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"Doing being a good parent" in the pediatric clinic: Parents' knowledge displays in advice requests on infants' everyday care

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ABSTRACT

Parents and pediatricians play pivotal roles in promoting a nurturing environment for children's growth and development, especially during the critical first thousand days of life. Given the challenges involved in infant care and rearing, parents often rely on pediatricians' professional support in a wide range of daily caregiving practices as diverse as complementary feeding, hygiene management, pacifier use, or sleep routines. Nevertheless, little attention has been devoted to the *in vivo* observation of how parents actually request advice on babies' everyday care, and how pediatricians attend to such requests. By adopting a conversation analysis approach to a corpus of 23 videorecorded Italian pediatric well-child visits, the article explores the different ways through which parents navigate the face-threatening activity of soliciting the pediatrician's advice on infants' everyday care and management. The analysis illustrates that parents overall display (different degrees of) prior knowledge and competence on the topics brought to the pediatrician's attention while, at the same time, acknowledging the pediatrician's expertise and professional role. In this way, I argue that parents display themselves as competent, knowledgeable, caring, and therefore "good parents". After discussing the results, in the concluding remarks I point to what seems to be a cultural change in parent-healthcare provider interactions.

1. Introduction

Children's everyday care and rearing involves a polyphony of expert voices that are institutionally responsible for the promotion of children's health and well-being (Caronia et al., 2023). When it comes to infancy, parents and pediatricians play pivotal roles in ensuring a nurturing environment to facilitate infants' growth and development. This is particularly relevant during the critical 'first thousand days of life' (Cunha et al., 2015), which, as literature has extensively shown, significantly impact individuals' long-term health, well-being, and social inclusion (e.g., Agosti et al., 2017; Thurow, 2016). As caring for a baby can be an overwhelming and challenging experience for parents, they often rely on pediatricians for guidance on a wide range of child-rearing issues as diverse as complementary feeding, diaper changing, pacifier use, or sleep routines. In this regard, pediatric well-child visits are the most suitable environment for dealing with such concerns as they are aimed at monitoring and evaluating children's global health and development as well as supporting parents in their new role. Even though understanding the interactional dynamics between parents and pediatricians in addressing childcare issues can help identify ways to improve communication and parental support - which in turn can benefit children's (long-term) health and development - little attention has been devoted to the *in vivo* observation of how parents request advice, and how pediatricians attend to such requests in real life well-child visits (but see Heritage and Lindström, 1998; Heritage and Sefi, 1992).

Adding fresh data and new insights to this overlooked aspect of pediatric visits, the article investigates how parents navigate the delicate discursive activity of soliciting expert advice on babies' everyday care during well-child visits. But why are parents' requests for advice relevant? While asking for advice has been described as a face–threatening activity for parents as it implies an admission of incompetence, lack of knowledge, or, at least, uncertainty on how to appropriately take care of their child (see Heritage and Sefi, 1992; Pilnick, 2003), I contend that, and empirically show how, it also indexes the advice seeker's *agency* and *competence*. By engaging in a first-positioned initiating activity (Schegloff, 2007) and taking the turn to ask, parents not only act as if they feel legitimized to actively participate in the visit but possibly perceive this practice as a way to stage themselves as caring, concerned parents who reflexively think about what to do to promote the best interests of their child.

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By employing a conversation analysis approach to a corpus of 23 videorecorded Italian pediatric well-child visits, the analysis shows that through the different ways parents design their advice requests, they consistently avoid displaying a relative lack of knowledge and/or competence concerning their baby's everyday care; rather, they engage in epistemic, deontic, and moral work so as to display themselves as competent, knowledgeable, and concerned parents. Nonetheless, by the very act of seeking advice, the parents downgrade - to different extents - their right to "know and decide" and recognize the "baby expert" status socially attributed to, and locally enacted by, the pediatricians. As I contend, parents seem visibly oriented toward finding a balance between two opposing yet equally preferable stances: on the one hand, they display their knowledge and entitlement to decide about their child's care, while on the other, they display their acknowledgment of the pediatrician's ultimate epistemic and deontic authority. In doing so, I argue that parents display their orientation toward culturally-informed models of "doing being" (Sacks, 1984, p. 416) "good" parents. "Good parenting" is not here conceived of as an a-priori definite set of "good practices" that parents (should) follow to act as "good" parents in contrast with other predetermined "bad practices". Rather, the article sheds light on the practices deployed by parents to display *their* understanding of what constitutes a "good" parent (for a similar approach, see Heritage and Lindström, 1998; Pillet-Shore, 2015; Prettner et al., 2023).

2. Advice sequences in healthcare settings

Giving medical and health-related advice constitutes a core component of physicians' everyday professional practice. The first groundbreaking work investigating the delivery and reception of advice in healthcare settings was the seminal paper by Heritage and Sefi (1992) on advice sequences in conversations between health visitors and first-time mothers. The description of advice as an interactional accomplishment provided by the authors has strongly influenced subsequent studies exploring advice in different healthcare contexts such as HIV and AIDS counseling (Kinnell and Maynard, 1996; Silverman, 1997), genetic risk communication (Sarangi & Clarke, 2002a, 2002b), patient-nurse interaction (Leppänen, 1998), patient-pharmacist interaction (Pilnick, 1999, 2001), or telephone helplines (Butler et al., 2009, 2010; Hepburn and Potter, 2011). The orientation toward *normativity* and the *epistemic asymmetry* between the advice-giver and the advice-seeker/receiver have been recognized as the two key features of advice (Heritage and Sefi, 1992; Hepburn et al., 2018). The normative dimension of advice refers to the fact that it promotes a possible future course of action that the advice recipient should undertake as it is considered (and treated as) the most appropriate, healthy, or standard. As such, giving advice is a morally laden practice as it implies framing the suggested course of action as the "ought to be", taking responsibility for that suggested conduct, and maintaining it as the most beneficial for the patient. However, it is not a prescription as it leaves the recipient with some room for choice (see Fatigante and Bafaro, 2014; Pilnick, 2003). Second, advice "assumes or establishes an asymmetry between the participants" (Hutchby, 1995, p. 221) since the advice-giver physician typically assumes the more knowledgeable position ("K+", see Heritage, 2012a, b) while the advice recipient and/or seeker patient occupies the less knowledgeable position ("K-", ibidem).

