

‘I see you have an injury there’: Physician’s communicative practices fostering unaccompanied minors’ interactional agency in the history-taking phase of the medical visit

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Abstract: The presence of unaccompanied minors (hereafter UAM) in the Italian welfare and healthcare system represents an underexplored phenomenon despite its strong pedagogical implications. In this article, we report findings from an exploratory case study on medical visits involving an Italian physician, three UAM with low communicative competence in the language of the visit, and two professional educators in charge of them. We adopt a Conversation Analysis informed approach to illustrate the physician’s communicative practices fostering UAM’s *interactional agency*, in the history taking phase of the medical visit. We single out and analyze two interactional practices, “Making the patient speak with a few words” and “Making the body speak”, and the resources deployed by the physician to implement them (i.e. the use of yes/no questions, deixis, and pointing). In the conclusions, we advance that our findings are relevant for a pedagogically oriented approach to medical education: the communicative practices illustrated in this study can be adopted by the professionals involved in taking care of UAM in order to maximize their active participation in the medical interaction.

Sinossi: L’accesso dei minori non accompagnati (UAM) al sistema sanitario italiano rappresenta un fenomeno nuovo e scarsamente indagato, nonostante le sue notevoli implicazioni pedagogiche. In questo articolo riportiamo i risultati di uno studio esplorativo che vede coinvolti un medico di famiglia, tre UAM con scarse competenze comunicative nella lingua della visita, e due educatori professionali. Adottando lo strumento teorico-analitico dell’Analisi della Conversazione, e focalizzandoci sulla fase anamnestica della visita medica, illustriamo due pratiche (“Far parlare il paziente con poche parole” e “Far parlare il corpo”) e le relative risorse comunicative (uso di domande chiuse, deissi e puntamento gestuale) utilizzate dal medico. L’analisi mostra che tali pratiche contribuiscono alla costruzione dell’*agency interazionale* dell’UAM. Nelle conclusioni, mostriamo come questi dati possano essere utili per una formazione medica sensibile e orientata alla dimensione pedagogica insita nelle professioni di cura.

¹ The article reports findings from a larger research project, and has been conceived and discussed by the three co-authors. We owe to Letizia Caronia the paragraph One, Three, Five; to Federica Ranzani the paragraph Two; to Vittoria Colla the paragraph Four

1. Introduction

The presence of unaccompanied minors (hereafter UAM) represents a challenge for the Italian welfare and healthcare systems that has strong, although underexplored, pedagogical implications. UAM experience a vulnerable condition due to their “unaccompanied” status as well as linguistic and cultural differences with respect to the host society. For these reasons, UAM’s access to healthcare services is mediated by professional educators, whose pedagogical goal consists in supporting minors in their everyday life while promoting their empowerment. Despite the presence of the accompanying educator, the socio-cultural-linguistic differences and asymmetries at stake in this triadic medical interaction may compromise the UAM’s active participation in the consultation and, consequently, in their healing process. Indeed, as the patient centered approach in medicine maintains (Heritage & Maynard, 2006a,b; Baraldi & Gavioli, 2013; Orletti & Iovino, 2018), practitioners’ attribution of agency to the patient is not only an issue of respect of the patients’ right to understand and decide (see the Italian law 219, December 2017) but also a means for maximizing their adherence to the therapy. At our knowledge at least, there are no studies on this specific inter-professionally managed medical encounter. Very little is known on how these triadic interactions unfold and how the physician and the educator cooperate to ensure both the UAM’s understanding of the diagnosis and their compliance with the treatment recommendations.

This article reports findings from the first case study on triadic medical visits involving an Italian general practitioner (GP), three UAM and two educators institutionally in charge of them.

