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"I Comply with the Recommendations": The Interactional Construction of 'Good Parenting' in Pediatrician-Parent Conversations

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Abstract
The paper sheds light on the invisible pedagogical dimension of pediatrician-parent interactions. It does so by adopting a Conversation Analysis-informed approach to a corpus of 23 video-recorded well-child visits involving two pediatricians and twenty-two families with children aged 0 to 18 months. In particular, the analysis focuses on how a mother seeks the pediatrician's advice on everyday baby care issues. The single-case analysis is illustrative of how parents in this corpus, when seeking advice, perform themselves as "good" parents: competent and knowledgeable on caring practices, concerned by their children's well-being, and concurrently sensitive to the ultimate epistemic and deontic authority of the pediatricians.

Keywords: pediatric visits, parenting, advice seeking, implicit pedagogy, Conversation Analysis.

Abstract
Il contributo porta alla luce l'invisibile dimensione pedagogica dell'interazione pediatra-genitore. L'approccio dell'Analisi della Conversazione viene applicato a un *corpus* di 23 visite di controllo crescita videoregistrate che coinvolgono due pediatri e twenty-two famiglie con figli tra gli 0 e i 18 mesi. Lo studio di caso si concentra sulla richiesta di consiglio di una madre al pediatra riguardo alla gestione quotidiana della sua bambina. L'estratto illustra in modo perspicuo come, durante le richieste di consiglio, i genitori coinvolti nello studio si "inscenano" come "buoni" genitori: competenti e informati sulle pratiche di cura, preoccupati del benessere del/la proprio/a figlio/a, e, contemporaneamente, attenti all'autorità epistemica e deontica del pediatra.

Parole chiave: visite pediatriche, genitorialità, richiesta di consiglio, educazione tacita, Analisi della Conversazione.

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Introduction

This contribution aims at shedding light on the invisible – and often neglected – *pedagogical* dimension of pediatrician-parent interactions occurring during a specific kind of pediatric visit: namely, well-child visits[2]. These are regular check-ups where the pediatrician evaluates the child's physical growth and socio-cognitive development according to the expected standard and provides parents with information concerning illness prevention, nutrition, and health and safety issues. Well-child visits therefore constitute a crucial site for monitoring and promoting babies' developmental milestones during the well-known critical "first thousand days of life".

The relevance of studying well-child visits from a pedagogical perspective is twofold. First, pediatricians are among the first professionals (together with early childhood educators) working at the transition between families' private «small cultures» (Holliday, 1999, *passim*) and larger sociocultural models and expectations of competent parenting practices and children's upbringing (see Caronia, Ranzani, 2022, 2023). Second, the pedagogical dimension of pediatricians' everyday (communicative) practices received little attention in both international and national literature (but see Caronia, Ranzani, 2022, 2023).

This paper aims to fill this gap by focusing on the interactional construction of "good parenting" in well-child visits. In particular, the single-case analysis of how a mother requests the pediatrician's advice about everyday baby management issues is illustrative of how parents in this corpus display their previous knowledge and competence about the topics submitted to the pediatrician's attention and, at the same time, acknowledge the pediatrician's expertise and professional role. In this way, when engaging in this discursive activity (i.e., seeking advice), parents display themselves as competent, knowledgeable, caring, and therefore "good parents".

In line with the phenomenological perspective that recognizes the crucial role of communicative practices for the collaborative constitution of local and social identities (Aronsson, 1998; Caronia, 2011; Raymond, Heritage, 2006; Zimmerman, 1998), the contribution focuses on the practices deployed by a mother to display *her* understanding of what

[2] *"Well-child visit" is the term used by the American Academy of Pediatrics. In Italy, they are known as* "visite di controllo-crescita" *or* "bilanci di salute"*; they are typically carried out by general pediatricians at pediatric primary care clinics*, Author's Note.

constitutes a "good" parent (for a similar approach, see among others Caronia, 2019; Galatolo, Caronia, 2018; Heritage, Lindström, 1998; Pillet-Shore, 2015). In other words, the analysis illustrates how parents implement and demonstrate their orientation to culturally-informed models of «doing being» (Sacks, 1984, p. 416) "good" parents.

1. *Epistemic and deontic gaps in doctor-patient interactions*

In the last decades, healthcare professions faced a progressive erosion of their epistemic and deontic authority (respectively, who has the ultimate right to know what, see Heritage, 2012a, 2012b; and who has the ultimate right to decide what about what, see Stevanovic, 2013; Stevanovic, Perakyla, 2012).

