Interprofessional Communication in Health and Social Care

Theoretical Perspectives on Practical Realities

Edited by
Stephanie Fox · Kirstie McAllum · Leena Mikkola

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***Stephanie**: First and foremost, we dedicate this book to our readers. You have been top of mind for us for many moons! Next, to engaged communication scholars working across disciplinary and paradigmatic boundaries in health and social care contexts. You inspire us! Finally, from the "kid" to Sami Antaki, for having me report on interviews with such a variety of people at the McGill University Health Centre all those years ago; it opened my eyes to the importance of interprofessional work and solid writing.*

***Kirstie**: To Mary and John Hartigan. Your creative and care*-full *interprofessional work has been an inspiration.*

***Leena**: To all those health and social care professionals I have been privileged to collaborate with. Your work is invaluable.*

FOREWORD

Communication is essential to every aspect of interprofessional work. Yet, we still need to better understand how communication is intertwined with the myriad challenges and practical realities that health and social care providers face when working together. Most often in interprofessional literature and practice, communication's role is understood as effective and timely information sharing between relevant individuals. This conception of communication is important, as many problems stem from ineffective information exchange. Indeed, health and social care systems serve diverse populations, and language or cultural barriers can, and frequently do, impede communication between health and social care providers and service users (patients/clients). A lack of coordination and collaboration among health and social care professionals, in both education and practice, leads to fragmented communication, which results in incomplete or inconsistent information sharing. This lack of coordination and collaboration then affects how openly health and social care providers communicate about, and with, service users. Often communication is hindered or obstructed by the outdated or inefficient information systems with which health and social care professionals are working.

However, we must add to this instrumental understanding of communication as information exchange to better understand other dimensions of interprofessional work. It is well known that a lack of clarity about the roles and responsibilities of health and social care professionals leads to not only miscommunications but also a lack of accountability within what are assumed to be homogenous teams. Likewise, it is frequent in health and social care teams that poor communication results from a lack of understanding of professional differences (and, in many cases, of professional similarities). Interprofessional curricula and professional trainings often address the need for professionals to be able to communicate their roles to others. However, communication is also important in how *team* roles are worked out, how power asymmetries are navigated, and how complex meanings are negotiated in interprofessional interactions, all of which cannot be explained solely through information sharing.

Another perennial challenge stems from a major shortcoming in health and social care, namely the inadequate involvement of patients in decisions concerning their care, which frequently leaves the patient with insufficient material on which to make informed choices about their health and/or social care needs. Similarly, communication within and between health and social care systems continues to be inadequate because not all health and social care students receive adequate training in professional communication skills. Inadequate training can result in a poor ability to explain complex health information to patients or their colleagues. Moreover, the negative consequences of poor interprofessional communication training can be compounded by the reality that in busy health and social care environments, there may be limited time for informed communication. These time constraints can contribute to emotional and psychological fallout, such as stress and burnout, now so frequently observed in the workforce.

In every setting, there will always be health and social care professionals who are resistant to change, such as the problems with adopting checklists and finding ways to hinder their integration. Other communication challenges can arise from the way in which health and social care professionals understand and use the word "interprofessional." Still, others derive from how these professionals behave in interprofessional settings and the different ways they use language in communicating within and across their professions. Clearly, the importance of communication to interprofessional work cannot be underestimated. Yet conceptual tools in the interprofessional literature are still limited.

This edited book introduces, describes, and explains many of the critical theoretical and practice issues related to interprofessional communication (some of which are outlined above) and that must be addressed in curricular and health and social care reforms. The education of health and social professionals has been remiss in its approach to teaching the skills necessary to communicate between professionals – it is to be hoped that educators and practitioners will pay close attention to the suggestions provided in this edited book and develop opportunities to carry this vision into not only classrooms, but also into clinical practice contexts.

Unique in the field, the book brings communication and management scholars together with interprofessional researchers, educators, and practitioners to offer a nuanced exploration of the ways that communication shapes and influences interprofessional collaboration. Chapters in the book examine communication's vital role in information transmission in practices such as case management and interorganizational patient transfers as well as in different stages along the patient's care trajectory. However, the book also explains communication's role in other aspects of interprofessional care, beyond sharing information, such as negotiating and understanding roles and giving voice to patients and their families in interprofessional interactions.

The ***first*** section of this book introduces interprofessional practice and the various ways that interprofessional communication can be conceptualized, from dominant functionalist understandings of communication as information transmission to social constructionist understandings of negotiated orders as viewed through the lens of communication in teams and in interprofessional collaborative care, which do not necessarily call on the same approaches. The utility of these different conceptions is mapped onto a continuum of interprofessional practices, and clarifications are offered for frequently used (and perhaps just as frequently misunderstood) terms to describe different forms of interprofessional working together. This section also describes frameworks currently used to teach interprofessional competencies, including communication.

The ***second*** section of this book explores fundamental processes and dynamics of interprofessional communication that are relevant across clinical contexts. These include sensemaking as a communicative explanation of the complex and interdependent work of shared practice, thus expanding instrumental notions of interprofessional communication as information transmission. Communication is a social process that shapes relationships and as such can foster or harm the wellbeing of collaborators. As a social process, the dialectal tensions inherent in interprofessional collaborative communication can be seen in a variety of ways, including power relationships in health and social care teams; the specific language used in communicating in small cultures (and the plethora of acronyms this occasions) and the deeply intercultural nature of professionality. These tensions make a strong impact and require health and social care professionals to be both professional and interprofessional. Relatedly, the question of interprofessional communication competence, which continues to be a matter of considerable debate, is turned on its head, proposing that competence is not (only) an individual skill but rather a shared accomplishment that must always be collectively worked out.

The ***third*** section of this edited book examines interprofessional communication in specific practices and contexts of care, for example, in efficient and coherent case management in the interorganizational integration of care; in the communication practices that foster patient- and family-centered care in complex clinical settings, including the NICU, primary care when collaborators do not speak the same language, and survivor care in oncology. The particularities of rural trauma care teams are considered through the lens of the communication style of collaborators.

A final note. Institutional dialogue can set up differential power and status relations in interactions involving a variety of health care professionals. The way that health and social care organizations frequently refer to health professions speaking of “medicine, nursing, and allied health professions,” thereby diminishing the status and autonomy of the professions lumped together as “allied health,” is one asymmetry perpetuated by language use. Such asymmetries create situations in which nonverbal cues and contextual nuances play a significant role in erecting interprofessional communication barriers that must be overcome in order to develop a well-functioning interprofessional care-providing or learning environment.

