Epistemic Trust as an Interactional Accomplishment in Pediatric Well Child Visits: Parents' Resistance to Solicited Advice as Performing Epistemic Vigilance

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Epistemic trust as an interactional accomplishment in pediatric well-child visits: Parents' resistance to solicited advice as performing epistemic vigilance

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Epistemic trust - i.e., the belief in knowledge claims we do not understand or cannot validate - is pivotal in healthcare interactions where trust in the source of knowledge is the foundation for adherence to therapy as well as general compliance with the physician's suggestions. However, in the contemporary knowledge society professionals can no longer count on unconditional epistemic trust: boundaries of the legitimacy and extension criteria of expertise have become increasingly fuzzier and professionals must take into account laypersons' expertise. Drawing on a conversation analysis-informed study of 23 videorecorded pediatrician-led well-child visits, the article deals with the communicative constitution of healthcare-relevant phenomena such as: epistemic and deontic struggles between parents and pediatricians, the local accomplishment of (responsible) epistemic trust, and the possible outcomes of blurred boundaries between the layperson's and the professional's "expertise". In particular, we illustrate how epistemic trust is communicatively built in sequences where parents request the pediatrician's advice and resist it. The analysis shows how parents perform epistemic vigilance by suspending the immediate acceptance of the pediatrician's advice in favor of inserting expansions that make it relevant for the pediatrician to account for her advice. Once the pediatrician has addressed parents' concerns, parents perform (delayed) acceptance, which we assume indexes what we call responsible epistemic trust. While acknowledging the advantages of what seems to be a cultural change in parent-healthcare provider encounters, in the conclusion we advance that possible risks are implied in contemporary fuzziness of the legitimacy and extension criteria of expertise in doctor-patient interaction.

Keywords: pediatrician-parent interaction; epistemic trust; resistance to solicited advice; epistemic vigilance; advice sequences

Introduction

In a groundbreaking work, Collins and Evans (2007) pointed to a critical issue for contemporary societies: the unresolved tension between expertise and consensus-based decision-making. The "legitimacy and extension criteria" (i.e., the rationale establishing who is entitled to know what, and which are the boundaries of the territories of expertise, if any, p. 113) that governed the socially sanctioned distribution of knowledge and the division of labor in traditional societies have become increasingly fuzzier. The tension between professional expertise and lay expertise (Sarangi, 2001) is particularly crucial in healthcare contexts, where professionals and service users share some territories of knowledge to which service users have primary access (Heritage, 2012a). When it comes to health, care, or upbringing, laypersons do have previous experience, old or newly acquired information, as well as semi-expert knowledge and specific folk theories. Not surprisingly then, healthcare professions have been particularly affected by the accountability turn (Peräkylä, 1998) and the consequent hybridization of epistemic and deontic rights (Drew, 2018; Heritage, 2012a,b; Stevanovic & Peräkylä, 2012; Stevanovic, 2013). Recent phenomena such as web-based self-diagnosis or parents' pressure in pediatric settings (Stivers, 2007; Stivers & Timmermans, 2020) index an emerging consequence of this redistribution of epistemic and deontic rights: the epistemic gap between the "professional vision" and the "lay vision" (Goodwin, 1994) has been reduced and professionals can no longer rely on epistemic trust (hereafter ET) - i.e., the belief in other people's knowledge claims we do not (fully) understand or cannot validate (Fonagy & Allison, 2014; Origgi, 2004, 2005; Schwab, 2008) - exclusively grounded on deference to epistemic authority. More often than expected, health professionals are confronted with the

need to build ET one interaction at a time. The interactive construction of ET is particularly relevant in pediatric settings for two main reasons. First, the contemporary fuzziness of expert knowledge boundaries can lead to unexpected outcomes such as vaccine hesitancy (Larson et al., 2014; Opel et al., 2013), unhealthy diets, or misuse of antibiotics (Stivers, 2005, 2007) that impact children's physical development. Second, at least in some countries, pediatricians are among the first professionals working with parents to manage a smooth transition from, and create a balance between, families' private "small cultures" and larger sociocultural expectations. Pediatricians are vectors of culture and participate in constructing normative models of "good parent", "children's well-being", and the moral suitability of everyday caring practices. How do parents receive pediatricians' advice? Do they unconditionally accept the expert's advice *qua* expert advice? If not, what are the consequences of suspending "blind trust"?

Drawing on a conversation analysis informed[1] study of a corpus of 23 videorecorded well-child visits[2], in this article we illustrate how ET is locally constructed in sequences where parents request the pediatrician's advice concerning the baby's everyday management. Following Heritage and Sefi (1992; but see also Pilnick, 2003), we consider advice the interactional practice through which the professional "describes, recommends or *otherwise* forwards a preferred course of future action" to the client (p. 368, our emphasis). Indeed, we assume that when an opinion, a confirmation, or even an assessment is requested from or provided by an expert it counts as advice, i.e., a suggestion on an ongoing or future course of action that - given the source - is relatively constraining although it leaves the recipient some

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[1] We use a formula proposed by John Heritage (Rome, 2022, or. com) as a label for studies that do rely on CA methodological techniques and constructs to show how meso or macro phenomena (like an intersubjective status of reasonable epistemic trust) are not pre-conditions of local interaction but rather participants' local accomplishment built one interaction at a time through communicative details. Without being aimed at describing conversational structures or practices as such, CA-informed studies use them as analytical tools.

[2] Well-child visits (term used by the American Academy of Pediatrics) are regular check-ups where the healthcare provider assesses the baby's growth and development according to the expected standard. In Italy these visits are carried out by pediatricians at pediatric primary care clinics.

room for maneuver (i.e., it is not a prescription). We show how ET is not only displayed through the immediate acceptance of the pediatrician's advice, but also built out of the parents' resistance performed in the interactional slot where, as literature shows, acceptance is ordinarily expected, i.e., after solicited advice (see Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Riccioni et al., 2014; Silverman, 1997). We advance that, in inserting sequence expansions rather than straightforwardly accepting the solicited advice, parents display "epistemic vigilance" (Sperber et al., 2010), i.e., the local withdrawal of unconditional ET that makes it relevant for the pediatrician to engage in accounting for her advice or otherwise addressing the parents' problematic reception of it. Once addressed by the pediatrician, epistemic vigilance leads to delayed acceptance, which we assume indexes responsible ET (Schwab, 2008). Contrary to unconditional or "blind" trust (Hardwig, 1985), responsible ET implies a certain amount of epistemic work on the advice content (e.g., comparison with knowledge from a different source), its source (e.g., the doctor vs. a parents' forum), or its evidential bases (e.g., Evidence-Based Medicine statistics vs. the individual clinician's judgment).