Several studies have shown how practices of accountability, i.e., the physician's need to justify his/her diagnostic reasoning and treatment prescriptions, have been gradually substituting the more authoritative "plain assertion" format (Peräkylä, 1998) that historically characterized the "voice of medicine" (Mishler, 1984). Concurrently, many studies have illustrated the pivotal role played by patients' contribution in shaping not only the local unfolding of the visit but even its outcomes (e.g., Gill *et al.*, 2010; Koenig, 2011; Stivers, 2007; Stivers, McCabe, 2021). This is particularly evident in pediatric visits, where parents increasingly display themselves both as competent and knowledgeable subjects (Hanell, 2017) – sometimes even challenging the pediatrician's diagnosis and prescriptions (Stivers, 2005, 2007) – as well as «surrogate decision makers» (Stivers, Timmermans, 2020, p. 63) for their children[3].

However, if the so-called patient's (and parent's) empowerment turn – together with other factors – has curtailed physicians' authority (Halpern, 2004), recent studies investigating actual naturally occurring conversations in medical contexts revealed that epistemic and deontic

[3] This (relatively) new involvement of parents in decision-making processes regarding their children's treatment plans can be considered as one possible consequence of broader sociocultural and historical changes investing contemporary western upper-middle-class families (see for instance the notion of «intensive parenting», Faircloth, 2014, *passim*, or «involved parenthood», Gigli, 2016, *passim*, my translation), where being a parent is more and more considered a life "project" and a "function" to exercise (Formenti, 2008; Gigli, 2016). *From now on, unless otherwise specified, footnotes are edited by this paper's Author*, Editor's Note.

imbalances between doctors and patients – to a certain extent inevitably – still persist (Pilnick, Dingwall, 2011; Stivers, Timmermans, 2020). Despite sharing the same macro-goal (i.e., taking care of the patient's health), doctors and patients experience an asymmetrical relationship mostly due to the differential distribution of relevant knowledge (i.e., biomedical vs. experiential knowledge) and to the social stratification of the participants' roles, namely the institutional role of the physician vs. the lay status of the patient. Correspondingly, they retain different control over the deontic domain: if doctors have the "power" and responsibility to prescribe treatments grounded on their expertise, patients (and/or caregivers) have control over compliance with doctors' recommendations.

This different distribution of epistemic and deontic rights impacts not only the outcomes of the visit, but also the (discursive) activities accomplished during the visit, such as asking, giving, and receiving advice.

1.1. *The epistemic and deontic asymmetries of advice: The case of well-child visits*

Epistemic considerations play a crucial part in framing the request, the delivery, and the reception of advice. A socially shared assumption underlying medical visits is that the physician can offer advice on medical and health-related problems relying on his/her expert knowledge, which is allegedly out of the realm of the patient. This assumption entails that – when engaging in sequences of advice – participants concurrently position themselves along an epistemic gradient (Heritage, Raymond, 2005); while the advice-giver physician saturates the more knowledgeable position ("K+", Heritage, 2012a, 2012b), the advice recipient and/or seeker patient assumes the relative less knowledgeable position ("K-", *Ibidem*). Advice sequences in medical interactions are also strictly related to deontic rights. Since advice-giving consists in «forwarding or promoting a possible future course of action» (Pilnick, 2003, p. 837) among alternatives, it gives the recipient room to choose and decide what to do. However, since it is provided by a doctor, the expert's advice acquires a normative connotation that prevents the recipient from easily ignoring or contesting it (but on parents' resistance to the pediatrician's advice see Caronia, Ranzani, 2023). For the above-mentioned reasons, scholars describe advice-giving, receiving, and seeking as delicate and face-threatening social actions (Heritage, Sefi, 1992; Heritage, Lindström,

1998, 2012; Shaw, Hepburn, 2013). As Fatigante and Bafaro put it, the physician's expertise-based authority «needs to be balanced with, on one hand, the entitlement s/he can claim in offering the advice and, on the other, the extent to which that advice impinges upon the freedom of the advice-recipient» (2014, p. 159).

Epistemic and deontic imbalances at stake in doctor-patient sequences of advice are even more evident in pediatric visits, where the management of knowledge asymmetries strictly intertwines with morally laden implications (Heritage, Sefi, 1992; Heritage, Lindström, 1998, 2012; Silverman, 1987; Stivers, 2007). Indeed, while receiving unsolicited advice clearly constructs the parent as "the one who does not know", asking for advice is not less morally implicative: it reveals a relative lack of knowledge or a certain degree of uncertainty regarding the more appropriate course of action to be undertaken. At the same time, as I contend, asking for advice displays parents' concern for their child's well-being, awareness of their possible incompetence, and sensitiveness to the pediatrician's epistemic and deontic authority on the matter.