In a previous article (Caronia, Colla, Ranzani, forthcoming), we focused on the educator’s “pivot move”, i.e. an interactional move through which the educator – selected by the doctor as his ratified addressee – multimodally passes his/her turn to the UAM. Building on these findings, and adopting a Conversation Analysis informed approach (Sacks, Schegloff, Jefferson, 1974; Sidnell & Stivers, 2013) to three video-recorded medical visits, in this article we focus on the physician’s communicative practices fostering UAM’s interactional agency in the medical visit. By interactional agency we mean “the right to speak and to actively participate in the conversation” (Bazzanella, 2009: 253). In particular, we focus on the “history taking” phase of the visit, in which the patients are typically considered as the “epistemic authority” (Heritage 2012; Heritage & Maynard 2006a,b), since they have “first hand” knowledge of their subjective status, symptoms and medical history, i.e. the relevant knowledge for the institutional purpose of this specific phase (Boyd & Heritage, 2006).

The article is structured as follows. In the introductory sections and drawing on extant literature, we describe the overall structure organization of medical visits and make a case of epistemic asymmetries and agency distribution at stake in this institutional event. Then we present a series of excerpts of video-recorded physician-UAM interactions occurring during the history taking phase of the visits. We analyze these excerpts by adopting a Conversation Analytic approach, which has proved to be well-suited for studying interactional practices as a tool for the ascription, recognition or denial of agency (Duranti, 2004; Donzelli & Fasulo, 2007). In the discussion we illustrate the interactional practices and resources through which the physician fosters the UAM’s interactional agency, i.e. constitutes the minor as a ratified and active participant in the medical interaction.

Taking into account both the limits and the heuristic strength of exploratory single case studies, in the conclusions we advance that the communicative practices we singled out in this study can be adopted by the physician in order to maximize the UAM patient’s active participation in the medical interaction. From this point of view our findings are relevant for a pedagogically oriented approach to medical education.

2. The medical visit: phases, epistemic asymmetries and agency distribution

As previous research has illustrated (see among others, Drew & Heritage, 1992; Heritage & Maynard, 2006a), medical encounters are structured according to a sequence of phases. Each phase is characterized by an institutional goal, a specific structure of participation and distinct boundaries to which the participants orient with “considerable exactness” (Heritage & Maynard, 2006b: 363). Drawing on the seminal works of Byrne and Long (1976), ten Have (1989) and Heat (1992), research concurs in identifying seven phases of the medical encounter. The first one is the “opening sequence”,

in which physician and patient establish an interactional relationship. This is followed by the “problem presentation”, aiming at identifying the reasons for the visit. In the following “history taking” phase, the patient is questioned by the physician in order to collect information concerning his medical history (e.g. previous medical conditions, current medications, family and social background). The core phase of the visit is the “physical examination”, in which the doctor inspects the physical condition of the patient. Then, the visit proceeds with the delivery of the “diagnosis” and the “treatment recommendation”: in these phases, the doctor assesses the patient’s condition and gives therapy instructions. The encounter ends with pleasantries that signal the “closing sequence”, i.e. greetings.

The phases differ in the locally relevant types of knowledge and related distribution of epistemic rights among participants (Heritage, 2010; Heritage & Raymond, 2005; Raymond & Heritage, 2006; Stivers *et al.*, 2011; Orletti, 2000; Pasquandrea, 2013). In the first part of the visit (i.e. problem presentation, history taking and physical examination) the patient emerges as the “epistemic authority” (Heritage, 2012), i.e. the most knowledgeable participant having “first-hand” access to the locally relevant type of knowledge (his subjective status, symptoms and medical history). Conversely, the physician is treated as the expert in the second part of the visit, i.e. the one possessing the relevant knowledge in the diagnosis and treatment recommendations phases.