Trust in healthcare interactions

A considerable body of literature has illustrated that trust between healthcare providers and clients plays a pivotal role in nurturing a successful therapeutic alliance, increasing clients' satisfaction and experience of care as well as maximizing patients' adherence to therapies (see among others Dalton et al., 2021; Hall et al., 2001; Lee & Lin, 2009; Mechanic & Meyer, 2000; Mikesell & Bontempo, 2022; O'Grady et al., 2014; Tarrant et al., 2003).

Interestingly enough, trust is often conceived as an overarching construct conflating different dimensions (e.g., interpersonal trust, affective-based trust, reputation-based trust, knowledge-based trust, relational trust, see for example Candlin & Crichton, 2013) that are not always or necessarily co-present. We may trust a doctor's bona fide and sincere moral

commitment in caregiving and the "do not harm" principle without believing they have the most updated expert knowledge on the issue at stake. We can also doubt their knowledge-based claims on the basis of alternative voices, previous experience, or personal stances. Although ET is not the only kind of trust at stake in doctor-patient interaction, it is at the core of its successful conclusion as we contend in the next section.

Epistemic trust in healthcare interactions

Research on ET argues for its phylogenetic, ontogenetic, and practical relevance (Csibra & Gergely, 2011; Goldman, 2001; Origgi, 2014). "Trust in the authenticity and personal relevance of interpersonally transmitted knowledge" (Fonagy et al., 2017, p. 177) enables individuals to build on others' experiences and knowledge and to believe what they do not (fully) understand, evaluate, or confirm. ET is particularly crucial in situations of "epistemic dependency" (Hardwig, 1985) as it allows human beings to believe that what is said to them matters and is truthful enough to become a basis for action and decision-making within an otherwise epistemically "opaque" situation (Csibra & Gergely, 2009, 2011). Clearly enough, this construct is pivotal in healthcare interactions where trust in the source of knowledge is fundamental for patient adherence to therapy as well as general compliance with the physician's suggestions. As we contend, ET is not necessarily a matter of a pre-existing inner disposition, emotional state ("affective attitude", Jones, 1996), or individual cognitive information processing as put forward by psychological and cognitive approaches to epistemics and social cognition (see Fonagy & Allison, 2014; Kissine & Klein, 2013; Sperber et al., 2010). Rather, it is often a step-by-step situated cooperative construction: participants locally co-build and display confidence in the physician's knowledge claims one interaction at a time, as the conversation unfolds.

In the last four decades, the epistemic tension and the related issues of expertise and asymmetry in doctor-patient interaction have received extensive attention in healthcare communication studies (e.g., Landmark et al., 2015; Pilnick & Dingwall, 2011; Robinson,

2001; Strong, 1979). In this regard, CA research significantly contributed to providing evidence on the active role played by patients and their companions in shaping the unfolding of the visit and even its outcomes (see Heritage & Maynard, 2006). In particular, it has been shown how patients and their companions can (and *do*) at times reply to physicians' advice and recommendations by displaying different forms of resistance, prompting the physician to provide concessions, justifications, or reformulations of their original proposal in pursuit of the normatively required preference for agreement (e.g., Roberts, 1999; Stivers, 2007). This jointly accomplished work of advice and recommendations negotiation has been observed in a vast array of different healthcare contexts, such as pediatric acute care encounters (see Stivers, 2005, 2007), health visitors service (Heritage & Sefi, 1992), oncology visits (see Costello & Roberts, 2001; Roberts, 1999), primary care encounters (Costello & Roberts, 2001; Koenig, 2011; Pilnick & Coleman, 2003), surgery (Hudak et al., 2011) as well as neurology consultations (Stivers & Timmermans, 2020; Toerien, 2021).

This stream of research paved the way for recent interest in the interactive construction of *epistemic* trust: one interaction at a time, participants build the conditions for a monitored ET out of momentary withdrawals of unconditional trust, displays of epistemic vigilance, and deployments of accountability.

Building on previous research on epistemics in social interaction (e.g., Drew, 2018; Heritage & Raymond, 2005), on trust as a discursive activity in healthcare interaction (Antaki & Finlay, 2013; Finlay & Antaki, 2012; O'Grady & Candlin, 2013; O'Grady et al., 2014), and on resistance to physicians' advice and recommendations (e.g., Costello & Roberts, 2001; Heritage & Sefi, 1992; Roberts, 1999; Stivers, 2007; Stivers & Timmermans, 2020; see above), in this article we contend that, and empirically illustrate how, ET is an interactional accomplishment. In order to investigate this trust-building process, we analyze sequences where parents display resistance to accepting the very advice they have solicited.

The epistemics of advice and the issue of trust: The case of well-child visits

An essential component of the physicians' institutional remit and everyday working practice is the provision of medical and health-related advice. As Pilnick suggests, (medical) advice consists in confirming, "forwarding or promoting a *possible* future course of action" among alternatives (Pilnick, 2003, p. 837, our emphasis) in ways that are relatively constraining (given the institutionally sanctioned epistemic authority of the advice giver), but still leave some room for the recipient's agency (see Fatigante & Bafaro, 2014). We contend that this gap between expertise-based constraints and the client's relatively free decision to follow the advice or not, is where epistemic considerations make a difference. Indeed, the epistemic gap between advice giver and advice seeker/recipient may not necessarily be a matter of knowing *vs.* not knowing, but may be a matter of being *more or less certain* about the course of action undertaken or to undertake. In this case, requesting the expert's advice can be a means to pursue reassurance and is often accomplished by asking for confirmation as to the appropriateness or suitability of a course of action the client has already undertaken or projected to undertake (see Heritage & Sefi, 1992). Further, although "medical advice" is often understood as asking for the expert's opinion on medical conditions or treatment recommendations, the doctor's advice is also often requested on peripheral issues perceived as related to health and well-being. This is often the case in pediatric visits where - at least in some countries - the pediatrician is also in charge of monitoring the growth and development of newborns. At least in this case, different "forms of advice" imply, and at the same time project, a "knowing better" position of the advice giver (Drew, pers. comm.; see also Heritage & Sefi, 1992).

