Giving Explanations
Primary Care Interactions with Elderly Patients as Educational Sites

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Abstract

Over the past decades, primary care has been significantly affected by the rapid aging of the population. Since older adults often experience chronic conditions, multimorbidity, as well as emotional and relational distress, a good relationship with the general practitioner (GP) is considered essential for taking care of the complex bio-psycho-social needs of this vulnerable population. Drawing on a corpus of video-recorded primary care visits of elderly patients, this exploratory case study sheds light on the unnoticed yet pervasive educational work enacted by the GP. Relying on conversation analysis theoretical and analytical constructs, the analysis focuses on the discursive practice of account whereby the GP explains health-related issues to elderly patients. The detailed analysis of physician-patient interaction reveals how the GP deploys recipient-designed, multimodal resources aimed at fostering shared understanding and building a therapeutic alliance with the patient, thereby orienting to patient-centered care principles. Limitations of the study and implications for medical education are discussed.

Keywords: *account; conversation analysis; elderly patients; healthcare interaction; patient-centered care.*

1. Introduction

Over the past decades, the rapid population aging has sparked debate about the multifaceted challenges and social consequences of this demographic transformation, including its impact on healthcare (see, among others, Bloom *et al.*, 2015; Prince *et al.*, 2015; Sciubba, 2020). As older adults often experience chronic conditions, multimorbidity, as well as emotional and relational distress, a good relationship with care professionals is considered essential for taking care of the complex bio-psycho-social needs of this vulnerable population (Deluigi, 2017; Hafskjold *et al.*, 2015; Luppi, 2015). In particular, primary care constitutes a fundamental site for

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addressing such diverse care needs and ensuring comprehensive, continuous, patient-centered care (Boeckxstaens & De Graaf, 2011). As emphasized by research and policies, effective communication between the general practitioner (GP) and elderly patients is pivotal for promoting patient agency and autonomy, increasing patient satisfaction, and maximizing adherence to therapies (WHO, 2004; Williams *et al.*, 2007). However, given the epistemic asymmetries at stake in any healthcare interactions (Pilnick & Dingwall, 2011), often exacerbated by old patients' fragile health status, limited health literacy and communicative difficulties (Adelman *et al.*, 2017), fostering patients' active participation in the visit and ensuring their understanding can be a challenging goal.

Drawing on a corpus of video-recorded primary care visits of elderly patients, this exploratory case study sheds light on the unnoticed yet pervasive educational work accomplished by the GP in the unfolding of the consultation. In particular, the article focuses on the GP's practice of account (Angell & Bolden, 2015; Antaki, 1994; Garfinkel, 1967; Parry, 2009), i.e., the discursive practice whereby the physician explains, clarifies, justifies, or provides the rationale regarding health-related issues to elderly patients. Relying on conversation analysis theoretical and analytical constructs (Sidnell & Stivers, 2013), the analysis unveils how, in and through the set of recipient-designed, multimodal resources deployed (e.g., formulations from technical into lay language, the use of regional language, metaphors and similes, iconic gestures, touching, pointing, and the use of material artifacts like documents or pens), the GP displays his orientation to make accessible and intelligible the biomedical information while concurrently avoiding treating the patient as an incompetent interlocutor. In this way, the GP visibly engages in achieving shared understanding and, at the same time, building a therapeutic alliance with the patient, thereby aligning to patient-centered care principles. As the article illustrates, by the very act of giving explanations, and through the ways such explanations are shaped, the GP not only addresses the biomedical dimension of disease (to cure) but he also takes care of patients' subjectivity (to care) (Bobbo, 2012; Ranzani, 2025a; Zannini, 2023).

Insights from this study can inform video-based medical education programs for GPs working with elderly patients aimed at fostering professionals' reflexivity and awareness of the educational work accomplished in and through the details of interaction.

2. Authority and accountability in contemporary healthcare interactions

Over the last decades, the physician–patient relationship has undergone deep socio-cultural transformations. The traditionally disease-centered, paternalistic model that dominated clinical practice at least until the late 1960s (Friedson, 1970) has been increasingly challenged and progressively

supplanted by a more egalitarian, cooperative framework, commonly referred to as "patient-centered care" (hereafter, PCC; Mead & Bower, 2000). With the aim of curtailing physicians' unilateral authority and monopoly over decision-making processes, PCC acknowledges the ethical and clinical value of patients' knowledge domains and is guided by the principles of patient autonomy, self-determination, and shared decision-making (see Castro *et al.*, 2016; Epstein & Street, 2011; Pilnick, 2022).