Addressing the many complex challenges addressed in this edited book requires a holistic approach that includes, for example, interprofessional communication training programs both on campus and in practice settings; the implementation of effective interprofessional communication strategies; and the use of technology to facilitate information exchange within health and social care systems. Such endeavors can promote a culture of open interprofessional communication and collaboration that is essential to overcome the challenges addressed in this book. By considering context, language variation, power dynamics, nonverbal communication, and identity, individual health and social care professionals can enhance their interprofessional communication skills and contribute to more effective and inclusive interprofessional collaboration. Interprofessional communication is, and will continue to be, a vast topic of concern for theorists, educators, and practitioners.

Vancouver, BC, Canada John H. V. Gilbert

ACKNOWLEDGMENTS

Many authors and editors create long lists of people who inspired their thinking, encouraged them to launch out, helped them write their books, and enabled their efforts to come to fruition. Those we work with, those we teach, those we interact with in interprofessional health and social care contexts, and those we love have all contributed immensely to this book's development. Yet, our collective work emerged primarily from a series of events that spurred our thinking, our decision making, and, ultimately, our collaborating: publisher emails asking for book proposals; hallway conversations with colleagues and students; and more sporadic meetings at international conferences where we discussed research, intervention, and practitioner and student needs.

When Kirstie sat down for a cup of tea in Stephanie's office in 2021, she mentioned that a publisher had approached her to see if she wanted to submit a book proposal. "What a great idea," Kirstie reflected, "but after a year of surviving pandemic-induced online teaching, I've decided that 2021 has to be my 'Year of No (to New Things).' Maybe next year can be the 'Year of the Book?'" The cogs were set in motion. Stephanie decided that a book about interprofessional communication would be a fascinating project. Moreover, it would be especially relevant in light of the rapid transformation of health and social care practices; demographic shifts as the population ages and comorbidities become more complex; developments in interprofessional education; and the increased attention that health and social care workers have received post-2020. Stephanie discussed the "Book Project" with Leena at the annual conference of the International Communication Association in Paris, in May 2022, and Kirstie and Leena talked over lunch (and a glass of excellent French wine) before it ended. Stephanie spent part of her sabbatical working with Leena in Tampere, Finland, in the second half of 2022. In-person meetings matter, and they make amazing things happen.

We launched a call for chapters that would explore interprofessional collaboration from a communication perspective, mobilizing our professional networks and personal contacts with researchers working on these issues. Thank you to all those who responded with enthusiasm, and best of all, with a short chapter proposal, which allowed us to create a rich, nuanced overview of the dynamics and challenges of interprofessional communication in health and social care contexts. Around the same time, Stephanie touched base with colleagues in the interprofessional field at the University of British Colombia, Canada, to ask for feedback on issues that they thought were essential to include in the book. We learned much from their feedback. After incorporating their insights, we submitted our official book proposal to Palgrave. We were so grateful to the book's anonymous reviewers for their comments and encouragement. One reviewer wrote: "An important aspect of this volume is the sophisticated conceptualization of the communicative process; such a conceptualization is missing from most work on interprofessional communication. Much of the work relies on a simplistic view of communication; the more sophisticated focus is a key strength of the proposed book." Our second reviewer noted that we would need to work hard to make communication's complexity accessible to practitioners and students in health and social care and interprofessional programs. And, indeed, we and the authors of each chapter did work very hard to make the book accessible, based on the maxim that there is nothing so practical as a good theory. To this end, we incorporated vignettes that would illustrate how theories played out in varied health and social care contexts. We created callout boxes that defined key terms and explained and synthesized complex concepts.

It has been a joy working with the author or group of authors of each chapter. Your engagement with interprofessional practice, responsiveness to questions and suggestions, and attentiveness to deadlines were exemplary. We learned so much from you! We were so excited about making your work widely available to practitioners, students, and researchers studying interprofessional communication in health and social care settings that we wanted the book to be open access. We are extremely grateful to the Social Sciences and Humanities Research Council of Canada (Insight grant 435-2020-1274), the *Fonds de recherche du Québec-Société et Culture* (*Relève professoral* grant 2021-NP-282893), and the Tampere University Library, Finland, for their financial support, which allowed us to do so.

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Tampere University, Tampere University of Applied Sciences, University of Eastern Finland, and the Wellbeing Services County of Pirkanmaa; and Laurianne Piette, Alice Carter, and the anonymous reviewers at Palgrave. *Many thanks to you all. Merci beaucoup. Kiitos.*

CONTENTS

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LIST OF FIGURES

CHAPTER 14

The Interprofessional Team as an Emergent Structure of Participation: A Case Study on Primary Care Visits of Unaccompanied Foreign Minors

Letizia Caronia and Federica Ranzani

Introduction

In the last twenty years or so, clinical practice has increasingly adopted a distributed expertise model. This model is based on the idea that the knowledge that makes a difference in the delivery of safe and effective care must be spread among different experts: professionals as well as laypersons such as patients and their natural caregivers. Two main and not surprisingly converging ideologies lie beneath this distributed expertise turn: patient (and family) centered care (Mead and Bower 2000) and the interprofessional collaboration approach (hereafter IPC).[1] The former underlines the patient's expertise about her illness and her agency (see Callout 14.1) in how to deal with it and treatment prescriptions. The latter underlines the need to create an osmotic relationship among the different territories of professional knowledge at stake in patient

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[1] For a brief history of these two ideologies and a review of the works they inspired, see A. Fox and Reeves (2015).

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care, and advocates for a flat hierarchy of and "respect for disciplinary contributions of all professionals" (Herbert 2005, 2; on the ideal of "clinical democracy," see S. Fox et al. 2021). As A. Fox and Reeves (2015) point out, the "focus on enhancing interprofessional collaboration acknowledges the unique expertise of various health *and social care professions*, while encouraging them to work together to coordinate care, streamline service and optimize treatment" (113, our emphasis).

Despite its ideological implications and hidden economic rationales, such as freeing up highly expensive medical time by diverting some practices to nurses' less costly time or displacing legal responsibility on the "empowered patient" (on the unstated but underlying reasons of such a turn, see A. Fox and Reeves 2015), IPC is increasingly reported as the golden standard of health care. Scientific as well as gray literature converges in adopting an "ought to be" perspective on IPC: Formal models of how IPC should unfold and practical guidelines are more and more common (see among others Interprofessional Education Collaborative Expert Panel 2011; Kreps 2016), and relatively recent work has even defined and validated a gold standard on how IPC should be operationalized in clinical settings to promote effective collaboration (see Careau et al. 2014).