In the last decades, pediatric consultations have received quite substantive attention (e.g., Aronsson & Rundström, 1988, 1989; Ekberg et al., 2022; Shaw et al., 2016; Silverman, 1987; Stivers, 2007). Yet after Heritage and Sefi's (1992) pioneering study on UK health visitors, the specific domain of everyday child management and parental care in the early

years remained under-investigated (but see Krippeit et al., 2014; Zanini & Gonzaléz-Martinez, 2015). Filling this gap, in this article we analyze the local achievement of parents' ET in Italian well-child visits.

These are periodic check-ups where the pediatrician examines and tracks the child's physical growth and his/her cognitive, emotional, and social development according to the expected standards. Since no diseases are typically at stake, well-child visits entail differences with respect to primary care visits as to the overall structural organization (e.g., the reasons for the visit, the diagnosis of a disease, and the related treatment prescription are not present). Additionally, topics of conversation mainly concern the typicality of the child's development, the normality of their everyday behavior as well as the suitability of the caregiving practices allegedly responsible for the child's well-being (e.g., sleeping postures, pacifier use). Here, the management of epistemic asymmetries concerns knowledge that a) is extremely "relevant to oneself" (Sperber et al., 2010), b) intertwines with morally loaded implications (Heritage & Lindström 1998, 2012; Heritage & Sefi 1992; Silverman, 1987), and c) is distributed along a continuum ranging from parents' lay expertise and the pediatrician's specialized knowledge. At least in countries where well-child visits are institutionally provided by a pediatrician, requesting advice on these issues implies submitting them to the "voice of medicine" (Mishler, 1984). However, children's everyday management is a territory where the epistemic boundaries between parents' and pediatricians' domains of expertise are blurred and not as clear-cut as in the case of diagnosing and treating acute diseases. Indeed, and as our study illustrates, potential struggles as to "who knows best" can be at stake as parents stage themselves as lay experts. Despite downgrading their right to "know and decide" (e.g., by the very act of seeking the pediatrician's advice), parents make use of their sources of knowledge to account for the advisable course of action, treat the pediatrician's advice as unsatisfactory, or even question it. We argue that, in staging themselves as competent and making it relevant for the pediatrician to engage in detailed accounts or, in some cases, changing their advice-

implicative opinion, parents exert epistemic vigilance as a step toward achieving responsible ET.

Bracketing any mentalist approach, we consider ET as interactionally accomplished when parents display agreement with or acceptance of the expert's advice.

Corpus and analytical procedure

This article reports data from a corpus of 54 pediatric visits audio and videorecorded in two pediatric clinics located in a north-center region of Italy. For the purpose of this study, we focus on a sub-corpus of 23 *well-child visits*, involving two general pediatricians and twenty-two middle-class families with children aged between 0 and 18 months. Participants' written consent was obtained according to Italian law n. 196/2003 and EU Regulation n. 2016/679 (GDPR 2016/679), which regulates the handling of personal and sensitive data. Approval from the Bioethics Committee of the University of Bologna was obtained (protocol n. 0087746). Data were transcribed using a simplified version of Jeffersonian transcription conventions (Jefferson, 2004; see Appendix B) and analyzed adopting a Conversation Analysis (CA) informed approach (see Sidnell & Stivers, 2013), which is widely used for the study of healthcare communication (e.g., Barnes, 2019; Heritage & Maynard, 2006; Montiegel & Robinson, 2022; Robinson & Heritage, 2014)[3]. Transcripts are presented in two lines: the original Italian and the almost literal English translation.

Advice giving. To identify sequences of advice in the corpus we draw on Heritage and Sefi's (1992) "loose" definition (Edwards, 2005), i.e., the interactional practice through which the professional confirms, "describes, recommends or *otherwise forwards* a preferred course of future action" to the client (p. 368, our emphasis). We identified: a) 67 instances of pediatricians' advice giving in first position, i.e., unsolicited advice that initiates a sequence

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[3] For a detailed overview of the different methodological approaches to health communication studies see Thompson, Parrott, and Nussbaum (2011, section VI).

and makes conditionally relevant a second pair part by the parent, which is either acceptance or different forms of resistance; and b) 78 instances of advice giving in second position, i.e., solicited advice provided by the pediatrician as the second pair part of a sequence initiated by the parents' explicit or implicit request for advice (see Heritage & Sefi, 1992).

Previous research demonstrates that the phase of the visit matters as to the range of activities accomplished by participants. Particularly, extant literature illustrates that the opening phases of the visits are the primary environment where patients (or companions) advance interpretations of their own (e.g., Gill, 1998; Gill et al., 2001) and even work to rule out potential diagnoses (e.g., Gill et al., 2010) or treatment prescriptions (e.g., Stivers, 2007). Therefore, we considered if and how advice sequences varied according to the different phases of the visit. We found that the majority of instances of advice sequences are concentrated in what we call the diagnostic-like[4] phase of the visit (37%, see Table A1, Appendix A). This is especially true for *solicited* advice: almost half of its occurrences take place in this phase (49%, see Table A1, Appendix A).

Apparently, this result seems to stand in stark contrast with previous findings suggesting that the diagnostic phase constitutes the apex of physicians' epistemic authority; therefore, patients' (or companions') contributions are minimal or even absent (e.g., Heath, 1992; Peräkylä, 1998, 2006). However, the prevalence of solicited advice in the diagnostic-like phase of these visits can be explained by the fact that, in this corpus at least, the diagnostic-like phase consists in the assessment of children's growth and development which is collaboratively built with caregivers. Indeed, in order to gain assessment-relevant

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[4] Since in well-child visits no disease-related symptoms are commonly at stake, an out-and-out diagnosis does not occur. However, after the physical examination, the pediatrician typically provides assessments about the child's growth and development based on both direct observation of the child and on the parents' reported information. Despite not constituting a diagnosis in the strict sense of the term, we consider the assessment of the infant's growth and development as constituting the diagnostic-like phase of the visit for two reasons. First, because of its position within the visit: with respect to the overall structural organization, it immediately follows the physical examination, like diagnosing (see Heritage & Maynard, 2006; Heritage & McArthur, 2019). Second, because of its similarities with the task-focused activities identified as typical of the diagnostic phase, i.e., delivering and receiving evaluations.

knowledge, pediatricians ask the parents directly to give information and deliver their own assessments of the child's everyday habits and behavior. As a result, it is possible to infer that parents may "take advantage" of this phase, in which their contributions are not only accepted but even expected and encouraged, to seek advice on their still unmet concerns.

