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Companions in immigrant oncology visits: Uncovering social dynamics through the lens of Goffman's footing and Conversation Analysis[1]

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ABSTRACT

This paper examines the role of companions in healthcare encounters, focusing on a previously unexamined context: the oncology visit with immigrant patients. By employing a methodological approach that combines elements of Goffman's footing and Conversation Analysis, this study discerns the social dynamics and communicative patterns among doctors, patients, and companions. Our focus on the companion yields an intricate picture of their multifaceted and dynamic participation, highlighting how their roles are not predefined and stable, but rather they are co-constructed and ongoingly negotiated among participants. Specifically, our analysis reveals that while companions initially maintain a peripheral position, aligning with the oncologist's focus on the patient as the primary recipient, they readily engage in active participation when the patient recruits them or when patient recipiency is problematic. As the anamnesis progresses, our investigation highlights the significance of the companion, showing their adept moves in response to the actions of both the patient and the oncologist. Their ability to offer linguistic assistance, insights into the patient's life circumstances, and documentation of previous tests is finely tuned to the developing interaction between the oncologist and the patient. In these ways the companions contribute to a more nuanced understanding of the patient and the overall effectiveness of the visit. The study's findings have significant implications for patient-centered care, particularly in diverse healthcare settings with immigrant patients. By recognizing and leveraging companion participation, healthcare practitioners can create more inclusive and equitable healthcare practices, optimizing their contributions for patient well-being.

1. Introduction

Although ancillary to the doctor and the patient in the interactional dynamics of healthcare encounters, the presence of a companion during the medical visit is both common and significant. As such it has garnered considerable research attention (Laidsaar-Powell et al., 2013; Troy et al., 2019). This paper contributes an original study of the topic, specifically focusing on the previously unexamined context of oncology visits involving immigrant patients.

By employing a methodological approach that integrates Goffman and Conversation Analysis, this study charts the companion's participation at a fine granular level, thereby discerning the intricate social relations and communicative patterns between them, the patient and the doctor. The primary hypothesis guiding our analysis proposes that in oncology visits with immigrant patients, the presence of a companion consistently influences the dynamics of interaction, yet does so in ways that are not predetermined. In a setting where the companion may serve various supportive roles—including interpretation, cultural mediation, emotional support, and information provision—we aim to explore how the companion's involvement unfolds, the specific actions they initiate or are recruited to perform, and the resulting interactional outcomes.

Following the contextualization of our study within pertinent literature, the subsequent section delineates our analytical framework, elucidating its capacity to identify participant roles and interactional dynamics. We then present our study's setting, dataset, and analytic procedures as a prelude to a detailed analysis of the companion's participation during the initial phase of the oncology visit with an immigrant patient. The closing section of this paper engages in a reflection on the potential of triadic medical encounters to enrich the patient experience and bolster the efficacy of oncologists' practice.

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Through this research, we aim to contribute to the growing body of knowledge surrounding the role and influence of companions in healthcare encounters, ultimately informing and improving the delivery of patient-centered care with immigrant patients.

2. Background

Two bodies of literature are especially relevant to our study: (1) Research on multilingual and intercultural healthcare communication and (2) research on the role of companions in medical encounters. In this section, we briefly overview them in order to delineate the intersectional area of our study.

(1) Research on multilingual and intercultural healthcare communication has surfaced the complexities and challenges associated with providing healthcare to individuals from culturally and linguistically diverse backgrounds (Ahmed et al., 2017). Studies have consistently shown that language barriers not only can lead to misunderstandings and decreased patient satisfaction but also to misdiagnoses and less favorable therapeutic outcomes (e.g. Binder et al., 2012). Research has also explored the interplay of language and culture, emphasizing the importance of understanding cultural norms, beliefs, and values that can influence health behaviors and decisions. There is evidence that culturally sensitive care leads to better patient outcomes and satisfaction (Butow et al., 2011). Overall, research attests to the significance of multilingual and intercultural healthcare communication in relation to health disparities attributed to socioeconomic status, discrimination and unequal access to healthcare services, most often aggravating rather than mitigating those disparities (Akhavan & Karlsen, 2013).

Albeit not widespread across medical contexts, in the US as well as in Europe, interpreting services for patients with limited proficiency in the host country's language have been the focus of several studies, yielding evidence that professional interpreters contribute to the clarity and accuracy of information exchange (Flores, 2005; Valero-Garcés, 2005). However, patients who may benefit from interpretation often prefer the presence of a family member or friend over professional interpreters (Kuo & Fagan, 1999; Edwards et al., 2005). Indeed, physicians themselves engage professional and family interpreters in distinct ways. Rosenberg et al. (2007) observed Canadian physicians orienting to the family interpreter as the patient's caregiver, thus establishing with them a "partnership" relationship. With professional interpreters, on the other hand, physicians followed the communication rules they were trained to follow, thus orienting to them as "translation machines."

Several other studies have shown that the interpreter's role is not straightforward and clearly defined. For instance, in a study of community interpreters in German hospitals, Meyer (1998) identified two distinctive actions carried out by interpreters, i.e. "actions carried out to support the interaction of the primary interlocutors, such as reproducing speech actions in the target language," and "actions carried out by the interpreter assuming the role of a primary interlocutor." Meyer observed that when the interpreter assumed the role of primary interlocutor, e.g. answering questions addressed to the patient or providing comments on others' turns, the patient participation in the encounter was reduced, as well as doctor-patient mutual understanding.

(2) The role of companions during medical visits has been a recurring topic of investigation within the domain of communication in healthcare contexts. Numerous studies have explored this phenomenon using a variety of research methodologies—including coding, ethnographic observation, and Conversation Analysis. They have provided descriptions of the multifaceted roles played by companions during medical visits, such as advocate, antagonist, or passive participant (Adelman et al., 1987). Other terms used include watchdog, significant other, and surrogate patient (Beisecker, 1989). These labels reflect the different and sometime concurrent ways in which companions function within the medical encounter. Among these roles, a notable distinction is made between those who assume a "passive" role, often characterized as mere observers (Ishikawa et al., 2005; Street & Gordon, 2008), and those who adopt an "active" role. Active roles involve activities such as fostering a partnership with the patient or advocating on their behalf (Del Piccolo et al., 2014; Ellingson, 2002).

