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Chapter 6

Pursuing understanding or engaging the patient? “Making the body speak” as a dilemma-overcoming practice in triadic primary care visits with unaccompanied foreign minors

Letizia Caronia (Università di Bologna, IT) Federica Ranzani

(Università di Bologna, IT) Vittoria Colla (Università di Modena e Reggio Emilia, IT)

Abstract

This chapter reports findings from a single-case study on primary care visits involving a general practitioner (GP), three unaccompanied foreign minors (UFMs) with low competence in the language of the visit, and two professional educators in charge of them. Adopting a conversation analysis approach, we illustrate a communicative practice deployed by the GP: “making the body speak”. Through this practice, the physician makes his own or the UFMs’ body multimodally relevant as an ostensibly available and intersubjectively sharable counterpart of words. The analysis shows that this practice is deployed to scaffold UFM patients in reporting their medical history. We advance that, through this recipient-designed practice, the GP overcomes the dilemma of

gathering information vs. acknowledging UFMs' identity as competent patients despite the linguistic gap.

Keywords: triadic primary care visits with unaccompanied foreign minors, dilemma of care, physician-patient interaction, 'making the body speak', interactional agency, conversation analysis, history taking

1. Introduction

The presence of unaccompanied foreign minors (hereafter UFMs) in the Italian healthcare system is a recent phenomenon that entails particular communicative challenges for the practitioners involved. Due to their "unaccompanied" status as well as linguistic and cultural background, UFMs are accompanied to the medical visit by professional educators. Although their institutional mandate consists in supporting UFMs in everyday life accomplishments, including healthcare

issues, they are not cultural linguistic interpreters and are not familiar with UFM's L1.

In this chapter, we report findings from an exploratory single-case study on triadic primary care visits involving a general practitioner, three UFM's with low competence in the language of the visit (i.e., Italian), and two professional educators institutionally responsible for them. A fundamental structural element of this type of visit is that neither the physician nor the professional educator is competent in the UFM patient's L1 and there is no interpreter available. Therefore, this is *not* an interpreter-mediated interaction, as are those dealt with in the other chapter in this section. Evidently, the absence of a professional interpreter limits the UFM's active participation in the medical interaction, which in turn can negatively impact the outcome of the visit and the UFM's healing process. Indeed, as well documented by recent research, the patient's active participation in the medical consultation is more than a moral matter; it is a condition maximizing therapeutic compliance (see among others Bigi 2016; Heritage and Maynard 2006). However, as research has established, in the case of patients with communicative impairments, engaging the patient is often an incompatible goal with respect to gaining reliable information and

ensuring understanding. The case of UFM's visits is part of this category of medical care encounters where practitioners face a "pursuing understanding vs engaging the patient" dilemma: the more the physician pursues information gathering and understanding, the more he has to interactionally exclude the UFM by addressing the professional educator; the more the physician engages the UFM patient, the more he risks missing the full comprehension of UFM's health conditions and medical history. How does the physician cope with this practical dilemma? Building on previous work (Caronia, Ranzani, and Colla 2020) and adopting a conversation analytic approach, in this chapter we illustrate the physician's communicative practices that foster UFM's "interactional agency", i.e., "the right to speak and to actively participate in conversation" (Bazzanella 2009: 253) in the history-taking phase of the visit.¹ We assume that fostering

¹ As an anonymous reviewer rightly remarks, focusing on the communicative practices deployed by the doctor when interacting with the UFM, i.e., on the dyadic interactions involving these two participants, can be misleading. As a matter of fact, the structure of participation of the encounter is triadic and the third party, i.e., the educator, actively participates in the unfolding of the visit even when doing being a "bystander" (Goffman 1981). In this case, as in any multiparty conversation, those who are locally acting as audience should be conceived of as co-authors (Duranti and Brenneis 1986). However, in this chapter, we deliberately focus on the doctor-patient dyadic interactions

interactional

occurring within the visits to illustrate what resources are deployed by the doctor when he directly addresses the patient and avoids including the educator as an official addressee. On the contribution of the educator in such triadic interactions see Caronia, Ranzani, and Colla (2020, 2022) and Caronia, Colla, and Ranzani (2020, 2022).

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agency is a way to display the acknowledgment of the patients' agency, i.e., their competence in managing their healing process. In particular, we focus on a practice that we call "making the body speak", which consists in the physician making his own or the UFM's body multimodally relevant as an ostensibly available and intersubjectively sharable counterpart of words. As we will show, this practice is typically deployed as a means to scaffold the patients in reporting their medical history.

The chapter is structured as follows. In the introductory sections, we briefly describe the UFM's reception system in Italy and the role of accompanying professional educators. After outlining the characteristics and specific asymmetries of triadic primary care visits with UFM's, we report extant studies on the use of the body as a semiotic resource in medical encounters with non-native patients. We then present a series of excerpts of video-recorded physician-patient interactions occurring during the history taking. In the analysis, we illustrate the resources deployed by the physician to implement the practice of "making the body speak", that is the use of verbal deixis, pointing, and iconic gestures representing the intended referent of the words being uttered (Kendon 2009; McNeill 1985, see also the notion of gestural

“demonstration”, Bavelas, Gerwing, and Healing 2014; Clark and Gerrig 1990; Enfield, Kita, and De Ruiter 2007). We argue that through the multimodal practice of “making the body speak”, the GP helps the patient grasp what type of contribution is requested, thus fostering mutual understanding and facilitating the UFM’s active participation in the medical encounter. In the conclusions, we advance the hypothesis that such a recipient-designed practice is a useful means for the GP to gather relevant information and acknowledge the UFM’s identity as competent patients despite the linguistic gap.