Despite this growing body of normative literature on IPC, there still is a relative lack of knowledge of how it is actually accomplished (or not) in the course of interaction as the outcome of observable communicative practices, especially within primary care (but see Fox et al. 2021). Due to clinical complexity often requiring different specialties and a pre-existing tradition of teamwork, the domains primarily concerned with IPC issues and affected by IPC informed policies have been hospital care (Reeves and Lewin 2004), specialist visits (e.g., cancer care, James et al. 2016), community care (Xyrichis and Lowton 2008), long-term treatments for chronic diseases (Barr et al. 2017), rehabilitation (Careau et al. 2014), and palliative care (Blacker and Deveau 2010). In fact, only relatively recently has primary care shown interest in IPC. Traditionally, in primary care, "many patient concerns [...] can be resolved or treated by a visit to a single health professional" (Fox et al. 2021, 125), but because of the growing complexity of primary care and increasing number of chronic conditions, the contribution of other professions has become increasingly relevant and often inescapable.

Among the factors that make "ordinary" primary care more complicated, linguistic obstacles and the patient's vulnerable condition can hinder achieving the main institutional goals of a medical visit: gathering information for diagnosing, ensuring understanding of diagnoses and treatment recommendations, and gaining compliance by leveraging the patient's agency and active involvement in the visit. Following a recent line of inquiry on how IPC in primary care communicatively unfolds and a "strong call for qualitative and observational methods to take communication out of its black box in the IPC literature" (Fox et al. 2021, 126), this chapter identifies *interprofessional attunement* (see Callout 14.2) as one form of interacting in interprofessionally managed care. It draws on data from a single case study concerning a socially and linguistically complex case: the primary care visits of unaccompanied foreign minors (hereafter, UFMs) who don't master the language of the visit. The visits are characterized by a triadic format of participation: the UFM patient is accompanied by a professional educator who is institutionally in charge of the UFMs' everyday care and assists them during any health care encounter as well as other ordinary and institutional tasks. Professional educators are not cultural and linguistic mediators and nor do they have any competence in UFMs' first language. Their professional expertise is in social care and consists of socio-anthropological and psycho-pedagogical applied knowledge. As we will illustrate, the co-presence of the physician and educator creates a form of participation where their respective and different domains of expertise, institutional mandates, goals, communicative models, and practices balance each other. The synergy made possible by mobilizing different professional agendas and communicative resources (e.g., closed- and open-ended questions, gaze direction, gestures) allows practitioners to reach an outcome that would probably not be attained without engaging in this (possibly unintentional) form of *interprofessional collaboration*.

Although primary care visits of asylum seekers and refugees are not representative of ordinary primary care work, they nevertheless constitute a particularly useful case that illustrates (1) the relevance of interprofessionality when dealing with socially and linguistically complex cases, and (2) how IPC can be accomplished one interaction at a time through various communicative resources—ways of speaking and other communicative modalities, such as gestures, body orientations, gaze, and even the use of objects—that are part of the everyday communicative repertoire of the participants. As we will illustrate, it is precisely by resorting to identifiable communicative resources and distributing the burden of communicating with linguistically (locally) impaired patients that professionals manage to overcome the typical dilemma of these encounters: maximizing information understanding versus following a patient-centered approach.

INTERPROFESSIONAL CARE: A *TEAM-BASED* OR A *TEAM-EMERGING* PRACTICE?

For the most part, the IPC literature considers "teams" or otherwise institutionally expected forms of interprofessional communication, collaboration, coordination, and cooperation in normative terms (e.g., Careau et al. 2014; WHO 2010): application-oriented studies, guidelines, and protocols provide definitions or even prescriptive models of how communication, collaboration, and cooperation among healthcare professionals *should* unfold. Notwithstanding the practical value of such a normative approach (as well as its ideological underpinning), it still fails to account for how interprofessional communication and collaboration unfolds "informally," that is, outside an official and constraining framework (e.g., "teamwork") that establishes a priori who has to and how to collaborate, coordinate, and cooperate with whom and for what clinical purpose. Adopting a constitutive model of communication and bracketing any normative approach on how IPC *should* unfold, in this chapter we make a case for IPC *as a team-emerging communicative practice*, that is, a way of interacting that makes the co-present professionals work and act *as* a "team." Indeed, we propose that the "interprofessional team" should not be considered as a preexisting participative structure institutionally set up and normatively encouraged so that "different health care professionals [can work] together to help consumers address their health problems" (Kreps 2016, 1). Instead, we define the interprofessional team as a way of working that is locally accomplished one interaction at a time by participants.

From this standpoint, "interprofessional team-based care" (Interprofessional Education Collaborative Expert Panel 2011, 2) is not necessarily a purposely designed and training-based form of care "delivered by intentionally created usually relatively small work groups in health care who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient" (ibid). Rather, we claim it is an *emergent* property of interaction where participants display, manage, and coordinate their different—and often hierarchically organized—expertise and institutional mandates. Locally accomplished and endogenously crafted "interprofessional collaborative practices" (WHO 2010) are therefore conceived of as potentially producing local forms of "interprofessional team-based care." Here, we describe a set of coordinated communicative moves that we call "interprofessional attunement."

The adoption of a constitutive model of communication to analyze communication as it actually unfolds in real-life conversations does not necessarily mirror the participants' analytical understanding of communication. On the contrary, it can be the researcher's theoretical perspective on how communication unfolds, a kind of second-order construct they use to make sense of what they observe in the field. The professionals "under scrutiny" have their own—more or less noticeable and acknowledged—"model of communication," depending on their professional culture, pre-service and in-service training, as well as experience. In our case study, the doctor and the educator are oriented to a "transmission model of communication" (the doctor) and a "transactional model of communication" (the professional educator). This orientation is visible in the different communicative practices they deploy: while the doctor seems more oriented to pursuing and ascertaining correspondence between encoded and decoded messages (e.g., by engaging in multimodal communication, translating specialized lexicon into everyday more accessible terms, see Caronia et al. 2020, 2022a, b), the educator engages more often in scaffolding the patient's meaning-making process, for instance, by reformulating the doctor's questions to adjust them to the patient's comprehension.

As the case study demonstrates, building interprofessional team-emergent care also amounts to bridging and intersecting models of communication that can be, and often are, very different both in their theoretical assumptions and in their practical consequences. By mapping the different communicative models and relative practices within a highly specific primary care setting, this chapter contributes to defining the repertoire of communicative forms through which IPC is—and therefore can be—accomplished *in vivo*. Indeed, in this study we follow a bottom-up approach well suited for delivering ecologically valid, practice-relevant findings, that is, results whose implications for policies and practices are rooted in, and therefore sensitive to, the constraints and possibilities of the IPC actually taking place within interprofessionally managed primary care visits.