This paradigmatic shift – driven by multiple factors including the rise of patient empowerment movements (Halpern, 2004; Timmermans & Oh, 2010), increased health literacy (Mårtensson & Hensing, 2012), yet also neoliberal economic interests (Light, 2010) – has led to significant changes in the ways healthcare practitioners and patients communicate during medical encounters.

As extensively documented by research adopting observational approaches to the study of 'naturally occurring interactions' (i.e., not elicited for research purposes), over the past 40 years or so healthcare interactions have witnessed a progressive shift from authority to accountability (Peräkylä, 1998, 2002; Stivers & Tate, 2019). On the one hand, evidence shows that patients have become more engaged (Timmermans, 2020), for instance, by offering interpretations of symptoms and candidate diagnoses (Gill *et al.*, 2001; ten Have, 2001), and by resisting clinicians' diagnostic pronouncements and treatment recommendations more often than expected (Caronia & Ranzani, 2023; Costello & Roberts, 2001; Stivers & McCabe, 2021). On the other hand, research illustrates that physicians increasingly provide accounts of their clinical assessment and therapeutic prescription, making the grounds of their reasoning explicit, available, and intelligible to patients (Angell & Bolden, 2015; Heat, 1992; Maynard, 2004; Parry, 2009; Peräkylä, 1998, 2006). As stressed by Peräkylä (1998, 2006), through accounts physicians balance their medical authority with accountability, that is they "treat themselves as accountable for the evidential basis of the diagnosis. This accountability, however, is maintained in ways that allow the doctor simultaneously to maintain authority in relation to the patient" (Peräkylä, 1998: 302). Accounting can also work as a way to treat patients as engaged and competent interlocutors, accomplishing "a sense of mutuality, understanding and agreement" (Maynard, 2004: 71), contributing to minimizing patient resistance and concurrently ratifying medical authority (Parry, 2009).

As research adopting self-report techniques has shown, providing clear and accessible medical explanations is typically considered the cornerstone of patient satisfaction, trust in the physician, participation in the visit, engagement in decision-making processes, and, ultimately, adherence to therapies (Chen *et al.*, 2017; Nakayama *et al.*, 2020). This becomes particularly crucial in visits with vulnerable patients, where the interplay of epistemic, social, communicative asymmetries can make patient involvement challenging or even unfeasible, and the risk of misunderstandings is high. This can be at stake for instance – and with all due differences – in the case of patients with intellectual disabilities (Antaki *et al.*, 2009; Chinn

& Rudall, 2019) or communicative impairments (Garcia, 2012), with non-native minor patients (Caronia *et al.*, 2020, 2022; Ranzani, 2025b), or, as in the case examined here, in primary care visits with older adults.

2.1 *Healthcare interactions with elderly patients*

Given the vulnerability of elderly patients, it is not uncommon for them to attend visits with a companion, whether a family member or a professional caregiver. It comes as no surprise that research on real-life healthcare interactions with elderly patients has focused on the crucial yet delicate role of companions during the unfolding of the visits, characterized by a tension between patient autonomy and caregivers' participation. For instance, Ekberg and colleagues (2015) analyze the involvement of family members during audiology appointments of old patients with hearing impairments in Australia. Interestingly, their study shows that companions are overall treated as unaddressed participants – rarely being invited to speak by the audiologist – yet they often self-select to contribute to the conversation. According to the authors, this format of participation "suggests that audiologists currently view the older adult with hearing impairment as the focal client in consultations, and family members' experiences may thus be inadvertently overlooked" (p. 74). These findings shed light on the potential consequences of prioritizing patient autonomous decision-making (vs. adopting a family-centered approach), which may come at the expense of patient understanding and of acknowledging the caregiver's experience and privileged knowledge of the patient. Another study conducted by Yan and Yang (2025) in Chinese outpatient visits shows a quite opposite scenario, stressing the active role played by family members, especially adult children, in steering decision-making processes. Their turn-by-turn analysis of triadic interactions unveils that the high deontic status of companions during treatment discussion is interactionally co-constructed to the detriment of patient autonomy in decision-making. Reflecting on the manifold possible reasons for such a format of participation, the authors discuss the risks of overemphasizing the role of cultural factors (i.e., Chinese familial values and relational autonomy as a guiding principle in Chinese medical care) while concurrently overlooking elderly patients' agency.