2. UFM’s in the Italian Reception System and the role of accompanying professional educators

According to the national law 47/2017 (also known as “Legge Zampa”), in Italy UFM’s are hosted in the so-called SIPROIMI reception system (Protection System for Beneficiaries of International Protection and for Unaccompanied Foreign Minors) until they turn 18 and 6 months. Within SIPROIMI residential care structures, UFM’s are supported by professional educators in the accomplishment of their everyday life activities. The educators’ institutional mandate mainly consists in scaffolding the

UFMs' encounter with the host society as well as promoting their
'empowerment' and sense of agency. In compliance with this
pedagogical

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mandate, educators work to broaden UFM's "spaces of possibility" (Contini 2014) by accompanying and supporting them in the accomplishment of their administrative, educational, and healthcare-related tasks. In order to foster UFM's self-reliance and agency, educators should guide them toward the achievement of autonomy and avoid acting on their behalf.

UFM's triadic medical visits represent a particularly challenging territory for educators to pursue the pedagogical mandate of their profession. In this setting, educators are supposed to maximize UFM's active participation in the visit by letting them speak for themselves whenever interactionally appropriate. However, educators should also ensure the effective exchange of biomedical information between the UFM patient and the physician. For this reason, educators may have to speak on behalf of UFM patients whenever their scarce communicative competence in the language of the visit prevents them from interacting effectively with the physician.

3. Triadic Medical Visits with UFM's: Asymmetries, agency ascription, and the 'dilemma of care'

Like any medical encounter, triadic visits with UFM's are characterized by a specific distribution of epistemic rights between the physician and the patient. In the first part of the visit, the patient is typically treated as the "epistemic authority" (Heritage 2012a,b), i.e., the most knowledgeable participant having first-hand access to the locally relevant type of knowledge (their subjective status, symptoms, and medical history). It is the physician's questioning activity during problem presentation, history taking, and physical examination that constructs the "voice of the life-world" (i.e., the patient's experiential knowledge, Mishler 1984) as the most relevant one.

Conversely, the physician acts and is ratified as the most knowledgeable participant in the second part of the visit. In the diagnosis and treatment recommendations phases, where expert knowledge is at stake, the physician typically produces assessments, advice, and recommendations, requiring only a few contributions by the patient. Therefore, in the second part of the visit, the "voice of medicine" (i.e., the physician's expert knowledge, Mishler 1984) emerges as the most relevant one.

Although recent studies show that this institutionally legitimated epistemic asymmetry can be challenged by the patient or patient's relatives in quite interesting ways (Ekberg and LeCouteur 2015;

Gill, Pomerantz, and Denvir 2009; Koenig 2011; Lindström and Weatherall 2015; Pilnick and Coleman 2003; Stivers 2005b, 2007; Stivers and McCabe 2021), it still appears to be at stake mostly when the patients' communicative competence hinders their full interactive participation, as in medical visits with UFM.

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In addition to the inherent tension between “the voice of the life-world” and “the voice of medicine”, triadic medical encounters with UFM s are characterized by further levels of complexity that make these visits unique even with respect to other kinds of triadic medical consultations (e.g., pediatric encounters, see Stivers 2001, 2005a,b, 2007; Tates and Meeuwesen 2001; Tates et al. 2002; interpreter-mediated interactions, see Baraldi and Gavioli 2013; Bolden 2000; Davidson 2000; consultations with impaired patients, see Antaki and Chinn 2019; Chinn and Rudall 2021; Muntigl, Hödl, and Ransmayr 2014; Nilsson, Ekström, and Majlesi 2018). There are three specific types of asymmetries that participants in UFM visits visibly orient to and make “actionable through talk” (Heritage 1997: 222). First, the linguistic asymmetry: patients have low or no competence in the language of the visit and none of the professionals involved is competent in patients’ L1. The interaction can also be characterized by a silent but still operating social asymmetry as UFM patients live in an extremely vulnerable condition, given their migratory paths and post-traumatic status. Last but not least, participants appear oriented to the primacy of biomedical knowledge over pedagogical expertise and praxis. In other words, professional

educators systematically align with the physician's actions and thus cooperate in maintaining their interactional dominance. However, despite their different institutional roles, both care professionals are expected to foster UFM patients' (interactional) agency. For professional educators, the promotion of UFM's agency constitutes the priority of their professional agenda (see section n. 2 above), while for the physician the acknowledgment of the patient's agency is functional to pursuing the overarching goal of their institutional mandate, that is treating the patient by maximizing understanding and compliance with therapies. Indeed, as reported by many studies and particularly by those proposing the so-called "patient-centered approach", acknowledging the patient's (interactional) agency is not only an ethical issue, but also a means to maximize patients' therapeutic compliance and, consequently, their healing (Barry and Levitan 2012; Greenfield et al. 1988; Kaplan, Greenfield, and Ware 1989; Mead and Bower 2000; Swenson et al. 2004). Yet given the interplay of the above-mentioned asymmetries, fostering UFM patients' agency by acknowledging their right to actively participate in interaction can be quite a challenging task. As we mentioned above, the more the physician pursues UFM's active participation, the more they risk missing the full comprehension of their health conditions and medical history; the more the physician

pursues information gathering and understanding, the more they have to interactionally exclude the UFM by addressing the professional educator.