In a nutshell, we contend and empirically illustrate that the necessary and sufficient conditions to provide "interprofessional team-based care" are few: the professionals' co-presence and the deployment of communicative resources oriented to collaborating in a way that manages the dialectical tension between connection and professional autonomy (see Chap. 7).

Triadic Interactions in Healthcare Settings

The interest in analyzing how healthcare interactions involving multiple parties (other than the physician and the patient) unfold in actual medical consultations has increased in recent years. The bulk of the research explores cases involving the participation of patients' "companions," that is, "people who support patients and attend health-care appointments with them" (Pino and Land 2022, 396). Among these observational studies of social interactions, pediatric care receives particular attention as the presence of parents (or other adult caregivers) is mandatory in the case of children who are minors (e.g., Aronsson and Rindstedt 2011; Stivers 2007). Similarly, companions' presence is expected in particularly sensitive settings such as end-of-life care (Pino and Land 2022), medical visits of patients with communicative or cognitive impairments (Garcia 2012; Muntigl et al. 2014), or oncology (Fatigante et al. 2021). As these studies illustrate, the delicacy of the contexts mentioned above makes the participation of the accompanying party particularly challenging. If, on the one hand, the patient-centered ideology informing healthcare services pushes for patient autonomy and the related right to "speak for themselves" (therefore, the companion's intervention on the patient's behalf is not institutionally desirable), on the other hand, fragile patients may not be able or willing to do so (therefore, the companion's intervention may be essential for attaining the visit's objectives at the expense of the patient-centered mandate; for similar considerations, see the next section). In this regard, research based on interaction analysis of observed patient consultations shows that intervening on the patient's behalf (e.g., by answering questions clearly addressed to the patient) does not constitute *per se* a "bad" practice that unavoidably undermines the principle of patient autonomy. Rather, companions intervene in a "carefully calibrated manner" (Antaki and Chinn 2019, 2029) that is (a) the result of a local adjustment to the specific interactional circumstances (e.g., the companion's intervention is prompted by the patient's or the professional's gaze or question or occurs when the patient does not answer a question asked by the health care professional, see Pino and Land 2022) and (b) contingent on the phase-specific goal of the visit (e.g., the companion revises the information provided by the patient in the problem presentation phase while concurrently preserving the patient's rights as the owner of the illness story, see Fatigante et al. 2021).

Callout 14.1 Agency

Notwithstanding the differences among the various definitions of agency, they all share a core meaning: agency refers to the capacity of an individual to act and make a difference in the social world. Many scholars add two other constitutive components: being in control over one's own action and having a choice (Duranti 2004; Giddens 1984). Strictly related to the notion of agency is that of autonomy. In a nutshell, autonomy generally refers to the extent to which individuals have the capacity and self-determination to make decisions without external influence or coercion. Despite some semantic overlap, the notions of agency and autonomy do not coincide. While agency emphasizes the ability to have an impact and make choices through the exercise of personal will, autonomy pertains to independence and freedom from external control. Agency and autonomy are considered fundamental ethical principles in the domain of health care as they uphold individuals' right and ability to make informed decisions about their health.

While healthcare interactions where the third participant is another healthcare professional have received less attention in social interaction literature, one case has been quite investigated: triadic interactions between the healthcare provider, the non-native patient, and the interpreter (e.g., Baraldi and Gavioli 2012) who attends the visit "with the sole communicative function of making understanding possible" (Gavioli and Baraldi 2011, 206). Research in this domain reveals that interpreters' contribution to the unfolding of the visit cannot be reduced merely to the accurate linguistic translation of others' talk on a turn-by-turn basis. Rather, interpreters play an active role by coordinating who speaks when and about what (Baraldi and Gavioli 2012), selecting what medical information has to be translated or not (Davidson 2000), or by expanding the rendition of the doctors' questions (Baraldi and Ceccoli Forthcoming).

Compared to the other kinds of triadic medical visits tackled above, triadic encounters with UFMs and their accompanying educators are potentially characterized by different layers of complexity and, therefore, they can be challenging in quite specific ways to the professionals involved in taking care of these patients. We discuss this in the next section.

A New Challenge for Primary Care: The Case of UFMs

Unaccompanied foreign minors (UFMs) are underaged children or adolescents who arrive in a country without their parents or other legally responsible adults. Internationally, UFMs are considered vulnerable persons who deserve care and support by the hosting society. Typically, they are hosted in residential structures where different professionals take care of them. In Italy, where this data was collected, professional educators are in charge of UFMs' everyday well-being. Their expertise is grounded in psycho-pedagogical and socio-anthropological knowledge, and they are institutionally expected to support UFMs in the accomplishment of their educational, administrative, and health-care tasks. Their pedagogical mandate consists in promoting UFMs' active participation and autonomy as much as possible. The presence of an educator is normatively required during primary care visits. The accompanying educator is expected to ensure the effective exchange of biomedical information (and therefore sometimes they speak for the UFM), and, concurrently, to maximize the UFMs' active participation in the visit by making them speak for themselves. The promotion of patients' agency also constitutes a cornerstone of the professional mandate of the co-present physician: while securing information understanding throughout the visit constitutes a primary goal, they are institutionally encouraged to foster patients' involvement in the visit as emphasized by the patient-centered approach. However, pursuing UFMs' participation can be quite a challenging task in this kind of visit since they are characterized by multiple asymmetries. In addition to the epistemic asymmetry ordinarily at stake in any medical encounter (Pilnick and Dingwall 2011; see Callout 14.3), the linguistic asymmetry can be particularly evident in these visits as the patients typically have low competence in the language of the visit and neither the physician nor the professional educators know the patients' first language (and no interpreter is present). The interaction can also be characterized by a social asymmetry since UFM patients often experience a fragile socio-psychological condition due to, alongside other factors, their migratory paths and post-traumatic status. Lastly, an interprofessional asymmetry may be operating: despite the pressure for a flat hierarchy in interprofessional collaboration, participants in the medical visit still orient to the primacy of the physician's biomedical knowledge over the educator's socio-pedagogical knowledge (on interprofessional power hierarchies, see Chap. 8 and A. Fox and Reeves 2015). Given this system of intertwined asymmetries, the goals of maximizing patient autonomy on the one hand and concurrently ensuring reciprocal understanding and information gathering on the other may become incompatible in these visits. In fact, the more the professionals prioritize biomedical information gathering and understanding, the more they have to exclude the UFM as the primary addressee (i.e., the person to whom talk is addressed); conversely, the more they prioritize the UFM patients' agency by directly addressing them, the more they risk missing the full comprehension of their medical history and overall health condition.