Beyond triadic interactions involving patients' companions, the analysis of dyadic exchanges between doctors and elderly patient received relatively less attention. For instance, Coupland and Coupland (1998) illuminate the identity work pertaining ageing and age-related health issues accomplished by participants in UK medical visits; Ekberg *et al.* (2014) investigate how audiologists (poorly) address patients' psychosocial concerns regarding hearing impairments in Australian audiology appointments, while a subsequent study (Ekberg *et al.*, 2017) highlights the interactional delicacy and challenges of talking about hearing aid costs.

Nevertheless, despite their relevance in this context, physician's accounts received – at least to my knowledge – little attention in previous research. One exception is the study by Beck Nielsen (2009) on Danish geriatric case conferences, which discusses the delicacy and functions of accounts provided by professionals on the patients' behalf, that is "when someone [the doctor] explains what another person [the elderly patient] has just said" (p. 231). However, a detailed analysis of how doctors provide accounts of their own talk remains underexplored. This article addresses this gap.

3. Data and methodology

This exploratory single case study draws on a corpus of 4 video-recorded primary care follow-up visits totaling 135,78 minutes. Data were collected in a public hospital in the Italian speaking part of Switzerland (i.e., Canton Ticino). The participants involved are a General Practitioner (GP), five elderly patients[1] (aged 73-92), and two companions present in two visits out of four (specifically, the patients' son). Written informed consent was obtained by all participants in compliance with EU Regulation n. 2016/679 (GDPR, 2016/679) prior to the video recordings. Ethical approval was granted by the Bioethics Committee of the University of Bologna.

The video recordings were transcribed adopting the transcription conventions developed by Gail Jefferson (2004). In line with the multimodal approach to social interaction (Goodwin, 2000; Mondada, 2007), transcriptions have been enriched with notations for gaze direction, gestures, and body orientations when ostensibly relevant for the participants in the unfolding of the interaction. Data were analyzed using conversation analysis (CA) theoretical and analytical tools (Sidnell & Stivers, 2013), which are extensively used in the study of healthcare interactions (for a recent review, see Parry & Barnes, 2024). Focusing on naturally occurring interactions, CA scholars analyze the tiniest detail of conversations to grasp not only the referential content of talk (i.e., *what* is said) but also the design of the turns at talk (i.e., *how* it is said) and their sequential position (i.e., *when* it is said), which are assumed to make a difference in the ongoingly and jointly produced sense-making.

Original conversations in the local language of Canton Ticino have been almost literally translated in Italian and English. For ensuring anonymity, all names have been fictionalized.

3.1. *Analytical procedures*

After repeated and rigorous scrutiny of the data, a total of 53 instances of physician's accounts have been identified in the dataset. Drawing on

1 While the corpus comprises four video-recorded visits, it includes five patients, since one consultation involved a married couple, both of whom were patients and were seen together during the same consultation.

previous literature (see among others Angell & Bolden, 2015; Antaki, 1994; Garfinkel, 1967; Heritage, 1984; Parry, 2009) and using a "loose" operational definition, I considered "account" the discursive practice accomplished through a set of multimodal resources whereby the physician explains, clarifies, justifies or provides the rationale regarding health-related issues to elderly patients (e.g., diagnostic tests procedures and goals, aims and side effects of medications, or the rationale of lifestyle advice and vaccinations).

Instances of doctors' accounts have been singled out and distinguished according to their sequential position (see Antaki, 1994): unsolicited accounts (i.e., volunteered by the GP in first position, N = 41) and solicited accounts (i.e., delivered in second position following the patient's explicit or implicit request[2], N = 12). As for the turn design, different multimodal resources are mobilized by the GP, including formulations from technical into lay language, the use of local language, metaphors and similes, iconic gestures, pointing, touching, and the use of material artifacts like documents or pens.

The reason for choosing accounts as the unit of analysis is twofold. First, it rests on empirical considerations: from the repeated scrutiny of the data, accounts emerged as a particularly recurrent discursive practice (N = 53), to which the GP devotes time and care. Along with data-driven reasons, theory-driven considerations also play a significant role. As mentioned above (see section 2), accounts are increasingly frequent in contemporary medical contexts, and their analysis can unveil whether and how professionals navigate the challenge of achieving mutual understanding and promoting patient agency, thereby pursuing (or not) a therapeutic alliance with the patient and orienting (or not) to PCC. For these reasons, and as the next section empirically shows, accounts constitute a perspicuous discursive environment for investigating the educational density of healthcare professionals' everyday working practices.

