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Practices of Inclusion in Primary Care Visits of Unaccompanied Foreign Minors : Allocating Agency as an Interprofessionally Distributed Intercultural Competence

This is the final peer-reviewed author's accepted manuscript (postprint) of the following publication:

Published Version:
L. Caronia, V. Colla, F. Ranzani (2022). Practices of Inclusion in Primary Care Visits of Unaccompanied Foreign Minors : Allocating Agency as an Interprofessionally Distributed Intercultural Competence. new york : Springer Verlag [10.1007/978-3-031-12626-0_10].

Availability:
This version is available at: https://hdl.handle.net/11585/907895 since: 2022-11-25

Published:
DOI: http://doi.org/10.1007/978-3-031-12626-0_10

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(Article begins on next page)

12 October 2024

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Caronia, L., Colla, V., Ranzani, F. (2022). Practices of Inclusion in Primary Care Visits of Unaccompanied Foreign Minors: Allocating Agency as an Interprofessionally Distributed Intercultural Competence. In: *Fatigante, M., Zucchermaglio, C., Alby, F. (eds) Interculturality in Institutions. Culture in Policy Making: The Symbolic Universes of Social Action* (Springer)

The final published version is available online at: https://doi.org/10.1007/978-3-031-12626-0_10

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Practices of inclusion in primary care visits of unaccompanied foreign minors: Allocating agency as an interprofessionally distributed intercultural competence.

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Abstract

The presence of unaccompanied foreign minors (hereafter UFMs) is a challenge for the Italian welfare and foreigner reception systems. The chapter builds on an exploratory study on the ways in which professional educators interact with other professionals to manage UFMs' access to care. In particular, it investigates triadic medical visits involving a general practitioner, an unaccompanied foreign minor, and his educator whose mandatory presence is aimed to support UFM patients throughout the encounter and make patient-physician communication as smooth as possible. Indeed, these institutional encounters constitute a perspicuous case to study how inclusion is performed (or not) through interprofessional interaction and the communicative resources whereby care professionals manage their often-incompatible goals and mandates. Adopting a Conversation Analysis-informed approach to a corpus of video-recorded visits, we describe the "pivot sequence ", a distributed discursive and multimodal practice whereby the educator(s) and the physician differently, but cooperatively manage the inclusion of the UFM as an active participant and intersubjectively overcome the "gathering information vs. allocating agency" dilemma typical of these institutional encounters. By enlightening the "interactive vigilance" of the educators (i.e., their capability to restore the UFM's agency whenever appropriate), we make a case for interprofessionally managed health care as a means to accomplish inclusion in interaction.

1. Introduction

Health care policies and practices are crucial domains where a society displays its explicit as well as tacit models of citizenship and larger worldviews, such as its orientation to inclusiveness. From this standpoint, the presence of unaccompanied foreign minors (hereafter UFMs) is a challenge for the Italian welfare and foreigner reception systems. Given their status as well as linguistic and cultural backgrounds, they may experience serious difficulties in accessing the (health care) services provided by the host society. To facilitate as much as

possible their inclusion, UFMs are hosted in residential care structures where professional educators support them in the management of everyday tasks. These professionals' expertise mostly relies on knowledge and practices aimed at fostering UFMs' agency, empowerment, and capability to cope with the constraints and possibilities of the new sociocultural environment. Despite playing a crucial role in mediating UFMs' encounters with the host society and its institutions (mainly education and healthcare systems), professional educators are *not* cultural-linguistic mediators and ordinarily have no competence in UFMs' L1.

The chapter builds on an exploratory single-case study[1] on the ways in which professional educators interact with other professionals to manage UFMs' access to care. In particular, it investigates triadic medical visits involving a general practitioner, an unaccompanied foreign minor, and his educator whose mandatory presence aims to support UFM patients throughout the encounter and make patient-physician communication as smooth as possible. Given the constitutively asymmetrical nature of doctor-patient interaction, the linguistic differences as well as the socially sanctioned interprofessional hierarchy (i.e., the primacy of medical knowledge *vs* pedagogical expertise) at stake in this setting (Caronia et al., 2020a,b, in press; Colla et al., 2020), these institutional encounters constitute a perspicuous case to study a) how inclusion is performed (or not) through interprofessional interaction and b)the communicative resources whereby care professionals manage their often incompatible mandates in this epistemically and socially complex institutional encounter. Following a phenomenologically oriented approach to the constitution of the crucial dimensions of everyday life (see Besoli & Caronia, 2018; Caronia & Orletti, 2019), we maintain that the ways in which the patient is conversationally treated (or not) as an interactionally and epistemically competent subject project (or not) a sense of agency (i.e., the sense of being a knowledgeable participant, a competent interactant, and an accountable agent capable of decision-making[2]) and, therefore, practically accomplish inclusion as an interactional achievement. Furthermore, we consider that the ways the physician and the

[1] The small size of this exploratory study (3 visits) needs to be accounted for. During the fieldwork, the right-wing government released a norm later transformed into law (d.l. 113/18, the so-called "*Decreto Salvini*", then law n. 132/18) that eliminated the possibility for UFMs having turned eighteen to obtain the residency permit for humanitarian reasons (which was almost always granted before this law). As a consequence, a kind of fear spread among the professionals involved in UFM care, who asked us to interrupt the fieldwork. But still, the data are extremely interesting as this is the first and – to our knowledge – the only video-recorded study ever done on this epistemically and socially complex landscape.