Advice sequences in healthcare interactions are also strictly related to deontic rights and authority (Stevanovic and Peräkylä, 2012). Since advice-giving consists of "forwarding or promoting a possible future course of action" from the alternatives (Pilnick, 2003, p. 837), 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 pediatricians' advice, see Caronia and Ranzani, 2024; Stivers, 2005).

It therefore comes as no surprise that research on healthcare professionals' advice-giving has described this activity as delicate and face-threatening (see Fatigante and Bafaro, 2014; Heritage and Sefi, 1992; Heritage and Lindström, 1998, 2012; Silverman, 1997). As Fatigante and Bafaro (2014) 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" (p. 159). In this regard, the bulk of the research focused on how healthcare professionals interactionally manage the delicacy of delivering advice so as to minimize the risk of patients' "face loss" and disaffiliative actions while at the same time pursuing their institutional mandate (e.g., Antaki and Bloch, 2020; Butler et al., 2009, 2010; Connabeer, 2021; Kinnell and Maynard, 1996; Leppänen, 1998). If giving advice constitutes a particularly challenging task for healthcare professionals as they have to manage the epistemic and deontic tensions at stake, it is not an easier job for patients to solicit advice as the next section illustrates.

2.1. Patients' advice requests and the delicate issue of knowledgeability

The epistemic and deontic asymmetries between the advice giver and the advice seeker/recipient are particularly evident when the request for advice comes from the patient: in and through this activity, the patient positions themself as the one who does not possess (or is uncertain about) relevant knowledge and as the one who does not know what to do, thereby projecting the physician as the epistemic and deontic authority. How do patients manage this delicate yet crucial activity?

Heritage and Sefi's (1992) seminal paper once again provides the most prominent analysis of how advice is sought in healthcare interactions. Focusing on the turn design level, the authors identified two main ways through which mothers sought the health visitor's advice. First, they used direct requests formatted as either open or closed questions. The authors noted that the majority of mother-initiated advice was packaged as requests for confirmation of proposed courses of action that, compared to open-formatted questions, conveyed a certain degree of knowledge or competence on the mothers' part and required only a "fleeting confirmation" (p. 371) from the professional. The second and more indirect way mothers deployed to solicit advice was through reports of an "untoward state of affairs" (p. 373) treated as potentially problematic. In these cases, it was up to the health visitor to determine whether the problems implied by mothers' reports were worthy of advice.

Interestingly, Heritage and Sefi found that mothers were overall reluctant to solicit advice either explicitly or implicitly. Indeed, in terms of the frequency of solicited advice, they identified a total of 7 occurrences of mother-initiated advice in their corpus, which amounted to 10% of the total of advice sequences (see Heritage and Sefi, 1992, p. 373). Clearly, the majority of advice sequences were initiated by the health visitor (90%). According to the authors, both the infrequency of mother-initiated advice and the design of their requests (i.e., privileging confirmation requests over open questions) index mothers' fears of being judged as ignorant or incompetent in their mothering skills by a person "with officially accredited competences to judge their conduct" (Heritage and Sefi, 1992, p. 366).

In line with Heritage and Sefi's findings on the (in)frequency of advice requests, other scholars have documented a paucity of occurrences of patients'/parents' requests for advice in different healthcare contexts like patient counseling by pharmacists (Pilnick, 2003) and HIV and AIDS counseling (Kinnell and Maynard, 1996; Silverman, 1997).

Only a more recent study carried out by Zayts and Schnurr (2012) provides us with a quite different scenario in terms of the frequency of occurrences of solicited advice. Analyzing interactions between expectant mothers and medical professionals in a prenatal screening program for Down Syndrome in a Hong Kong hospital, the authors report that mothers explicitly asked for the doctor's advice "in one third of the 100 consultations […] recorded" (p. 196). However, by paying particular attention to how physicians manage mothers' advice requests on testing options, fewer insights on how mothers design their requests and manage their relative K- position are offered. Nonetheless, the examples provided by the authors (and described as representative of the entire corpus) seem to show that mothers are not so reticent to overtly display their lack of relevant knowledge.[1] In sum, the findings of Zayts and Schnurr (2012) seem to stand in stark contrast with the requests for advice analyzed by Heritage and Sefi (1992) in health visitor service both in terms of their frequency and turn design. Even though the authors do not explicitly interpret parents' claims of no knowledge as related to the specific territories of professional and lay expertise, it seems reasonable to infer that when decisions about screening tests (i.e., a biomedical domain) are to be made, asking for the expert's opinion does not entail a maternal "loss of face" as in the case of everyday baby caring practices. Child-rearing is arguably a territory where the boundaries between parents' and pediatricians' respective domains of expertise are blurred and are not as clear-cut as in the case of diagnosing and treating acute, chronic, genetic, or other kinds of severe diseases.

The next section addresses the specific characteristics of well-child visits.