Building on previous analysis of the communicative resources deployed by both professionals (Caronia, Colla, and Ranzani 2020, 2022; Caronia, Ranzani, and Colla 2020, 2022), in this study we focus on dyadic interactions between the

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physician and the patient (see footnote n. 3 above). These interactions mostly occur in the phases of the visit where the educator has fewer (or no) epistemic rights: history taking and physical examination. Indeed, in these phases, it is the UFM who has primary access to the first-hand experiential knowledge of his current and past health condition. In the following section, we analyze how the dilemma of “pursuing understanding vs engaging the patient” is addressed by the physician in the history-taking phase. Indeed, in this phase, it appears to be particularly binding given that participants generally accomplish complex language-based activities: inquiring and reporting.

3.1 History taking and UFM: Making the patients report their medical history despite the linguistic gap

The history-taking phase represents a core component of medical consultations. Its goal consists in both gathering information on the patient’s medical history (e.g., present and past problems, family and social background, previous treatments) and initiating the process of “differential diagnosis” (Athreya and Silverman 1985; Stivers 2007). History taking is characterized by a series of

question-answer sequences, typically initiated by the physician (Boyd and Heritage 2006). There is no ‘neutral’ question in the unfolding of the physician’s interview: each question “establish[es] particular agendas for patient’s response, embod[ies] presuppositions about various aspects of the patient’s health, bodily awareness and background knowledge of medicine, and incorporate[s] ‘preferences’” (Boyd and Heritage 2006: 154).

In the case of history taking with UFM, gathering relevant and reliable information on the patient’s medical history can be particularly complex. Unevenly distributed among artifacts and people (see Sterponi et al. 2017), relevant information is both written in UFM’s health records and known by the educator and/or the UFM. Indeed, UFM patients have primary access to their current and past illness-related status, but they lack the linguistic competence necessary to make this knowledge accessible to the physician. On the contrary, the linguistically competent professional educator has primary access to UFM’s ‘textualized illness’ but only a partial, second-hand knowledge of their ‘embodied illness’. Although the UFM’s low linguistic competence in the language of the visit makes it very difficult for the physician to carry out the goal of the history taking, it remains essential for the care professional to get information directly from the UFM patients (and not from the co-present, linguistically

competent professional educators) as they are the only ones having detailed, first-hand knowledge of their entire medical history. The history-taking phase, therefore, represents a “perspicuous case” (Garfinkel and Wieder 1992) for observing how the physician manages to get information from UFM patients in this complex epistemic and communicative

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landscape. As findings from a previous study on the same data set and other studies suggest (Caronia, Ranzani, and Colla 2020; Gerwing and Dalby 2014), using the body as a semiotic resource constitutes a valuable means for the physician to maximize mutual understanding and gain access to relevant information across a linguistic divide.

4. Using the body as a semiotic resource in healthcare interactions

Since Heath's seminal work on bodily conduct in medical consultations (1984, 1986), many scholars have focused on the interplay and coordination of talk and embodied resources in healthcare settings. Following Heath's notion of "body work" (2006), different studies have analyzed "how bodies are practically and interactionally organized as sites of medical work and medical training" (Lindwall 2014: 126). In particular, the bulk of research has mainly focused on practitioners' and patients' co-construction of the (patient's) body as a site of clinical evaluation (see among others Galatolo and Cirillo 2013; Galatolo and Fasulo 2018; Heath 2006), patients' multimodal report of their

pain (see among others Heath 1989, 2002; Hydén and Peolsson 2002; Rowbotham et al. 2014), and professionals' embodied conduct in instruction sequences in various medical settings, including medical training (Hindmarsh and Pilnick 2002, 2007; Hindmarsh, Hyland, and Banerjee 2014; Hindmarsh, Reynolds, and Dunne 2011; Lindwall, Johansson, and Rystedt 2014; Luff, and Heath 2009; Mondada 2011, 2014; Svensson, Zemel and Koschmann 2014).

In this very rich landscape of studies, the use of the body and gestures in medical consultations with non-native patients has surprisingly received less attention. Focusing on interpreter-mediated interaction, Pasquandrea (2011) has illustrated how patients' inclusion in triadic interaction is negotiated through gaze and body postures (see also Krystallidou 2014; Kristallidou and Pype 2018). In a similar setting, Gerwing and Li (2019) have analyzed interpreters' "body-oriented gestures" (i.e., gestural indications or demonstrations that make the body an integral part of the speaker's meaning, Gerwing 2017). The authors have shown how these mutually accessible hand movements constitute "a window into the interpretation process" (p. 24) and can therefore provide occasions for ascertaining mutual understanding. Only two studies, at least to our knowledge, have been devoted to investigating body movements and gestures in *dyadic* interactions

(i.e., without the intervention of the interpreter) between healthcare professionals and non-native patients. Analyzing the physicians' hand movements in treatment plan discussions, Gerwing and Dalby (2014) have shown that medical speech and gestures are co-expressive phenomena, with gestures

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serving several semantic functions (e.g., representing abstract concepts like regularity or concrete actions and body parts).