[2] Although the notion of "agency" has been diversely conceived and defined by different scholars (see Giddens, 1984; Duranti, 2004; Cooren, 2004, 2010; for a review see Ahearn, 2001), all the definitions share a core meaning: the power to make a difference. Scholars commonly acknowledge the central role played by language and social interaction in the construction of the participants' (local) agency (see for examples the notions of "interactional agency", Bazzanella, 2009; "interactional initiative", Heritage & Robinson, 2006a, p. 89, and "enunciative agency", Fasulo, 2007, p. 217).

educator orient toward UFM patients' agency display, locally implement, and possibly complementarily merge their respective institutional goals as well as their "professional vision" and practices (Goodwin, 1994).

Adopting a Conversation Analysis-informed approach to a corpus of video-recorded visits, we will focus on the discursive and multimodal practices whereby the educator(s) and the physician differently but cooperatively manage the inclusion of the UFM as an active participant in the first part of the visit (i.e., the problem presentation and history-taking phases). Although "inclusion" is currently used as a semantically self-evident concept, a normative principle that should govern social interaction, we consider it quite opaque and vague or – at least – too multidimensional to be used without proposing an operational definition. For the purposes of this study, we conceive of "inclusion" as an interactive practical accomplishment consisting in communicatively allocating agency to the interlocutor and providing them with room and ways for actively participating in the interaction. In a few words, we consider inclusion as something that people *do* in interaction. Assuming that next-speaker selection is the basic indicator of agency allocation, we illustrate how next-speakership is (re)distributed among the participants. Specifically, we analyze a three-part, interprofessionally-accomplished sequence that we call 'pivot sequence'. We contend that, through this sequence, the care professionals share the burden of solving the practical dilemma at stake within such an epistemically complex triadic visit: ensuring information gathering and understanding *vs* empowering the UFM by allocating him as much agency as possible. We advance that seeking a balance between such "incompatible goals" is a crucial intercultural competence that cannot but be distributed between the diverse professionals involved in such an encounter. In fact, and despite recent claims on the patient's active involvement as a means to enhance therapeutic compliance (see among others, Stewart, 1995; Roter, 1977, 1995; Williams et al.,2000), in certain circumstances the institutional mandate and professional culture of the physician make them prioritize "pursuing understanding" over "acknowledging agency". This orientation can be interprofessionally counterbalanced by the educators' institutional mandate and professional culture that provide them with an "interactive vigilance", i.e., the capability to grasp any candidate interactional locus for attributing interactional agency to the UFMs.

The chapter is structured as follows. In the introductory sections, we first delineate the crucial role of educators in the Italian reception system as well as the basics of their institutional mandate. Then, we review the main outcomes of studies concerning epistemics, question formats, and agency allocation in medical visits and make a case of the specific

structural traits of those involving UFMs. After describing the study design and methodology, we illustrate the interactional moves that constitute the pivot sequence: 1. the physician's 'oscillatingly addressed question', i.e., a question characterized by the simultaneous or in-quick-succession use of different and/or inconsistent resources for next speaker selection (Caronia et al., 2021; Colla et al., 2020), 2. the sequentially relevant 'pivot move' by the educator, i.e., 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. In the concluding section we argue that the physician's oscillatingly addressed question and the educator's pivot move are endogenous resources through which the professionals share the burden of navigating the complex epistemic landscape of such an encounter and practically handle the "pursuing understanding *vs* allocating agency" dilemma. By enlightening the "interactive vigilance" of the educators (i.e., their capability to restore the UFM's agency whenever appropriate), we make a case for interprofessionally managed health care as a means to accomplish inclusion in interaction. Shifting toward an applied perspective, we propose considering the awareness of the communicative practices that constitute UFM patients' agency as an intercultural competence of the professionals working for the UFM's inclusion in the host society.

2. The Educators' Institutional Role in the Italian Reception System

The presence of UFMs represents a new and challenging phenomenon for the Italian welfare and reception systems. Given their "unaccompanied" status as well as linguistic and cultural backgrounds, UFMs may experience serious difficulties in accessing health care and social services (Lynch, 2001; Crowley, 2009; Saglietti, 2019). For this reason, the national law 47/2017 (also known as "Legge Zampa") has recently strengthened UFMs' rights and protection: they are now hosted in the so-called SIPROIMI reception system (System of Protection for International-Protection Holders and Unaccompanied Foreign Minors) until they turn 18 and 6 months. Within SIPROIMI residential care structures, UFMs are supported by professional educators in the accomplishment of their everyday life activities.

