The role of educators in medical visits of unaccompanied foreign minors. Interprofessional collaboration as a resource for fostering agency

Il ruolo dell'educatore nelle visite mediche di minori stranieri non accompagnati. La collaborazione interprofessionale come risorsa per la promozione di agency

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ABSTRACT
Adopting a phenomenological perspective to the study of educational events, this contribution aims to investigate the role of educators during medical visits of unaccompanied foreign minors (UFMs). The study reports data collected during fieldwork conducted at a public primary care clinic. Data were video recorded and analyzed relying on Conversation Analysis theoretical and analytical tools. The fine-grained analysis of words, gazes, gestures, and movements reveals that educators perform as promoters of UFM patients' agency. Furthermore, the analysis uncovers how UFMs' inclusion and agency are fostered through a synergic interprofessional collaboration between the educator and the physicians. Insights from this study constitute a valuable empirical resource for underpinning training programs aimed at fostering the "reflexive practitioner".

Collocandosi nel solco della tradizione fenomenologica, il presente contributo intende esplorare il ruolo dell'educatore durante le visite mediche di minori stranieri non accompagnati (MSNA). A tal fine, vengono riportati i dati di una ricerca video-etnografica condotta in un ambulatorio pubblico di medicina generale. I dati, raccolti tramite videoregistrazione, sono stati analizzati utilizzando gli strumenti teorico-analitici dell'Analisi della Conversazione. Attraverso l'analisi meticolosa di parole, sguardi, gesti e movimenti, lo studio mostra come gli educatori si "mettano in scena" quali attivatori di agency del paziente MSNA. Inoltre, emerge come la promozione di *agency* dei MSNA sia il frutto di una sinergica collaborazione interprofessionale tra educatore e medico. I risultati dello studio costituiscono una preziosa risorsa per la formazione dei professionisti dell'educazione volta a promuovere lo sviluppo di competenze riflessive rispetto al proprio ruolo e al potere del linguaggio.

KEYWORDS
Unaccompanied foreign minors | Educator | Patient agency | Interprofessional collaboration | Conversation analysis
Minori stranieri non accompagnati | Educatori | Agency del paziente | Collaborazione interprofessionale | Analisi della conversazione

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Introduction

Over the last years, the presence of unaccompanied foreign minors (hereafter, UFMs) has brought about new challenges for the Italian welfare system. Due to their "unaccompanied" status as well as sociocultural and linguistic background, UFMs may face harsh obstacles in accessing social and health care services. The SAI network[1] (*Sistema di Accoglienza e Integrazione*, "Reception and Integration System") is aimed at providing support and promoting the socio-economic inclusion of this vulnerable population in the host society (see Giovannetti & Olivieri, 2022).

Within SAI residential care structures, UFMs are supported by educators in the accomplishment of their daily activities (Agostinetto, 2017; Salinaro, 2021), including administrative, educational, and medical-related tasks. In this context, the educator's institutional mandate mainly consists of promoting UFMs' empowerment and agency while refraining from acting on their behalf and avoiding establishing a dependency bond. In other words, educators should balance the paradoxical dimension at stake in any educational relationship (Fabbri, 1996).

This tension is particularly evident in medical consultations, where educators should maximize UFM patients' active participation in the visit and, at the same, ensure effective exchange and shared understanding of medical information with the physician.

Building on previous findings from an exploratory single-case study (Caronia, Colla & Ranzani, 2020, 2022; Caronia, Ranzani & Colla, 2022), this article sheds light on the role of educators during real-life primary care visits of UFMs. Adopting a Conversation Analysis approach (Sidnell & Stivers, 2013) to a corpus of video-recorded visits, the fine-grained analysis of words, gazes, gestures, and movements reveals that educators "perform" (Goffman, 1959) as promoters of UFM patients' agency. Furthermore, the analysis uncovers how UFMs' inclusion and agency are fostered through a synergic interprofessional collaboration between the educator and the physicians. In line with a phenomenological approach to the constitution of the crucial dimensions of everyday life (see Besoli & Caronia, 2018; Bertolini, 1988), we consider that the extent to which the patient is treated (or not) as an interactionally and epistemically competent subject can foster or hinder their agency – that is, the sense of being a knowledgeable participant, a competent interlocutor, and a responsible decision-maker.