Additionally, studies have explored how companions either support or hinder patient autonomy (e.g. Clayman et al., 2005; Ishikawa et al., 2005; Pino & Land, 2022). This is evident when companions assume the role of speaking on behalf of the patient, asking questions on their behalf, volunteering information, interrupting the patient, or even belittling them. In some instances, companions act as surrogates or pseudosurrogates, effectively sidelining the patient's voice as if they were incapable of speaking for themselves (Mazer et al., 2014).

Remarkably, there has been a dearth of research investigating how companions engage in turn-taking during medical encounters and the relationship between their conversational contributions and the broader multiparty configuration of the interaction. Studies within the Conversation Analysis (CA) paradigm are exceptions. With their focus on multimodal aspects of turn-taking and the sequential unfolding of interaction, these studies have shown that companion's roles are not only multiple but also fluid and interactionally stipulated (Fatigante et al., 2021; Fioramonte & Vasquez, 2019; Pino & Land, 2022). Companions' participation is shaped interactionally, moment-by-moment, often emerging in response to subtle gestures and vocal cues.

Drawing from this line of CA research, our paper explores how participants delineate and organize their roles and contribution, in the context of the first oncology visit of immigrant patients accompanied by a companion. Specifically, we focus on the initial phase of the visit, the anamnesis, and examine how companions take on roles and perform actions that articulate relations and alignments with both patient and doctor.

3. Charting participation

Building off the understanding that the companion's roles are dynamic, co-constructed, and interactionally negotiated, we chart the companion participation over the course of the anamnesis. We define and map out participation through a conceptual and analytic framework that combines Goffman and Conversation Analysis, specifically footing and turn allocation analytics.

In a series of essays and most centrally in the 1979 article published in Semiotica, with the title "Footing," Goffman provides a framework for analyzing participation in interaction that nuances the traditional model of talk in two fundamental ways: (1) he argues that the notions of speaker and hearer are too coarse, in fact even misleading, and suggests "decomposing them in smaller, analytically coherent elements" (Goffman, 1979, p. 6). (2) he calls attention to nonverbal resources in the management of talk in interaction, pointing out that "the terms 'speaker' and 'hearer' imply that sound alone is at issue, when, in fact, it is obvious that sight is organizationally very significant too, sometimes even touch." (ibid., p. 6)

In decomposing the notion of the hearer, Goffman distinguishes between the sensory process of auditing and the social role of listener, as one might be hearing the talk while not having the "official status as ratified participant in the encounter" (p. 8). Omitting description of additional differentiations that are not relevant to this study, and the medical encounter more broadly, another important distinction Goffman advances, within the category of ratified participants, is between addressed recipients and unaddressed ones. This distinction allows for a number of important noticings, e.g. whether there is a primary dyadic

axis of conversation, which Goffman calls "dominating communication," and which also makes possible "subordinate communication; " whether (or not) individual participants are recruited selectively as recipients.

In decomposing the notion of the speaker, Goffman refers to the role of articulating the talk, the acoustic issuing of utterances as animator. The author is the creator of the speech uttered. The distinction between animator and author is most transparent in reported speech. With accountability being an inherent dimension of social interaction, and most saliently in institutional talk, the production format of an utterance also includes the principal, who is given the responsibility for what is said. Furthermore, an utterance typically represents a character, "a protagonist in a described scene, …who belongs to the world that is spoken about, not the world in which the speaking occurs" (p. 19), which Goffman refers to as figure.

Goffman's conceptual toolkit offers analytic purchase for discerning not only communication responsibilities and privileges in the medical visit but also, relatedly, the participants' enacted, claimed, projected and negotiated subject positions and epistemic statuses. Specifically, we can notice whether and when the companion is selected as the addressed recipient and by whom. We can characterize the production format of doctor's, patient's and companion's utterances, thereby identifying their subjective and intersubjective stances (epistemic and affective) and alignments.

Subject positions and participation statuses in medical visits can be further delineated by considering the turn-taking system, specifically turn allocation and distribution. As Sacks, Schegloff and Jefferson stated "for socially organized activities, the presence of 'turns' suggests an economy, with turns for something being valued–and with means for allocating them, which affects their relative distribution, as in economies" (Sacks et al., 1974, p. 696). Turns and turn allocation are therefore tightly connected to participation statuses and privileges, delineating interactional asymmetries and control.

Examining how companions come to have a turn-at-talk, and when they get selected as next speakers, and by whom, can provide information about the companions' status in the medical encounter. Furthermore, analyzing the companion's turns in terms of the actions they perform will provide a deeper understanding of their importance for both the patient and the doctor, as well as their impact on shaping the ongoing communication.

4. Setting, dataset, and analytic procedure

Our data collection was carried out in the oncology departments of two medium-size hospitals in a large metropolitan area in Italy. The study received approval from the Ethical Committee of both hospitals. Written informed consents were obtained from all participants, i.e. the doctors, the nurses, the patients, individuals who accompanied them, and any other hospital personnel who entered the consultation room during the visit. Names and other references, which might lead to the participant's identification of personal data, were rendered anonymous.

Our dataset comprises 16 video-recorded first oncology visits with immigrant patients and companions. While these are all first time encounters with the oncologist, the patients have already received a cancer diagnosis (delivered by a range of other specialists, e.g. surgeon, radiologist, gynecologist) and they often have already undergone a surgical removal of the tumor. The goals of the visit with the oncologist are to assess the severity of the tumor and to formulate a treatment plan (such as chemotherapy or hormone therapy), aimed at attenuating the risk of recurrence.