The educators' institutional mandate consists in mediating the encounter between UFMs and the host society, as well as promoting their active participation and empowerment. In compliance with this pedagogical mandate, the educators work to broaden UFMs' "spaces of possibility" (Contini, 2014), supporting and accompanying them in the accomplishment of their administrative, educational, and health care tasks. In order to foster UFMs' self-reliance

and agency, educators should scaffold and support them but avoid acting on their behalf. UFM triadic medical visits represent a challenging territory for the exercise of these "paradoxical injunctions" of the educators' profession (Fabbri, 1996). In this setting, educators are expected to both ensure the effective exchange of biomedical information (and therefore sometimes speak for the UFM), and, at the same time, maximize UFMs' active participation in the visit by making them speak for themselves. As we mentioned before, professional educators are not cultural linguistic mediators and ordinarily they are not competent in UFMs' L1 even though they do act as 'mediators' in the UFMs' institutional encounters such as medical visits.

In the next section, we provide an overview of the management of knowledge in medical visit and the practices that mostly impact on the local (de)construction of the patients' agency, i.e., their sense of being a knowledgeable participant, competent interactant and active agent of their own healing path.

3. The management of knowledge in medical visits: doctor's questions and the construction of the patient's agency

Stressing the importance of acknowledging patients' agency, several studies converge toward the suitability of what has been called the "patient-centered approach" (Mead & Bower, 2000; Castro et al., 2016). Within this approach, the acknowledgement of patients' agency is not only an ethical issue (see the Italian law 219/17), but also and above all a means for maximizing patients' well-being and adherence to therapies. Different practices and loci of medical visits are deemed more or less suitable for promoting the patient's sense of agency, which strictly depends on the relevant knowledge as well as the types of activity at stake in the different phases of the visit.

As literature maintains, the constitutive phases of the medical visit differ in the locally relevant types of knowledge and related distribution of epistemic rights among participants (Heritage & Maynard, 2006a,b; Stivers, 2007). In the first part of the visit (i.e., problem presentation, history taking, and physical examination), the patient is typically and consistently treated by the physician as the "epistemic authority" (Heritage, 2012a,b), i.e., the most knowledgeable participant having "first-hand" access to the type of knowledge locally relevant (their subjective status, symptoms, and medical history). In these initial phases, it is the physician's questioning activity (Robinson, 2006; Boyd & Heritage, 2006; Heritage & Robinson, 2006a; Heritage, 2010) that particularly displays their orientation to the patient's

epistemic authority in the domain of their experiential knowledge ("the voice of the life-world", Mishler, 1984). Conversely, the physician acts and is ratified as the most knowledgeable participant in the second part of the visit. In the diagnosis and treatment recommendation phases, the physician typically produces assessments, advice, and recommendations, requiring little input by the patient. In this way, the "the voice of medicine", i.e., the physician's expert knowledge (Mishler, 1984), emerges as the most relevant.

The linguistic and interactional practices adopted in all the phases of the medical visit crucially impact on the construction of patients' agency as it is in and through the interaction that participants locally manage the patient's sense of 'making a difference' and being in control of their healing path. However, and given the patient's epistemic status, the first phases of the visit are probably the most relevant for the (de)construction of the patient's agency. Indeed, through the questioning activity the physician can acknowledge (or not) the patients' (relative) epistemic authority, give them more or less room to contribute, and treat information from their territory of knowledge as more or less relevant, thus allocating them more or less agency.

A longstanding tradition of research has highlighted the different effects of question design on patients' responses (Roter & Hall, 1992; Boyd & Heritage, 2006; Heritage, 2010). Above all, scholars have observed how close-ended questions tend to produce shorter and more focused answers than open-ended questions, which on the contrary invite longer and more detailed responses. Building on this evidence, Heritage and Robinson (2006a) largely demonstrate how different types of doctors' opening questions "affect the interactional "space" or "slot" within which patients present their problems" (p. 90) and are routinely associated with patients' more or less extended reports. For example, open-ended general inquiries (type 1 questions, Robinson & Heritage, 2006) invite an extensive problem presentation and constitute patients as "active authorities" (p. 279). Conversely, closed-ended questions (type 2 questions, such as general confirmatory questions and symptoms confirmatory questions) frame patients as "passive authorities" (p. 280). However, and despite the alleged suitability of open-ended questions for maximizing the patient's agency, it is worth stressing that they require a substantial communicative competence in the language of the visit by patients. On the contrary, and despite having been associated with projecting a passive role, close-ended questions allow the patient to participate effectively with just a few words. Clearly enough, involving patients in the medical interaction, acknowledging their epistemic competence, and projecting a sense that they are agentive participants in the

interaction and leaders of their health care process can be challenging tasks when patients do not possess satisfactory competence in the language of the visit, as is typically the case with UFMs.

4. Triadic Medical Visits with UFMs: The Asymmetries and Incompatible Goals of Care

Research on triadic medical visits has mainly concerned pediatric encounters (see among others Stivers, 2001, 2005a,b, 2007; Tates & Meeuwesen, 2001; Tates et al., 2002), interpreter-mediated interactions (see among others Bolden, 2000; Davidson, 2000) as well as consultations with impaired patients (see among others Antaki & Chinn, 2019; Chinn & Rudall, 2019; Muntigl et al., 2014; Nilsson et al., 2018). Yet, compared to these kinds of medical visits, triadic encounters with UFMs are potentially characterized by further levels of complexity and, therefore, they can challenge in quite specific ways the professionals involved in taking care of these patients.