Stevenson's study (2014) has shed light on the multimodal ways through which pharmacists and non-native patients engage in dyadic sequences, momentarily excluding the interpreter from the interaction. Specifically, the author found that patients and pharmacists resorted to gestures that either demonstrated a medical device or indicated the relevant part of the body. These gestures, combined with the use of limited English, were effective in promoting a basic, shared understanding between pharmacists and non-native patients.

Adding to this line of inquiry, in this study we investigate how the physician mobilizes his own or the UFM patient's body as a semiotic resource in order to maximize mutual understanding and gather information during the history taking despite the language divide.

In the next sections, we present the data and the analytical procedures of this study.

5. Data collection and analytical procedures

The data for this single-case exploratory study are drawn from a corpus of three video-recorded primary care visits totaling 88.72 minutes. Each visit involved an Italian general practitioner, a UFM patient, and a professional educator. The second author was also present during the visits with her role limited to positioning and switching on/off the video camera. The UFM participants in the research were aged between 16 and 18 and had low or no competence in the language of the visit. The participants were recruited by the second author through her work connections and their written consent was obtained according to EU Regulation n. 2016/679 (GDPR 2016/679) and Italian law n. 196/2003 which regulates the use of personal and sensitive data.

The excerpts presented here have been transcribed and analyzed according to conversation analysis techniques (Jefferson 2004; Sacks, Schegloff, and Jefferson 1972; Sidnell and Stivers 2013), which are broadly applied to the study of healthcare naturally occurring interactions (see Barnes 2019; Drew, Chatwin, and Collins 2001). In line with the multimodal approach to social interaction (Goodwin 2000; Mondada 2016), transcripts have been enriched with notations for gaze, gestures, body movements, and orientations when ostensibly relevant for participants as a means to unfold the interaction. Transcripts are presented in two lines: the original turns in Italian are followed by an idiomatic

translation in American English. For the sake of anonymity, all names have been fictionalized.

6. “Making the body speak”: Using the body as a semiotic resource

Focusing on physician-UFM dyadic sequences in the history taking, in the next sections we illustrate the practice that we call “making the body speak” (see also the notion of “body-oriented gesture”, Gerwing 2017). Although the use of other semiotic resources can be theoretically possible, in our data at least this practice is multimodally accomplished through the use of verbal deixis, pointing (i.e., making gesturally relevant the part of the body at stake), and iconic gestures (i.e., gestures that visually represent the core meaning of the utterance) (see Table 1).

Table 1 – Resources used by the physician for “making the body speak”

		Resources used
The physician mobilizes...	His own body	<ul style="list-style-type: none"> • Verbal deixis • Gestures: <ul style="list-style-type: none"> a. Pointing toward his own body b. Iconic gestures

	<p>The UFM patient's body</p>	<ul style="list-style-type: none"> • Verbal deixis • Gestures: <ul style="list-style-type: none"> a. Pointing toward the patient's body
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We found 28 occurrences of the practice “making the body speak” in the history-taking phase. In only 2 cases out of 28, the physician mobilizes the patient’s body; in the remaining cases, he mobilizes his own body either by pointing to it (N=5) or by using iconic gestures (N=21). The examples in the next section illustrate how the physician uses his own body as a semiotic resource for maximizing the patient’s understanding.

6.1 Making the physician’s body speak

In the following exchange, the physician asks for information about an eye problem just reported by the patient. In doing this, he makes his own body speak by using two iconic gestures that visually represent what is treated as the core meaning of the utterance.

Ex. 1 – Malik (3.30 – 03.37)

P = Patient, Malik (18

years old)

GP = General

practitioner

- | | | |
|---|---|---|
| 1 | G | fanno prurito? |
| | P | do they itch? ((rubbing his clenched hands together))^[fig. 1] |
| 2 | P | <i>((nods))</i> |
| 3 | G | mh? |

4 -
 P sì.
 yes.