Advice reception. The following step consisted in analyzing 'what happens next', i.e., the interactive slot where parents receive advice and display (or not) ET, i.e., a straightforward acknowledgment of the pediatrician's advice. Irrespective of advice sequential position, parents' reception appears to vary along a continuum that ranges from plain acceptance to overt rejection, passing from minimal to stronger forms of interactive resistance (see Shaw & Hepburn, 2013), i.e., an interactively displayed epistemic stance through which parents treat the pediatrician's advice as "thinkable", a claim to confirm, agree upon or contest rather than as an instruction to be followed or information to be acknowledged. We consider these different ways of receiving advice as practices deployed to make actionable different degrees of epistemic vigilance (see Figure 1).

Figure 1 - Caption: *Ways of receiving advice and displaying epistemic trust: a continuum*

Figure 1 - Alt-text: *A double-headed arrow representing a continuum. At the bottom are listed the different possible ways of receiving advice, while at the top the corresponding degree of deployed epistemic vigilance.*

Figure 1 - Long description: *A double-headed arrow representing a continuum. At the bottom are listed the different possible ways of receiving advice, from the left: "plain acceptance", "minimal resistance", "stronger resistance", and "overt rejection". At the top, on the left pole of the continuum is "Unconditional epistemic trust", while on the right pole is "Epistemic vigilance". It is shown that through plain acceptance parents display unconditional epistemic trust, while through the different forms of resistance they deploy different degrees of epistemic vigilance.*

Unconditional Epistemic Trust		**Epistemic Vigilance**	
	-	+	++
Plain Acceptance	Minimal Resistance	Stronger Resistance	Overt Rejection

We consider plain acceptance cases where the pediatrician's advice is recognized as such and straightforwardly acknowledged. It displays unconditional ET.

We consider minimal forms of interactive resistance as displaying the lowest degree of epistemic vigilance: these are instances where parents align with the advice content but, at the same time, treat it as not really informative. In our corpus, they do so through displays of independent knowledge (e.g., confirming tokens, see Heritage & Sefi, 1992; Shaw & Hepburn, 2013). Stronger forms of resistance display higher degrees of epistemic vigilance. Instead of straightforwardly acknowledging the pediatrician's advice, parents question it by a) mobilizing other epistemic sources (e.g., personal habits, past experiences, others' opinions), and b) through requests for confirmation, suggestions of alternative courses of action, or proposals of contrastive opinions that make it relevant for the pediatrician to address them.

Occurrences of overt rejection are cases where the pediatrician's advice is rejected explicitly and straightforwardly. After the parents' rejection, the sequence is immediately closed, and the conversation moves on to another topic.

Since research on advice sequences demonstrates that advice sequential position has an impact on its reception, we also considered the frequency of the different ways in which parents received advice according to its sequential position, i.e., solicited or unsolicited advice (see Table 1).

Table 1

Parent's Advice Reception Per Advice Position

	Plain acceptance	Minimal resistance	Stronger resistance	Overt rejection	Tot
Solicited advice	51 (65,38%)	**18 (23,07%)**	**9 (11,53%)**	0	78 (100%)

Unsolicited advice	30 (44,77%)	26 (38,80%)	7 (10,44%)	4 (5,97%)	67 (100%)
Tot	81	44	16	4	145

Although our data confirm previous findings on the prevalence of acceptance in sequences of *solicited* advice (vs. unsolicited, see Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Riccioni et al., 2014; Silverman, 1997)[5]; nevertheless, they reveal a fairly recurrent display of epistemic vigilance even when the advice has been requested: one time out of three parents minimally or strongly resist solicited advice. We therefore consider sequences of resistance to *solicited* advice as a "perspicuous case" (Garfinkel & Wieder, 1992) for analyzing the interactive accomplishment of ET: while parents display their acknowledgment of the pediatrician's epistemic authority by asking for advice, they often appear to withdraw unconditional ET and engage in forms of epistemic vigilance.

The sequences we focus on are structured as follows:

(1) parents request the pediatrician's advice as to the suitability of a course of action they have already undertaken or have heard about

(2) the pediatrician provides an "advice-implicative assessment" (Shaw et al., 2015)

(3) parents resist the advice

(4) the pediatrician addresses parents' resistance

(5) parents accept the advice, or the pediatrician formulates his/her previous one.

Accomplishing (responsible) epistemic trust: Parents' display of different degrees of epistemic vigilance

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[5] Although we are aware that advice-giving design can impact advice receiving, for the purposes of this article we mainly consider advice position and focus on parents' resistance to solicited advice, i.e., cases where resistance is less expectable (see Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Riccioni et al., 2014; Silverman, 1997).

In this section, we provide examples of how ET is built out of the parents' display of epistemic vigilance performed through different forms of resistance. As we will illustrate, responsible epistemic trust is not a punctual phenomenon, rather it appears to be built over a series of activities as it takes time to emerge across extended interaction. The specific longitudinal temporality of this phenomenon requires taking into account extended (or long) sequences (Psathas, 1992). In these units of interaction, participants suspend the straightforward interactional accomplishment of the action initiated by a first pair part (e.g., advice request) by recurring to different forms of expansion (see Schegloff, 1990, 2007), such as elaborating on previous talk, prefacing the incoming one, questioning a previous question, or adding unrequested information (on the coherence and boundaries of long sequences and the activities that develop across this kind of sequence, see Galatolo et al., 2015; Traverso, 2012). Expanded sequences emerge from a momentary rupture of the progressivity of interaction (i.e., its unmarked, smooth unfolding along the expected sequence of types of turn). As previous studies on the organization of talk in interaction demonstrate (see Stivers & Robinson, 2006), breaking the progressivity of interaction is a meaningful action that creates an interactional slot for participants to engage in particular activities. In the case under scrutiny, by suspending acceptance of the advice they have requested and inserting expansions that in turn make the pediatrician account for her own advice, parents engage in building a monitored form of ET. Consequently, only through the analysis of extended sequences is it possible to show how this form of trust unfolds, from the advice request to its vigilant acceptance, passing through the parents' deployment of local resistance and the pediatrician's locally occasioned accounts. Given the length of the sequences and their analysis, we provide only examples of minimal and stronger forms of resistance that display different degrees of epistemic vigilance.