4. Results: giving explanations as an educational activity

This section presents the preliminary results on the GP's accounts in primary care interactions with elderly patients. Specifically, focusing on dyadic sequences between the GP and the patient (less explored in prior literature, see section 2.1), the analysis addresses cases in which, through accounts, the

2 As literature on real-life interactions has long established, making a request is not only done explicitly via interrogative forms but is can also be accomplished in implicit, indirect ways, such as through declaratively formatted reports (Gill *et al.*, 2001). Future research is needed to systematically investigate which social actions occasion the GP's solicited accounts in this corpus.

GP provides patients with *explanations*[3] concerning their health. By the very act of giving explanations, and through the rich set of multimodal resources mobilized, the GP engages – possibly beyond his own awareness – in an educational activity (Friberg *et al.*, 2007; Zannini, 2023).

Ex. 1 – "The explanation as you say comes from the Aspirin" (2.04 – 3.00)

D: general practitioner
P: patient (woman, 92 years old)

We join the conversation at the beginning of the visit, when the GP is summarizing the patient's treatment plan and discussing with her the appropriateness of the current medications.

1 D dopo ^(.) l'ha gà u:l ul ^^aspirina car^^^dio,
dopo lei ha la l' aspirina cardio
then ^(.) you have the: the ^^cardio aspi^^^rin,

2 D ^*((looking and pointing at the document on his legs))*

3 D ^^*((turning to P))*

4 P ^^^*((nodding))*

5 P [certo]
certo
[sure] *((visibly rolling up her sweater right sleeve))*

6 D [ca l'è ^la] medesina di- per ul:
che è la medicina di per la
[that is ^the] medicine of- for the:

7 D ^*((touching his own chest near the heart and making a slight upward and downward "flow" movement))*

8 D par la circolazion e il cor,
per la circolazione e il cuore
for the blood circulation and the heart,

9 *((P stops rolling up the sweater sleeve and shows a bruise on her right arm; D is looking at the documents))*

10 D dop- ^ah ecco. la ma fa vedé ^^un ematoma=
dop- ah ecco lei mi fa vedere un ematoma
the- ^oh there. you are showing me a ^^hematoma=

11 D ^*((looking at P's bruise))*

12 D ^^*((looking and touching P's bruise))*

3 As stressed by Heritage (1984), accountability has a "double edged character" (p. 182): in a nutshell, on the one hand, it refers to how interlocutors make their social actions intelligible and recognizable to others (Garfinkel, 1967), while, on the other hand, it refers to how interlocutors justify their actions at the emergence of a breach in the routinary course of actions, that is to manage a problematic situation (Buttny, 1993). In this article, the latter dimension of accountability (i.e., justification) is not addressed.

13 P =sì=
sì
=yes=

14 D =ca l'ha gà.
che lei ha
=that you have. *((P keeps looking and touching P's bruise))*

15 P l'ho picà l'ho picà cuntra la porta de la docia.
l'ho picchiato l'ho picchiato contro la porta della doccia
I've hit it I've hit it against the shower door.

16 D ho capì.
ho capito
I see.

17 *((15 sec. not transcribed. D asks whether this kind of hematoma appears often, P replies it occurs when she bumps hard into something))*

18 D la spiegazion cuma la dis le ^al vegn da l'Aspirina
la spiegazione come dice lei viene dall'aspirina
the explanation as you say ^comes from the Aspirin

19 *^((touching P's hand))*

20 D quindi l'è una bona roba, al vor dì che l'ha capì ben
quindi è una cosa buona, vuol dire che ha capito bene
so it's a good thing, it means you understood correctly
((touching P's arm))

21 P sì [sì sì.
sì sì sì
yes [yes yes. *((nodding))*

22 D [^perché la sa to e a cusa la ^^serviss=
perchè si prende e a cosa serve
[^why you take it and for which ^^purpose=

23 D *^((smiling and looking at the accompanying son))*

24 D *^^((looking back at P))*

25 P =sì sì esatt.
sì sì esatto.
=yes yes exactly.

26 D quindi la vegn da l'Aspirina però ^anca dal fatto che
quindi viene dall'aspirina però anche dal fatto che
so it comes from the Aspirin but ^also from the fact that

27 D *^((looking at P and touching her arm))*

28 D passando gli an la pel la vegn [pusé
passando gli anni la pelle diventa più
as years pass by the skin becomes [more
((looking at P and pinching softly her skin))

29 P [pusé fina
più fine
[thinner

30 D pusé fina=
più fine
thinner= *((looking at P))*

31 P =eh eh.
eh eh
=yeah yeah. *((nodding))*

32 D e quindi l'è meno elastica [e la sa proteg meno
e quindi è meno elastica e si protegge meno
and therefore it is less elastic [and it protects itself less
((looking at P))