In 25% of the visits (4) in our dataset the immigrant patient displayed no familiarity with Italian language beyond the greeting formulas. These patients came to the visit with a companion sharing their mother tongue and who was proficient in Italian. In another 25% of the visits (4) the immigrant patient had partial proficiency in Italian, needing at times interpretation, both for comprehension and production. Three of them came to the visit accompanied by an Italian native speaker, and one by an immigrant companion (sharing native language and country of origin). In 50% of the visits (8), the immigrant patient was proficient in Italian and came with an immigrant companion in five encounters and with an Italian companion in three encounters.

The visit video-recordings were fully transcribed according to conversation analytic conventions (see Appendix for details). For the present study, we have focused on the first few minutes of the encounter, specifically the first phase of the visit, the anamnesis. Within this initial phase, the oncologist grapples with important tasks, including the identification of the patient (and, by extension, the companion) and an assessment of their proficiency in the Italian language. This emphasis on the initial phase uniquely illuminates the emergence of companion participation in a manner that is distinctive to this dataset.

In the anamnesis, we thus examined every turn produced by the companion, considering (i) when the companion takes a turn at talk; (ii) whether the turn is the product of self-selection or other-selection and if other-selected by whom; (iii) whether it is an initiation or a response. The examples included in the Findings section were selected as the clearest illustrations of the phenomena prevalent in our data corpus.

5. Findings

5.1. Recruitment of the companion for a speakership role in the anamnesis

As mentioned above, our dataset comprises immigrant patients with varying degrees of language proficiency, ranging from near-native speakers to those who struggle to comprehend or communicate in Italian. However, it's noteworthy that the oncologists in our study tend to assess the patient's language skills indirectly. Specifically, the patient's proficiency in Italian is seldom made explicit as a topic, such as through direct questions like "lei parla italiano?" ("do you speak Italian?") or "capisce quello che dico?" ("do you understand what I am saying?"). Throughout our dataset, in the initial exchanges, the oncologist's focus is consistently on the patient, who is addressed verbally (using honorifics, last or first name) and/or through gaze. The companion takes on the role of an interlocutor, either through recruitment by the patient (in 7 of the 16 visits) or through self-selection (in 8 of the 16 visits).

In only one visit, the companion's verbal contribution is absent: A Peruvian patient, residing in Italy for several years and fluent in Italian, is accompanied by two companions. He never seeks their involvement during the medical history, however, and they also refrain from self-selecting to participate. Throughout the anamnesis, the oncologist directs attention solely to the patient, with the companions maintaining silence and assuming a near-statuatory presence.

In the following two sections, we elucidate the primary methods of selecting companions for their initial involvement in the anamnesis. This will be exemplified through four representative instances, with two examples for each selection mode. Additionally, our analysis delves into the actions companions take when either recruited or self-selected.

5.1.1. Patient selection of the companion

In example 1, as shown in Fig. 1, we meet Olivia, a 44-year-old woman from Cameroon, fluent in French and English, with Italian proficiency at conversational level. She is employed as domestic worker and caregiver. Accompanying her to the visit is the daughter of Olivia's employer. Participants in all examples are indicated with the following

```
1    ONC      senta.  Olivia?
              listen. Olivia?
2    PAT      [si.
              [yes.
3    com      [turns gaze to PAT, smiling
4    ONC      in passato ha avuto altre malattie?
              in the past did you suffer any other illness?
5    PAT      eh:: dai- ((turns to COM)) diab[et°i=h°
          →   eh:: dai- ((turns to COM)) diab[et°i=h°
6    COM  →                                  [diabete.
                                             [diabetis ((looking at
              PAT))
7    ONC      diabetica.
              diabetic. ((writing on PAT's record))
8    PAT      e::: pressio- alta pressione anche.
              a::nd pressu- high pressure also.
```

Fig. 1. Example 1.

labels: ONC(ologist), PAT(ient), COM(panion).

After a brief greeting exchange while gaining their seating positions, the oncologist begins the anamnesis, opening the sequence by overt verbal selection of the patient as recipient (line 1). Once the patient displays recipiency (line 2), the oncologist launches the anamnesis, with its typical Q&A format (Heritage, 2010), holding his gaze on the patient. The patient understands the first question the oncologist asks (line 4) but encounters difficulty in pronouncing the answer correctly in Italian. As she restarts, after a mispronounced first syllable, the patient turns to gaze at the companion (line 5). To this non-verbal recruitment for help, the companion responds promptly providing the correct pronunciation of the medical term (line 6). The companion keeps her gaze on the patient, her reply thus constructed for her, as parenthetical or subsidiary with respect to the primary dyadic doctor-patient axis. The oncologist meanwhile had turned his gaze to the medical record on his desk, handwriting on it. He displays recipiency and understanding (line 7), uttering a slightly different formulation (i.e. adjectivizing the noun), of the patient and companion answers. Alternating his gaze between the medical record, wherein he's writing, and the patient, the oncologist asks a few more questions to which the patient replies with no problem.

In the next example we observe a similar process of selection of the companion as addressed recipient and their emergence as interlocutors for both the patient and the oncologist. In example 2, as shown in Fig. 2, we meet Melissa, a 41-year-old woman from the Philippines, with Italian proficiency at conversational level. She is employed as domestic worker by the companion.

After a brief exchange of greetings and settling into their seats, the oncologist starts the anamnesis by explicitly selecting the patient as the addressed recipient, addressing her as "signora Melissa" (i.e., an honorific + first name) (line 1). Once she acknowledges his summon (yes, line 2), seven Q&A pairs proceed smoothly (lines 3 to 21), with the oncologist maintaining his focus on the patient, except when making notes on the medical record. However, the eighth question (inquiring about the patient's age when delivering her only child, line 21) doesn't receive a straightforward response. It appears that the patient is audibly calculating to determine the answer based on her son's age (6 years old). Before she completes her response, the oncologist offers a candidate understanding (line 24), which, turns out to be incorrect. As the patient negates the proposed answer, she turns her head and gaze toward the companion (line 25), who proffers a clarification (line 26). The companion's clarification addresses two issues simultaneously: not only the age of the child but also his gender. In responding to the question about having children, the patient had answered "one" with the feminine form "una" (line 19), while she has a son (who would be "uno"). The doctor had consequently used the feminine term ("figlia"). In acknowledging the companion's contribution, with a repeat in line 29, the oncologist aligns with the gender designation she indicated.