5 (1.2)

6 G quando ti succede, quando ^sei fuori,
 P when does it happen, when ^you're
 outside,

7 G ^((moves his
 P *right hand with a finger pointed outward*))[fig. 2]

8 G ^o anche quando sei dentro?=
 P ^or also when you're inside?=
9 G ^((moves his right hand with a finger pointed
 P *inward*))[fig. 3]

10 P = anche quando sono dentro.
 = also when I'm inside.

Fig. 1 – GP

*rubs his
clenched
hands
together*



Fig. 2 – GP

*moves his right
hand with a
finger pointed
outward*



Fig. 3 – GP moves his right hand with a finger pointed inward



When P tries to report, with a few words, that his eyes have been burning in the last few days (not transcribed), GP asks him a series of yes/no questions (on yes/no question as a resource in this corpus, see Caronia, Ranzani, and Colla 2020). The first question is whether his eyes itch (“do they itch?”, line 1). Note that, while issuing the question, GP makes a hand gesture: he rubs his clenched hands together as to convey a friction between them (line 1, fig. 1). Through this iconic gesture, GP ‘makes his own body speak’; that is, he uses his own body, particularly his hands, as a semiotic resource that visually represents what is conveyed as the core meaning of the state of affairs addressed by the question (i.e., the “itching”). The use of this recipient-designed gestural translation demonstrates GP’s orientation to addressing the patient and maximizing his active participation in the interaction despite his scarce competence in the language of the visit. The practice of making the body speak actually works: in the following turn, P displays his understanding of GP’s question by providing a non-verbal answer (he nods, line 2) and then a verbal confirmation (“yes”, line 4). After a short gap (line 5), GP continues questioning P. Explicitly linking to the itching problem discussed until then (“when does *it* happen?”, line 6), GP asks whether it happens only when the patient is outdoors or also when he is

indoors (lines 6-9). Once again, GP accompanies the question with two hand gestures that provide a visible representation of the words “outside” and “inside” (lines 7 and 9). Specifically, in correspondence to the word “outside”, GP moves his right hand with a finger pointed outwards, in the direction of the window (fig. 2); conversely, when he issues the second part of the question and the word “inside”, he moves the same hand in the opposite direction (fig. 3). Interestingly, with his gestures (lines 7 and 9), not only does GP make his body say the uttered words in ways that can be understood by P, but he also marks the syntactic structure of his turn by multimodally distinguishing the two components of his question (“when you’re outside” and “or also when you’re inside”). In so doing, GP guides the UFM patient in understanding his turn as an *alternative* (i.e., “either-or”) question. In his reply (line 10), P provides an appropriate, type-conforming answer: by recycling part of GP’s turn (“*also when I’m inside*”), P chooses one of the two alternatives provided in GP’s question.

The next example, which constitutes the unfolding of ex. 1, shows how the physician’s use of different iconic gestures to represent the same concept can be more or less effective in maximizing understanding and prompting UFM patients’ answers. We join the interaction when the physician is collecting additional information concerning P’s eye condition.

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Ex. 2 – Malik (3.43 – 03.51)

P = Patient, Malik (18

years old) GP =

General Practitioner

- 1 GP **lacrimano anche?**
do they water too? *((making a 'flow' gesture and looking at P))*^[fig. 4-5]
- 2 (0.2) *((P stares silently at D))*
- 3 GP o fanno so^lo,
or do they on^ly,
- 4 GP ^*((rubs index and thumb of both hands))*^[fig. 6]
- 5 GP ti danno fastidio,=
they bother you,=
- 6 P =sì=
=yes=
- 7 GP =fanno prurito. ^fanno anche la lacrima?
=they itch. ^do they tear too?
- 8 GP ^*((mimes tears falling down his face))*^[fig. 7]
- 9 P no.

Fig. 4-5 – GP makes a 'flow' gesture



*Fig. 6 – GP
rubs index and
thumb of both
hands*



*Fig. 7 – GP
mimes tears
falling down his
face*



In the turn at line 1, GP asks P a yes/no question concerning a possible symptom related to the eye condition just reported by P (“do they water too?”, line 1). While issuing the question, GP makes his own body speak by producing an iconic gesture: he rotates his semi-closed right hand as to represent the act of “flowing” (see fig. 4 and 5). However, despite the interrogative intonation and GP’s gaze direction that unequivocally selects P as the next speaker (line 1), GP’s turn is followed by a small gap during which P stares at GP without providing any answer (line 2). In the absence of an answer on the part of P, GP expands his

previous turn by formulating an alternative question (“or do they only”, line 3) accompanied by a hand gesture (GP rubs the index and the thumb of his own hands, line 4). Arguably, this gesture contributes to conveying the meaning of the question as it visually represents the concept of “itching”, which is not uttered by GP (until line 6). Yet in this case, GP does not even give P the time to answer and rapidly formulates his alternative question into an assertion (“they bother you”, line 5), which is quickly confirmed by P (line 6). After demonstrating his understanding through a formulation of the previously described symptom in a falling intonation

(“they itch”, line 7), GP repeats his initial question concerning tears by slightly reformulating it (“do they tear too?”, line 7). In so doing, GP treats P’s previous silence (in line 2) as a signal of non-comprehension and continues pursuing information gathering (on the different functions of silence in interaction see among others, Jefferson 1989; Stokoe et al. 2020). Once again, while issuing the question concerning the tears, GP produces an iconic gesture (line 8), which is very different from the first one: he mimes tears falling down his own face with his index fingers, thus depicting the concept being uttered (see fig. 7).

Compared to the previous gesture generically miming the action of “flowing” (line 1, fig. 4-5), the gesture in line 8 appears to be more ‘iconic’, that is more accurate in representing the semantic meaning of the uttered word it is coupled with, i.e., ‘watering eyes’. Indeed, GP’s gestural formulation in line 8 appears to foster P’s understanding more than the previous one. As a matter of fact, while the question in line 1 was followed by silence, in line 9 P finally provides a type-conforming negative answer (Raymond 2001) with no delay, thus demonstrating his understanding of GP’s question.