2.2. Advice in well-child visits and the morality of parenting

Well-child visits are routine health checks where the healthcare provider (in Italy, the family pediatrician) examines and tracks the child's physical growth and his/her cognitive, psychomotor, emotional, and social development according to the sex- and age-specific expected standards. In particular, in the age range from 0 to 18 months, pediatricians measure the baby's weight, length/height, and head circumference; they do neurosensory screening and evaluate sight and hearing; they perform behavioral, social, emotional, and developmental screening; they inform parents about immunization programs; they answer any possible questions or concerns regarding child rearing practices. In a nutshell, the general aim of well-child visits is to provide a global assessment of the child's health status and developmental milestones from a preventive perspective and to support caregivers in their new, challenging role. Despite their cruciality, previous studies have predominantly focused on a variety of pediatric settings as diverse as acute care encounters (Stivers, 2007), pediatric oncology units (Aronsson and Rundström, 1989), palliative care (Ekberg et al., 2019), or allergy consultations (Jenkins et al., 2020), leaving less explored the specific domain of children's everyday care and management (but see Heritage and Sefi, 1992; Krippeit et al., 2014; Zanini and González-Martínez, 2015).

The epistemic and deontic tensions at stake in sequences of advice in healthcare interactions are particularly evident in pediatric well-child visits, where the management of knowledge asymmetries are notably interwoven with morally loaded implications (see Heritage and Sefi, 1992; Heritage and Lindström, 1998, 2012; Silverman, 1987).

As parents are socially expected to be responsible for looking after, monitoring, and promoting children's health and well-being in competent and knowledgeable ways, requesting advice on everyday baby management issues can put parents in a morally sensitive position. While, as I argue, soliciting advice can be interpreted as indexing a caring, concerned parent, still it can be received as implying a failure to know how to act in the best interests of the child and, consequently, a failure to perform as "good parents". In fact, when asking for the pediatrician's advice, parents are faced with a "moral dilemma": if, on the one hand, withholding their doubts and concerns on how to manage their babies by avoiding asking for advice risks indexing a lack of interest and "caring attitude", on the other, drawing doubts and concerns to the pediatrician's attention by asking for advice risks displaying a lack of knowledge and/or competence on how to appropriately take care of the child. As a matter of fact, "morality is ubiquitous" (Heritage and Lindström, 1998, p. 399) in these visits: as sequences of advice illustrate, parents' lay theories and conduct are the unofficial "assessable" of these institutional encounters.

3. Data and methodology

This study draws on a corpus of 23 pediatric well-child visits videorecorded by the author in two public pediatric clinics located in a North Italian region. The study involved two general pediatricians and twenty-two middle-class families (constituted of 21 mothers and 6 fathers) with children aged 0–18 months. Participants were recruited by the author using convenience sampling. Written consent was obtained by all participants in compliance with Italian law n. 196/2003 and 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 data were transcribed and analyzed employing conversation analysis (CA) theoretical and analytical constructs (Sidnell and Stivers, 2013; Jefferson, 2004) which are used extensively in the study of healthcare communication (Barnes, 2019). In a nutshell, CA is a data-driven, micro-analytical approach to the study of naturally occurring social interaction (i.e., not elicited by the researcher) that focuses on how participants accomplish social actions through multimodal conduct (i.e., using verbal as well as bodily, facial, and material resources; see Mondada, 2014). Transcripts are presented in two lines: original Italian and an almost literal English translation. For the sake of anonymity, all names have been fictionalized.

4. Analytical procedures

To identify sequences of advice in the corpus, I drew on Heritage and Sefi's (1992) former definition, i.e., the interactional practice through which the professional "describes, recommends or otherwise forwards a preferred course of future action" to the client (p. 368). I considered this definition sufficiently "loose" and provisory (Edwards, 2005) to grasp the fact that activities other than describing or recommending appeared to be treated as advice in the corpus. Indeed, Heritage and Sefi's (1992) description of advice is "deliberately broad" (Pilnick, 1999, p. 614) so as to "allow for the issue of what counts as advice to be treated as an empirical matter" (Butler et al., 2010, p. 266). From this standpoint, I assume that when an opinion, a confirmation, permission, or even an

[1] See for instance the following cases: "Which is the best for me? I don't know" (ex. 1, p. 201), or "because of course you may know better than I do when it comes to medical thing. So what do you suggest?" (ex. 2, p. 204).

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 institutionally sanctioned epistemic authority of the advice giver - is relatively constraining (i.e., it is not information giving) although it leaves some room for maneuver to the recipient (i.e., it is not a prescription).

After rigorous scrutiny of the video recordings, I identified a total of 145 instances of pediatricians' advice-giving. Then, I classified the instances of pediatricians' advice-giving according to their sequential position and identified: a) 67 instances of advice-giving in first position (46%), i.e., unsolicited advice that initiates a sequence and makes sequentially relevant a second pair part by the parent (acceptance or different forms of resistance, see Caronia and Ranzani, 2024), and b) 78 instances of advice-giving in second position (54%), 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.

For the purposes of this article, I focus on instances of *solicited* advice. The reason is threefold. First, because this discursive activity is underexplored compared to the extensively investigated activity of professionals' advice-giving. Second, though related, this corpus is a privileged observatory for the study of solicited advice given the higher frequency of such requests compared to data from previous studies. Finally, parents' requests for the expert's advice constitute a perspicuous environment for investigating how participants interactionally manage their epistemic and deontic rights as well as how they orient themselves toward the culturally shared models of "good parenting".

By paying particular attention to the turn design level, I identified two main activities through which parents solicit the pediatrician's advice on baby care issues: questioning (N = 43) and reporting (N = 35).[2] Within the former activity, parents design their question-formatted advice requests via two main grammatical formats: open questions (N = 7) and polar questions (N = 36). Interestingly, and in line with Heritage and Sefi's (1992) findings, polar questions are packaged as requests for confirmation of either a proposed future course of action (N = 34) or about an already undertaken course of action (N = 2). I consider question-formatted requests for advice as explicit requests since they make an advice-implicative answer from pediatricians sequentially relevant, i.e., outright advice, confirmation, permission, or assessments about the proposed or undertaken conduct (on "advice implicative actions", see Shaw et al., 2015). As for the report-formatted advice requests, they are grammatically packaged as declarative statements reporting: 1) a (often treated-as-problematic) baby's conduct (N = 19); 2) an (often treated-as-problematic) already undertaken course of action (N = 10); 3) the intention to undertake a future course of action (N = 6); or 4) a (often treated-as-problematic) mother's conduct (N = 1). I consider report-formatted requests for advice as implicit requests since they do not make sequentially relevant a subsequent delivery of advice, but they create a discursive environment in which it can be provided. As Drew (1984) put it, "reportings recurrently involve a speaker detailing some activities or circumstances without explicitly stating the implications of the reporting, an upshot or consequence. […] It is left to recipient to discover the upshot of a reporting" (p. 137). Given the specific institutional context of the well-child visit and the institutionally relevant goals, activities, and identities at stake, pediatricians in this corpus (often) treat parents' reporting as *doing* seeking advice.

