he asks for the patient's "document" by talking about P in the third person (*un document suo così lo trovo prima* 'a document of *his* so that I can find *him* faster', line 6). In so doing, he clearly addresses E as his main interlocutor and excludes P from the interaction. By producing a prolonged *sì* 'yes' and starting to leaf through the folder (line 7), E projects the granting[G1][VCv2] of D's request while also conveying that it will take her a while to find the record requested.

While E is looking for the medical record in the folder (line 8), D asks P a question concerning his previous visit: this new shift in addressivity is carried out through a series of multimodal resources (lines 9-11). First, D uses the second person singular form of subject pronoun and verb (*tu* 'you' [sing.], line 9). Concurrently, D turns his gaze toward P and points at him (line 10, see Fig. 3b). While talking about a previous issue of P (*i problemi di infezione* 'the problems of infection', line 9), D touches his own lips, thus indicating the body part he is referring to (line 11, Fig. 3c). Through this gesture, D orients to P's scarce linguistic competence and clearly selects him as the addressee. Also, note that by designing the question in the format 'statement + negative tag', the physician constructs himself as knowledgeable about P's previous visit and related illness (see Heritage 2010); at the same time, by asking P for the last word, he acknowledges his epistemic authority. In the following turn, P ratifies himself as D's addressee by answering D's question (*sì tante volte* 'yes many times', line 12).

In this excerpt, D carries out a double shift in his addressivity. When needing information that is provided at length in paper records, D excludes P and addresses E. Conversely, when asking for information that can be provided with just a few words, D addresses P to collect information deriving from his first-hand knowledge.

6. Discussion

Adopting an interactive approach to inclusion in conversation and considering addressivity as an indicator of interactive in/exclusion, in this article we analyzed a series of excerpts where the physician makes a shift in his addressivity during the history-taking phase of the visit. Particularly, we distinguished between the physician's 'inclusionary shift' (i.e. the physician first addresses the professional educator and then the UFM patient) and 'exclusionary shift' (i.e. the physician first addresses the patient and then excludes him by addressing the professional educator instead). The analysis showed *how* and *when* these shifts occurred.

In including the UFM patient, the physician deploys different resources and practices, namely: the marked use of subject pronouns (line 9, ex. 1 and 3), close-ended questions (lines 12-14, ex. 1; line 9, ex. 3), UFM-directed gaze, body orientations and gestures (line 10, ex. 1; lines 10-11 ex. 3), metacommunicative practices such as 'do you understand Italian?' (line 9, ex. 1), and a practice that we call 'making the body speak' (lines 14 and 15, ex. 1). Through these resources and practices, the physician displays his orientation toward gathering reliable information and maximizing mutual understanding despite the UFM patient's low competence in the language of the

visit. As for its sequential position, the inclusionary shift appears to occur when relevant information can be communicated with a few words (ex. 3), and when relevant information, despite being hardly communicable with a few words, is possessed only by the UFM patient and not the professional educator (ex. 1). The UFM patient thus emerges as the voice of 'embodied illness' (see the notion of 'patient embodied', Robinson 1998, 105).

Conversely, the physician excludes the UFM patient by talking about him in the third person (line 11, ex. 2; line 6, ex. 3), as well as through gaze direction toward the professional educator at the end of the turn (line 4, ex. 2) and the use of specialized medical terms (lines 1 and 6, ex. 2). As illustrated in ex. 2 and 3, the exclusionary shift occurs when the physician requests paper records (ex. 3) or requires information that is inscribed in the records and/or is potentially known by the professional educator (ex. 2). In this way, the professional educator is constructed in interaction as the voice of 'textualized illness' (see the notion of 'patient inscribed', Robinson 1998, 105).

Interestingly enough, our analysis of the physician's inclusionary and exclusionary practices has shed light on the specific hierarchy of sources of information at stake during these encounters. Indeed, electronic and paper health records appear to be the physician's privileged source of reliable biomedical knowledge. When medical records are not available and the physician can choose between the patient's first-hand knowledge of his medical history and the professional educator's second-hand knowledge, he seems to privilege the latter (i.e. the knowledge of the interlocutor who is more competent in the language of the visit) over the former (i.e. the knowledge of the participant who has scarce linguistic competence). When none of these sources is available, the physician resorts to the UFM patient's first-hand access by selecting him as the ratified addressee and next speaker. However, the physician's practices of interactive inclusion also occur on another occasion: when the UFM can contribute to the report of his own medical history with just a few words.

7. Concluding remarks: Finding a balance between inclusion and (unavoidable) exclusion

As this article has shown, in choosing whether to include or exclude the UFM patient in the medical interaction, the physician in our study appears oriented to finding a balance between gathering sufficient and reliable information on the one hand, and maximizing the patient's active participation on the other. Indeed, the physician does not invariably address the UFM patient, as if he were merely complying with the 'patient-centered approach' framework. On the contrary, he addresses the UFM in ways and moments that are both consistent with the epistemic landscape at stake and sensitive to the linguistic competence necessary to transfer the relevant knowledge. By

addressing UFM patients whenever their linguistic and epistemic competences make it feasible, the physician contributes to fostering UFMs' (interactive) inclusion as well as to defining their locally relevant identity: despite their low competence in the language of the visit, UFMs are still (recognized as) epistemically competent patients. A status that – as literature advances – positively correlates with adherence to treatment recommendations.

Focusing on ordinary practices and conversations, this study illuminates how normative and macro-structural features (e.g., international guidelines, national laws and policies) are implemented through micro-interactional practices and resources (e.g., the use of subject pronouns, gaze direction, body orientations and gestures) that contribute to UFMs' local inclusion and exclusion, as well as to defining their locally relevant identities. Although the size of this single case study does not allow generalizations or claims concerning formal structures of practical action, it nevertheless sheds light on both a practical dilemma which doctors within the UFM reception system deal with, and communicative practices to cope with this dilemma locally. By pointing to the strength of language and interactional micro-details (Caronia and Orletti 2019), this study indicates the awareness of such a strength (Pino 2013) as a core component of the pre-service and in-service training of professionals involved in UFMs' reception in the health care system as well as other institutional contexts of the host society. Last but not least, we contend that this study provides an example of how the macro objectives proposed by the ICD perspective can be implemented in and through concrete, dialogue-based micro practices. Indeed, as we have shown, shifting addressivity is an effective practice for promoting UFMs' active participation in the medical dialogue while also maximizing mutual understanding and therefore the treatability of UFMs' health issues. In this sense, this micro practice can be used as a means to achieve the fundamental goals of intercultural dialogue, such as increasing participation and fostering equality.

8. Appendix – Transcript conventions

`WORD`	louder talk
`[word]`	overlapping talk
`(.)`	pause shorter than 0.2 seconds
`(1.5)`	pause measured in seconds and tenths of a second
`=`	absence of any discernable silence between two turns
`>word<`	rushed talk
`<word>`	slow talk
`(word)`	uncertain hearing
((word))	description of nonverbal events (e.g. gestures)
`wo:rd`	prolongation of the sound

^	point where nonverbal event begins
word	talk uttered with emphasis
.	falling intonation
,	slightly rising intonation
?	strongly rising intonation (typical of questions)
( )	incomprehensible words
°word°	talk that is markedly quiet or soft
–	prior word or sound is cut off

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