The following example immediately follows ex. 2. It illustrates another type of gesture used by the physician in ‘making his own

body speak': pointing.

Ex. 3 – Malik (3.51 – 03.54)

P = Patient, Malik (18

years old) GP =

General Practitioner

- 1 GP *il naso è libero?*
the nose is it free?
- 2 GP *((points to his nose with two fingers))*^[fig. 8]
- 3 GP *((shows the two fingers))*^[fig. 9]
- 4 P *sì.*
yes.

Fig. 8 – GP points to his own nose



Fig. 9 – GP shows the two fingers



In this example, GP further questions P on the eye problem. In the turn at line 1, GP asks P whether his nose is free. In issuing the question, GP makes his body speak: he touches his own nose, thus making multimodally relevant and visible to P the part of the body he is verbally referring to (line 2, fig. 8). Interestingly, GP's pointing can be seen as not merely identifying the referent of his talk, but also as *specifying* it. Indeed, with this gesture, GP touches his own nose with two fingers, each one pointing to a different side of it (see fig. 8). This double-pointing gesture makes salient not only the nose in general but also, and more specifically, each single nostril. GP's following gesture showing the two fingers (line 3, fig. 9) further conveys the idea that, when inquiring about P's "nose", GP is in fact referring more specifically to both his

nostrils.

Note that GP's gestures perform an interactional function as well.

Indeed, by pointing at his own nose, GP marks a change of topic with regard to the previous object of inquiry, that is, P's eye symptoms (see ex. 2). In this way, not only does GP help P gain a better understanding of the referent of the talk (i.e., his nose), but he also guides him in the progression of the anamnestic questioning activity.

Although the propositional content of GP's question is only partially conveyed through gesture (GP points at the referent of his talk, i.e., the nose, but does not visually represent the concept "free"), the unfolding of the interactional sequence reveals that the practice of making GP's body speak is effective in fostering P's understanding and engagement. In the following turn, P provides a type-conforming answer ("yes", line 4) which, despite being very short, still demonstrates P's comprehension and contributes to advancing GP's knowledge of the matter at hand.

If the practice of making the physician's body speak is the most recurrent in our corpus, it is not the only one. As the next section shows, the physician also

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happens to make the *patient's* body speak as a means to foster mutual understanding while acknowledging UFM's' interactional agency in the medical encounter.

6.2 Making the patient's body speak

In the following example, the physician 'makes the patient's body speak', that is, he treats its current features as signs that tell the patient's medical history. By making relevant the patient's body through verbal deixis and pointing, the physician also appears oriented to fostering the patient's interactional agency by scaffolding his contribution despite his low competence in the language of the visit.

Ex. 4 – Mahdi (05.38 – 05.51)

GP = General Practitioner

P = Patient, Mahdi (17 years old)

- 1 GP TU TI RICORDI: E: CHE PROBLEMI, -
DO YOU REMEMBE:R EH:M WHAT PROBLEMS, - ((looking at P))
- 2 GP SE HAI AVUTO QUALCHE PROBLEMA (.) DI SALUTE:? hai avuto dei:
IF YOU HAVE HAD ANY (.) HEA:LTH ISSUES? did you have any:
- 3 **GP vedo che c'hai una ferita lì**
I see you have a wound there ((pointing at P's right arm))^[fig. 10]
- 4 P sì=
yes= ((looking at the wound))
- 5 GP =° (che cos'è?) °
=° (what is it?) °
- 6 P ((touches the wound))
- 7 GP che ferita è quella lì una bruciatura?
what kind of wound is that one a burn?
- 8 P () non è Italia
() it's not Italy ((touching the wound and looking at D))

Fig. 10 – GP points at P's arm



In the turn at line 1, GP initiates the history taking by asking P if he can remember his past “problems”. Through the marked use of the second person subject pronoun (“*tu*”, line 1) and his gaze direction (see line 1), GP unequivocally selects P as his interlocutor, thus acknowledging his “epistemic authority” in the history-taking phase (Heritage 2012a,b). Yet, even before finishing the question, GP carries out a self-repair and issues a close-ended question specifying the nature of the problem he is referring to (“*past health issue*”, not a generic one, line 2). GP does not wait for P’s answer and, after another self-repair (“*did you have any*”, line 2), he finally produces an assertion (“*I see you have a wound there*”, line 3). By using the spatial deictic “*there*” combined with the pointing gesture (line 3, fig. 10), GP makes relevant a scar on P’s arm, thus identifying a visible trace of his *past* health issue. In other words, GP *reads* P’s body, interpreting its current features as signs of the patient’s past health experiences that may be relevant for the history taking. In this sense, the body is treated by GP as a ‘speaking’ entity, that is, a teller of P’s medical history. Yet, at the same time, the body is also mobilized as a resource for scaffolding P’s narration of his (medical) history: in making its affordances relevant, GP establishes P’s body as an inspectionable object (see Galatolo and Cirillo 2017; Galatolo and

Margutti 2016; Heath 2006) that serves as a shared and accessible elicitor of information on the part of the UFM. In addition, by making relevant P's past health issues, GP assumes the burden of selecting what is relevant to talk about. In this way, GP guides P in the progression of the medical interaction, helping him understand what type of contribution is requested.