The next sections illustrate how, while acknowledging the pediatricians' epistemic and deontic primacy by the very act of seeking advice on issues related to baby management, parents are overall reluctant to display their lack of knowledge and competence. Rather, through the ways they design their requests for advice, they display different degrees of knowledge and competence and occupy different positions along the epistemic gradient (i.e., less knowledgeable [K−] or more knowledgeable [K+], Heritage, 2012a, b).[3] In doing so, they perform "being good parents." The excerpts are presented in a crescendo of parental displays of knowledge.

5. Results

5.1. Asking the pediatrician's advice by displaying some degree of knowledge: the case of confirmation requests

In line with Heritage and Sefi's (1992) analysis of mother-initiated advice sequences, requests for confirmation are the most common format adopted by parents seeking a pediatrician's advice in this corpus (N = 36). By asking for confirmation, parents attribute the primary right to know and decide what is best for their child to the pediatricians but, at the same time, claim their (partial or uncertain) knowledge of the issue at hand. Parents'[4] confirmation requests about proposed future courses of action (N = 34) or already undertaken courses of action (N = 2) invite the pediatricians to either validate or reject parents' claims.

The following example shows how a mother skillfully asks for the pediatrician's advice on complementary feeding by asking him to confirm her proposal from among suggested alternatives.

Ex. 1 – PI_5_24 – 01 – 20 (19.07v1 – 00.08v2)

M: mother P: pediatrician G: grandmother

We join the conversation right after the physical examination. M is standing close to the couch dressing her 5-and-a-half-month-old son and is out of the view of the video camera. P is sitting at the desk, writing at the computer, and G is sitting in front of him. Immediately before the conversation starts, P asked M what the baby is eating at the moment. M replies that she is giving the baby only breastmilk but that she would like to start complementary feeding.

[2] As previous research on epistemics in social interaction has demonstrated (e.g., Drew, 2018; Heritage, 2012a,b; Sidnell, 2012), the activities of "asking" and "telling" in first position index a differential distribution of knowledge between the speaker and the recipient: while by asking a question the speaker typically projects a more knowledgeable stance to the recipient, conversely the activity of telling typically presupposes that the speaker "knows more" than the recipient. As is well known, through the ways speakers design their questioning and telling activities, they modulate their relative epistemic position and adjust the depth of the epistemic gradient (Heritage, 2012a, 2012b). For example, by using hedges such as "I think" or "I suppose", or evidentials such as "it seems" or "it appears", a speaker can downgrade the basic K+ position inherent in the telling activity. Similarly, different question designs serve to regulate the K-position presupposed by the very act of asking a question. While, in a nutshell, open questions typically display the speakers' lack of knowledge, confirmation requests convey a certain degree of knowledge by the speaker and reduce the epistemic gap between speaker and recipient (for a detailed discussion on the complex relationship between question design, epistemics, and action formation, see Heritage, 2012a,b; Heritage and Raymond, 2021; Raymond and Heritage, 2006).

[3] For space reasons, instances of open questions (N = 7) whereby the parents position themselves in the lowest degree of the epistemic gradient will not be analyzed here.

[4] Even though the excerpts analyzed involve only mothers, displays of knowledge are also performed by the (few) fathers participating in the study. While this sample is by no means representative, the fact that the majority of the visits are led by the mother suggests the persistence of a gendered division of childcare.

1 M eh però dottore non mi ricordo qua-
but doctor I don't remember whe-

2 M devo cominciare con la pappina
do I have to start with the baby food

3 M solo a pranzo?
only for lunch?

4 (0.7) *((P keeps looking at the computer))*

5 M per qualche settimana,
for a few weeks,

6 M e poi anche a cena?=
and then for dinner too?=

7 M =o posso fare pranzo e cena?
=or can I do both lunch and dinner?

8 (1.5) *((P momentarily stops writing at the computer))*

9 M non mi [ricordo.
I don't [remember.

10 P [no. *((writing at the computer))*

11 P si inizia solo con la- con la-
one starts only with the- with the- *((writing at the computer))*

12 P solo con quella di mezzogiorno,
only with the lunchtime,
((writing at the computer))

13 M ah ok.
oh ok.

The excerpt starts with M asking P for advice on how to start complementary feeding. In line 1, she prefaces the advice request with the "I don't remember" interactional resource ("but doctor I don't remember whe-", line 1) which mitigates the assertiveness of her following turn while at the same time evokes a prior knowledge of the projected state of affairs (note that she is not a first-time mother). The topic at hand is made explicit in lines 2 and 3, where M asks P to confirm whether she has to start giving the baby mashed food only for lunch. By asking him to confirm an "embedded proposal" (Heritage and Sefi, 1992, p. 370) within her request and prefacing it with the "I don't remember" strategy, M constructs herself as uncertain about the most appropriate course of action but still partially knowledgeable on the issue at stake: she displays knowing that there are ad hoc guidelines for giving complementary food to the baby, but she does not remember them. Concurrently, M treats P as the epistemic and deontic authority: he is the one entitled to "know best" and decide when in the day complementary food should be first introduced (note the use of the Italian deontic modal *devo*, "I have to", line 2, which further strengthens P's right to establish the "ought to be").