2. *Data, methodology, and analytical procedures*

The study draws from a dataset of 23 video-recorded well-child visits involving two pediatricians and twenty-two families with children aged between 0 and 18 months. Participants written consent was obtained according to EU Regulation n. 2016/679 (GDPR 2016/679) and Italian law n. 196/2003[4], which regulate the use of personal and sensitive data. For anonymity purpose, pseudonyms substitute any use of participants' name or other identifying information.

Data were transcribed and analyzed adopting a Conversation Analysis approach (Jefferson, 2004; Sacks *et al.*, 1974; Sidnell, Stivers, 2013), which is broadly used for the study of naturally occurring interactions in healthcare contexts (Barnes, 2019; Heritage, Maynard, 2006) and has proven to be well-suited for providing empirical basis for the design and implementation of medical and patient education interventions (see Antaki, 2011, 2013; Pino, Parry, 2019; Robinson, Heritage, 2014). Transcripts are presented in two lines: the original Italian transcript is followed by an almost literal translation in American English.

[4] *For full details on the abovementioned laws, see* References, Editor's Note.

Advice seeking. To identify sequences of advice in the corpus (see also Caronia, Ranzani, 2022, 2023), I adopted Heritage and Sefi's (1992) definition, i.e., the interactional practice through which the professional confirms, «describes, recommends or *otherwise forwards* a preferred course of future action» (p. 368, my emphasis) to the client. After identifying the instances of pediatricians' advice giving (N=145), I distinguished between advice delivered by the pediatrician *without any request* by the parents (N=67) and advice *requested* by the parents (N=78), on which this paper focuses.

For reasons of space, in the next section I analyze a «single fragment of talk» (Schegloff, 1987, p. 101) where a mother seeks the pediatrician's advice on a feeding practice. Even though parents in this corpus design their requests for advice in different ways (e.g., by asking to confirm a proposed future course of action or an already undertaken course of action, by reporting a treated as problematic conduct or the intention to undertake a certain future course of action), the excerpt chosen for analysis is illustrative of a recurrent phenomenon in this corpus: when seeking advice, parents interactionally construct themselves as "good" parents.

3. *Analysis: The interactional construction of the "good" parent*

The following example shows how, despite downgrading her right to "know and decide" by the very act of seeking the pediatrician's advice, a mother stages herself as a competent, knowledgeable, and caring parent.

Ex.1 - VA_5_11.11.19 (7.12 – 8.06)
P=pediatrician; M=mother

1	M	io (.) ho preso **I (.) have taken**
2	M	senza la sua:: (.) autorizzazione= **without you::r (.) authorization=**
3	M	=ma (.) >ho guardato le dat-< **=but (.) >I've looked at the dat<**

4	M	l'Aptamil tre **the Aptamil three**[5]
5	M	perché [ormai siam] vecchi **because [by now we are] old**
6	P	[^si:::,] **[^ye:::s,]** ^*((looking at M))*
7	M	ve[ro?] **ri[ght?]**
8	P	[ce]rto,= **[su]re,=**
9	M	**=>mh<.** *((nodding))*
10	M	devo ancora iniziare **I still have to start**
11	M	però [ho preso il tre]. **but [I've taken the three].**
12	P	[eh lei (.) l'an]no **[eh she (.) turns]**
13	P	lo comp^ie:= **one ye^a:r=** ^*((looking at M))*
14	M	=esatto **=exactly**
15	P	[il quattordici, **[the fourteenth,** *((looking at the computer))*

[5] "Aptamil 3"© is a kind of fortified formula milk, specific for children aged 1 to 2 years.

16 M [>infatti devo ancora iniziare<
[>indeed I still have to start<

17 M perché mi: mi attengo alle:
because I: I comply with the

18 M le (.) indicazioni.
the (.) recommendations.

At the beginning of the excerpt, M tells P that she has bought the Aptamil 3© for the baby. This information is delivered in a quite interactionally elaborated way in terms of the epistemic and deontic work carried out by M. First, in line 1, M initiates her informing trajectory by stating that she has taken something.

However, rather than completing the turn with the direct object at issue, she inserts a further layer of information, that is she did not ask for P's permission (line 2). In this way, M projects the incoming information as something possibly problematic and, at the same time, acknowledges P's epistemic and deontic authority on the matter (note the use of the deferential pronoun "*suo*", in Italian, line 2). Immediately after, M provides an account for her initiative undertaken without consulting P ("but I've looked at the date", line 3).