1. Interprofessional collaboration as the golden standard of patient-centered care

Over the last decades, the paternalistic, disease-centered model of care characterizing doctor-patient relationship since the late '60s (Byrne & Long, 1976; Freidson, 1970) has been gradually substituted by the push toward a more symmetrical and cooperative approach, also known as "patient-centered care" (Mead & Bower, 2000). It consists of providing all pertinent information (including risks and possible side effects of treatments or surgery interventions), soliciting patients to share their own views and preferences, taking into account patients' lay knowledge, involving them in decision-making processes, adopting a biopsychosocial approach, and promoting the building of a therapeutic alliance based on shared power and responsibilities. In a nutshell, the primary objective is to enhance quality care and patient compliance with therapies while respecting patients' right to self-determination, empowering them, and ultimately promoting their agency.

The growing complexity and hyper-specialization of contemporary healthcare contexts – due to dif-

1 The Italian UFMs' reception system has rapidly evolved in recent years. Initially called SPRAR ("System for Asylum Seekers and Refugees"), after the decree-law of October 3, 2018, it has been renamed SIPROIMI ("Protection System for Persons with International Protection and Unaccompanied Foreign Minors"). The SAI has been lately introduced by the decree-law of October 21, 2020.

ferent factors such as the increasing number of chronic conditions and multimorbidity, population aging, as well as linguistic obstacles – have contributed to making the implementation of patient-centered care particularly challenging. To address such complexity, collaboration between different health and social care professionals with their unique expertise and professional background is now considered essential to deliver quality care (see Fox & Reeves, 2015; Kreps, 2016).

The normative pressure toward enhancing interprofessional collaboration is also a matter of concern for primary care (Fox et al., 2021), where the increased presence of vulnerable patients has urged physicians to coordinate their expertise with social workers, including educators (for a critical account on interprofessional collaboration and patient-centered care as normative ideologies, see Fox & Reeves, 2015). From this standpoint, UFMs' primary care visits constitute a perspicuous case to investigate whether and how physicians and educators manage their different institutional roles and responsibilities and cooperate (or not) to foster patient agency.

2. Knowledge asymmetries and patient agency in healthcare interactions

Research has long demonstrated that knowledge asymmetries between patients and physicians are a constitutive and core element of doctor-patient interaction (Friedson, 1970; Pilnick & Dingwall, 2011). While patients possess first-hand, experiential knowledge of their body and symptoms, physicians hold biomedical expert knowledge to inspect and assess patients' lay knowledge: this makes them retain epistemic primacy and responsibility to diagnose and prescribe treatments (Lindström & Karlsson, 2016; Maynard, 1991).

However, far from being a static, overarching structure, literature has empirically shown that the distribution of relevant knowledge varies throughout the visit according to the specific phase and activity (see, among others, Heritage & Maynard, 2006). In the first part of the visit (i.e., problem presentation, history taking, and physical examination), the patient is typically treated as the "epistemic authority" (Heritage, 2012a, 2012b) since he/she is the most knowledgeable participant having first-hand access to the type of knowledge locally relevant (their subjective status, symptoms, and medical history). Conversely, in the second part of the visit (i.e., diagnosis and treatment recommendation), the physician consistently acts and is ratified as the most knowledgeable participant by virtue of their biomedical expert knowledge. Furthermore, in and through the communicative practices deployed in the different phases of the visit, the patient agency is locally acknowledged, negotiated, or even denied. It is particularly in the first phases of the visit that the (de)construction of patient agency becomes crucial.

Research has extensively illustrated that the physician's questioning activity makes the difference in acknowledging (or not) the patient's epistemic authority relative to their subjective status, and promoting (or not) their involvement in the visit (see, among others, Boyd & Heritage, 2006; Robinson & Heritage, 2006). As put by Heritage and Robinson (2006), different types of questions "affect the interactional 'space' or 'slot' within which patients present their problems" (p. 90), thereby allocating more or less agency. However, maximizing patient participation in the visit and acknowledging their agency may be challenging when patients have low linguistic competence in the language of the visit, as is the case of UFMs.