Upon P not answering (line 4), M continues her advice request trajectory and enriches her former proposal with additional information: should the meal be given only for lunch for a few weeks (line 5) and then also for dinner (line 6)? Immediately after (see the latching, line 7), and despite the transition relevant place being reached, M keeps the turn and proposes an additional course of action alternative to the one previously indicated (=or can I do both lunch and dinner?", line 7). Through the ways M designs her advice request, i.e., by asking for confirmation rather than using an open-ended question and by listing and proposing two different and pretty specific options, M performs herself as having at least some partial knowledge and competence on how to deal with complementary feeding. Furthermore, she performs herself as a mother who cares, and knows how to care, for her baby. At the same time, by displaying uncertainty and asking P to choose and validate at least one of the proposed future courses of action, she projects P as the epistemic and deontic authority.

A fairly long gap follows M's advice request (line 8): even though P stops writing at the computer for a moment, he does not provide any reply. Thereupon, in line 9, M recycles the "I don't remember" interactional resource already deployed in line 1 ("I don't remember", line 9). This repetition can be heard as doing different things. First, it may be seen as a pursuit of a response from P as he did not provide it in the interactional locus where it was expected (see line 8). Second, it reiterates M's uncertainty concerning the most appropriate feeding practice while concurrently revealing some prior knowledge: the unstated

yet conveyed message is that she used to possess relevant knowledge of how complementary feeding should begin, but at present, she cannot recall it. Disclosing some prior knowledge can be heard as less morally problematic and face-threatening than not knowing at all. Third, the repetition can be considered an account of the contrasting alternatives put on the table by M's advice request. Finally, it can be seen as a way to downgrade her incursion into P's epistemic and deontic domain: knowing and suggesting the most appropriate age-specific feeding practice should be part of the pediatrician's professional remit.

At this point, in partial overlap with M's prior turn (line 9), P disconfirms M's second proposal in favor of the first one: when starting the transition from milk to solid food, the baby has to be given complementary food only for lunch ("no. one starts only with the-with the-only with the lunchtime", lines 10–12). Note that the advice is not only provided in the form of a "non-personalized advice" (Silverman, 1997; see the Italian impersonal form of the present tense, *si inizia*, "one starts", line 11) and therefore packaged as a general normative rule, but the disconfirming "no" in turn-initial position also frames its content as unquestionable. In this way, P does a number of things with his words: 1) he establishes his epistemic and deontic authority on the matter, 2) recognizes M's partial knowledgeability by confirming one of the two alternatives embedded in her proposal, and 3) conveys a culture-specific and ideal model of weaning according to which complementary food has to be introduced following a specific and established timeline. The sequence is finally closed with M's acceptance of P's advice ("oh right", line 13; on the use of "oh right" to convey advice acceptance, see Heritage and Sefi, 1992) which treats the information provided by P as "news" and ratifies P as the ultimate epistemic and deontic authority on the subject.

The next example shows how a mother asks the pediatrician to confirm an embedded proposal, which however is disconfirmed and rejected.

Ex. 2 – PI_2_16.10.19 (18.17 – 18.31 v1)

M: mother P: pediatrician F: father

We join the conversation at the initial stage of the visit, where the pediatrician is providing different pieces of advice and soliciting questions from the parents about the management of their one-week-old newborn child.

1	M	anche il discorso del cambio pannolino adesso:, also the issue of the diaper change now:,
2	M	cioè lo laviamo sempre solo con l'acqua? I mean shall we still clean him only with water?
3		(0.5) *((P is looking at the computer, M looks at him))*
4	M	se non ci son problemi unless there are problems
5	M	non stiamo neanche a mettere cremine, robe? we don't even put any lotion, stuff?
6	P	^no allora la cremina con coll'ossido di zinco, ^no so the lotion with the the zinc oxide, ^*((stops looking at the computer and turns toward M))*
7		che fa un effetto un po' barriera, that gives a bit of a barrier effect,
8		e prote[gge un] po' (dalla), and prot[ects a] bit (from),
9	M	[o k],
10	P	quella si può mettere. you can put that one.
11	M	ok. >°quello non ci son problemi°<. ok. >°there are no problems with that one°<.

At the beginning of the excerpt, M first establishes the diaper changing of her one-week-old son as the relevant topic of discussion ("also the issue of the diaper change now:," line 1) and then asks for advice on how to clean the baby in that circumstance ("I mean shall we still clean him only with water?", line 2). M's question is formatted as a confirmation request on a proposed future course of action that, as in ex. 1, works to construct herself as uncertain about the most suitable conduct but still partially informed and competent on the issue at stake: she displays herself as possessing semi-expert knowledge of the fact that a newborn baby's genital area should allegedly be cleaned only with water for at least the first weeks of life. Interestingly, M's turn also implies that they are currently cleaning the baby just with water (see the adverb "still", line 2), and therefore the request for confirmation on the most appropriate future conduct can also be heard as a request for validation of the already undertaken parental conduct. After a short gap where P is looking at the computer (line 3), M expands her turn and elaborates the advice request by making more explicit and specific the source of her doubts, namely the use of baby lotions to clean the baby's genitalia ("unless there are problems we don't even put any lotion, stuff?", lines 4 and 5). M's formulation of the content of her previous confirmation request (lines 1 and 2) into a more specific one (lines 4 and 5) can be heard as doing different things: first, as pursuing a response from P; second, as asking for permission to use lotions; and third, as re-asserting her partial knowledge on the topic at hand and displaying her concern. Concurrently, by delegating to P the ultimate right to validate and make a decision on the proposed future courses of action, she interactionally treats P as the epistemic and deontic authority.