How do the two care professionals manage this incompatible agenda? As we will show, it is precisely (a) the educator's specific institutional mandate and relevant expert knowledge, (b) her way of cooperating without intruding in the medical territory of knowledge, and (c) the doctor's orientation to such displayed non-medical expertise, which allows participants to overcome the "maximizing understanding versus allocating agency" dilemma of this kind of visit.

No Cure Without Care: Exploring Interprofessionality in the Making

In the next section, we show (1) how interprofessionality is accomplished "in the making" through observable communicative resources that are mobilized throughout the different phases of the UFMs' medical visits and (2) how these resources allow practitioners to collectively overcome the tension between ensuring understanding and allocating agency. We draw on a corpus of three videorecorded primary care visits of unaccompanied foreign minors (UFMs) collected in an Italian general practice public clinic.[2] In line with the constitutive model of communication, we use theoretical and analytical constructs from conversation analysis (CA)[3] (Sidnell and Stivers 2012) to analyze the excerpts presented in the following section. The video recordings have been transcribed using CA conventions and enriched with notations for gaze, gestures, body movements, and orientations when ostensibly relevant for participants.

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[2] Each visit involved a general practitioner, a UFM patient, and an educator. The UFMs participating in the study were aged between 16 and 18 and had low competence in the language of the visit (i.e., Italian). Participants' consent was obtained according to the Italian and European laws regulating the handling of personal and sensitive data (GDPR).

[3] Conversation analysis (CA) is an observational, micro-analytic approach to the study of real-life audio and/or video recorded "naturally occurring" interactions, that is, not elicited by the researcher. It is based on the transcription and close analysis of the tiniest details of participants' communicative resources, including language, bodily conduct, and the use of material artifacts. The transcription conventions include not only the transposition of the content of talk (*what* is said) but most importantly the different modalities of talk production (*how* it is said), including participants' multimodal conduct (gaze directions, body posture, movements, and gestures), vocalizations (e.g., laughter) and other interactional features such as the length of silences, overlapping talk, or intonational contours. The advantage of adopting CA to analyze healthcare interaction is that it enables (a) the identification of observable communicative strategies that can foster (or hinder) patient participation in the visit, (b) the investigation of the association between observed communicative behaviors and specific outcomes (e.g., patient satisfaction, compliance), and (c) the identification of visible communicative patterns that healthcare providers can reflectively analyze in training programs and adopt with more awareness when interacting with patients.

Dealing With the "Maximizing Understanding Versus Allocating Agency" Dilemma: An Interprofessionally Achieved Goal

The following excerpt is drawn from the problem-presentation phase of the visit, where patients are typically treated as the epistemic authority having access to the relevant knowledge (e.g., symptoms, medical history). We show how, through an interprofessionally accomplished interactive sequence that we call a "pivot sequence" (see Caronia et al. 2020, 2022a), the professional educator and the physician cope with the "maximizing understanding versus allocating agency" tension by constituting the UFM patient as a ratified participant, that is, a participant in the conversation who is clearly addressed by the speaker and who is expected to take on the speaker role.

What follows is an example of the "pivot sequence," which is composed of three interactional moves: (1) the physician's "oscillatingly addressed question," that is, a question characterized by the simultaneous or in-quick-succession use of different and/or inconsistent resources for next speaker selection, (2) the "pivot move" by the educator, that is, a multimodal contribution through which the educator constructs the UFM as the physician's responder, and (3) the participants' (re)orientation to the UFM as the physician's responder (Fig. 14.1).

Example 14.1 Malik[4] (03.14–03.18)
D = Physician; E = Educator; P = Patient (Malik, 18 years old)

In line 1, D asks for the reasons for the visit by means of a yes/no question, which displays the physician's orientation to the patient's low competence in the language of the visit. Indeed, properly answering this type of question requires less linguistic competence than required by open-ended questions. P is also selected through another feature of turn design: lexical choice. The use of the second person singular form of the verb ("are you," line 1) and the lexical item "problem" (the Italian *problema* is a very common term, part of the basic lexicon) concur with question format in constructing P as D's addressee despite P's low linguistic competence.

However, D concurrently looks at the documents held by E (line 2, see Fig. 14.2) and then directly at E (line 3, Fig. 14.3). In this way, E is *also* selected as the physician's addressee. Note that D's gaze direction toward E at the end of the turn is considered to further stress who is the selected next speaker. Through this oscillatingly addressed question, D treats both E and P as addressees of his question, while prioritizing the educator as the respondent.

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[4] For privacy reasons, all names have been fictionalized and likenesses blurred.