Beyond the institutionally sanctioned epistemic asymmetry governing the medical visit (see section 3 above), further asymmetries may be at stake. First, the linguistic asymmetry. Patients typically have low competence in the language of the visit; neither the doctor nor the educators know the patients' L1, and ordinarily there is no cultural-linguistic interpreter available. 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 could be oriented to the socially sanctioned hierarchy of professional expertise and the consequent stratification of professionals' interactional rights that is routinely at stake when physicians interact with other care professionals. For example, and perhaps not surprisingly, in our study the educators typically aligned with the physician's initiatives and therefore ratified his epistemic primacy, e.g., they answered the questions concerning the patient whenever directly and unequivocally addressed and generally, they did not produce first-positioned moves or diagnosis-like statements. In so doing, they cooperated in maintaining the physician's 'interactional dominance' and oriented to the primacy of biomedical expertise over pedagogical knowledge and praxis. However, and despite their different institutional roles, both care professionals involved in triadic visits are expected to foster UFM patients' agency. For the educators, promoting UFMs' agency is the primary institutional goal, while for the physician the acknowledgement of patients' agency is functional to pursuing the overarching goal of their

institutional mandate, which is treating the patient by maximizing understanding and compliance with therapies.

Given the interplay of the above-mentioned asymmetries, fostering UFMs' agency during the visit can be quite a challenging task. Indeed, the more professionals pursue biomedical information gathering and understanding, the more they have to exclude the UFM as the intended recipient of their talk; the more they pursue UFM patient's agency by addressing him[3], the more they risk missing the full comprehension of his health conditions and medical history. How do the professionals cope with this dilemma? Which resources do they rely upon?

In the next sections we present the data and analytical procedures of a single-case study aimed at answering these questions by exploring how a physician and two educators coped with this dilemma one interaction at a time, mobilizing some endogenous resources that appear to be quite effective in performing inclusion as an interactional achievement.

5. Data, Corpus, and Procedures

The excerpts presented in this paper are drawn from a corpus of three video-recorded medical visits. Each medical visit involved an Italian general practitioner, a UFM patient and an educator. The researcher was also present during the medical visits with her role limited to positioning and switching on/off the video camera. The UFMs participating in the research were aged between 16 and 18 and had low or extremely low competence in the language of the visit. The participants were recruited by the third author through her work connections and their consent was obtained according to the Italian laws regulating the handling of personal and sensitive data. The excerpts presented here have been transcribed using Conversation Analysis conventions (Jefferson, 2004). In line with the multimodal approach to social interaction (Goodwin, 2000; Mondada, 2016), transcriptions have been enriched with notations for gaze, gestures, body movements and orientations when ostensibly relevant for participants as a means to unfold the interaction. Original conversations in Italian have been almost literally translated in English and, for the sake of anonymity, all names have been fictionalized.

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

The next sections illustrate a specific interprofessionally accomplished sequence that we consider as a practice of inclusion insofar as it allocates agency to the UFM patient: the 'pivot sequence'. It develops after a particular sequence-initiating turn by the physician: the oscillatingly-addressed question[4], which makes it relevant for the educator to engage in what we call the pivot move. The pivot move, in turn, leads to participants' (re)orientation to the UFM patient as the physician's responder.

For reasons of clarity, in the next section we present examples of the first and second components of the pivot sequence. We then analyze examples of the whole sequence.

6. Constituting the UFM patient as the next-speaker: An interprofessionally distributed practice

In the peculiar epistemic and linguistic landscape of UFM visits (see section 4), the physician's questions and the sequence they initiate appear to be crucial sites for the management of the "incompatible goals" of the encounter: gathering relevant information *vs* acknowledging the patient's agency (e.g., by recognizing their epistemic authority as to their subjective status). As our study illustrates, in these visits two additional dimensions of physician's questions, other than the format (see Heritage & Robinson, 2006a), appear to concur in projecting (or not) the patient's agency: addressivity and/or next speaker selection. Following Auer (2017, 2021), we consider these phenomena non-coextensive. At least in multiparty conversation, while next speakership implies addressivity, the opposite is not always true as a speaker can address more than one participant (addressees) while at the same time indicating a privileged next speaker.

By taking into account 1) the linguistic and morpho-syntactic elements of turn design (see among others, Drew, 2013), 2) turn-taking procedures such as self or other next-speaker selection procedures, and overlapping talk (see among others, Hayashi, 2013; Lerner, 2003), and 3) embodied resources such as gaze direction, gestures and body orientations (see among others Rossano & Stivers, 2010; Mondada, 2007), we identified three types of physician questions that differ according to their addressivity. We distinguished: a) patient-addressed questions; b) educator-addressed questions, and c) oscillatingly-addressed questions, i.e. sequence-initiating turns characterized by the physician's simultaneous or in-quick-succession use of different and/or inconsistent resources in *addressee* selection (Caronia et al., 2021).

[4] We found occurrences of this type of question (and the following sequence) only in the problem presentation and the history-taking phases of the visits.