3. The intersection of asymmetries in UFMs' primary care visits

UFMs' visits are characterized by further levels of asymmetries compared to other kinds of triadic medical encounters with pediatric or non-native patients (Bolden, 2000; Stivers, 2007). In addition to the epistemic asymmetry at stake in any medical encounter (see section 2), linguistic asymmetry can be an extremely

relevant issue. As UFM patients typically do not master the language of the host society, shared understanding and effective exchange of information may be at risk. Furthermore, this linguistic divide is exacerbated by the fact that neither the educator nor the physician knows the patient's L1, and most of the time there is no cultural-linguistic interpreter available (except for particularly severe cases). Second, UFMs often experience a vulnerable life condition due to many factors, above all their migratory background and related post-traumatic stress status (Longobardi, Veronesi & Prino, 2017). For this reason, UFMs' medical visits can also be characterized by a socio-psychological asymmetry among the participants. Finally, a socially and institutionally sanctioned interprofessional hierarchy may be at play: physician's biomedical expertise is typically presupposed and ratified as more relevant and valuable than educators' pedagogical one. This interprofessional asymmetry is visible in this corpus by the fact that the educator routinely aligns with the physicians' addressivity (see Caronia, Colla & Ranzani, 2020), or by the few occurrences of educators' first-positioned initiatives.

Despite their different institutional roles and mandates, the two care professionals share a common goal: promoting UFMs' patient agency. While the physician should foster patient agency in order to align with the patient-centered approach and maximize shared understanding and compliance with therapies, for the educator it is a matter of implementing their primary pedagogical objective of fostering UFMs autonomy and empowerment. However, given the complex interplay of asymmetries at stake, pursuing this goal can be challenging. For instance, it may be the case that, in order to avoid misunderstandings, the physician excludes the patient from the interaction and rather asks health-related questions to the educator (despite the patient being the epistemic authority over his own symptoms and medical history). How does the educator manage this interactional challenge in the opening stage of the visit, where the patient is the epistemic authority? How and to what extent does the educator work to establish the patient as the legitimate interlocutor?

The next sections aim to answer these questions by focusing on the educators' communicative resources deployed to foster UFM patient agency.

4. Data and methodology

This exploratory single-case study is drawn from a corpus of 3 primary care visits of UFMs video recorded by the author in a public clinic in North Italy. Each visit involved a general practitioner (GP), a UFM patient, and an educator. The UFMs involved in the study were all male aged between 16 and 18 and had little linguistic competence in Italian at the time of data collection.

Participants were recruited via convenience sample through the author's work connections. Written informed consent was obtained by all participants in compliance with Italian law n. 196/2003 and EU Regulation n. 2016/679 (GDPR), which regulate the handling of personal and sensitive data.

Data were transcribed and analyzed relying on Conversation Analysis theoretical and analytical tools (Sacks, Schegloff & Jefferson, 1974; Sidnell & Stivers, 2013). This observational, micro-analytic approach has proven fruitful in the study of naturally occurring interactions (i.e., not elicited for research purposes) in healthcare settings (for a recent review, see Parry & Barnes, 2024). In line with a multimodal approach to social interaction (Mondada, 2007), transcripts have been enriched with notations for gaze directions, gestures, and body movements when ostensibly relevant for the participants to unfold the conversation. Transcripts are presented in two lines: the original Italian transcript is followed by an idiomatic translation in American English. For the sake of anonymity, all names have been fictionalized.

5. Results

The video recordings have been repeatedly scrutinized to identify whether and how patients' agency was acknowledged or denied by the two care professionals in the unfolding of the visit (for an in-depth, quantitative account, see Caronia, Colla & Ranzani, 2020). For the purpose of this study, the analysis focuses on how, through the micro-details of communication, the educator contributes to fostering the UFM's agency and locally building interprofessional collaboration with the GP.

The following excerpt illustrates two communicative practices deployed by the educator. First, he carries out a "pivot move" (Caronia, Colla & Ranzani, 2020, 2022), that is a multimodal practice whereby the educator selected as the privileged next speaker withholds the answer to the physician's question and turns toward the patient. In this way, he makes it relevant for the physician to (re)orient to the patient as the responder. Second, he formulates (Garfinkel & Sacks, 1970) the doctor's question in pursuit of P's answer.