Minimal resistance: claiming independent knowledge by confirming the pediatrician's advice

In the following excerpt, a mother exerts a minimum degree of epistemic vigilance: she claims independent knowledge of the right thing to do by confirming – rather than acknowledging (see Heritage & Sefi, 1992) – the pediatrician's advice-implicative assessment in the interactional locus where acceptance is expected.

(1)

PI_02_16.10.19 - (19.26_20.00v1) – "Yeah that's for sure"

M: mother; F: father; P: pediatrician

We join the conversation during the history-taking phase of the visit, when M asks P how to manage a pacifier with her one-week-old newborn son, a practice generally not recommended by experts since it can interfere with newborns' feeding habits.

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1   M  e:: l'escamotage del ciuccino lo stiamo provando=
       a::nd the escamotage of a pacifier we are trying it=

2   M  =nel senso che: lo tranquillizza (.) cosa facciamo?
       =I mean tha:t it calms him down (.) what shall we do?

3      (0.5) ((M and F are looking at P, P's face is turned downward, and his eyes are closed))

4   M  che quell'      [altro:]   ^ciuccia ancora il dito:
       since the other [o:ne  ]is ^still sucking his finge:r

5   P                  [(    -)]   ^((opening his arms in the air))

6   P  no allora meglio-
       no well better- ((looking at M))

7   P  meglio il ciuccio del      [dito,
       better a pacifier than his  [finger, ((looking at M))

8   M                             [ah quello sicuramente
                                   [yeah that's for sure

9   P  meglio niente che il ciuccio
       better nothing than a pacifier ((looking at M and smiling))
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10  P  però: ^a questo punto (non è che)
       bu:t  ^at this point (it's not that) ((looking at M and smiling))

11  F           ^ ((laughing and looking at M))

12  M            ^ ((laughing and looking at F))

13  P  ((coughing and looking down))

14  P  però,
       but,

15     (1.5) ((P is moving his right arm in the air, M and F are looking at him))

16  P  diciamo che di fronte a- a stadi di- di        ^irrequietezza
       let's say that dealing with-with- phases of-of ^restlessness
       ((looking at M))

17  M                                                    ^((nodding))

18  P  ^e: che possono         ^^compromettere poi::
       ^a:nd that may la::ter ^^compromise ((looking at M))

19  M  ^((nodding))

20  F                          ^^((nodding))

21  P  il ritmo delle poppate e tutto il resto,
       the breastfeeding schedule and all the rest, ((looking at M))

22  M  eh, ((nodding and looking a P with a concerned expression))

23  P  ^va bene il ciuccio.
       ^a pacifier is ok. ((looking at M))

24  M  ^((nodding))

25  F  ^°mh°.

26  M  ^((nodding and looking at the baby))
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In line 1 M prefaces her explicit request for advice ("what shall we do?", line 2) by reporting the practice to be commented on (i.e., giving the baby a pacifier) and by providing an account ("it calms him down", line 2). In designing her turn, she mobilizes a certain number of resources to stage herself as a competent parent (on mother's designing advice seeking to display relative "knowledge or competence", see Heritage & Sefi 1992, p. 370). By

formulating what they are doing as an "escamotage" (line 1), she presents the advisable course of action as a conscious strategy, i.e., the pacifier is not used on a mindless or commonsensical basis, but according to her semi-expert knowledge of the "right thing to do". Secondly, she provides the account - the pacifier keeps him calm - by adopting the "telling the baby's side" resource (Silverman, 1987), therefore staging herself as a concerned and informed mother who knows what is best for her child. However, with the very act of seeking advice, she displays her recognition of P's expert knowledge on the matter. Upon P not answering (see the gap, line 3), M pursues a response by inserting further information (the other son is still sucking his finger, line 4; a behavior that experts consider problematic). This first-hand knowledge-based expansion embodies the semi-expert presupposition that the reported state of affairs (still sucking his finger) is consequential to not having used a pacifier (on using first-hand relevant knowledge to channel the pediatrician's trajectory, see Stivers 2007, p. 69)[6]. M's expansion therefore appears to channel P's reply toward confirming the "advisable" course of action provided in lines 1 and 2 ("a::nd the escamotage of a pacifier we are trying it==I mean tha:t it calms him down"). In line 6, P eventually provides a reply to M's previous request for advice ("what shall we do?", line 2). He saturates the responsive slot with a "no" in turn initial position (line 6), which displays his negative stance toward the state of affairs reported in M's expansion (i.e., the other baby is still sucking his finger). The "no" is followed by an advice-implicative assessment: better a pacifier than his finger. Entering the turn before the first possible completion point, M confirms P's assessment with an upgrading form (see the emphasizing Italian discourse marker "ah", "yeah that's for sure", line 8). Both the sequential position and the type of activity (confirming with upgrading, rather than

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[6] The unsuitable consequences of using a pacifier as well as its benefits are part of contemporary parents' semi-expert knowledge as an outcome of increasing caregiving socialization. Indeed, this territory of knowledge is precisely where struggles between parents' and physicians' epistemic and deontic rights can occur. Although still asking for advice, parents have their own ideas on caregiving and some semi-expert knowledge that they use to channel or resist even the advice they have requested. For recent data on the ways parents resist and even challenge medical authority, see Stivers and Timmermans (2020).