P's response finally arrives in line 6. However, a problem of "face" emerges as P produces a dispreferred move in his responsive turn: he disconfirms M's proposal. Indeed, with a "no" in turn-initial position, P first rejects M's proposal of avoiding using lotions ("no so the lotion with the zinc oxide", line 6), then provides a biomedically-informed explanation for his disconfirmation ("that gives a bit of a barrier effect and protects a bit (from)", lines 7 and 8), and finally provides his advice - the content of which contrasts with M's suggestion ("you can put that one", line 10). In this way P: 1) addresses M's doubt and grants her permission to use the zinc oxide lotion; 2) provides an account for his advice; 3) locally undermines M's knowledgeability on the matter at stake; and 4) establishes his epistemic and deontic authority. The sequence is closed when M accepts P's advice ("ok. >°there are no problems with that one°<", line 11), thereby aligning with P as the ultimate authoritative voice. Yet, note that by formulating P's advice ("you can put that one", line 10) as "there are no problems with that one" (line 11), M displays her understanding of the course of action suggested by P and her commitment toward it, which can be seen as an attempt to "repair" her face previously compromised by P's rejection of her proposal.

To sum up, the examples in this section have shown how the mothers perform "being a parent" by interactionally constructing themselves as partially competent and knowledgeable but caring mothers, who explicitly submit their requests and doubts to the pediatrician's attention for their final validation. It seems as if "doing being a good parent" in these cases does not only correspond to mobilizing the (uncertain) repertoire of first-hand, semi-expert knowledge available, but it also means seeking and acknowledging the expert's voice.

In the next section, two cases of report-formatted advice requests are analyzed. Compared to the examples analyzed so far, the epistemic and deontic gradient between the pediatrician and the parent is less steep.

5.2. Soliciting the pediatrician's advice by displaying a higher degree of knowledge: the case of report-formatted requests

As previously mentioned, parents' report-formatted requests for advice occur 35 times out of a total of 145 advice requests (see section 4). These implicit requests are grammatically designed as declarative statements that, compared to confirmation requests, project a more knowledgeable status of the speaker (Sidnell, 2012).

Ex. 3 – PI_5_24 – 01 – 20 (19.07v1 – 00.08v2)

M: mother P: pediatrician G: grandmother

We join the conversation right after the physical examination. M is standing close to the couch dressing her son and is out of the view of the video camera. P sits at the desk, writing on the computer, and G sits in front of him.

1	M	col primo febbraio on the first of February
2	M	volevo cominciare con le pappine I'd like to start with the baby food
3		(2.0) *((P is looking and writing at the computer))*
4	P	s:ì sì direi: (.) di sì. ye:s yes I'd say: (.) yes. *((writing and looking at the computer))*
5	M	che ha cinque mesi e mezzo, since he'll be five and a half months,

At the beginning of the excerpt, M reports her willingness to start giving complementary food to the baby ("on the first of February I'd like to start with the baby food", lines 1 and 2). In contrast to asking for P's advice through a confirmation request (as in ex. 1 and ex. 2) that projects a more knowledgeable position to the recipient, the use of a report-formatted request for advice constructs M as the most competent interlocutor on the issue at stake. In fact, through this report, M steps into the "baby-expert" (Heritage and Sefi, 1992, p. 365) territory of expertise and claims her epistemic and deontic authority to know and decide when complementary feeding should start ("on the first of February", line 1) and what type of food is more appropriate ("I'd like to start with the baby food", line 2). In this way, she constructs herself as an informed, caring, and therefore "good" mother. Note that the use of the Italian imperfect tense *volevo* ("I'd like to", line 2) conveys the sense that the decision has already been taken, but still, it does so in a fairly mitigated fashion (as opposed to the more assertive present simple *voglio*, "I want to", and to the more tentative conditional tense *vorrei*, "I wish").

After a 2-s gap (see line 3) where P is writing diagnostic-like information previously gathered at the computer (not transcribed), P provides a confirmation that retrospectively treats M's report as an implicit request for advice ("ye:s yes I'd say: (.) yes", line 4). Note that through this advice-implicative confirmation, P grants M permission to start with complementary food and concurrently re-affirms his right to ultimately validate the course of action proposed by M. Interestingly, P's partially hedged response ("I'd say: (.) yes", line 4) can be seen as a means of mitigating his delicate position of being the entitled authority who is "giving permission" to M to give complementary food to her child. Note that P's delayed reply can be explained by the fact that while M reports her intention to give the baby complementary food, P is engaged in another activity, that is entering diagnostic-like information on the electronic health record (see lines 3 and 4, where P is looking and writing at the computer). At this point M expands her turn by providing an account for her proposal ("since he'll be five months and a half", line 5), which further constructs her as a knowledgeable and competent mother, i.e., she knows exactly which age is appropriate for complementary feeding. Through the way M constructs her report, she asserts her primary rights of knowledge and decision-making about her baby's feeding practice thereby performing her doing "being a good parent".

The next example shows another case of stronger knowledge display by a mother.

Ex. 4 – VA_5_11.11.19 (6.00 – 6.34 v.2)

P: pediatrician M: mother

We join the conversation after the physical examination. P is sitting at the desk filling out the diagnostic checklist and M is sitting in front of her holding the baby. Earlier in the consultation, M reported to P that the baby - who is almost 1 year old - often sucks her finger.

1	M	io di ciucci siccome già sono contraria al ciuccio
		I about pacifiers because I'm against the pacifier
2	M	>si figuri il dito<,
		>just think about the finger<,
3	M	e: le ho sempre preso lo zero sei mesi,
		a:nd I've always taken her the zero six months,
4	M	perché [per me] è inutile
		because [for me] it's useless
5	P	[se.]
		[yeah.] *((looking at M))*
6	M	prendere i ciuccioni,
		to take the big pacifiers,
7	P	infatti anche io [sono] di questo av[viso]
		indeed [I'm] of the same op[inion]
8	M	[eh.] [ok] bene.=
		[eh.] [ok] all right.=
9	P	=e non vanno cambiati
		=and they don't have to be changed
10	P	vanno mantenuti piccoli
		they have to be kept small
11	M	zero sei mesi vanno bene,
		zero six months are ok,
12	P	esatto.
		exactly.