In both Example 1 and 2, the patient has recruited the companion to assist her in responding to a doctor's inquiry, when communication difficulty has emerged. In Example 1, the companion is sought out to ensure the accurate pronunciation of a medical term in Italian, whereas in Example 2, the patient relies on the companion's knowledge of her family background and history to address a trouble in comprehension. Said in more technical CA terms, in both instances, as the patient initiates a repair sequence, she recruits the companion's intervention to enact the repair proper. In both instances, the companion proves to be readily accessible and adept for the task at hand, and the oncologist ratifies the companion's involvement by acknowledging her interventions. In the discussion section, we will propose that under circumstances of patient-recruitment, the companion mediates the interaction between the doctor and the patient, preserving their face and preempting the dispreferred move of other-repair (Fox, Benjamin, & Mazeland, 2013; Schegloff, 2007).

5.1.2. *Companion self-selection*

In this section, we illustrate another common method through which the companion assumes a speakership role in the anamnesis, namely through self-selection. In example 3, as shown in Fig. 3, we meet Irina, a 46-year-old woman from Ukraine, fluent in Ukrainian, with Italian proficiency at conversational level. Accompanying her to the visit is an Italian friend.

After a brief greeting exchange, the oncologist arranges papers on his desk and while looking at the medical form he asks confirmation about the patient's previous meeting with another doctor, Dr. Rubini, who is the surgeon who operated on the patient's breast. The syntactic composition and prosodic contour of his turn is worth unpacking: first the discourse marker "allora" (line 1), which in Italian is used in turn initial position as turn-taking as well as frame-changing marker (Bazzanella, 1995), here signaling the transition from the greeting phase to the opening of the visit proper, with the anamnesis. Then a declarative segment "first visit from Dr. Rubini" (line 2), a truncated form (a noun phrase with the verbal phrase omitted) uttered while arranging papers on the desk, thus not explicitly selecting a recipient. Lifting his gaze towards the companion first and then the patient, the oncologist adds the independent clause, specifically an epistemic hedge ("I believe"), and then a question tag ("no?") (line 3)—this nonverbal and verbal assemblage soliciting more clearly a reply. Both the companion and the patient confirm the accuracy of the oncologist's statement, demonstrating an equal level of knowledge access as anticipated by the question (lines 4 and 5, respectively).

Looking at the documents, the oncologist continues his inquiry, building on the confirmed information ("therefore," line 6) but is interrupted by the companion, self-selecting herself to ensure that the oncologist is aware of who is the patient (line 7). While taking the floor

1 ONC allora signora Melissa
so madam Melissa
2 PAT °si°
yes.
3 ONC in famiglia qualcuno ha avuto malattie particolari?
in your family did anyone suffer any specific illness?
4 PAT no con mia madre diciamo: si=si con mia madre
no with my mother, I mean, yes=yes with my mother
5 è morta di tumore
she died of cancer
6 ONC a che cosa?
what kind?
7 PAT al sangue ( )
in the blood ( )
8 ONC ( ) una leucemia forse?
leukemia perhpas
9 PAT si °( )°
yes
10 ONC i fratelli e le sorelle stanno bene?
brothers and sistets are well?
11 PAT si tutti quanti
yes all of them
12 (1.0)
13 ONC lei in passato ha sofferto di problemi di salute?
did you suffer from health problems in the past?
14 PAT no=no.
no=no. ***((shaking her head))***
15 ONC è sposata?
are you married?
16 PAT si.
yes ***((nodding))***
17 ONC ha figli?
do you have children?
18 PAT una. si.
one ***((f.))*** **yes**
19 ONC una.
one ***((f.))***
20 PAT °si°
°yes°
21 ONC a quanti anni ha avuto la figlia?
how old were you when you had your daughter?
22 PAT (ora sono) trentaquattro anni, (quindi) trentacinque
(at present they are) thirtyfour years, (so) thirtyfive
23 adesso trentase- ha: sei anni,
now thirtysi- (she) has:: six years old.
24 ONC quindi l'anno scorso c'ha avuto la figlia?
so it's last year that you had your daughter
25 PAT → no:: [da:
no:: [since: ***((turns to gaze the companion))***
26 COM → [no e:m l'ha avuto:, (.) [il bambino ha sei anni.
[no ehm she had him,(.) [the child ***((m.))*** **is six years old** ***((looks at ONC))***
27 PAT [io-
[I-

28 ha sei anni
he's six years old ***((turns to ONC))***
29 ONC il bambino ha sei [anni, lei ha?
the child is six years old, you are?
30 COM [è un [maschetto
[he's a boy.
31 PAT [quindi trentacinque, quarantuno.
[so thirtyfive, fortyone.
32 ONC lei ha quarantuno.
you are fortyone.

Fig. 2. Example 2.

1	ONC		allora (.) **so (.) *((sits down at the desk))***
2			prima visita da parte del dottor rubini. **first visit with dottor rubini. *((arranging documents on the desk; places medical record in front of himself))***
3			*((looks up at COM and PAT))* credo. no? ***((looks up at COM and PAT))* I believe. no?**
4	COM	→	si= **yes**
5	PAT		=si **yes**
6	ONC		quindi- **therefore-**
7	COM	→	*((points at PAT, looking at ONC))* la signora. ***((points at PAT, looking at ONC))* the lady.**
8	ONC		si si immagino. ho visto il nome, immag- **yes yes I figured. I saw the name, I fig-**
9	COM		ah si *((laughing))* **ah I see *((laughing))***

Fig. 3. Example 3.