33 P [ecco.
ecco
[right. *((nodding))*

34 D quando la cata i culp a vegn fora subit un blu
quando prende i colpi viene fuori subito un livido
when you hit something a bruise appears immediately
((looking at P))

35 P eh sì sì.
eh sì sì
oh yeah yeah. *((nodding))*

At the beginning of the excerpt, D is reading on P's medical records the list of medications she is currently taking (see D's gaze direction and pointing gesture toward the paper file, line 2), more specifically the cardio aspirin (line 1). In overlapping with P's confirmation ("sure", line 5), D provides an unsolicited account whereby he makes explicit the therapeutical aims of this drug: it serves for the circulation and the hearth functioning (lines 6-8). In doing so, he carries out a particularly sophisticated multimodal work. First, he shifts from a technical jargon ("cardio aspirin", line 1) into lay, accessible terms ("circulation, hearth", line 8), thereby facilitating P's understanding and establishing a common ground. Furthermore, note that while starting such explanation trajectory, D touches his own chest in proximity to the hearth making an upward and downward "flow" movement (line 7). Through this iconic gesture, he anticipates the referential content of talk proffered immediately after, i.e., the circulation and the hearth (line 8). Together with the use of the local dialect, this multimodal behavior appears to facilitate P's understanding and participation in the visit. As the following turn illustrates (line 9), P seems to demonstrate her comprehension of D's account: by rolling up the right sleeve of her sweater and showing a bruise on her arm, she a) implicitly conveys that she is knowledgeable about the cardio aspirin's possible side effects and b) makes it sequentially relevant for the physician to inspect it. Upon noticing the bruise (line 10), D makes a metalinguistic formulation ("oh there. you are showing me a hematoma", lines 10 and 14) and closely observes P's arm by also touching it (lines 12 and 14; on the forms and functions of touch in medical interactions see, among others, Drewery, 2022; Ma *et al.*, 2023; Simone *et al.*, 2024). After P's volunteered clarification of the cause of the bruise ("I've hit it against the shower door", line 15), D displays his understanding ("I see", line 16) and further investigates on the frequency of the presence of such hematoma (not transcribed). Interestingly, right after this exchange, D accomplishes another account whereby he explains that the cardio aspirin is the cause of such bruises: "the explanation as you say comes from the aspirin" (line 18). Through this solicited account, D does different things with words (Austin, 1962). First, by making verbally explicit the causal relationship between P's bruise and the cardio aspirin just implicitly inferable through P's bodily behavior (line 9), D clarifies and confirms the interpretation conveyed by P. Second, by the very act of recognizing P's authoriality ("as you say", line 18), D emphasizes P's knowledgeability and agency, constructing her as a competent interlocutor. Furthermore, note that by delicately touching P's hand (line 19), he appears oriented to display a recipient-design, compassionate form of care (Durkin *et al.*, 2021; Routasalo, 1999). This orientation is also visible in the following turns, where D praises P for her correct understanding of the aims and functions of the cardio aspirin ("so it's a good thing, it means you understood correctly", "why you take it and for which purpose", lines 20 and 22; note again the use of touch, line 20). After P's confirmation ("yes yes exactly.", line 25), and despite the sequence can be considered techni-

cally closed (see also the downward intonation of P's confirmation, line 25), D expands his explanatory trajectory: without any request from the patient's part, he first elliptically reasserts the aspirin as the cause of the bruise, and then introduces another possible explanation, i.e., as the years go by, the skin becomes thinner and less elastic, and the chances of getting bruises when hitting something increase (lines 26-34). Like the previously delivered accounts, also in this case D carries out a particularly sophisticated multimodal work. By touching P's arm (line 27), pinching softly her skin (line 28), and constantly looking at P (lines 26-28, 30, 32, and 34), D treats P as the ratified interlocutor (Goffman, 1981) and appears to enact compassionate care. Importantly, the use of explanatory connectives ("so", line 26; "therefore", line 32), explicitly frame this sequence as "doing account" and treats the bruise made relevant by P as an accountable matter. In doing so, he not only validates P's contribution as worthy of explanation but also treats it as appropriate and competent. Furthermore, the consistent use of Canton Ticino regional language together with the mobilization of everyday, lay language (see for instance the formulation from "hematoma", line 10, into "*blu*", "bruise", line 34; lexical choices such as "elastic", "it protects itself less", line 32, "hit something", line 34) can be hearable as further promoting patient's understanding. In a few words, in and through the multimodal resources mobilized by D to explain the cardio aspirin aims and scope first (lines 6 – 8) and the hematoma etiology then (lines 18 – 34), D visibly displays his orientation toward fostering P's engagement in the visit and achieving shared understanding, without undermining P's face (Goffman, 1955). Arguably, P's overlapping completion of D's turn ("thinner", line 29) and her acknowledgment tokens and nodding (lines 31, 33 and 35) concur to display not only that a mutual understanding has been accomplished but also P's agency.