At the beginning of the excerpt, M explicitly asserts her aversion to the use of the pacifier ("because I'm against the pacifier", line 1) and then specifies that she is even more against the thumb sucking (">just think about the finger<,", line 2). In and through this turn, M carries out impressive epistemic and moral work. First, she establishes the topic of the pacifier as the relevant matter of discussion and constructs it as a "moral object" (i.e., the use of the pacifier is explicitly treated as a "wrong", "bad" practice). Second, she claims her independent knowledge of the socially sanctioned appropriate conduct when it comes to babies' suction (i.e., both the pacifier and the finger are "bad" practices, but the finger is "worse" than the pacifier). Furthermore, she firmly asserts her right to evaluate what is the alleged best conduct (i.e., she assesses that the pacifier is better than the finger), thereby intruding upon P's territory of expertise. Finally, by aligning to what is framed as the socially sanctioned appropriate opinion and conduct, M constructs herself as a "good mother" who is sensitive and aware of the delicateness of such an issue.

Immediately after that, M reports a practice that she has been carrying out (see the use of the temporal deictic "always", line 3): not only did she use the pacifier intended for children aged from zero to six months when the baby was under six months of age, but she now continues to use it even though her daughter is 1 year old (line 3). In this way, M affirms her deontic authority to make autonomous decisions concerning the use of the pacifier: she has not only decided and evaluated on the basis of her knowledge what is the best course of action for the child, but she has undertaken it without first asking P's opinion. Retrospectively, M's preface in lines 1 and 2 can be heard as an account serving to lessen the possibly problematic nature of her conduct: on the one hand, M has stepped into P's epistemic and deontic domain (i.e., knowing, evaluating, and deciding by herself the most suitable practice), while on the other, she has bought pacifiers designed for very young babies despite the fact her child is almost 1 year old. Yet, importantly, by the very fact of reporting her own opinion (line 1), evaluation (line 2), and previous conduct (line 3), M is making them available, and therefore inspectable and assessable, by P (see Drew, 1984).

Then, despite the fact the transition relevant place has potentially been reached, M keeps taking the turn and provides an account for her (potentially problematic) conduct of using pacifiers for younger babies ("because for me it's useless to take the big pacifiers", lines 4 and 6). Through this account, M continues her work of staging herself as a knowledgeable, competent, and caring mother while concurrently channeling P's attention toward considering her decision and granting her permission to use the pacifier for younger babies (line 3) rather than the use of the pacier *per se* (line 1).

Immediately after that, P replies by agreeing with M's stance concerning the appropriateness of the use of "small" pacifiers: "indeed I'm of the same opinion" (line 7). By ratifying the appropriateness of M's caring practice and the rationale behind that practice, as well as aligning with M's embedded moral stance (i.e., since using big pacifiers is constructed as a "wrong" practice, by implication M, who gave the baby small pacifiers, is a "good mother"), P acknowledges M's knowledgeability and competence on the matter at hand and re-establishes her epistemic and deontic rights to assess and validate the most appropriate approach to the child's care. Then, P continues her trajectory and provides a "non-personalized", and pretty prescriptive, piece of advice: "they don't have to be changed they have to be kept small" (lines 9 and 10). In this way, P firmly asserts her epistemic and deontic authority. The sequence is closed after M's advice acceptance is displayed through a summary of the content of P's advice ("zero six months are ok,", line 11; on summarizing the just-offered advice as a form of acceptance, see Silverman, 1997), and the ultimate validation on the part of P is provided ("exactly", line 12).

To sum up, the examples presented in this section have shown how the parents in this corpus skillfully position themselves in the higher position on the epistemic and deontic gradient, yet without overtly undermining physicians' ultimate authority. Indeed, through the ways they report their intentions (see ex. 3), opinions, evaluations, and conduct (see ex. 4), they assert their primary right to know and decide what is best for their child while at the same time bringing these very same intentions, opinions, evaluations, and conduct to the pediatrician's attention, who consistently treat them as assessable, advisable objects.

6. Discussion

This study focused on parents' requests for advice from pediatricians about babies' everyday care and management. The quantitative analysis revealed that more than 50% of advice sequences identified in the corpus are solicited by parents. This finding is quite interesting if compared with previous results from a similar (although not identical) well-child context. Drawing on data gathered in 1982 in the UK, Heritage and Sefi (1992) and Heritage and Lindström (1998, 2012) depicted a somewhat different scenario: when interacting with health visitors, first–time mothers solicited advice only one time in ten.[5]

If differences with Heritage and Sefi's corpus are quite striking at the frequency level (see section 7 below for a candidate interpretation), similarities emerge at the turn design level: as the analyses have illustrated, like in Heritage and Sefi's data, parents in this corpus solicit the pediatrician's advice through two main activities, that is questioning (i.e., explicit advice requests) and reporting (i.e., implicit advice requests). Furthermore, as in Heritage and Sefi's study, explicit advice requests are predominantly formatted as requests for confirmation (of a proposed future course of action) that attribute the primary right to know and decide what is best for the baby to the pediatricians but at the same display parents' (partial or uncertain) knowledge of the issue brought to the pediatrician's attention.