1	ONC		°allora° **°so°**
2	(1.0)		
3	ONC		( ) (.) allora lei è Mahmoud Salah Alaudeen. **( ) (.) so you are Mahmoud Salah Alaudeen.** ***((pointing at notebook on his left, on the desk))***
4	PAT		°Ahmad Salah° **°Ahmad Salah°**
5	onc		**points to another paper on the desk**
6	ONC		no. h:: [Salah Rashid lei è. **no. h:: [Salah Rashid you are.**
7	COM	→	[no. **[no. *((busy taking docusments out of a folder))***
8	ONC		ecco qua. **there it is.**
9	PAT		mh mhm **mh mhm *((nodding))***
	[...]		*((few turns omitted: ONC talking to the camera person))*
10	ONC		.h come sta? **.h *((turns from computer screen to PAT))* how are you?**
11	(1.2)		
12			eh:: diciamo:: solo il: problema del bagno sempre[:: **well let's say it's just the toilet issue as us[ual**
13	ONC		[mhm. **[mhm.**
14	COM	→	vabbe' però sta bene. **alright but he's well. *((looking at ONC))***
15	onc		**glances at COM, slightly lowering head and turns to PAT**
16	PAT		problema del bagno sempre, **the toilet issue always,**
17	ONC		okay. **okay.**

Fig. 4. Example 4.

on her own initiative, the companion's intervention here maintains a participation framework in which the patient remains the primary recipient of the oncologist's communication.The oncologist affirms his awareness (line 8), looking briefly at the patient before turning his gaze down to his notebook.

In example 4, Ahmed, a 59-year-old man from Egypt, fluent in Arabic, with Italian proficiency at conversational level, comes to the visit accompanies by his Italian wife (see Fig. 4).

At the outset of the anamnesis, progress is hindered by uncertainty regarding the patient's name identification. The oncologist seeks clarification, shifting his gaze between paperwork and the patient, and the patient responds clarifying. As the clarification exchange is being completed, the companion self-selects (line 7) to affirm the oncologist's

understanding, echoing his negation. The companion self-selects again a few seconds later: the oncologist has addressed the patient asking him how he's doing (line 10) and the patient is reporting evacuation difficulties (he has undergone a surgery for a gastro-intestinal tumor) (line 12). The companion's intervention comes immediately after the patient's response and offers a different, more general and positive assessment (line 14). By self-selecting and looking at the oncologist while responding, the companion positions herself as a relevant interlocutor for the doctor. Consequently, the companion's contribution subverts the participant framework established by the doctor's question, which designated the patient, not the companion, as the ratified addressee and next speaker. Moreover, it provides an alternative to the patient's response. The doctor's subsequent action acknowledges both participants as addressees: as he turns his head and gaze away from the computer screen towards the patient, he briefly glances at the companion and offers a subtle nod (line 15). However, it is the patient who remains the doctor's primary recipient, thus upholding the primacy of his epistemic status over that of the companion.

Example 3 and 4 demonstrate that the companion also assumes a speaking role in the interaction through self-selection. In Example 3, the doctor has not explicitly addressed the patient when the companion self-selects, leading to a situation of ambiguous recipiency. In example 4, the companion's intervention significantly alters the participation framework established by the oncologist. In both cases, the oncologist acknowledges the companion as a speaker, albeit rather minimally.

By considering together the practices of patient-selection and self-selection, we can note that although both practices lead to the companion being recognized as a ratified interlocutor in the communicative exchange, self-selection challenges the institutional ethos of patient-centeredness. The legitimacy of one such initiative on the part of the companion appears to depend on how clearly the companion's turn serves to support the patient's status. Moving forward, we will explore how the companion's involvement unfolds, highlighting its constant renegotiation and dependency on key factors: who selects the companion and the actions they undertake.

5.2. How the Companion's involvement shifts upon becoming a ratified interlocutor

Once the companion has gained recognition as an interlocutor in the communicative exchange, their involvement becomes more frequent as well as varied. While their first bid at participation as a speaker occurred through patient- or self-selection, as the anamnesis progresses, the doctor is also seen directly addressing the companion. To illustrate, we examine the progression of Olivia's anamnesis (Example 1) and Irina's anamnesis (Example 3). Due to space constraints, we focus on one instance of patient-selection and one instance of self-selection, chosen from the four cases presented in Section 5.1.

In example 5 as shown in Fig. 5, we pick up from where example 1 ended. Here the oncologist alternates his gaze between the medical record, wherein he's writing, and the patient, while proceeding to ask a few more questions, to which the patient replies with no problem.

In line 4, when the patient encounters pronunciation difficulties once more—the same type of issue for which she had previously sought assistance from the companion—the companion self-selects to offer the correct pronunciation, looking at the patient (line 5). Shortly after she self-selects again (line 12, "and the second time?"), this time implementing a different action: she prompts the patient to complete her answer, which she had announced to comprise two elements (line 2). This interactional contribution is especially interesting in that it supports the patient in answering comprehensively to the oncologist question. As such, it promotes the felicitous unfolding of the ongoing activity, i.e. the anamnesis, and acts in support of the oncologist too.

The fourth time the companion takes the floor, once again through self-selection, she shifts footing, turning to gaze and address the oncologist and using the first person plural, to speak on her and the patient behalf (lines 16 and 18). As an announcement, this shift in footing also entails changes in roles and responsibilities, with the companion indicating experiential knowledge that can warrant her reliability as information provider. In that capacity, the companion also orients towards supporting the progression of the anamnestic activity. The oncologist acknowledges the information provided by the companion and adjusts his own footing by using the first person plural (line 19). However, it's worth noting that his response does not confirm the companion's attempt to shift the topic, enacting the oncologist's control over what and how to examine next, in the course of the anamnesis.