The next excerpt shows another example of account whereby the GP explains the rationale of a diagnostic test and the anatomy of the esophagus.

Ex. 2 – "The esophagus is like a tube" (1.22 – 2.16)

D: general practitioner
P: patient (woman, 73 years old)

We are the opening of the visit. Just before the beginning of the excerpt, the patient reported to the physician that another doctor prescribed her a diagnostic test, the Esophageal Transit Study. However, she also stressed that she had received no explanation regarding the aims and procedures of this test from the other doctor, and asked the co-present physician to provide further details, displaying some resistance to undergoing it ("he didn't explain it to me but I was a bit adverse. Apart that now I'm feeling a bit better and I didn't want to do it and I wanted to hear from you what you say"). This prompted a solicited account from the GP whereby he

explained that the patient's throat problems may be due to the reflux, and this test serves to check this hypothesis.

1 D probabilment al vor vedé ^cuma l'è ca sa sposta ul-
probabilmente vuole vedere come si sposta il
probably he wants to see ^how it moves the-
2 D ^*((looking at P and making a hand movement from the mouth to the chest))*
3 D quel che la manda giù ^come si sposta dentro nell'esofago
quello che manda giù come si sposta dentro nell'esofago
what you swallow ^how it moves into the esophagus
4 D ^*((looking at P and repeating the hand movement from the mouth to the chest))*
5 D quando ariva giò fina fina al'isto[mic.
quando arriva giù fino fino allo stomaco
when it goes down as far as the [stomach.
6 M [mh.
[mh. *((looking downward))*
7 D questo l'è important perché eh
questo è importante perché eh
this is important because well
8 D l'esofago l'è fai come ^un tubu [(in sé)]
l'esofago è fatto come un tubo in sé
the esophagus is like ^a tube [(per sé)]
9 D ^*((looking at P and mimicking a tube shape with his hands))*
10 P [mh mh]
[mh mh]
11 D e ehm ^tucares movas un po' tipo una bisa
e ehm dovrebbe muoversi un po' come una biscia
and mh ^it should move a bit like a grass snake
12 D ^*((squeezing his hands))*
13 D nal senso che ^us contrae in modo regolare
nel senso che si contrae in modo regolare
meaning that ^it contracts in a regular way
14 D ^*((squeezing his right hand))*
15 D in modo che ^li sping in giò ul contenuto
in modo che spinge in giù il contenuto
so that it ^pushes the content down
16 D ^*((makes a movement with his right hand from up to down))*
17 D però a capita cul e:- (.) per carità ^l'è mia l'è mia vegia
però capita con e per carità non è mica non è mica vecchia
but it happens with eh:-(.)I mean ^you're not you're not old
^*((smiling))*

18	D	ma cul pasà di an ma con il passare degli anni **but as the years go by** *((smiling))*
19	P	no ahah a go pù gnanca vint'an no ahah non ho neanche più vent'anni **no ahah I'm not twenty anymore** *((laughing))*
20	D	eh. cul pasà di an a capita ogni tant che ul- eh con il passare degli anni capita ogni tanto che il- **yeah. as the years go by sometimes it happens that the-**
21	D	ul- i ^contrazion dell'esofag a i diventan irregular il le contrazioni dell'esofago diventano irregolari **the- the ^contractions of the esophagus become irregular**
22	D	^*((squeezing repeatedly his right hand))*
23	P	mh. **mh.**
24	D	e quindi al post che ^permet a quel che sa manda giò e quindi al posto di permettere a quello che si manda giù **and so rather than ^allowing to what you swallow**
25	D	^*((moves his hand up and down))*
26	D	da pasà nurmalmente il a blocan opur i a respingen indré di passare normalmente lo bloccano oppure lo rispingono indietro **to pass through normally they block it or they push it back**
27	P	mh mh. **mh mh.**
28	D	e quel esam as servis par quell e quell'esame serve per quello **and that test serves that purpose**
29	D	par capì cuma l'è che sa mov ul cibo dentro l'esofago per capire come si muove il cibo dentro l'esofago **to understand how the food moves inside the esophagus**
30	D	sa l'è un transito. questo è un transito. **this is a transit.**
31	P	mh mh. **mh mh.**