The phases of the medical encounter also differ in the linguistic and interactional practices adopted: if physicians engage in questioning the patients in the first part of the visit, they require less communicative contributions on the part of the patients during the diagnosis and treatment recommendation phases. Indeed, the interactional practices adopted in the different phases crucially impact the construction of the patient’s agency, i.e. their competence in making the difference in the unfolding of the visit². As emphasized by the studies proposing the so-called “patient-centered approach” (Mishler, 1984; Heritage & Maynard, 2006b; Mead & Bower, 2000; Baraldi & Gavioli, 2013; Orletti & Iovino, 2018), the patients’ interactional agency (Bazzanella, 2009: 253, see also the notion of “enunciative agency”, Fasulo, 2007: 217) as well as their agentivity in the healing process are managed and even constituted (or not) in and through the interaction. Following this approach, the acknowledgement of the patients’ agency is not just a matter of ethics (see the Italian law 219/17), but also and above all a means to maximize their adherence to the therapy.

As a matter of fact, involving patients in medical interaction can be difficult when they have little linguistic competence and/or experience extremely fragile social conditions, as is the case with triadic medical encounters with UAM.

2.1 Triadic medical visits with UAM: the multiple asymmetries at stake

As literature illustrates (Orletti, 2000; Heritage & Maynard, 2006a, b; Heritage, 2010; Stivers *et al.*, 2011), many types of asymmetry can be made actionable through talk during the visit. First, what is at stake is an institutional epistemic asymmetry, i.e. the socially sanctioned privilege of the expert knowledge (“the voice of medicine”, Mishler, 1984) over the experiential knowledge (“the voice of life-world”, *ibidem*) and the correspondent asymmetrical status of those who embody these epistemic positions. Secondly and grounded on epistemic asymmetry, there is the interactional asymmetry, i.e. the socially ratified power to establish who speaks, when and about what (see Orletti, 2000; Orletti & Iovino, 2018). However, triadic encounters with UAM are characterized by further levels of complexity, above all the linguistic asymmetry. The UAM patients have little or no competence in the language of the visit and neither the educator nor the physician know their first language. In addition, the interaction is characterized by a strong social asymmetry as UAM live in an extremely fragile condition given their migratory paths and post-traumatic status. Last but not least, these interactions are characterized by the socially sanctioned hierarchy of professional expertise and the consequent

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 (i.e. the power to make a difference) and scholars commonly acknowledge the central role played by language and social interaction in the construction of participants’ (local) agency (see among others Duranti, 1997; 2004).

stratification of professionals' interactional rights (for an analysis of the interprofessional asymmetries see Caronia, Colla, Ranzani, forthcoming; Caronia, Ranzani, Colla, 2019).

In this paper, we focus in particular on the interactional practices deployed by the physician to recognize UAM as active agents of their own healing while, at the same time, ensuring full understanding of the medical talk.

2.2 Taking history from UAM: Obtaining information with few words

The history-taking phase represents a core component of medical consultation, encompassing several aspects of the patient's illness history such as present and past problems, family and social background, as well as previous treatments. It is characterized by a series of question-answer sequences, typically initiated by the physician (Boyd & Heritage, 2006). The institutional goal of this phase consists in both collecting information on the patient's medical history and initiating the "differential diagnosis"³ process (Athreya & Silverman, 1985; Stivers, 2007). There is no neutral question in the unfolding of the physician's interview: questions "establish particular agendas for patient's response, embody presuppositions about various aspects of the patient's health, bodily awareness and background knowledge of medicine, and incorporate 'preferences'" (Boyd & Heritage, 2006: 154).

In the case of triadic medical interactions with UAM, this phase can be particularly complex (and therefore interesting to analyze from a pedagogical viewpoint). Although the UAM's low communicative competence makes it very difficult for the physician to carry out the institutional goal of the history-taking, it remains essential for the doctor to get information from the UAM patients, as they are the only ones possessing the knowledge of their entire medical history. The history-taking phase therefore represents a "perspicuous case" (Garfinkel & Wieder, 1992) for analyzing how physicians attribute interactional agency to UAM patients, constructing them as ratified listeners and/or selected next speakers, despite their low linguistic and communicative competences in the language of the visit.