Although these questions appear to be oscillatingly addressed, they still project a privileged *next speaker* mostly through gaze direction in turn-final position (see Auer, 2017, 2021). In this paper, we focus on oscillatingly-addressed questions characterized by the simultaneous use of different and inconsistent resources[5].

In the next sections, we illustrate this physician's sequence-initiating turn and the reply it makes relevant: the educator's pivot move.

6.1. The physician's oscillatingly-addressed question

Although there are only a few (10 out of 62 total questions in problem presentation and history-taking phases), the physician's oscillatingly-addressed questions constitute an extremely interesting phenomenon, as they demonstrate the physician's orientation toward both effectively gaining relevant information (by relying on the present educator), and projecting the UFM patient's active participation. Indeed, although they suggest the educator as the privileged next speaker through gaze direction in turn-final position, they still open up the field of addressivity to the UFM patient as well.

The excerpt below provides an example of the physician's oscillatingly-addressed question.

Ex. 1 – Malik (03.13 - 03.16)

D = Physician
E = Educator
P = Patient (Malik, 18 years old)

```
1   D   adesso  ^sei  qui  per  un  altro ^^problema?
        now are ^you[SING] here for another ^^problem?
2   D           ^((looks at the documents E's holding))
3   D                                       ^^((looks at E))
```

In this excerpt, the physician uses three different addressee selection resources at the same time: person form of the verb, lexical choice, and gaze direction. Importantly, each of these resources constitutes the patient *or* the educator as the physician's interlocutor: the second person singular form of the verb as well as the common lexical item "problem" select the UFM patient as the addressee (line 1), while the physician's gaze direction also constitutes the

[5] For reasons of space, we do not analyze examples of questions characterized by the in-quick-succession use of different and incoherent addressivity resources (see Caronia et al., 2021).

educator as an addressee (lines 2 and 3). In other words, through the simultaneous and non-consistent use of different addressee selection resources, the physician distributes addressivity between the educator and the UFM patient. However, the gaze direction in turn-final position (line 3) does more than addressing (also) the educator: it projects him as the privileged next speaker. In a few words, through the oscillatingly-addressed question, the physician selects the educator as the next speaker, while also constituting the UFM patient as his addressee.

The oscillating nature of the physician's addressivity appears to pave the way to a particular "next": the educator's pivot move.

6.2. The Educator's Pivot Move

In half of the cases[6], the physician's oscillatingly-addressed question is followed by the educator's pivot move that is a multimodal practice through which the educator (re)directs the physician's question to the UFM patient. The following excerpt provides an example of the pivot move.

Ex. 2 – Malik (03.13 - 03.16)

D = Physician
E = Educator
P = Patient (Malik, 18 years old)

```
1   D   adesso  ^sei qui per  un  altro  ^^proble^^^ma?
        now are ^you[SIN] here for another ^^proble^^^m?
2   D           ^((looks at the documents E's holding))
3   D                                     ^^((looks at E))

4   E                                     ^^((looks at D))
5   E                                             ^^^((visibly turns toward P))
```

In line 4, the educator – who has been selected as the next speaker by the physician's oscillatingly-addressed question (lines 1-3) – withholds the answer to the question and then visibly turns toward the UFM patient (line 5), thus orienting to him as the candidate next speaker.

[6] In the remaining cases, the physician's oscillatingly addressed question is followed by an answer by the educator or the UFM patient, or no answer at all.

In our corpus, *all* pivot moves are preceded by the physician's oscillation in addressivity, which therefore appears to play a crucial role in paving the way to this kind of action by the educator. In turn, the pivot move appears to be effective in constituting the UFM patient as the next speaker: after the pivot move, the UFM patient provides an answer in three of five cases, while in the remaining two cases, the physician or the educator redirects the question to the UFM. An *interactional sequence*,therefore, seems to be at stake: we call it the "pivot sequence".

6.3. The Pivot Sequence

The pivot sequence constructs the UFM as the physician's responder, that is as an epistemically competent patient, and is structured as follows:

1) The physician's oscillatingly-addressed question
2) The educator's pivot move
3) The participants' (re)orientation to the UFM patient as the physician's responder

The next excerpt shows the whole sequence initiated by the physician's question already analyzed in ex. 1. The physician's oscillatingly-addressed question is followed by the educator's pivot move and, in this case, by the UFM patient's answer.

Ex. 3 – Malik (03.14 – 03.18)

D = Physician
E = Educator
P = Patient (Malik, 18 years old)

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

```
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. 1a]
3   D                                     ^^((looks at E))[fig. 1b]

4   E                                     ^^((looks at D))[fig. 1b]
5   E                                             ^^^((visibly turns toward P))[fig. 1c]
```