The excerpt starts with D's explanation of the absent doctor's prescription of the Esophageal Transit Study (lines 1-5). Through this solicited account, which follows P's explicit request for clarification (not transcribed), D explains the medical purpose of this diagnostic test, that is checking the movement of the food in the esophagus to the stomach. While issuing this account, D seems unequivocally oriented to facilitate P's understanding and promote her participation in the visit: the consistent use of the local dialect along with everyday jargon ("how it moves", lines 1 and 2, "what you swallow", line 2, "when it goes down", line 5), the repeated iconic

gesture visually representing the movement of the food inside the esophagus to the stomach (lines 2 and 4), and the gaze direction toward P (lines 2 and 4) concur to make more accessible the biomedical content of D's talk, thereby promoting P's comprehension and participation. As the following turn shows, P's minimal acknowledgment ("mh.", line 6) produced in partial overlapping with the end of D's turn suggests P's understanding, or at least it signals her attentiveness.

However, even though the sequence can be considered technically finished, D keeps the turn at talk and accomplishes another long account sequence: he starts explaining the relevance of this diagnostic test and the anatomy of the esophagus (lines 7-30). Considering its sequential position, this expansion may be due to the patient's previously communicated skepticism toward taking the test (not transcribed), which is also arguably visible in the multimodal behavior accomplished in line 6 (i.e., while uttering the minimal token "mh", she is looking downward). In terms of its design, this explanatory trajectory is particularly elaborate and resorts to different multimodal resources. First, it is prefaced by an explicit reference to the relevance of this test ("this is important because", line 7), which, on the one hand, alerts P to pay attention, and on the other, can be heard as a persuasive strategy (Huma *et al.*, 2020) aimed at minimizing patient's resistance (Maynard, 2004; Stivers & Timmermans, 2020). After that, D starts explaining the anatomy of the esophagus (lines 8, 9, 11-15). In doing so, he mobilizes twice the rhetorical device of the similes: first, he compares the shape of the esophagus to a tube (line 8) and multimodally accompanies this simile with an iconic gesture aimed at visually representing it (line 9). Then, after P's acknowledgement tokens showing understanding ("mh mh", line 10), he compares the movement of the esophagus to that of a grass snake (line 11) and squeezes repeatedly his hands in correspondence of this rhetorical device (line 12). This entanglement of 'verbal' and 'non verbal' resources (see also the use of the local dialect, the use of everyday language and the gaze direction toward P) seems clearly oriented to make the content of this medically relevant account more accessible to P and therefore facilitates her understanding and participation in the visit, without compromising P's face. However, the account trajectory has not yet finished. Using an explanatory connective ("*nel senso che*", in Italian, "meaning that", line 13), D now makes explicit the rationale of his simile: like a grass snake, the esophagus contracts regularly to push the food down (lines 13-16). Again, the use of the local dialect, the lay register, and the iconic gesture that visually represents the downward movement of the food inside the esophagus (line 16) further contribute to making it easier for P to grasp the meaning of D's talk. At this point, D's explanation continues by narrowing the general description of the esophagus to the idiosyncratic, age-specific situation of the patient: as years pass by[4], the

4 Note that D's self-interruption (line 17), smiles (line 17 and 18), mitigations (lines 17 and 20), and P's joke and laughing (line 20) contribute to interactionally frame the

contractions may become irregular and push the food backwards (lines 17-26). This expansion is enriched with multimodal elements that further display D's orientation toward facilitating P's understanding, i.e., the iconic gestures that visually represent the core semantic content of D's talk (lines 22 and 25), the use of everyday jargon (line 21, 24, 26), and the use of explanatory connectives (line 24). This extended account sequence closes with a synthetized explanation of the rationale of the Esophageus Transit Study, whereby D de facto goes back and provides a definite answer to the former request of explanation solicited by P ("that test serves that purpose to understand how the food moves inside the esophagus this is a transit", lines 28-30). Note that through the acknowledgment tokens provided by P (lines 23, 27 and 31), a common ground seems to be established.

5. Discussion and conclusion

This exploratory single case study has illustrated the rich set of multimodal resources whereby a GP provides accounts to elderly patients in primary care, shedding light on the pervasive educational work enacted by the healthcare practitioner – possibly beyond his own awareness – during everyday professional practice (Bobbo, 2012; Ranzani, 2025a; Zannini, 2023).