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

3. Data collection and analytical procedures

Data consist of three video-recorded medical visits totaling 88,72 minutes. Each medical visit involves an Italian General Practitioner, one UAM patient and the educator institutionally responsible for him. The UAM participating in the research are aged between 16 and 18 and have a minimal (or no) competence in Italian. The participants were recruited by the second 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, 2007), transcriptions have been enriched with notations for gestures, gaze directions and body orientations when ostensibly relevant for the participants in the unfolding of the interaction. Original conversations in Italian have been almost literally translated in English and all names have been fictionalized.

4. The physician's interactional practices fostering UAM's (interactional) agency

For the purpose of this study, we firstly scrutinized video recordings focusing on the constitution of the UAM's "interactional agency". We selected "addressivity"⁴ as the main indicator of the physician's construction of the UAM as an active participant: we assume that addressing someone as a

³ The "differential diagnosis" represents the clinical method through which physicians consider possible causes of the patient's illness by rejecting a series of hypothesis before making the final diagnosis.

⁴ The term "addressivity", which was firstly used by M. Bakhtin, indicates an essential property of language in use, i.e. its being always oriented to a listener (Brown, 2005).

candidate interlocutor (i.e. ratified listener and/or next speaker) is the necessary basic dimension of attributing interactional agency. To trace the practices of attribution of interactional agency, we paid attention to the multimodal resources employed by the physician, namely: 1) linguistic and morpho-syntactic elements of turn design (Drew, 2013), 2) turn-taking procedures, e.g. self vs. other next speaker selection procedures and overlapping talk (see Hayashi, 2013; Lerner, 2003), 3) embodied resources, e.g. gaze direction, gestures and body orientations (see Goodwin, 1981; Kendon, 1972; Mondada, 2007).

As our preliminary quantitative analysis reveals (Caronia, Colla, Ranzani, forthcoming), in the first part of the visit (i.e. problem presentation, history taking, physical examination), the physician appears oriented to addressing the UAM in 72% of the cases, thus acknowledging the “epistemic authority” resulting from his first-hand experience of the illness. Particularly, in the history taking phase, the physician addresses the patient in 60% of the cases⁵. These overall quantitative data combined with the peculiar complexity of history taking phase (see par. 2.2.) made relevant for us to investigate in detail the interactional practices through which the physician attributes interactional agency to the UAM in this specific phase. We identified five practices through which the physician addresses the UAM and/or prompts his contribution in the medical interaction (see Table 1).

	Practices	Resources for implementing the practice
1	Making the patient speak with a few words	Yes/no questions Making hypothesis Narrowing the question
2	“Making the body speak”: Constructing an intersubjective referential object	Pointing Deixis
3	Using “translation practices”	Verbal formulations Gestural formulation
4	Doing “oscillating addressivity” (Caronia, Colla, Ranzani, forthcoming; Caronia, Ranzani, Colla, 2019)	Gaze Personal pronouns Verbal forms
5	Verifying the state of inter-comprehension	Other-repetitions (see Rossi, forthcoming) Other-initiated repair (Schegloff, Jefferson, Sacks, 1977; Drew, 1997) Metacommunicative activities (see Pugliese, Ciliberti, Anderson, 2003)

Table 1: The physician’s communicative practices fostering UAM’s interactional agency in the history-taking phase of medical visit

In this paper we focus mainly on practices n.1 resource a), i.e. the use of yes/no questions and practice n.2. However, excerpts may also include examples of other practices as they are often intertwined.

⁵ In the remaining 40% of cases, the physician addresses the co-present educator.

4.1 Making the patient speak with a few words through yes/no questions

If the use of yes/no questions by the physician is a common feature in the history taking phase (see among others Boyd & Heritage, 2006; Heritage & Raymond, 2012), our data illustrate a peculiar phenomenon: the physician resorts to a series of yes/no questions as a means to make the UAM “narrate” his past health care problems with a few words (practice 1, resource a), Table 1). The next example illustrates how the physician orients to the UAM’s low communicative competence in the language of the visit by asking a series of yes/no questions, i.e. closed question formats requiring a minimal feedback on the part of the UAM.