As a matter of fact, the subsequent question posed by the oncologist does not pertain to chemotherapy but instead delves into the patient's family history (line 22). Despite this, the oncologist's gaze remains fixed on the companion. Aligning with the oncologist next-speaker selection, the companion begins to respond, although her answer does not provide the solicited information and instead redirects the inquiry back to the patient (line 24). It is worth noting the restart and slight reformulation of the oncologist prepositional phrase "in the family," which the companion clarifies with "in your family." With this turn, she resumes her role as linguistic support, as initially enlisted by the patient, rather than serving as an information provider. The companion is cut off by the oncologist, who rephrases his query, enumerating the most relevant family members (line 25). While the companion holds her gaze onto the patient, the oncologist holds his onto the companion, only turning to the patient at the end of the turn (line 26). After the patient has answered to his query (lines 27 and 29), he turns again towards the companion eliciting from her more information relevant to the visit underway. While selecting verbally and nonverbally the companion as recipient of his query, the oncologist uses the second person plural, aligning with the pronominal reference used by the companion (line 30). The companion nods in response (line 31). In the turns that follow, the oncologist will shift to the formal third person singular, addressing the companion only. The companion will use the first person plural once more before switching to refer to the patient in the third person.

In summary, in Olivia's visit, we observe an increase in the companion's involvement as the anamnesis unfolds. By monitoring gaze patterns and pronoun usage, it is evident that the companion strives to maintain the patient's central role as the primary recipient, even when speaking on her behalf.

Another notable observation is that although the companion's initiations become more frequent, not all are endorsed. Under close supervision by the oncologist, some are ratified while others are not, particularly those that align with the course of action initiated by the oncologist versus those that deviate from it. As for the patient, we observe that her participation as speaker seems to decline, with her verbal inputs becoming brief and less frequent. She appears more frequently as a passive figure in the exchange between the oncologist and the companion. However, tracking her gaze and non-verbal cues (notably, reaching for documents in her purse right when the doctor requests them) indicates that the patient is fully engaged and comprehending the oncologist's dialogue with the companion.

We shall now consider how Irina's anamnesis unfolds (see Fig. 6 below).

Like the one right before, seen in example 3 (lines 2–3), the oncologist question has a similar syntactic structure and does not explicitly select an addressee (line 1). Subsequently, the oncologist adds a tag question, briefly lifting his gaze on the companion (line 4). As the oncologist looks at her, the companion nods slightly and shifts her gaze to the patient, who then responds, confirming the doctor's statement (line 6). Despite the redundancy of her reply at this point, the companion produces additional nods while gesturing towards the patient (line 7). So, it appears that during this initial phase of the exchange,

```
1   ONC      è stata mai operata?
             did you ever undergo surgery?
2   PAT      si (0.4) [due volte.
             yes (0.4)[two times.
3   ONC               [a- (0.4) dica.
                      [wh- (0.4) tell me.
4   PAT      prima pe: fibro- f°ebbr°=
             first for fibro- f°ebbr°=
5   COM  →   =fib[roma.
             =fib[roma. ((looking at PAT))
6   pat          [turns gaze to COM
7   PAT      fibroma.
             fibroma.
8   (1.2)   ((ONC writes on record))

9   ONC      all'utero
             to the uterus ((while writing))
10  PAT      sì.
             yes.
11  (4.0)  ((ONC writes; COM continues looking at PAT))

12  COM  →   °e la seconda volta?°
             and the second time?
13  PAT      ((looks at COM)) sisaria.
             ((looks at COM)) cecaria.
14  COM      ah si un cesareo si.
             ah yes a ceserean yes.
15  PAT      (          ) mia figlia
             (          ) my daugther
16  COM  →   perché (0.6) ((turns to ONC))
             because (0.6) ((turns to ONC))
17  onc      stops writing; looks at COM
18  COM  →   noi veniamo già da una: prima chemio.
             we come already with a: first chemo.
19  ONC      okay. adesso ricostruiamo un po' tutto.
             okay. we're going over all that now.
21  (2.0)

22  ONC      in famiglia qualcuno ha avuto problemi di salute?
             in the family, did someone have health problems?
             ((looking at COM))
23  (0.5)  ((COM turns to PAT who is looking downward))

24  COM      in fa- nella t[ua famiglia-
             in fa-   in yo[ur familiy-
25  ONC                    [papà, mamma, fratelli, sorelle,
                           [dad, mom, brothers, sisters
26           hanno avuto tumori?
             did they have tumors? ((turning gaze to PAT))
27  PAT      no                  solo questa: diabeti:-
             no ((shaking head)) only this: diabeti:-
28  ONC      solo il diabete mh
             only diabetes mh
29  PAT      e:: [pressione alta.
             a:nd [high blood pressure.
30  ONC           [allora mi diceva che avete già una storia di:
                  [so ((turns to COM)) you were telling me that you had
             already a history of:

31  com      ((nods, looking at ONC))
32  ONC      malattia. c'ha della: documentazione?
             ((glances at PAT)) illness. ((looks at COM)) do you have
             some documentation?
33  COM  →   si.  [abbiamo tutto qua.
             yes. [we have everything here. ((ostensive hand gesture
             toward PAT))
34  ONC           [relativo a questo?
                  [pertaining to this?
35  COM      si.
             yes.
36  pat      ((opens her purse on her lap))
37  ONC      posso vederla un attimo?
             may I take a look at it briefly?
38  COM      si si.
             yes yes.
39  (1.0)  ((PAT searches for documents inside her purse))

40  COM      che è cominciata l'anno scorso,
             which started last year,
41  onc      ((writes on medical record))
42  COM  →   e:: ha avuto un primo ciclo di-
             a:nd she had a first cycle of- ((turns to PAT stretching
             her arm toward her))
43           ha fatto un primo ciclo di chemio, e:
             she has done a first cycle of chemo, and:
44  pat      ((places documents on the desks and looks at ONC))
```

Fig. 5. Example 5.