acknowledging) signal M staging herself as epistemically competent. She claims independent knowledge of the fact that sucking a pacifier is better than sucking a finger and treats P's advice-implicative assessment as pretty obvious by coming in before he completes his turn (on early entries in the adviser's turn as a display of competence, see Pilnick, 2001). By engaging in confirming rather than straightforwardly acknowledging P's advice implicative assessment, M breaks the progressivity of interaction and makes it relevant for P to account for his claim. In doing so, she displays (a minimal degree of) epistemic vigilance. Interestingly enough, P completes his turn by stating the ideal course of action ("better nothing than a pacifier", line 9), which is not the one undertaken by the parents and assessed as acceptable by P immediately before ("better a pacifier than his finger", line 7). By stating what would be the "best practice" (line 9), P re-affirms his epistemic authority and his right to establish the "ought to be". He now has a practical problem: he ratified the parents' course of action by providing a positive advice-implicative assessment ("better a pacifier than his finger", line 7) and concurrently affirmed quite the opposite ("better nothing than a pacifier", line 9). P keeps the turn and appears to solve this problem by adding an account where he gives information on the conditions under which the use of a pacifier is acceptable. He introduces the account with a contrastive marker ("but", line 10) that projects a counter argument or the reversal of the discursive trajectory. Indeed, the self-interrupted second turn component ("at this point (it is not that-)", line 10) sounds as an inchoative downgrading of the just provided claim ("better nothing than a pacifier", line 9), which could be heard as an indirect negative assessment of the course of action undertaken by parents: i.e., they are giving the baby a pacifier. P's smile at M (line 9) multimodally contributes to downgrading the potential critical stance embedded in line 9. The multimodal work of mitigation of P's potential negative evaluation of the parents' conduct (line 9) is also collaboratively accomplished by the parents, who look and laugh at each other (lines 11-12) while P introduces his (projected as) counter argument with the "but" in turn initial position (line 10).

Reciprocal laughs in this position can indeed be seen as a resource for the parents to manage the potential critique implied in P's claim (line 9), mitigate the relevance of the issue by treating it as laughable, and build affiliation between them.[7]

Using format tying, P recycles his contrastive marker ("but", line 14) and, while introducing the incoming account with some hesitation markers (see the quite long intra-turn pause in line 15 and the downgrading evidential marker "let's say", line 16), he formulates M's former justification ("it calms him down", line 2) for the advisable course of action (parents are giving the baby a pacifier) using a more formal, although not hyper-specialized, lexical register (lines 16, 18, 21). In doing so, P a) frames his advice-implicative assessment as a logical consequence of his expert knowledge, b) patrols his domain of expertise previously entered by M, and c) reaffirms his expert knowledge-based assessment, which he clearly states in line 23: a pacifier is ok. By providing the expert-knowledge basis for his advice-implicative assessment which contrasts the "golden rule" (of which he displayed he is knowledgeable of, i.e., better nothing than a pacifier, line 9), P does two things with words: he reassures parents and does not really counter the course of action they have undertaken, but rather the epistemic basis of their decision. In a few words, P reaffirms expert knowledge over parents' lay expertise as the legitimate basis of assessment, deviation from the norm, and decision-making.

In synthesis, by not engaging in plain acceptance, M's confirming plus upgrading turn in line 8 ("yeah that's for sure") transformed the expert advice ("better a pacifier than a finger", line 7) into a "thinkable", "accountable", "justifiable" issue: she pursued accountability by making relevant for P going beyond what she treated as already known

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[7] Laughter has been carefully investigated as a relevant multifunctional component of talk, which plays a crucial role in establishing meaning (not necessarily nor always humor, see Potter & Hepburn, 2010) and shapes the social organization of the interaction (see Glenn, 2003). It may be used as a resource by participants to cope with delicate aspects of the interaction (Haakana, 2001), as a marker signaling or masking troubles in talk (e.g., obscenity, see Jefferson, 1984) or to manage affiliation between co-participants (Glenn, 2003). It is commonly assumed that the laugh is highly indexical and 'locally responsive' (Sacks, 1974, p. 348): it refers to and defines the element immediately preceding the laugh as laughable (see Jefferson et al., 1987; Schenkein, 1972).

information. Only after P explicitly detailed and formulated in a more formal register the reasons why "giving the baby a pacifier" could be preferable to not giving it, did the parents eventually accept the expert advice they had requested some turns before (see the nodding at lines 24 and 26 and the acknowledgement token at line 25). Participants cooperatively engaged in what we consider an interactive accomplishment of (responsible) ET.

Stronger resistance: Reducing the realm of advice applicability by quoting a competing opinion

The following excerpt illustrates how - by reporting a mutual acquaintance's voice - a mother displays a higher degree of epistemic vigilance: she resists the pediatrician's advice and makes it relevant for her to consider the quoted alternative and eventually change her mind.

(2)

VA_14_18.12.19 - (16.46 – 17.38) – "Because Emilia told me"

P: pediatrician; M: mother

We join the conversation right after the physical examination: P is writing the infant's head circumference on the computer, while M introduces new information that will be treated as advisable by P. The father is dressing the baby on the couch, while M and P engage in the following dyadic exchange.

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1   M  e l'altra      [   cosa      ],
       and the other [   thing     ],

2   P                 [°trentotto°   ]
                      [°thirty-eight°]
                      ((writing the head circumference on the computer))

3   M  ne ho parlato con l'Emilia l'altro      [giorno:]
       I talked about it with Emilia the other [day:   ]

4   P                                          [sì::   ]
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```
                                           [yea::h ]

  5  M  lei dorme meglio a pancia in giù.
         she sleeps better face-down.

  6  P  va bene (.) è lo [    stesso        ]
         that's ok (.)    [it's the same thing]

  7  M                    [     va bene?    ] (.) ok.
                          [     is it ok?   ] (.) ok.

  8  P  è lo stesso.
         it's the same thing.

  9  M  perché  l'Emilia [    mi diceva     ]
         because Emilia   [    told me       ]

 10  P                    [   °non è grave°  ]
                          [°it's not important°]

 11  M  andrebbe messa di lato
         she should be placed on her side

 12  P  sì (.) ^non è grave (.) nel senso,
         yes (.)^it's not important (.) I mean,

 13  M          ^((nodding))

 14  P  l'importante è che  ^quando dorme la notte
         the important thing ^is that when she sleeps at night

 15  M                          ^((nodding))

 16  P  ^cioè se sta nel vostro letto    ^^la vedete e la sentite
         ^I mean if she stays in your bed ^^you can see and hear her

 17  M  ^((nodding))                     ^^((nodding))

 18  P  se sta nella Next-to-me
         if she is in the Next-to-me

 19  P  è meglio se è piuttosto sul fianco
         it's better if she lies on her side

 20  P  ^>più che a pancia sotto<
         ^>rather than face-down<

 21  M  ^((nodding))

 22  P  ^di giorno che voi siete svegli    pre[senti è::        ],
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```
        ^during the day when you are awake pre[sent eh::        ],

23   M   ^((nodding))

24   M                                        ^[quindi di notte no    ]
                                              ^[so not during the night]