Overall, the analyses have shown that parents in this corpus consistently engage in skillful interactional work so as to avoid displaying their relative lack of knowledge and/or competence. Indeed, by significantly privileging confirmation requests (N = 36) and declaratives (N = 35) over open questions (N = 7), and by packaging their turns in ways that display their (different degrees of) previous, semi-expert knowledge on the issue brought to the pediatricians' attention (e.g., by embedding proposals in their requests, see ex. 1 and ex. 2; expressing their preference and accounting for it, see ex. 3; establishing in first-position the "right" thing to do, see ex. 4), the parents consistently display themselves as competent, knowledgeable, caring, and therefore "good" parents. Nonetheless, by the very act of soliciting advice, they downgrade (to different extents) their right to "know and decide" and recognize the "baby expert" status (Heritage and Lindström, 1998) socially attributed to, and locally enacted by, the pediatricians. As the analyses have illustrated, well-child visits constitute a perspicuous site for analyzing how parents face the moral dilemma inherent in advice requests about childcare issues. Compared to other pediatric contexts aimed at diagnosing and/or treating different types of diseases, childcare is a domain where there is a greater expectation that parents will have some degree of knowledge and competence, especially when they are not first-time parents or their children are older than newborns. In this delicate context, displaying prior knowledge - even if uncertain - is arguably seen as less morally problematic and face-threatening than disclosing an outright lack of knowledge and competence.

[5] As previously mentioned, the rarity of patients' advice requests has been documented in other healthcare settings (Kinnell and Maynard, 1996; Pilnick, 2003; Silverman, 1997). The fact that the *frequency* of parents' advice requests in this corpus is more in line with findings from more recent data on interactions between expectant mothers and physicians in prenatal screenings (see Zayts and Schnurr, 2012) can be seen as one possible consequence of the increased participation of (certain) patients and parents in contemporary medical encounters (see Timmermans, 2020). However, given the different institutional contexts, goals, and identities at play, making a comparison between my findings and Zayts and Schnurr's is hardly attainable.

7. Concluding remarks

As this study has revealed, parents' requests for pediatricians' advice concerning infants' caregiving practices is a frequent phenomenon in pediatric encounters. Even though asking for advice on the everyday management of their baby can put parents in a morally sensitive position as it may be perceived as implying a failure to know how to act in the child's best interests, in contrast to previous studies (Heritage and Lindström, 1998; Heritage and Sefi, 1992) parents in this corpus do not appear reluctant to request the pediatrician's support. The reticence to solicit advice identified in Heritage and Sefi's study was interpreted by the authors as related to the face–threatening dimension of advice seeking in that specific institutional context: when babies' everyday care and management is at stake, asking for advice is - by definition – an admission of incompetence, lack of knowledge, or, at least, uncertainty on how to appropriately take care of their child and perform "competent" motherhood (see also Pilnick, 2003).

The fact that 40 years later in a similar (although not identical) context parents appear to sensibly ask for advice regarding baby care more often suggests that this activity is no longer necessarily perceived by parents as transforming them into an "object of evaluation" and "judgment" (Heritage and Sefi, 1992, p. 366). This difference can be interpreted as a hint of the documented sociocultural change in parents' participation in healthcare interactions,[6] where increasingly parents display themselves as competent and knowledgeable subjects (see Prettner et al., 2023; Stivers, 2007; Stivers and Timmermans, 2020) - sometimes even challenging the pediatrician's diagnosis and recommendation (Stivers and McCabe, 2021; Caronia and Ranzani, 2024) - as well as acting as "surrogate decision makers" (Stivers and Timmermans, 2020, p. 63) for their children.[7] From this standpoint, I advance that even the request for advice can assume a quite different interactional meaning: rather than being an admission of incompetence, uncertainty, "lack of knowledge and competence, or ability to cope without assistance" (Pilnick, 2003, p. 839), seeking advice indexes the advice seeker's *agency* and *competence*. In engaging in such a practice, the parents not only act as if they felt legitimized to actively participate in the consultation (e.g., taking the turn to ask or engage in other first-positioned activities) but possibly perceive this practice as staging them as caring, concerned, "engaged" (Timmermans, 2020) parents who reflexively think about what to do in their child's best interests. Such engagement resonates with the widely recognized sociocultural turn in contemporary parenting (especially as regards western upper-middle-class families), where parental involvement in child rearing is increasingly socially expected and normatively encouraged (see for instance the notion of "intensive parenting", Faircloth, 2014). As the analyses revealed, even when their way of requesting advice implies a relative lack of knowledge, parents still do not hesitate to engage in this discursive activity. In doing so, they display awareness of their unknowing position and willingness to learn. In other words, through the different ways that parents request the pediatrician's advice, they display awareness of their limits and possible incompetence, yet also their being concerned with, and informed about, their child's health and well-being, as well as sensitivity to the pediatrician's authority on the matter. In doing so, parents seem visibly oriented toward finding a balance between two opposing, yet equally preferable, stances: on the one hand, they display their entitlement to know and decide about their child's care, while on the other, they display their acknowledgment of the pediatrician's socially privileged epistemic and deontic authority.

[6] These considerations are particularly interesting if compared with the seminal studies on pediatrician-parent interactions carried out by Barbara Korsch and her research group in the US in the early '70s (Korsch and Negrete, 1972). They illustrated that despite mothers reported to be often unsatisfied with the amount and type of information provided by pediatricians, they were overall hesitant in asking questions and sharing their major concerns and expectations with doctors. Interestingly, this reluctance to voice their doubts and concerns was associated with a general dissatisfaction with the doctor's behavior (reported through post-visit interviews) and with low levels of compliance with the recommendations (gathered through follow-up interviews). Future research could explore whether the increased participation of parents in pediatric consultations may influence parents' satisfaction with the visit as well as compliance with the doctor's advice.

[7] Further longitudinal analysis is needed to corroborate this hypothesis (on limits and possibilities of CA-informed longitudinal studies, see Clayman and Heritage, 2021; Deppermann & Doehler, 2021).

Ethical statement

Participants' written consent was obtained in compliance with Italian law n. 196/2003 and 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 (protocol n. 0087746). The signed consent forms are archived at the Department of Education Studies, University of Bologna, Via Filippo Re, 6, 40126, Bologna, Italy.

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Declaration of Competing interest

There are no potential conflicts of interest to declare.

Data availability

The authors do not have permission to share data.

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