1 D adesso ^sei qui per un altro ^^proble^^^ma?
now are ^you[SING] here for another ^^proble^^^m?

2 D *^((looks at the documents E's holding))*[fig. 14.2]

3 D *^^((looks at E))*[fig. 14.3]

4 E *^^((looks at D))*[fig. 14.3]

5 E *^^^((visibly turns toward P))*[fig. 14.4]

6 D *((stops looking at E and looks at P))*[fig. 14.5]

7 P sì e:: il mio occhio che °mi brucia°
yes e:: my eye that °itches° ((looking at D))

Fig. 14.1 Excerpt 1: Problem-presentation phase

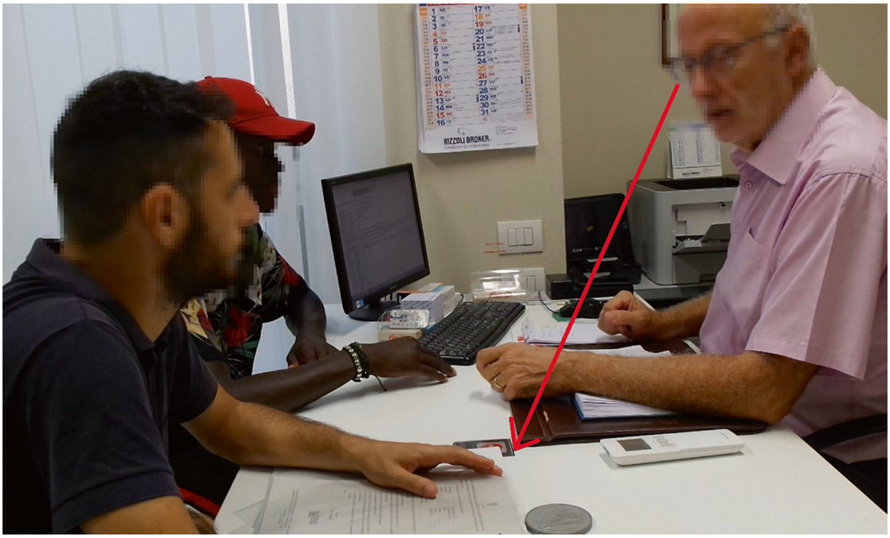

Fig. 14.2 D looks at the documents held by E

Yet, E withholds answering D's question and, after making brief eye contact with him (line 4, Fig. 14.3), he visibly turns his head toward P (line 5, Fig. 14.4). In doing so, E makes a "pivot move": he (re)directs the physician's question to P, selecting him as the next speaker. In the following turn, D aligns with E's multimodal construction of P as the responder: D looks at P too, thus unambiguously constituting him as the next speaker (line 6, Fig. 14.5). Then, P positively answers D's yes/no question ("yes," line 7) and provides the reason for his visit ("my eye itches," line 7).

By cooperatively constituting P as the ratified respondent, D and E observably *act as a team*: they synergically mobilize micro-communicative resources

Fig. 14.3 D looks at E, E looks at D

Fig. 14.4 E visibly turns toward P

that reorient the participants toward the attribution of agency to P while ensuring the effective exchange of relevant information. In other words, both professionals step back from exclusively pursuing their respective primary institutional goals; rather, they interactionally attune to the other professional's stance.

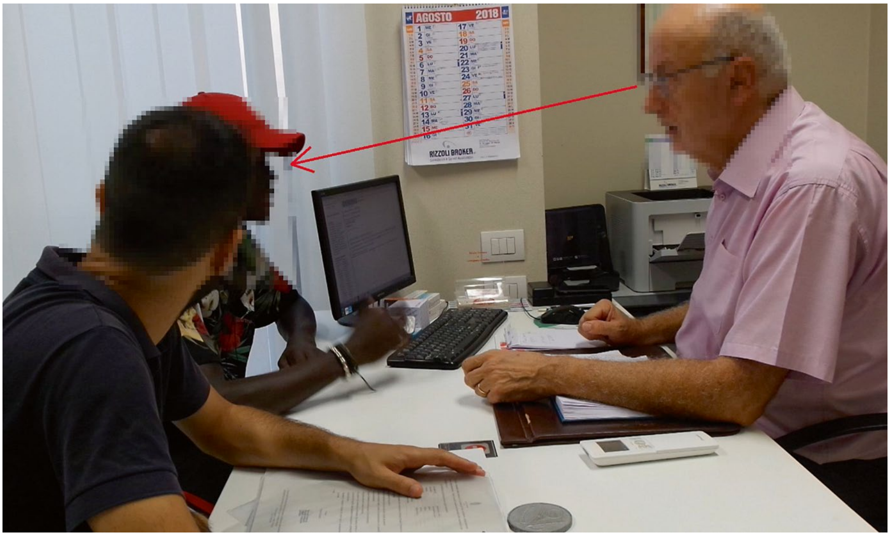

Fig. 14.5 D stops looking at E and looks at P

The next example shows how the "maximizing understanding versus allocating agency" dilemma is dealt with during the treatment-recommendation phase, where the physician's epistemic authority typically prevails. We show that in this phase, both care professionals seem more oriented to ensuring the full comprehension of information by momentarily treating the patient as an unratified participant, that is, a participant who, despite being present and despite being the subject of the talk, is treated as a mere bystander (Fig. 14.6).

Example 14.2: Malik (6.46–7.15)
D = Physician; E = Educator; P = Patient

We join the conversation when D proffers the treatment recommendation, that is, using eye drops twice a day. From line 1 to line 3, D clearly addresses P by using the second person singular ("I am giving you," line 1) and the gaze direction (line 3, Fig. 14.7). This means D addresses P as the ratified interlocutor. Yet, D continues describing the treatment procedure by shifting addressivity: he looks only at the educator (lines 4, 7, 9, 10, see Fig. 14.8; alternatively, he looks at the computer, lines 6 and 7), refers to the co-present patient in the third person singular ("he puts an ophthalmic ointment," line 7, "he *drop* a bit of ointment," line 10), and uses technical jargon ("ophthalmic ointment," line 7). In so doing, D seems more oriented to prioritizing that treatment information is clearly understood by E. Importantly, note that E aligns with him being selected as the sole addressee of D's talk by repeating part of the procedure (line 5), looking at D (line 5), and by displaying his understanding (line 11).

1 D allora ti do
so I am giving you[SING] ((looking at the computer))

2 D due volte al giorno da usare il collirio
eye drops to be used twice a day ((looking at the computer))

3 D ne metti un paio di gocce
put[SING] a couple of drops ((looking at P))[fig. 14.7]

4 D per occhio=
per eye ((looking at E))[fig. 14.8]

5 E =°per occhio°
=°per eye° ((looking at D))

6 D e alla <u>sera</u> (.) e:: prima di andare a letto,
and at <u>night</u> (.) eh:: before going to bed, ((looking at the computer))

7 D mette una pomata oftalmica.
he puts an ophthalmic ointment. ((looking at E and then at the computer))

8 *((6.0 sec. not transcribed. D tells E that the ophthalmic ointment comes out from its tube as a thin filament))*

9 D davanti allo specchio
in front of the mirror ((looks at E and opens his eye with his fingers to demonstrate how to apply the ointment))