In the following turn (line 4), P multimodally orients to the scar made relevant by GP: he confirms GP's declarative ("yes") and looks at the wound. Despite providing minimal feedback, P's turn nevertheless demonstrates that a common understanding of the referent has been reached. This minimal common ground constitutes the point of departure for the following interactional sequence, where the physician asks P for information about the wound (from line 5). GP's practice of 'making the patient's body speak', therefore, appears to constitute an effective means to create an intersubjectively shared object of talk and establish a minimal common ground that serves as a basis for the subsequent talk.

In a similar fashion, in the next example the physician 'makes the patient's body speak' by making multimodally relevant the scar on the UFM's arm once again. We join the conversation when the physician is gathering additional information concerning the past treatment of the wound.

Ex. 5 – Mahdi (6.44 – 07.00)

GP = General Practitioner

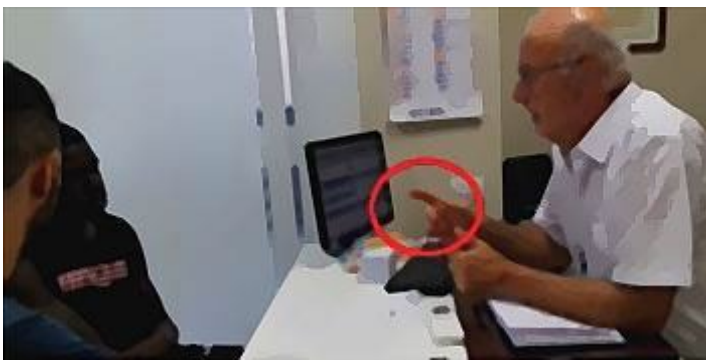
P = Patient, Mahdi (17 years old)

1 GP HANNO CUCITO?
DID THEY SEW? (*miming the act of sewing while looking at P*)

p. 161

- 2 P no:.
- 3 GP quindi ^quel taglio lì te lo sei tenuto così (.) sanguinante,
so ^that cut there you kept it like that (.) bleeding,
- 4 GP ^((points at P's arm))^[fig. 11]
- 5 P sì ma sono andato in farmacia dopo
yes but I went to the pharmacy afterward ((pointing to the scar))
- 6 GP hai messo: u:na benda, hai messo un disinfettante, =
you pu:t a: bandage, you put some antiseptic, =
- 7 P = sì =
= yes =
- 8 P = poi sei venuto su così,
= then you have grown up like this,
- 9 GP quindi un taglio superficiale perché se no ()
therefore a superficial cut otherwise ()

Fig. 11 – GP points at P's arm



In the turn at line 1, GP multimodally asks P whether the wound on his arm has been stitched. It is interesting to note that, in issuing the question, GP makes his own body speak by using an

iconic gesture representing the act of sewing (line 1). After P's negative answer ("no", line 2), GP makes a hypothesis concerning what might have happened after the injury ("so that cut there you kept it like that bleeding", line 3). In uttering his turn, GP resorts to the spatial deictic "there" (line 3) and points at P's arm where the wound is located (line 4, fig. 11), thus making multimodally relevant the scar on P's arm once again. In so doing, GP seems oriented to maintaining a shared focus on the topic upon which a common ground has just been established, i.e., the wound on P's arm (see also ex. 4). Concerning a topic that is part of P's first-hand knowledge, GP's hypothesis can be seen as a request for information. Indeed, it is treated as such by P who, in the following turn, replies by reporting that he went to the pharmacy after having been injured (line 5). In providing a type-conforming answer to GP's request

for information, P maintains the shared focus on the wound and demonstrates his full understanding of GP's question. Making the patient's body speak therefore appears to be an effective practice for preserving the joint attention toward both the topic and the ongoing activity, that is, collecting information about P's past medical history.

7. Discussion

Building on previous work (Caronia, Ranzani, and Colla 2020) and adopting a conversation analysis informed approach, the analysis has illustrated "making the body speak", a practice consisting of the physician making multimodally relevant his own or the UFM's body as an ostensibly available and intersubjectively sharable counterpart of words. As the examples have shown, this practice is typically used as a means to scaffold UFM patients in reporting their medical history and is accomplished through the use of verbal deixis coupled with two different types of gestures: pointing and iconic gestures.

In making *his own* body speak, the GP frequently resorts to iconic gestures, mainly hand movements that visually represent what can be considered as the core meaning of the utterance (see ex. 1, lines 1, 6-9; ex. 2, lines 1, 3-4, 7-8). With these gestures, the GP uses his own body as a semiotic resource, thus locally crafting and relying on a multimodal semiotic system potentially understandable to the UFM patient. As we have shown, GP's iconic gestures are typically followed by the patient's timely and type- conforming reply, which demonstrates the patient's understanding of GP's prior multimodal turn (see ex. 1, lines 1-2, 6-10). Yet, as ex. 2 shows, GP's iconic gestures do not always work. Their communicative effectiveness in fostering UFM's understanding and consequent active participation seems to depend on the degree of their iconicity: the more they pictorially reproduce features of the referent, the more they appear to disambiguate GP's talk (see ex. 2, line 1 vs 7-8). Another resource used by the physician to implement the practice of making his own body speak is pointing. In ex. 3, GP's gesture indicating the part of the body he is verbally referring to appears to be effective in fostering the patient's understanding of the newly established referent and in prompting the patient's reply.