1 ONC quindi un problema di mammella.
therefore a breast problem. *((looking at medical record))*
2 *((lifts gaze))* immagino.
***((lifts gaze))* I guess.**
3 (0.4)
4 ONC mhm?
mhm? *((looking at COM))*
5 com ***((looks at PAT slightly nodding))***
6 PAT si.
yes.
7 com → ***((nods and points to PAT))***
8 COM → qui c'è: tanto lei ce l'avrà sicuramente.
here there is: anyway you might have it for sure.
((moving documents on the desk nearer to ONC))
9 ONC no. preferisco farle io le domande.
no. I prefer to ask myself the questions.
10 COM prego
sure.
((A phone call takes the oncologist attention for appox 2 min))
11 ONC e lei rispetto alla signora è?
and who are you with respect to her? *((to COM))*
12 COM sono un'amica.
I'm a friend.
13 ONC un'amica.
a friend.
14 COM faccio da: mediatrice linguistica.
I serve as language broker. *((smiling))*
15 ONC mediatrice linguistica. (.) non è male.
language broker (.) that's not bad.
16 **(0.8) *((PAT and COM laugh))***
17 ONC a:llora.
so. *((leaning towards, looks at medical record on desk))*
18 <radruc> irina ((reading; PAT's last and first name))
19 onc ***((lifts gaze to PAT))***
20 PAT radiruc.
radiruc. *((smiling))*
21 ONC radiruc.
radiruc.
[…] 3 Q&A omitted: ONC asks about place & date of birth & phone number
22 ONC che lavoro faceva in Ucraìna?
what was your job in Ukraine? *((looking at PAT))*
23 PAT (alvanic)
(alvanic)
24 ONC eh?
what? *((looking at PAT))*
25 PAT (ALVAnic)
(ALVAnic)
26 onc ***((turns to COM))***
27 COM em: lavorava in una fabbrica con: procedimenti galvanici.
em: she worked in a factory with galvanic procedures.
28 ONC galvanici.
galvanic. ((writing on record))
29 COM mhm.
mhm.

30 ONC ha malattie particolari a parte questa?
do you have any specific illness beside this one?
31 pat *((lift shoulders))*
32 ONC non prende mai medicine
do you ever take medicines?
33 PAT no. medicine come: prende::va: un po' della pressione,
no. medicines like: to::ok for a while for blood pressure,
34 ONC quindi è ipertesa.
so you are hypertensive. *((writes on record))*
35 PAT non è che (.) adesso non prendo proprio,
it's not that (.) at the moment I am taking nothing at all,
36 ONC perché?
why?
37 PAT *((lift shoulders))* perché io ho fatto tre mesi,
***((lift shoulders))* because I did three months,**
38 dopo non c'ho pressione.
and then I had no pressure.
39 COM non ha più la pressione alta e allo-
she does not have high blood pressure anymore and then-
40 PAT non c'ho pre[ssione.
I have no pre[ssure.
41 ONC [non c'ha la pressione alta o s'è stufata?
[does she has no high blood pressure or was she fed up? *((to COM))*
42 PAT no [no ( )
no [no ( )
43 COM [no no se la misura. se la misura.
[no no she does measure it. she does.
44 ONC ah mh.
okay.

Fig. 6. Example 6.

there is a reluctance to address the companion directly, both from the doctor's side, who refrains from directly selecting her, and from the companion herself, who, when intervening, signals towards the patient with her gaze and pointing.

After these initial exchanges, however, the companion takes a clear initiative to call the oncologist attention towards medical documents related to the cancer diagnosis and surgery that the patient brought to the visit. This intervention (line 8), accompanied by a verbal component, is oriented to progress the anamnesis by providing additional pertinent information. While supportive of the oncologist's efforts, it also arguably infringes on the doctor's authority. Indeed, the doctor declines to review the documents immediately, indicating a preference to first inquire via Q&A with the patient.

After the brief phone conversation with a colleague (requesting a test for another patient), the oncologist repositions the medical record on top of other papers on the desk and turns to the companion to ask about her relationship to the patient. Responding to the doctor's question, the companion presents herself as a friend of the patient (line 12), who is there to provide communicative support, as "language broker" (line 14). The oncologist offers a sequence closing assessment, acknowledging the utility of such form of support ("that's not bad," line 15). Interestingly at this point he turns to the patient addressing her explicitly with his following questions, to obtain a set of biographical information. A difficulty in understanding emerges when the oncologist asks about the patient's job in Ukraine. Her reply is not intelligible to the doctor who solicits a repair (line 24). The patient's repeat in higher volume (line 25) is not resolutive and the oncologist turns to the companion (line 26), who promptly provides clarifying information (line 27). Thus, we note that in this instance, the companion is recruited to provide information on behalf of the patient only after the communication trouble remains unresolved between the doctor and the patient. The preference for maintaining the patient as primary recipient and information provider is set aside when there is a risk of accurate information not being obtained.

In the final segment of the transcript (lines 32 to 44), we observe another instance where the companion plays a crucial role in ensuring accurate collection of information during the anamnesis and in maintaining the patient's status as a reliable information provider and interlocutor for the doctor: When the oncologist asks about other illnesses and whether the patient takes any medication, the patient's answer that she is no longer taking blood pressure meds is deemed problematic by the oncologist, who asks for an account (line 36, "why?"). The patient explains why she has stopped the medication (i.e. after a 3-month treatment, the blood pressure returned to normal) but her formulation is slightly ungrammatical (lines 37 and 38). The companion intervenes at this point, via self-selection, addressing the oncologist, to rephrase the patient's explanation in a more standard form (line 39). In fact, she begins to elaborate an explanation herself, on behalf of the patient ("and then-"), which remains incomplete as the patient repeats her statement (line 40) and the oncologist takes the floor again. Not ready to accept the veracity of the statement, the oncologist addresses the companion turning the patient into a figure, whose motives for interrupting the medication are dubious (line 41). The patient promptly denies the insinuation (line 42) before the companion does the same, adding corroborative information (line 43) to reinforce the patient's trustworthiness.

In summary, Irina's anamnesis illustrates that even when the companion enters the communicative exchange via self-selection, thus through no explicit recruitment by the patient or the oncologist, the companion orients to preserve the primacy of the patient as the oncologist's primary recipient. Meanwhile, the oncologist manages the companion's contributions to optimize efficiency in pursuing his objectives, sometimes at the expense of the patient, who may be relegated to a passive role or have her assertions questioned.