25   M                                        ^((shaking her head))

26   P   ^potete metterla anche a pancia sotto.
         ^you can also put her face-down.

27   M   ^((nodding))

28       ((5 lines omitted))

29   P   di notte se voi volete dormire
         during the night if you want to sleep

30   P   è meglio che controlliate che non sia a pancia sotto
         it is better if you check she is not face-down

31   M   ok.

32   P   però sul fianco per esempio va bene.
         but on her side for example it's ok.

33   M   ((slightly nods and smiles while looking at the baby))
```

The sequence starts with a news-announcement by M ("and the other thing", line 1) followed by a preface that frames the incoming information as something she has already talked about with a mutual acquaintance ("I talked about it with Emilia the other day", line 3). By prefacing the incoming report in this way, M projects relevance on it, alerts the co-participant that another voice has been consulted, and paves the way for her use of reported speech.[8]

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[8] As an anonymous reviewer rightly remarks, reporting that the teller has already talked about the matter with someone else does some interactional job. It contributes to forming the action accomplished by the mother – i.e., soliciting advice - by "merely" reporting a fact. It is indeed reasonable to assume that it is precisely this preface - which depicts the teller "talking about" the matter with someone else - that makes it relevant for the pediatrician treating the mother's report as doing "soliciting advice". This is a typical case of "next turn proof procedure", i.e., the analyst aligns with what is ostensibly the case for participants: it is the pediatrician who treats the report as a request for advice, which she provides in line 6. This is why we call the parent's action a "report-formatted advice request".

With an "alignment token" (Stivers, 2008), P invites M to continue her narrative. M then delivers the information in the form of a report-formatted assessment "from the baby's side": her baby daughter sleeps better if she is face-down (line 5), which is treated by P (see line 6) as an implicit request of advice (see Heritage & Sefi, 1992). In her reply to M's report-formatted advice request, P constructs the advisable as non-problematic by a reinforced advice-implicative assessment ("that's ok, it's the same thing", line 6). No hesitation nor minimal disruptions in fluency justify M's expansion: instead of straightforwardly acknowledging the advice, she problematizes it by asking for confirmation (line 7). After a minimal gap, M provides an acknowledgment token, but her previous problematization makes it relevant for P to reaffirm her no-problem assessment ("it's the same thing", line 8). At this point, in line 9, M again breaks the progressivity of interaction and explicitly contrasts P's advice-implicative claim, but in an indirect way: she mobilizes the voice of the already evoked acquaintance. By reporting that it would be better to turn the baby on her side (lines 9 and 11), M enters P's territory of expertise while downgrading her right to do so: M's use of indirect reported speech produces a *simulacrum* of neutrality (Holt & Cliff, 2007) and allows her to question P's advice without assuming the responsibility for the "competing version" (Silverman, 1987, p. 32). P's reception of M's turn is quite complex and displays a progressive change in her advice, contingent to its sequential position with respect to M's contribution. While the first component of her turn ("it's not important", line 10) comes in *before* M's quote, and still formulates the positive assessment of the advisable practice (although downgrading it from "that's ok, it's the same thing" in line 6, to "it's the same thing" in line 8, to "it is not important" in line 10), the second component (line 12) is uttered *after* M's turn completion. The competing reported advice is now available: the second turn constructional unit starts with a further but far less fluent confirmation (see the intra-turn pauses, line 12) and ends with the typical account-preface token - I mean - as if the speaker perceived what she said as needing some revision. The more M goes on reporting the

acquaintance's advice, the less P displays certainty as to her epistemic stance and recedes from her previous advice.

From line 14 to line 20, P explains under which conditions the baby *should* sleep on her side or *can* sleep face-down. She starts the contribution by sensibly reducing the extension of applicability of her previous advice (from 'face-down is ok' to 'only if she is under the direct supervision of awake parents'), and concludes it by pretty much reversing it: if she stays in a "Next-to-me"[9] crib it is better if she lie on her side rather than face-down (lines 18-20). The new advice is provided but, despite M's acknowledgment token (line 21), P keeps her turn and accounts for her previous (and opposite) advice: during the day when the parents are awake and present, they can put the baby face-down (lines 22 and 26). By hyper contextualizing her initial advice, P downgrades its force and reduces its domain of applicability, therefore indirectly claiming the larger validity of the competing advice and re-establishing her deontic right to validate it (line 26).

After a few turns where M reengages in "telling the baby's side" (not transcribed), in line 29 P takes the turn to account for and confirm the cooperatively constructed advice: if parents want to sleep, it is better to make sure that the baby is *not* face-down, but on her side (lines 29, 30, 32). At the end of this long sequence and thanks to M's use of reported speech and skillful management of types and sources of knowledge, P *de facto* reverses her advice, which M eventually accepts (see lines 31 and 33).

The notably high degree of epistemic vigilance displayed by the mother transforms the decision-making process into an arena where multiple perspectives and related alternatives should be compared and taken into account (e.g., another person's advice, the baby's preference). In this case at least, responsible ET is accomplished through a joint rejection of the pediatrician's former advice in favor of the acquaintance's advice, voiced by the mother and accounted for by the pediatrician.

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[9] The "Next-to-me" is a bedside sleeping crib merchandized by an Italian children's brand.

Discussion

Building on previous research on epistemics in social interaction (e.g., Drew, 2018; Heritage & Raymond, 2005), on trust as a discursive activity in healthcare interaction (Antaki & Finlay, 2013; Finlay & Antaki, 2012; O'Grady & Candlin, 2013; O'Grady et al., 2014), as well as on a long-standing tradition of studies on patients' resistance to physicians' advice and recommendations in healthcare visits (e.g., Costello & Roberts, 2001; Heritage & Sefi, 1992; Koenig, 2011; Pilnick & Coleman, 2003; Roberts, 1999; Stivers, 2007; Stivers & Timmermans, 2020), in this study we presented data from advice sequences in well-child visits. We focused on the interactional achievement of an intersubjective status that we call responsible epistemic trust. The quantitative analysis shows that one time out of three, parents resist the pediatrician's advice despite having solicited it, thus suspending unconditional epistemic trust. Different practices are deployed by parents in our corpus to resist the solicited advice, therefore engaging in epistemic vigilance:

(1) displaying previous knowledge of the advised practice (ex. 1, line 8);

(2) asking for further confirmation of the advice just provided (ex. 2, line 7);

(3) reporting competing opinions (ex. 2, lines 9 and 11).

Resistance is also undertaken through "mere" interactive means: even when they affiliate with the pediatrician's advice, parents often enter their confirming contribution *before* any possible completion point in the pediatrician's turn, which is a way to treat the expert advice as already known, obvious, and therefore not so "expert" (ex. 1, line 8). Similarly, they provide an anticipated summary of the pediatrician's advice as if it were not so new for them (ex. 2, line 24).

While soliciting advice in such an institutional encounter is – by definition - an activity through which parents display their epistemic dependency and project a more knowledgeable status to the pediatrician, they appear to undermine this same status any time

they receive the advice as if it were either obvious as in (1), or questionable as in (2). In both cases, parents break the progressivity of interaction by suspending the immediate acceptance of the pediatrician's advice in the interactive slot where it is expected. Instead, they insert expansions (Schegloff, 2007; Stivers, 2013) that make it relevant for the pediatrician to engage in the following (not mutually exclusive) activities:

(1) accounting for their advice by packaging it as a consequence of expert knowledge (ex. 1)

(2) displaying that they have considered the infant's perspective (ex. 2)

(3) possibly changing their own advice (ex. 2)

Eventually, the sequence is closed: parents accept the accounted (ex. 1) or reformulated advice (ex. 2). We consider delayed acceptance as indexing the interactive accomplishment of responsible ET.

Corroborating previous results on the prevalence of acceptance in sequences of *solicited* advice (Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Riccioni et al., 2014; Silverman, 1997) while confirming a trend singled out by Stivers' research on antibiotic prescriptions (2002, 2005, 2007), our study shows that parents do engage in challenging the pediatrician's advice even when they solicited it. By acting as if they were entitled to resist the pediatrician's expert opinion (at least by not always receiving it as unquestionable), parents perform epistemic vigilance, and therefore partially undermine the pediatrician's epistemic and deontic authority. In a few words, parents did not act as if they blindly trusted the pediatrician *qua* pediatrician.

Concluding remarks

As our data show, through their skillful use of types and sources of knowledge, parents do epistemic work: when information is relevant for them, as is the case with the suitability of caring practices, more often than expected they withdraw unconditional trust and more or less

explicitly question the pediatrician's advice. Although plain acceptance still occurs as the most frequent activity, one time out of three the requested advice on the suitability of their own caring practice is submitted to epistemic monitoring and not accepted upon unconditional ET. In light of how the sequence unfolds, even the request for advice retrospectively acquires quite a different interactional meaning. Rather than being an admission of uncertainty, a "lack of knowledge and competence, or ability to cope without assistance" (Pilnick, 2003, p. 839), it displays the advice seeker's competence and agency and opens up an arena for "debating the expert's advice" more than being the sequential condition for its acceptance. Aligning with previous findings reporting that patients can and *do* resist what may not fit their situations or align with their preferences (e.g., Costello & Roberts, 2001; Gill et al., 2010; Heritage & Sefi, 1992; Koenig, 2011; Pilnick & Coleman, 2003; Roberts, 1999; Stivers, 2007; Stivers & Timmermans, 2020; Toerien, 2021), our study adds fresh data on resistance to *solicited* advice and shows that one time out of three, parents suspend unconditional epistemic trust. This data is interesting as it partially counters data collected and analyzed forty years ago in which parents were described as mostly accepting solicited advice right away (Heritage & Sefi, 1992). This difference is longitudinally interesting as it indexes what appears to be a socio-cultural change concerning the asymmetry between the voices of experts and laypersons on infant caregiving.

Although more longitudinal studies are needed to corroborate this result, we advance that, at least within these encounters, the legitimacy criterion of expertise (i.e., who is entitled to possess the relevant tacit as well as explicit knowledge, Collins & Evans, 2007) and the extension criterion (i.e., where the boundaries - if any – are "between the knowledge of the expert and the knowledge of the layperson", p. 10) changed their domain of applicability: increasingly more often, pediatricians can no longer count on blind ET based exclusively on deference to authority. The advantages of this cultural change concerning the health professionals' recognition of the parents' agency and expertise are quite obvious. Less

obvious are the latent risks implied in the contemporary widening of the legitimacy and extension criteria of expertise in doctor-parent interaction. As recent phenomena such as vaccine hesitancy (Opel et al., 2013; Reich, 2016), parents' pressure for antibiotic prescription (Stivers, 2007), or resistance to prescription of preventive drugs (Stivers & Timmermans, 2020) index, the decline of unconditional trust based on deference to the voice of medicine can also lead to problematic outcomes: from the flattening of any relevant difference between expert knowledge and layperson knowledge in decision-making to the necessity of adopting public norms if the service user's trust in expert knowledge definitely turns into mistrust.

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Appendix A

Table A1

Distribution of solicited and unsolicited advice sequences per phase of the visit

	Opening stage	Reason for the visit	History taking	Physical exam.	Diagnostic-like phase	Treatment recommend.	Closing stage	Tot
Solicited advice	12 (15,38%)		8 (10,25%)	7 (8,97%)	38 (48,71%)	8 (10,25%)	5 (6,41%)	78 (100%)
Unsolicited advice	15 (22,38%)		11 (16,41%)	9 (13,43%)	17 (25,37%)	9 (13,43%)	6 (8,95%)	67 (100%)
Tot	27 (18,15%)		19 (13,10%)	16 (11,03%)	55 (37,93%)	17 (11,72%)	11 (7,58%)	145 (100%)

Appendix B

Transcription conventions adapted from Jefferson (2004)

,	Slightly upward intonation
?	Upward intonation
.	Falling intonation
[	Onset of overlapping talk
]	End of overlapping talk
=	Latching
(0.0)	Silences in tenths of a second
(.)	Brief interval of less than two-tenths of a second
wo:::rd	Prolongation of the immediately prior sound
wo-	Abrupt cut-off or self-interruption of the sound in progress
( )	The transcriber was unable to get what was said
(word)	Talk is dubious
w<u>or</u>d	Stress or emphasis
((words))	Transcriber comments and descriptions
°word°	Quieter talk
WORD	Louder talk
>word<	Faster talk
<word>	Slower talk
^	Starting point of correspondence between an embodied conduct and a stretch of talk