6 D *((stops looking at E and looks at P))*[fig. 1d]

7 P sì e:: il mio occhio che °mi brucia°

yes e:: my eye that °itches° *((looking at D))*

Figure 1a. D looks at the documents held by E

Figure 1b. D looks at E, E looks at D

Figure 1c. E visibly turns toward P

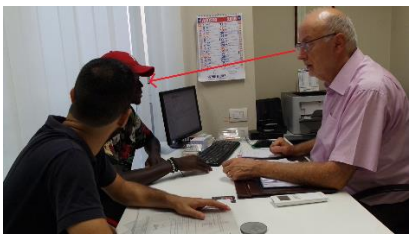

Figure 1d. D stops looking at E and looks at P

In the turn at line 1, D asks for the reasons for the visit by means of a type 2 opening question (that is a yes/no question projecting (dis)confirmation, see Heritage & Robinson, 2006a), which constrains both the content and the extent of the patient's report (at least with respect to type 1 general inquiries). In the case of UFM visits, the use of type 2 opening questions displays the physician's orientation to the patient's low competence in the language of the visit. Indeed, answering this type of question properly requires less linguistic competence than required by open-ended questions (see Caronia et al., 2020b). P is further selected through another feature of turn design: lexical choice. The use of the second person singular form of the verb ("are you") and the lexical item "problem" (the Italian *problema* is a quite common, open-class term, part of the basic lexicon) cooperate with question format in constructing P as D's addressee despite his low linguistic competence.

Yet, E is also selected as the physician's addressee because D concurrently looks at the documents held by E (line 2, fig. 1a) and then directly at E (line 3, figure 1b). Note that D's s gaze direction toward E is located in turn-final position, which is considered to further stress who the selected next speaker is (see Auer, 2017, 2021). Through this oscillatingly-addressed question, the physician distributes addressivity to both E and P, while allocating the next turn to E.

However, E does not provide an answer to D's question and, after making brief eye contact with him (line 4, fig. 1b), he visibly turns his head toward P (line 5, fig. 1c). In doing so, E realizes 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: he looks at P too, thus unambiguously constituting him as the next speaker (line 6, fig. 1d). Then, P (who has been looking at D from the beginning of the excerpt, thus demonstrating his readiness to respond) positively answers to D's polar question ("yes", line 7) and discloses the reason for his visit ("my eye itches"). The pivot move appears to be effective in reorienting the participants toward the attribution of interactional agency to P.

The following excerpt presents another occurrence of the pivot sequence ending with the UFM patient's answer to the physician's question.

Ex. 4 – Malik (02.21 – 02.24)

D = Physician
E = Educator
P = Patient (Malik, 18 years old)

We join the conversation when D is reading P's electronic records and asking information about past conditions.

1 D ^avevi ^^ male^^^ da qualche parte?

^did you have^^ pain^^^ somewhere?

2 D ^*((looks at P))*

3 D ^^*((looks at E until the end of the turn))*[fig.2a]

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

5 E ^^^*((turns toward P))*[fig.2b]

6 D *((looks at P))*[fig.2c]

7 P sì è:: il mio occhio che: brucia.

yes i::t's my eye tha:t itches.

Figure 2a. D looks at E until the end of the turn, E looks at D

Figure 2b. E turns toward P

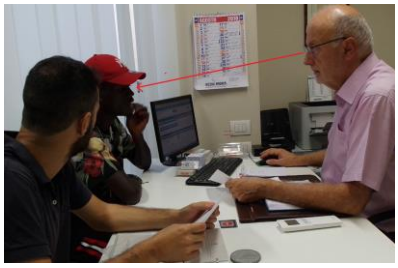

Figure 2c. D looks at P

In line 1, D asks about P's past health problems. Through the use of the second person singular form of the verb ("did you have", line 1), lexical choice (the Italian *male* is part of the fundamental lexicon) and gaze direction in turn-initial position (line 2), D selects P as his addressee. Yet, by moving his gaze toward E (line 3, fig. 2a), D also selects E as his addressee. Note that D keeps looking at E until the end of the turn, thus selecting E not only as an addressee but also as the privileged next speaker.

However, E does not align with D's turn allocation: after brief eye contact with D (line 4, fig. 2a), he rapidly turns toward P (line 5, fig. 2b). Through this pivot move, E (re)allocates the turn to P, constituting him as the answerer to D's oscillatingly addressed question. In line 6, D aligns with E's turn (re)allocation: he looks at P too, thus ratifying him as the candidate next speaker (line 6, fig. 2c). In line 7, P answers. Although the answer does not appear to respond to D's question (P reports the actual problem of the visit rather than past problems); nevertheless, he intervenes and uses a fairly complex syntactic structure.

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The following example illustrates another occurrence of the pivot sequence. Unlike the previous excerpts, in this case we do not have the patient's answer in third position, but rather the physician (re)directing his question to the patient.