10 D fa cadere [un filo di crema
he drop [a bit of ointment ((looking at E))[fig. 14.9]

11 E *[°ok ok° ((nodding))*

Fig. 14.6 Excerpt 2: Treatment/Recommendation phase

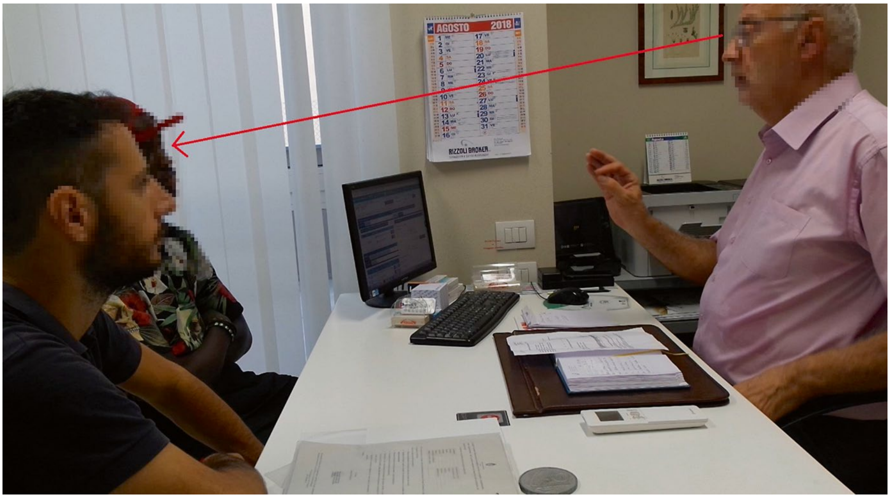

Fig. 14.7 D looks at P

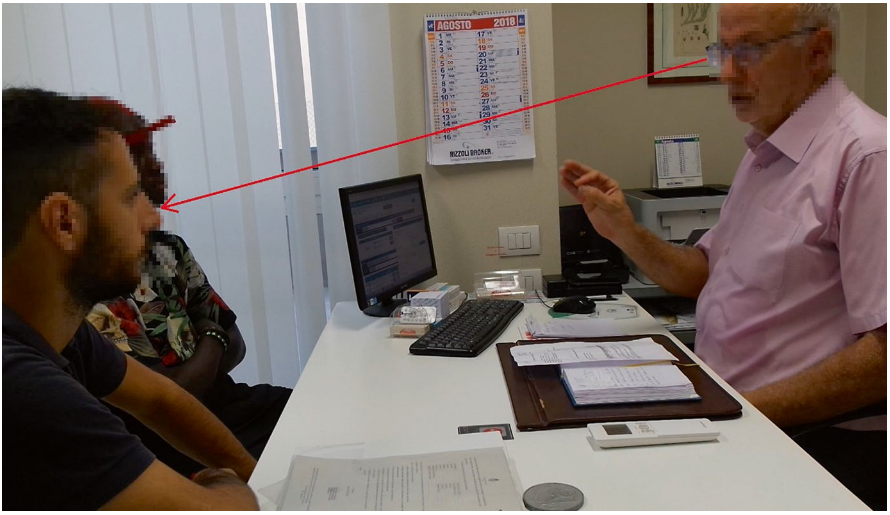

Fig. 14.8 D looks at E

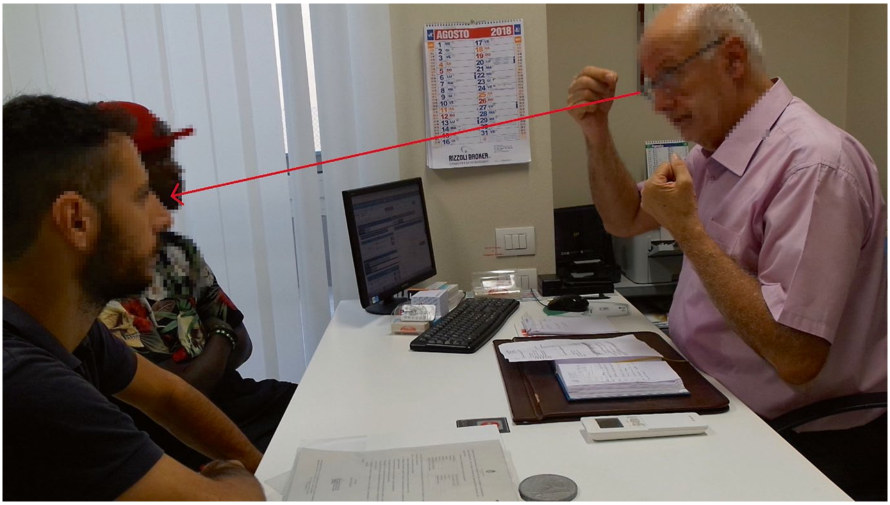

Fig. 14.9 D looks at E

Contrary to Example 14.1, here E *does not* (re)direct D’s talk toward P, thereby momentarily constituting P as an unratified participant. In this way, D and E observably cooperate to ensure that relevant information is successfully exchanged even if this means locally excluding the patient from the ongoing talk and, therefore, not interactionally acknowledging his agency (Fig. 14.9).

In the next section, we discuss the possible reasons why, and outline the communicative resources whereby the two care professionals differently but cooperatively work to navigate the "maximizing understanding versus enhancing agency" dilemma throughout the different phases of the visit.

Discussion: Interprofessional Attunement as a Way of Working Together

As the examples illustrate, the two professionals work differently but cooperatively to navigate the "maximizing understanding versus enhancing agency" dilemma throughout the different phases of the visit. While the doctor appears to be more (yet by no means exclusively) oriented to maximizing efficacy in the information exchange, the educator appears to be oriented to enhancing the patient's agency whenever this goal does not compromise understanding. Far from causing struggles in interaction, these different orientations (arguably related to the professionals' different institutional mandates and professional knowledges) produce an observable dialectical tension between connection and professional autonomy, which amounts to producing a balance among the different stances at stake: neither pursues only his primary goal and both take into account and are responsive to the other professional's stance. We call this way of working together *interprofessional attunement.*

Callout 14.2 Interprofessional Attunement
We define "interprofessional attunement" as a way of interacting whereby different professionals cooperatively work together by taking into account and being responsive to the specialized expertise and institutional agenda of the other co-present professional. Rather than exclusively pursuing their primary professional goal, interprofessional attunement entails the work of interactional monitoring and synchronization to the other practitioner's specific professional mandate. We consider this work of ongoing reciprocal adjustment to each other's professional culture as a local, interactive accomplishment, that is, something that the professionals *do* in the interaction through a set of synergically mobilized communicative resources (e.g., lexical choice, gaze direction, gestures). This interactionally accomplished work of "interprofessional attunement" allows the participants to act *as* a team.

Example 14.1 perfectly illustrates how, even where a hierarchy of professional expertise is at stake, professionals orient to each other's expert stance and *therefore* succeed in balancing the incompatible goals at stake when taking care of linguistically (locally) impaired patients: "allocating agency" versus "maximizing understanding." The educator who, in this setting, is in the inferior epistemic position, can reorient the structure of participation (see the pivot move, Example 14.1, line 5) thanks to his professional competence. Yet the doctor is also open to pursuing the "allocating agency" pole of the dilemma (see the oscillating addressivity move, Example 14.1, line 1), and displays his alignment[5] with the educator's newly established structure of participation (see Example 14.1, line 6).