Ex. 1 - Mahdi (06.40 – 06.49)

P = Patient (Mahdi, 17 years old)

D = Physician

D and P are talking about the scar on P’s arm.

1	D	e riman- è rimasta così? <i>and it remain- has remained like that? ((looking at P))</i>
2	P	(.) sì sì. <i>(.) yes yes. ((touching his scar))</i>
3		(1)
4	D	cioè (.) ha sanguinato, (.) gli ^han dato dei punti? <i>that means (.) it bled, (.) did ^they give it stitches?</i>
5	D	^ <i>((mimes sewing while looking at P))</i>
6		(1)
7	D	HANNO CUCITO? <i>DID THEY SEW? ((miming sewing while looking at P))</i>
8	P	no:. <i>no:.</i>

Table 2: Ex. 1 - Mahdi (06.40 – 06.49)

In the turn at line 1, D asks P (see the direction of D’s gaze, line 1) a yes/no question (“and it remain- it has remained like that?”) concerning the condition of the scar on his arm. Despite the closed format, D’s polar question makes relevant elaboration and sequence expansion (Heritage, 2010: 54; Seuren, Huiskes, 2017) insofar as it establishes the relevance of a topic that is located within the patient’s territory of knowledge and accessible only to him. However, probably due to his scarce communicative competence in the language of the visit, P answers the question by producing just a minimal verbal contribution (“yes yes”, line 2). Although type conforming (Raymond, 2001), the patient’s reply is treated as not satisfactory by the physician who, after a remarkable gap (see line 3), expands on P’s previous turn (“that means”, line 4) by making a hypothesis on what may have happened (“it bled”) (practice n. 1, resource b), Table 1) and by issuing another yes/no question (“did they give it stitches?”, line 4). While asking this closed question, D looks at P, thus selecting him as the responder, and concurrently mimes the act of sewing (line 5). Getting no answer (see the gap at line 6), D formulates his previous turn into another yes/no question (“did they sew?”, line 7). Through the formulation, D translates the medical expression “give stitches” into the everyday language verb “sew”, and concurrently repeats the gesture visually representing the act of sewing (line 7, practice n. 3, resources a) and b), Table 1). D’s formulation prompts P, who answers with a minimal type

conforming contribution (“no”, line 8) that, nevertheless, advances the doctor’s knowledge of his past health status.

As this example illustrates, by addressing the patient through a series of yes/no questions, the physician orients to the UAM’s low communicative competence in the language of the visit and manages to pursue the institutional goal of the history taking phase (i.e. collecting information about the patient’s medical history).

In the next section we illustrate another practice deployed by the physician in our data: the professional regularly resorts to making relevant a part of the patient’s body.

4.2 “Making the body speak”: Constructing an intersubjective referential object

The following example illustrates how the physician fosters the UAM patient’s contribution in the history taking phase by making relevant a part of his body through gesture and deixis (practice n. 2, resources a) and b), Table 1). Thus doing, the physician appears oriented to making the UAM speak despite his low communicative competence.

Ex. 2 – Mahdi (05.10 – 06.00)

D = Physician

P = Patient (Mahdi, 17 years old)

We join the conversation when D starts asking P about his previous medical conditions. In the immediately preceding part of the visit, the history taking was characterized by a dyadic interaction between the physician and the educator.

1	D	tu ti ricordi: che problemi,- <i>do you remember: what problems,- ((looking at P))</i>
2	D	se hai avuto qualche problema (.) di <u>salute</u> ? hai avuto dei: <i>if you have had any (.) <u>health</u> issue? did you have any:</i>
3	D	vedo che c’hai una ferita lì <i>I see you have an injury there ((pointing P’s right arm))</i>
4	P	sì <i>yes</i>

Table 3: Ex. 2 – Mahdi (05.10 – 06.00)