A common thread in both Olivia's and Irina's anamneses is that once the companion and the doctor establish a mutual dynamic of addressing each other, the patient's epistemic authority is more rarely invoked and sometimes she becomes the figure in the exchange between doctor and companion.

6. Discussion & conclusion

As an illustration of a methodological approach that combines Goffman's footing and Conversation Analysis, this paper showed the fruitfulness of charting turn-taking and participation for uncovering the interactional dynamics in complex social encounters, such as the oncology visit with companions. This approach nuances studies that operating at a more macro-level identified and coded roles (see as instances, Ellingson, 2002; Street & Gordon, 2008; Del Piccolo et al., 2014; Mazer et al., 2014), leaving the details of how these roles emerge and unfold unexamined.

Our turn-by-turn analysis underscored the significance of companions in the context of oncology visits with immigrant patients shedding light on their multifaceted and dynamic role within the opening phase of the medical encounter, the anamnesis. Specifically, our findings revealed that at the very beginning of the visit the companion maintains an audience position, aligning with the oncologist orientation towards the patient as their primary recipient, despite the uncertainty of the communicative conditions. The companion, however, demonstrates to be readily available for a more active participation.

When the companion begins to speak through patient selection, our analysis showed that the oncologist responds endorsing their involvement, thus aligning with the patient's choice. We have also observed instances where the companion's speaking role emerges through self-selection, particularly when patient recipiency is unclear. Even in these cases, the oncologist acknowledges the companion's turn. However, Example 4 presents a notable exception: during the visit of an Egyptian patient with his Italian wife, the companion took the initiative early on to offer an alternative answer to what the patient had provided to the oncologist. In this case, the doctor barely acknowledges the companion's self-selection, continuing the exchange without addressing the companion's divergent answer.

In essence, at the beginning of the anamnesis, the preferred format is for dialogue to occur primarily between the patient and the doctor—-even amidst uncertainty regarding the patient's proficiency in Italian—with the companion needing justification to actively participate in the communicative exchange. The companion gains legitimacy as a speaker when recruited by the patient to offer linguistic support or by the doctor to provide information. However, when the companion's intervention supplants or contests the patient's voice (as in example 4), or begins to encroach on the doctor's role, altering the course of action he is conducting—e.g. prompting a review of documents while the oncologist is still inquiring about the patient's medical history (example 6)—the doctor either explicitly blocks the attempt or disregards it.

Examining the companion's utterances, our study indicates that the companion navigates tactfully in response to the actions undertaken by both the patient and the oncologist—a finding that aligns with earlier CA studies on the role of companions in medical encounters (see section 2 above). The companion's ability to offer linguistic assistance, insight into the patient's life situation, and documentation of previous tests is finely attuned to the unfolding interaction between the oncologist and the patient. Furthermore, we have observed that the companion's turns are also sensitive to the subtle changes in interactional dynamics, often mitigating face-threatening circumstances (Goffman, 1967) for either the patient or the doctor. We have witnessed instances where the companion bolstered the patient's epistemic authority when the oncologist questioned the information provided by the patient (as in example 6). Additionally, we have observed the companion's efforts to prevent misunderstandings on the part of the oncologist (as in example 2).

Consistent with previous research examining the influence of companions, particularly with vulnerable patients (e.g., individuals with advanced cancer as studied by Mazer et al., 2014) and immigrant patients (e.g. Meyer, 1998), we've noticed a weakening of patient's

epistemic authority and involvement (as speaker and addressed recipient), coupled with an increase of the companion's engagement, as the anamnesis progresses. Adding novelty to this line of research, our study has shown *how* this pattern emerges, revealing that it develops gradually and is always co-constructed, initiated by any of the three participants, depending on the unfolding circumstances, and requiring alignment from the others involved. While attesting to this pattern, our analysis also reveals the ongoing fluidity of the participation format. Recognizing the adaptability of participation could better equip the doctor to effectively manage the interaction and uphold the centrality of the patient's perspective.

In closing, there are several areas that remain to be investigated regarding the role of the companion in medical encounters with immigrant patients. Extending the analysis of companion's participation throughout the visit is a natural extension of this study. Furthermore, it would be beneficial to conduct additional research on patient satisfaction and preferences regarding the companion's role. Understanding the patients' perspectives, expectations, and perceptions could help optimize the companion's involvement in a way that better meets patient needs.

CRediT authorship contribution statement

Laura Sterponi: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Marilena Fatigante:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Cristina Zucchermaglio:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Francesca Alby:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix

Transcription Conventions

. The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence
? The question mark indicates rising intonation, not necessarily a question
, The comma indicates "continuing" intonation, not necessarily a clause boundary
::: Colons indicate stretching of the preceding sound, proportional to the number of colons
– A hyphen after a word or a part of a word indicates a cut-off or self interruption
word Underlining indicates some form of stress or emphasis on the underlined item
WOrd Upper case indicates loudness
° ° The degree signs indicate the segments of talk which are markedly quiet or soft
> < The combination of "more than" and "less than" symbols indicates that the talk between them is compressed or rushed
< > In the reverse order, they indicate that a stretch of talk is markedly slowered
= Equal sign indicate no break or delay between the words thereby connected
(( )) Double parentheses enclose descriptions of conduct
(word) When all or part of an utterance is in parentheses, this indicates uncertainty on the transcriber's part
( ) Empty parentheses indicate that something is being said, but no hearing can be achieved
(1.2) Numbers in parentheses indicate silence in tenths of a second
(.) A dot in parentheses indicated a "micropause", hearable but not readily measurable; ordinarily less than 2/10 of a second
[Separate left square brackets, one above the other on two successive lines with utterances by different speakers indicates a point of overlap onset.
hh letter "h" indicates hearable aspiration
→ marks the line with focal phenomenon

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