Ex. 1 – Mahdi (10.23 – 10.35)
D = Physician
E = Educator
P = Patient (Mahdi, 16 years old)

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

1	D	^adesso ^^c'è un motivo ^^^per cui venite qui? ^now ^^is there a reason ^^^why you come here?
2	D	^*((looks at the documents E is keeping on the desk))*
3	D	^^*((looks at E))*
4	E	^^*((looks at D))*
5	E	^^^*((looks at P))*
6	D	*((stops looking at E and looks at P))*
7	P	*((looks down))*
8		(1.0)
9	D	qual è?= what is it?= *((looking at P))*
10	P	*((looks at D))*
11	E	=come mai Mahdi? =why Mahdi?
12	E	sei voluto venire qua dal dottore? did you want to come here to the doctor?

D's opening question in line 1 is particularly complex in terms of its addressivity (see Brown, 2005). Even though D verbally addresses both E and P by using the second person plural ("venite", in Italian, line 1), while issuing the first part of the question ("is there a reason", line 1) E is selected as the main interlocutor through gaze direction (see lines 2 and 3). However, after a brief eye contact with D (line 4), E visibly turns his head toward P (line 5) thereby carrying out a "pivot move": he passes the turn to P, selecting him as the expected answerer of D's question. What happens next is particularly interesting from a pedagogical standpoint: D stops looking at E and shifts his gaze toward P (line 6). In this way, D aligns with this re-orientation of the participation structure carried out by E, thus participating in constituting P as a competent, agentive interlocutor.

Despite P has been multimodally ratified as the next speaker by both E and D, he does not provide an answer and looks down for a second (lines 7 and 8). At this point, D prompts P to disclose the reason for the visit by means of an interrogative open question ("what is it?", line 9; see also the gaze direction unambiguously directed toward P). Immediately after (see the latching, lines 9 and 11), E intervenes by formulating the physician's question (line 11): he makes explicit its deictic references and uses the personal name next speaker selection strategy (Lerner, 2003). In doing so, E treats D's question as needing further clarification for achieving an answer by P, and, concurrently, orients to P's low linguistic competence.

By performing the "pivot move" first, and formulating D's question after, E carries out a subtle but impressive educational work. Through the micro-details of interaction, he contributes to fostering the UFM patient's agency by collaborating with the physician to achieve the institutionally relevant activity at stake: disclosing the reason for the visit.

6. Concluding remarks

This single-case study empirically illustrated the key role played by the educator during primary care visits of UFMs. As the analysis has shown, the educator radically concurs to establish the way the UFM patient is interactionally and epistemically treated throughout the visit. Indeed, the educator skillfully balances patient engagement and the pursuit of an effective exchange of medically relevant information and shared understanding. By carrying out the "pivot move" (Caronia, Colla & Ranzani, 2020, 2022) and formulating the physician's question, the educator is visibly oriented toward acknowledging the UFM patient as a competent interlocutor despite the linguistic gap. As a matter of fact, by refraining from answering on the UFMs' behalf, the educator steps back and recognizes the patient's linguistic and communicative competence in answering that specific question without compromising the smooth unfolding of the conversation. Furthermore, by locally constituting the UFM as a competent respondent during the opening phase of the visit (i.e., the problem presentation), the educator contributes to acknowledging the patient's phase-specific epistemic authority. To put it differently, the UFM patient is conversationally treated as a competent and legitimate interlocutor when it comes to disclosing the reason for the visit relative to his body and symptoms. It is precisely by constituting the UFM patient as an interactionally and epistemically competent subject that the educator contributes to locally fostering UFM's agency. But there is more than that. The communicative resources deployed by the educator to foster patient agency appear oriented to establishing an interprofessional collaboration with the physician to pursue patient-centered care. By grasping the ambiguous addressivity and potential intelligibility of the physician's question for the non-native patient, the educator's interventions are functional to cooperate with the physician to a) obtain relevant information from the UFM patient and b) allocate agency to the UFM. The fact that the physician aligns with the re-orientation of the participation structure carried out by the educator displays that a synergic interprofessional collaboration has been locally (co)constituted.

As this article has perspicuously illustrated, the educators involved in the study enact their "professional vision" (Goodwin, 1994) by maximizing patients' chances to be included and actively involved in the visit

whenever interactionally and epistemically appropriate. In this way, they orient to balance the autonomy-dependency tension at stake and show that their pedagogical expertise makes a difference in fostering UFMs' agency.

Insights from this study can constitute a valuable empirical resource for underpinning training programs aimed at enhancing educators' awareness of the "power of language" (Duranti, 2007) and fostering the "reflexive practitioner" (Mortari, 2003).

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