In the turn at line 1, D issues a yes/no question asking P if he can remember his past “problems”. In this turn, D selects P as an interlocutor through the marked use of the second person subject pronoun (“you”, line 1) and his gaze direction (see line 1), thus orienting to him as the “epistemic authority” (Heritage, 2012). Even before finishing the question, D carries out a self-repair: he formulates another close-ended question specifying the nature of the problem he is referring to (“past health issue”, not a generic one, line 2). D does not wait for P’s answer and further formulates his question into another closed question (“did you have any”, line 2). While doing that, however, D self-interrupts again and produces a declarative (“I see you have an injury there”, line 3). By using the spatial deictic “there” and the pointing (line 3), D makes relevant a scar on P’s arm, thus locating on P’s body a trace of his past health issue. In other words, D *reads* P’s body, interpreting its current appearance as a sign of past health experiences relevant for the history-taking phase. In so doing, D treats P’s body as an inspectionable object (see Heath, 2006; Galatolo, Margutti, 2016; Galatolo, Cirillo, 2017), which serves as a shared and accessible elicitor of information on the part of the UAM. Given the UAM patient’s low linguistic competence, and therefore the difficulties in creating a “common ground” through the dialogue, the reference to the patient’s available body constitutes an effective practice to create an intersubjectively shared object of talk.

By substituting his previous yes/no questions (lines 1 and 2) with a declarative locating the trace of past health issues on the patient's body (line 3), the physician orients to the UAM's low communicative competence in the language of the visit: instead of asking him to produce a contribution concerning his past health issues on the basis of a question to be understood (as in lines 1 and 2), he indicates the patient a trace of a past health issue, assuming the burden of selecting what is relevant talking about. In this way, the physician guides the patient in the progression of the medical interaction, helping him understand what type of contribution is requested. In other words, D performs (albeit probably unintentionally) a pedagogical sequence: he scaffolds the UAM patient's participation in the medical interaction by projecting the kind of contribution locally expected on his side.

5. Concluding remarks

In this article, we analyzed two communicative practices deployed by the physician in the history taking phase that foster the UAM's interactional agency: making the patient speak with a few words and making the body speak. We analyzed the resources the physician used to implement these practices: respectively, the use of yes/no questions and the use of pointing and verbal deixis. As our analysis illustrates, the physician performs an extremely subtle interactive work that facilitates the UAM's active participation in the medical interaction: he seems to be oriented to the UAM patient's low linguistic competence, while systematically addressing him as a knowledgeable and competent subject. This orientation is analytically inferable by the use he makes of yes/no questions and the patient's body as an intersubjectively sharable object. While the use of yes/no question is typical of the history taking phase, in our data the physician interlocks a series of yes/no questions as to make the UAM "tell" his medical history with the few words he knows in the language of the visit. In this way, the physician maximizes the patient's active participation, rather than addressing and seeking help from the co-present educator. Similarly, the physician elicits the UAM's contribution by selecting and making relevant some ostensible signs on his body that become an intersubjectively shared referential anchoring of a prompt for further elaboration.

An attentive analysis of the physician's practices reveals that they also constitute pedagogical actions, even though implicit and probably unintentional: through his practices acknowledging the UAM's interactional agency, the physician locally (re)constructs the minor as a competent subject by scaffolding him toward the appropriate form of participation. In doing so, he acts as if he was promoting the UAM's empowerment and autonomy, i.e. two typical pedagogical aims.

Despite the exploratory and single-case design of this study, the practices and resources we identified can be suitable for medical education and healthcare professionals' training based on endogenous resources and sensitive to the pedagogical dimension inherent to health care professions (Mortari & Saiani, 2013; Mortari, 2015). Indeed, our findings show how, through the micro-details of interaction, it is possible to foster UAM's active participation in the medical interaction despite their low competence in the language of the visit. As fully demonstrated by research on medical care interaction, the acknowledgement of the patient's agency is not only a matter of respect and ethics, it is also an ingredient to maximize their compliance to medical treatment. In a few words, by pursuing the UAM's interactional agency, the physician is not only recognizing the UAM as the subject of his own healing process, he is also, and by that very fact, maximizing the probability of his adherence to therapies.

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