Pointing was also used as a resource for making *the patient's* body speak. In our data, this practice is used by the GP to establish a

minimal common ground on a topic related to the patient's clinical history (see ex. 4) and to maintain a shared focus on the anamnestic topic upon which a common ground has already been established (ex. 5). In both cases, the GP treats the patient's body as a semiotic resource, that is, he interprets its current features as signs that represent

the patient's medical history. By 'making the patient's body speak' through verbal deixis and pointing, the GP also appears oriented to fostering the patient's interactional agency.

**8. "Making the body speak" as a dilemma overcoming
practice: Concluding remarks**

In this exploratory single-case study, we investigated the endogenous resources mobilized by a GP to overcome a practical dilemma emerging in triadic primary care visits involving UFM's and their professional educators: how to pursue efficiency in information gathering and understanding without undermining the patient's epistemic authority and his sense of being the primary addressee of the physicians' talk? The issue is far from secondary as the Italian reception system (SIPROIMI) cannot count on cultural linguistic interpreters. As a matter of fact, when visiting UFM's, physicians rely on professional educators' second-hand knowledge of the UFM's reasons for the visit and proximal medical history, and on information inscribed in various

documents. The physicians' capacity to craft a local semiotic ecology (Streeck 2010) enabling them to engage in dyadic interactions with the UFM is then the only resource to gain first-hand information while including the UFM as the privileged interlocutor. As we mentioned in the first section of the chapter, this is more than an ethical issue; it is a condition for maximizing the patient's compliance with therapies. In our data, the GP appears to be oriented to both goals that, in such an encounter, appear quite incompatible. As demonstrated in previous studies, when understanding is compromised, the physician prioritizes information seeking and selects the educator as his main interlocutor (Caronia, Colla, and Ranzani 2020).

However, any time the UFM patient can contribute to the ongoing interaction notwithstanding his low competence in the language of the visit, the physician avoids recurring to the professional educator's knowledge (see Caronia, Ranzani, and Colla 2022). Relying on a local form of foreigner talk (Ferguson 1975), the GP deploys a certain number of recipient-designed semiotic resources (Caronia, Ranzani, and Colla 2020). In this chapter, we analyzed what we called "making the body speak". Through this practice, the physician uses his own and the patient's ostensibly present bodies in different and non-mutually exclusive ways: as a means to translate word meanings or orient the attention to the visually

available referent, and as a sign *per se*. Particularly relevant appears the way in which the GP mobilizes his professional vision (Goodwin 1994) to make salient some affordances of the patient's body and treat them as "inscriptions" (i.e., marks that are visible and therefore shared by the participants, Streeck and Kallmeyer

2001) standing for past injuries. In doing so, he channels the patient's cognition toward *past* events and offers a visible prompt for what unfolds as a jointly accomplished report. In a few words, the body is used both as a means to point to the salient features of what is talked about, and as "the visible structure of the environment it indicates" (Streeck, Goodwin, and Le Baron 2011: 1).

The combination of pointing gestures and inscriptions makes the body work as a semiotic artifact (Enfield 2005) that scaffolds cognition and mutual understanding, and allows the unfolding of the interaction despite the linguistic gap. Beyond the efficacy of such an "ecology of gestures" (Streeck 2010) in our corpus, what we want to stress is the physician's engaging in a kind of *semiotic bricolage* where different resources enable him to pursue two sometimes incompatible goals: ensuring information gathering and understanding while, at the same time, acknowledging the agency of a patient who cannot rely on his linguistic competence by creating a discursive environment that allows the patients to exert their interactional agency. He maximizes cooperation in the unfolding of the interaction by building an intersubjectively

sharable referential ground. As Gerwing and Li (2019) have it, body and gestures “thus bridge experiential and epistemic gaps between physician and patient, facilitating reference to areas of the body without the need for specialized biomedical language” (p. 178).

8.1 Limitations and directions for future research

The main contribution of this exploratory study consists in shedding light on a multimodal practice used by a physician to overcome a practical dilemma inherent to UFM’s medical visits, i.e., “making the body speak”. We acknowledge that a limitation of this study is the small size of the sample, which does not allow generalizations or definitive conclusions as to the efficacy of this practice. Further investigation would be necessary to test the hypothesis suggested by our study that this practice facilitates UFM’s active and effective participation in the visit. Nevertheless, this study singles out an endogenous resource whose ecological validity makes it suitable as a viable tool in the physician’s repertoire of communicative practices. Although similar practices have been described in other medical settings, “making the body speak” needs further investigation in the specific case of triadic

UFM visits, where multiple asymmetries are at stake and both professionals involved do not master the patient's language and past health history.

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