Ex. 5 – 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[PLUR] come here?
2   D   ^((looks at the documents E's keeping on the desk))
3   D           ^^((looks at E until the end of the turn))[fig. 3a]
4   E           ^^((looks at D))[fig. 3a]
5   E                                   ^^^((looks at P))[fig. 3b]
6   D   ((stops looking at E and looks at P))[fig. 3c]
7   P   ((looks down))
8       (1)
9   D   qual è?=
        what is it?= ((looking at P))
10  P   ((looks at D))
11  E   =come mai Mahdi? (.) sei voluto venire qua dal dottore?
        =why Mahdi? (.) did you want to come here to the doctor? ((looking at P))
12  D   PERCHÈ SEI VE[NUTO]?
        WHY DID  YOU [COME]? ((looking at P))
13  P               [mi ^fa] male qua la schiena
                    [my ^back] hurts here
14  P                   ^((touches the lumbar part of his back))
```

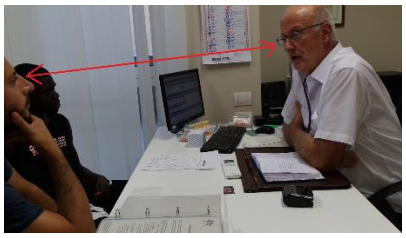

Figure 3a. D looks at E until the end of the turn, E looks at D

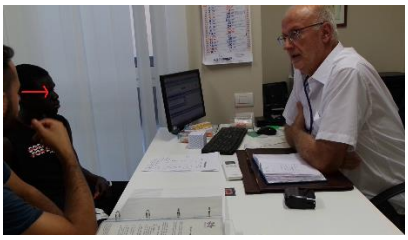

Figure 3b. E looks at P

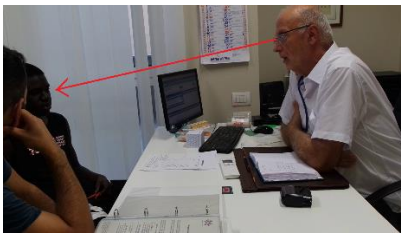

Figure 3c. D stops looking at E and looks at P

As in excerpt 3, D introduces a new phase of the visit through the temporal deictic "now" (line 1), which signals the end of the history-taking phase. He then verbally addresses both E and P by using the second person plural form of the verb (the Italian *venite*, line 1). However, while pronouncing "is there a motive", D starts looking at E and continues until the end of the turn (see line 3, fig. 3a). In this way, D selects E as the next speaker.

After making brief eye contact with D (line 4, fig. 3a), E turns his head toward P without providing any answer to the question (line 5, fig. 3b). In this way, E carries out a pivot move and selects P as the responder to D's question. By shifting his gaze from E to P, D aligns with E's turn (re)allocation and ratifies P as the next speaker (line 6, fig. 3c). Despite having been multimodally ratified as the next speaker by both E and D, P does not answer and looks down for a second (lines 7 and 8). At this point, D formulates his previous question ("what is it?", line 9) by unequivocally selecting P as the answerer (see D's gaze direction, line 9). After P looks at D without providing any answer (line 10), E intervenes. In line 11, E formulates D's question in narrower terms by means of a multi-TCU turn. He starts by recruiting P's attention to the problem of the visit by addressing him with his first name (Lerner, 2003). Then, he makes his own question more explicit by recycling D's deictic "here" (line 1) and specifying it as "here to the doctor" (line 11). Note that E's formulation contains an expansion in the second TCU: by saying "did you want to come here", E emphasizes the patient's agency as to the doctorability of the reason for the visit (Heritage & Robinson, 2006b; Halkowski, 2006). In overlapping with D's further formulation of the initial question ("why did you come?", line 12), P enters the conversation as the ratified knowledgeable reporter of his own illness ("my back hurts here", lines 13 and 14).

7. (Re)Allocating Agency to the UFM Patient: The Pivot Sequence as a Resource

In the previous section, we illustrated the pivot sequence that is constituted of the doctor's oscillatingly-addressed question, the pivot move by the educator, and the following participants' (re)orientation toward the UFM as the responder to the doctor's question. In our data, the pivot sequence is far from being frequent[7]. Yet, despite its few occurrences, this sequence is particularly meaningful as it appears to be a resource for the professionals to cope with a recurring dilemma in this type of triadic visit: maximizing gathering and understanding of biomedical information *vs* acknowledging UFMs' agency and therefore interactively accomplishing inclusion.

The first component of the sequence is the doctor's oscillatingly-addressed question. Being characterized by the simultaneous or in-quick-succession use of different and/or non-consistent resources in addressee selection, this type of question distributes addressivity to both the educator and the UFM patient. In our data, the patient is selected as the physician's addressee through the use of the person form of the verb (second singular, see ex. 3, line 1; ex. 4, line 1; or plural ex. 5, line 1) and through the use of common lexical items (for example *problema*, ex. 3, line 1; *male*, ex. 4, line 1). Concurrently, the educator is also selected as the physician's addressee: beyond the use of the second person plural form of the verb, the doctor's main resource is gaze direction toward the documents handled by the educator and the educator himself (ex. 3, lines 2-3; ex. 4, lines 2-3; ex. 5, lines 2-3). Although both the educator and the UFM patient are addressed, the educator appears to be projected as the privileged next speaker by the doctor's gaze direction in the end of the turn (ex. 3, line 3; ex. 4, line 3; ex. 5, line 3). As our data illustrate, despite eventually indexing the educator as the privileged next speaker, the physician's oscillatingly-addressed questions significantly open up the field of addressivity to the UFM patient as well. We contend that, in doing so, they project the acknowledgement of UFM's interactional agency and pave the way to the educator's pivot move. Without determining its occurrence, the oscillatingly addressed question provides an environment that makes it sequentially relevant. Indeed, in our data the educator's pivot move never occurs when the doctor unequivocally addresses the educator and ratifies him as the person entitled to speak on behalf of the UFM patient. Rather, it occurs *only* after the physician's oscillatingly-addressed question. Through the pivot move, the educator selected as the privileged next speaker withholds the answer to the physician's question and turns toward the patient, thus breaking the progressivity of interaction (see Stivers & Robinson, 2006). In this way, he makes it relevant for the physician to (re)orient to the patient as the responder (ex. 3, line 6; ex. 4, line 6; ex. 5, line 6 and line 9), and for the