Through this account, M a) treats her action as something based on her previous first-hand knowledge and not as grounded on a mindless naïve base, and b) downgrades the potentially problematic nature of having entered P's domain of expertise (i.e., by knowing and deciding by herself what is the best thing to do for the baby). The direct object is finally uttered in line 4, where M states that she has taken the formula milk "Aptamil three" (a kind of formula milk for children aged 1 to 2 years). By stressing the word "three" (line 4), M evokes her knowledge concerning what kind of formula milk is more suitable for her own child. Immediately after, she continues her telling by providing an additional account that further constructs herself as a knowledgeable and competent mother who knows the culture- and age-specific babies' feeding practices ("because by now we are old", line 5).

Furthermore, knowing what age her child is, belongs to her experiential epistemic domain: in other words, it is something she is entitled to know with certainty. After P's overlapping confirmation in line 6, M asks for P's advice and final validation through a request for confirmation

("right?", line 7). In this way, M recognizes P's epistemic and deontic authority but still, in part, displays her ones (on the different epistemic stances embedded in different types of questions, see Sidnell, 2012). Then, in line 8, P provides an upgraded confirmation ("sure"), to which M aligns ("mh", see also the nodding, line 9).

Interestingly enough, despite the sequence can be considered technically closed, M carries on with her telling and adds another piece of information: she has not given yet the Aptamil three to the baby (line 10). Immediately after, M repeats again the kind of Aptamil milk she has taken ("but I've taken the three", line 11). This latter unit is produced in overlapping with P's turn in line 12, where P provides what can be heard as an account for her previous confirmations ("yes", line 6, and "sure", line 8): the baby is turning one year the fourteenth (meaning the fourteenth of November, so three days after the visit), so it is ok that M has bought the Aptamil 3©. In this way, P a) ratifies M's conduct, thus re-establishing her authority on the matter, and b) contributes to transmitting culturally shared models of babies' feeding practices. Note that in line 16 M repeats again that she has not yet started feeding the baby with Aptamil 3©, and then she accounts for this decision by explicitly stating that she follows the recommendations ("because I comply with the recommendations", lines 17-18).

In doing so, M continues her work of constructing herself as a caring mother who retains the epistemic and deontic rights to know and decide what is the appropriate age- and culture-specific feeding practice for her baby. Concurrently, her competence as a "good" mother resides also in acknowledging the pediatrician's expertise and in following meticulously and faithfully the general normative rules.

4. *Concluding remarks*

The analysis has illustrated how, while asking for the pediatrician's advice, a mother displays herself as a competent, knowledgeable, caring, and therefore "good" parent (see Heritage, Sefi, 1992; Heritage, Lindström, 1998). Despite downgrading the right to "know and decide" by the very act of seeking advice (thus projecting a more knowledgeable status to the pediatrician), through the different ways parents in this corpus design their requests for advice (e.g., by asking for confirmation or by reporting a problematic state of affairs) they make interactionally relevant their expertise so as to avoid displaying a relative lack of knowledge or competence.

In this way, parents not only do epistemic (and deontic) but also moral work: I advance that while asking for a piece of advice can be conceived of as an activity displaying a lack of knowledge or need for assistance, the forms through which parents ask for advice rather index their being concerned by and informed about their child's well-being and caring practices. Moreover, at least in these visits, doing "being a good parent" is also accomplished through the acknowledgment of the pediatrician's epistemic and deontic authority and socially sanctioned professional role.

To conclude, pediatrician-parent interaction can be considered a site of «informal education» (Tramma, It. Ed. 2009, *passim*, my translation) where cultural models of good parenting, appropriate caregiving practices, and children's well-being are both enacted by the parents and ratified by the expert. Far from being a mere "biomedical knowledge sounding box", the pediatrician acts as a culture-maker, and therefore his/her voice is profoundly *pedagogical*.

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Appendix

Jeffersonian Transcription Conventions

(.) = falling intonation
(?) = strong rising intonation
(,) = slight rising intonation

[…] = Overlap, simultaneous talk

= Latching = absence of a silence of a normal length or to extend ones turn

(0.5) = Silence, measures in 10th of a second

(.) = small pause under 2 10th of a second

Underlining = emphasis

CAPITAL LETTERS = loud talk

>fast< = increased speed

<slow> = decreased speed/stretch

Colo:::ns = stretch the prior sound

- = cut-off

((…)) = description of an action

(…..) = uncertain of what was said