We consider these moves as communicative practices available to participants that can be exploited in similar circumstances. The communicative resources used to accomplish these practices are various. Consider first the "oscillating addressivity" practice. Lexical choice (e.g., the use of personal pronouns), gaze direction, and body movements are mobilized by the doctor to open up the field of addressivity and include both of the other interlocutors: the patient who is the "epistemic authority" on his symptoms, clinical history, and reasons for the visit, and the co-present educator, who has the linguistic means to efficiently transfer that knowledge. While prioritizing the educator as respondent—and therefore displaying his orientation to efficiency in information gathering—the doctor still appears sensitive to the "patient agency" pole. Consider now the "pivot move" practice: by skillfully exploiting the fissure of the doctor's oscillating addressivity, the educator withdraws his role of respondent and passes it to the patient. Here too the resources are multimodal. Although the example reports only bodily resources (see Example 14.1, line 5), linguistic resources are also at stake, such as formulating the doctor's question as if it were straightforwardly directed to the patient, translating words from technical jargon to everyday language, or clarifying potentially ambiguous terms (see Caronia et al. 2020, 2022b).

However, and as Example 14.2 illustrates, a kind of interprofessional coordination is also at stake when the doctor does not address the patient as the ratified interlocutor at all. As we have seen, the educator aligns with the structure of participation projected by the doctor, that is, he accepts and supports the activity of momentarily excluding the patient from the interaction and accepts being the sole ratified addressee of the physician's talk. Concurrently, the educator downgrades his professional mandate of enhancing the UFM's agency. In this case, the dilemma is cooperatively resolved by locally prioritizing full understanding over orienting to the patient-centered framework. Why? Can we consider this common case as a kind of interprofessional collaboration or is it a specimen of the typical subordination of low-ranked professional knowledge (e.g., education) and related priorities to high-ranked expertise (e.g., biomedical knowledge) and agenda? To answer this question, it is worth noticing that these apparently contradictory stances by the educator are not fortuitous; rather, they appear to be consistent with the phase-specific relevance of the patient's epistemic status, and the degree of linguistic competence necessary to actively participate within each phase.

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[5] By alignment, we mean that a participant displays their acceptance of the communicative role projected and/or the activity undertaken by their interlocutor. For instance, in this case, the doctor shows he accepts addressing the patient as his primary addressee, which is the structure of participation the educator oriented to immediately before.

Callout 14.3 Epistemic Status

The notion of “epistemic status” refers to what information is known, how it is known, and the persons’ rights and responsibilities to know it (Heritage 2012a, b). For example, physicians are socially entitled to possess biomedical expert knowledge and are expected to manage this kind of knowledge better than the patient. They are the “epistemic authority” on this territory of knowledge. The notion of “epistemic authority” refers to who, in an interaction, is entitled, socially expected to be, and interactively recognized as the one who knows best within a defined territory of knowledge. However, participants position themselves toward their epistemic status, aligning or not to what is socially expected: they can claim more or less knowledge than expected, reject the epistemic status projected in the course of interaction, or claim to possess a kind of knowledge they are not entitled to possess. For example, patients may adopt a stance that claims a greater knowledge regarding their diagnosis than their layperson’s epistemic status would indicate. The notion of “epistemic stance” refers to the moment-by-moment expression of relative knowledge. Related to the notion of epistemic status and authority is the notion of “epistemic asymmetry.” It refers to the unequal distribution of relevant knowledge between doctors and patients, where patients’ first-hand, experiential knowledge is ordinarily inspected and assessed by the doctor who holds biomedical expert knowledge. Epistemic asymmetry is strictly related to the issue of medical dominance and power.

Rather than pursuing patient agency as if it were unconditionally the right thing to do to be patient-centered, the educator evaluates its local appropriateness at that moment in the interaction. In the first phase of the visit, where the patient is the epistemic authority regarding his clinical history and reasons for the visits and can communicate with a few words (e.g., yes or no answers) and some gestures, the educator works to maximize the patient’s agency and makes the doctor align with his own professional mandate. On the contrary, in the second phase of the visit—where the crucial issue at stake is the understanding of the diagnosis and treatment recommendations—the educator aligns with the physician’s attempt to maximize understanding of clinical information, collaborates in pursuing this phase-specific goal, and locally downgrades his professional agenda.

Through an ongoing interlaced upgrading/downgrading of reciprocal professional priorities and mandates, the educator and the doctor collaborate to ensure full understanding (therefore necessarily excluding the patient from the ongoing interaction) or to enhance the patient’s agency (therefore including the patient in the ongoing talk) in ways sensitive to the local, phase-specific goals and constraints of the encounter. We suggest that it is precisely because of their respective and different overarching institutional goals and professional cultures as well as the reciprocal attunement of their different—and at times opposite—institutional mandates and even models of communication that they succeed in pursuing the incompatible goals of this kind of visit and accomplish teamwork as an emergent structure of interprofessional care.

Concluding Remarks

Investigating observable interprofessional collaborative practices *actually* deployed in healthcare encounters (Pullon et al. 2016; Fox et al. 2021) shows how interprofessionality can be—and actually is—pursued and accomplished through endogenous communicative resources regardless of professionals' awareness. Our exploratory study sheds light on a way of working together that we call "interprofessional attunement": by being locally responsive to each other's moves and taking into account the constraints and possibilities set by the specific phase of the visit, professionals *work as a team* and reach an outcome (pursuing the incompatible goals of this kind of medical visit) that would probably not be attained without engaging in this (possibly unintentional) form of *emergent* interprofessional team-based care.

What appears to make the difference in providing effective and patient-centered care to UFM patients is less the flattening of interprofessional hierarchies as put forward by the so-called "clinical democracy" (see Long et al. 2006) than the professionals' interactive coordination and respect for each specific domain of expertise as well as a moment-by-moment orientation to the other professional's communicatively displayed stance. This reciprocal orientation is not a vague attitude but the outcome of identifiable communicative practices (such as the oscillating addressivity, the pivot move, the alignment to the other professional's stance) and communicative resources (e.g., recipient-designed lexical choice, gaze direction, body orientation).

We contend (and have empirically illustrated) that the necessary and sufficient conditions to provide "interprofessional team-based care" are few: professionals' co-presence and the deployment of what we call "interprofessional attunement." If the first condition is system-based, policy-dependent, and therefore professionals are not in control of it, the second condition is totally in their hands. This is an important point. By making the case of interprofessionally performed "ways of communicating" (e.g., distributing addressivity, engaging in the "pivot move"), we advance that the resources for providing "interprofessional team-based care" are already part of professionals' communicative repertoire. Once made observable and recognizable through analysis, they become formalizable, learnable, and transferable, that is, ways of communicating that transcend the here and now of the single case study and can be reflectively adopted in similar workplaces and circumstances.

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