[7] The physician's oscillatingly addressed questions are 10 out of 62 total questions in the problem presentation and history-taking phases. 5 of 10 times, the oscillatingly addressed questions initiate a pivot sequence.

patient to provide the answer to the physician's question (ex. 3, line 7; ex. 4, line 7; ex. 5, line 13).

As our data show, the pivot sequence appears to be consistent with two overall structural features: 1) the phase-specific relevance of the patient's epistemic status and 2) the degree of linguistic competence necessary to make it "actionable through talk" (Heritage 1997: 222). As we pointed out, the physician's oscillatingly addressed questions and the pivot sequence they initiate occur only in the first part of the visit, namely where the patient is the most knowledgeable party (see among others, Heritage & Maynard, 2006a,b; Robinson, 2006; Robinson & Heritage, 2006). The pivot sequence therefore appears to be phase-aligned: despite UFM patients' low competence in the language of the visit, the physician's oscillatingly addressed question projects the acknowledgement of their interactional agency, and the following educator's pivot move constructs them as epistemically competent patients. As for the second structural feature, the pivot sequence appears to be sensitive to the UFMs' degree of linguistic competence. The oscillatingly addressed questions in our corpus feature common lexicon and are formatted in ways that make short (mainly yes/no) answers relevant (see ex. 3, line 1, ex. 4, line 1; ex. 5, line 1). Similarly, the educator's pivot move selects the UFM patient as the next speaker when his linguistic competence makes it possible for him to efficiently answer the physician's question (see ex.3, line 7; ex. 4, line 7).

In a few words, in this sequence aimed at gaining relevant information, the professionals appear to overcome the interactional as well as clinical dilemma of the visit: gathering relevant information *versus* allocating agency to a patient who has a K+ epistemic status, but too low a linguistic competence to make it inspectable for the physician. While the physician addresses both the educator and the patient as ratified participants, he ultimately selects the educator as the next speaker, thus relatively prioritizing gaining understandable information over acknowledging agency. Through the pivot move, the educator seems to balance the physician's stance and prioritize agency attribution: by drawing on the distributed addressivity of the physician's previous question, he redirects next speakership to the UFM, thus displaying his orientation toward maximizing his client's agency. As our data illustrates, the educator's move in second position is effective in reorienting the physician toward the attribution of interactional agency to the UFM.

8. Interprofessionally-Accomplished Care: Concluding Remarks

Similarly to other types of triadic medical interactions where the patient has low or no competence in the language of the visit, and even more so due to the absence of an interpreter, UFM visits are characterized by a dilemma: either professionals orient to maximizing the gathering and understanding of biomedical information *or* they pursue the acknowledgement of UFMs' agency. As our study illustrates, the more the physician pursues epistemic accuracy, the more they have to recruit the accompanying person and risk excluding the patient; conversely, the more they include the patient as their main interlocutor, the more they risk missing the gathering and understanding of relevant information. While the first alternative infringes patient-centeredness and minimizes the patient's participation, the second alternative can impact on the diagnosis and consequent treatment recommendations. Despite the claim for patients' active involvement as a means to enhance therapeutic compliance, in some circumstances the overarching institutional goal of the physician makes them prioritize "pursuing understanding" over "acknowledging agency". This is often the case with UFMs: although they have primary access to their present problem and past medical history, they typically do not have the linguistic competence to make this information available to the physician. The risk that the UFM becomes the "talked-about present patient" is therefore high. However, it can be reduced by the *interprofessional format of participation* we have illustrated. As our exploratory study suggests, the care professionals institutionally involved in this type of visit appear to share the burden of overcoming the "pursuing understanding *vs* allocating agency" dilemma. Indeed, while the physician displays their "professional vision" (Goodwin, 1994) by maintaining an orientation toward "seeking information" as the main activity of the first phases of the visit, the educator enacts their professional vision and mandate by "allocating agency" to the UFM whenever interactionally appropriate. As our study illustrates, seeking a balance between such incompatible goals cannot but be an interprofessionally distributed intercultural competence, at least within this interculturally and linguistically challenging health care encounter.

Despite its exploratory design, this study has identified a communicative practice that appears to attain such a balance and achieve inclusiveness: the pivot sequence. In and through the unfolding of this intersubjectively distributed sequence, the physician's primary institutional goal is counterbalanced by the educators' competence in performing "interactive vigilance", i.e., the capability to grasp any candidate interactional locus for attributing interactional agency to the UFMs. Although provisory, our findings suggest that triadic medical visits involving a physician and a professional educator can have positive outcomes in terms of achieving inclusion as long as their respective professional practices are oriented to build a genuinely interprofessional working culture.

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