Results show that, in this dataset, (a) accounts constitute a frequently accomplished discursive practice (N = 53); (b) unsolicited accounts (N = 41) are more frequent than solicited (N = 12); and (c) the GP deploys recipient-designed multimodal resources which appear oriented to making accessible and intelligible the biomedical content of the information while concurrently avoiding treating the patient as an incompetent interlocutor. In doing so, the healthcare practitioner engages in non-formal teaching activities (Friberg *et al.*, 2007; Zannini, 2023) and displays his orientation to PCC principles (Mead & Bower, 2000; Pilnick, 2022).

Regardless of the GP's possible individual inclination or other endogenous and exogenous factors that may play a role in accomplishing patient-centered practices (e.g., the structural organization of the visit or socio-demographic characteristics), the frequency of accounts in this dataset is in line with prior research on healthcare interactions (Angell & Bolden, 2015; Parry, 2009; Peräkylä, 1998, 2006) and primarily suggests that the GP treats health-related issues as *accountable* matters, i.e., something that needs to be explained and made intelligible by the patient. While further investigation is needed to determine whether solicited and unsolicited accounts differ in forms and functions and whether their accomplishment changes depending on the different phases of the visit, the greater frequen-

topic of age as a delicate matter (on delicacy and trouble telling in dialogic interactions see, among others, Jefferson, 1988; 2015; on age-identity discourse in geriatric care, see Coupland & Coupland, 1998).

cy of unsolicited accounts may be seen as a visible consequence of the socio-cultural transformation in doctor-patient communication documented in previous literature, where accountability practices are increasingly embedded in the culture of care of physicians' everyday work (e.g., Peräkylä, 1998, 2006; Stivers & Timmermans, 2020). As discussed below, this does not imply that medical authority has faded away.

Furthermore, giving an account in first or second position is not equivalent and carries different implications for the patient's face (Goffman, 1955). In particular, unsolicited accounts de facto position the interlocutor as someone in need of explanations, thereby risking portraying them as less knowledgeable or even incompetent. However, through the ways accounts are designed in this dataset, the GP seems to minimize this face-threatening risk. The turn-by-turn, detailed analysis of the excerpts has illustrated that the GP is observably engaged in ensuring understanding and fostering patients' agency, avoiding treating them as incompetent or not self-sufficient individuals. This complex, educational work is done through a set of multimodal, recipient-designed resources, like explicitly acknowledging patients' knowledge (Ex. 1), using the patients' local language, which is typically spoken primarily by elderly (Ex. 1 and Ex. 2), praising the patient (Ex. 1), shifting from technical to lay language (Ex. 1), touching the patient as a form of compassionate care (Ex. 1), making iconic gestures that visually represent the core meaning of the utterance (Ex. 1 and Ex. 2), looking directly at the patient (Ex. 1 and Ex. 2) – even in the first excerpt where the accompanying son is present –, and using similes to make more familiar the anatomy and functioning of the esophagus while, presumably, persuade the skeptical patient (Ex. 2). Patients' acknowledgment tokens, nodding, and partial completion of the doctor's talk suggest that the GP's interactional work is effective, at least locally, in ensuring patients' understanding and concurrently promoting their agency. Although oriented to PCC principles, the multimodally accomplished accounts are also functional to ratifying GP's medical authority: by the very act of making an explanation, the GP embodies a more knowledgeable position and patrols his domain of expertise.

5.1 *Limitations and practical implications*

As with any qualitative, exploratory single case study, the results presented in this article are limited to the specific context under investigation and are therefore not generalizable. In addition to the small sample size, the sampling bias typical of any ethnographic-informed research is also at play: since this is a convenience sample statistically non-representative, the researcher gains access only to the "lifeworld" of those who choose to participate in the study and consent to be video-recorded, who are arguably positively selected. Even though the phenomena observed may not be "typical" or "recurrent", the forms of communication identified and analyzed in this article are characterized by high ecological validity (Pal-

lotti, 2001) and are particularly valuable for medical education purposes: once identified and made visible through analysis, they can be formalized, taught, and transferred in other contexts, going beyond the specificity of the single case. Designing medical education training programs grounded on video recordings and transcripts of real-life medical visits represents a heuristically powerful opportunity for healthcare providers to foster professionals' reflexivity (Mortari, 2003; Schön, 1983) and awareness of the invisible yet pervasive educational work enacted in and through interaction.

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