

Bringing the epistemic gaze of education into the pediatric clinic: When parents report the teachers' voice to challenge the pediatricians' advice

Federica Ranzani

Università di Bologna

Abstract: In the contemporary knowledge society, tensions among different epistemic cultures and professional visions are increasingly common. When it comes to childcare, the need to consider the relationship between different expertise is even more relevant as different institutionally sanctioned caregivers (e.g., parents, healthcare professionals, nursery staff, preschool and schoolteachers) are responsible for children's healthy development. But what happens when the caregivers' voices do not align? Drawing on a corpus of 54 video-recorded pediatric visits and adopting a discourse analysis approach, this single-case study focuses on how a mother reports the teacher's voice to resist the pediatricians' advice on the management of a delicate topic (i.e., talking about death with the child). The article sheds light on how hierarchies of professional knowledge are locally negotiated and challenged: the teachers' gaze and the pedagogical expertise it embodies are discursively treated by the parent as the legitimate epistemic and deontic authority over the pediatrician's biomedical gaze.

Keywords: discourse analysis, knowledge hierarchies, pediatric interaction, resistance, reported speech

Sinossi: Nella società della conoscenza che caratterizza la contemporaneità, le tensioni tra culture epistemiche e visioni professionali differenti appaiono sempre più diffuse. Nell'ambito della cura dell'infanzia, la necessità di considerare molteplici forme di expertise è ancor più cruciale in quanto diversi caregiver (e.g., genitori, professionisti sanitari, educatrici/educatori, insegnanti) concorrono alla promozione del benessere di bambini e bambine. Cosa accade, tuttavia, quando le prospettive dei caregiver non sono allineate? A partire da un corpus di 54 visite pediatriche videoregistrate e adottando l'approccio metodologico dell'analisi del discorso, il presente studio di caso esamina come una madre, riportando la voce dell'insegnante, metta in discussione il consiglio della pediatra in merito alla gestione di un tema delicato (i.e., parlare della morte con il bambino). L'articolo mostra come le gerarchie di saperi vengano localmente negoziate e ridefinite nel corso dell'interazione: la voce riportata dell'insegnante e l'expertise pedagogica che essa incarna sono discorsivamente costruite dal genitore come l'autorità epistemica e deontica legittima, assumendo una posizione privilegiata rispetto allo sguardo biomedico della pediatra.

Parole chiave: gerarchie di saperi, resistenza del genitore, comunicazione pediatra-genitore, analisi del discorso, discorso riportato

Introduction

In the contemporary “knowledge society” (Knorr Cetina, 2007), tensions among different epistemic cultures and professional visions (Goodwin, 1994) are far from rare. This is particularly evident in healthcare contexts, where the expertise of care professionals intertwines with the “lay expertise” (Prior, 2003) of service users, engendering a multivocality of expert voices and potential epistemic struggles over who has the ultimate right to decide and on which epistemic basis.

When it comes to pediatric care, the need to consider the relationship between different forms of expertise is even more relevant as promoting children’s well-being and healthy development is a shared mandate of different institutionally sanctioned caregivers (e.g., parents, healthcare professionals, nursery staff, preschool and schoolteachers). While pediatricians hold epistemic authority in the biomedical domain, parents retain first-hand knowledge of their child in everyday family life, and they often have previous experience, intergenerationally transmitted knowledge and specific commonsensical, semi-expert theories of childcare and parenting (see for instance the role of web-based knowledge sharing, Demozzi et al., 2020a,b). This epistemic landscape can generate tensions of knowledge or even “competence struggles” (Heritage & Sefi, 1992) between the pediatrician and the parent as to who is entitled to know and decide the most suitable caregiving practice for the child’s best interest. As a matter of fact, parents often report or refer to other experts’ opinion in the unfolding of these institutional encounters (Caronia et al., 2023, 2026), thereby making relevant for the pediatrician to take into account the perspective of another absent care professional (e.g., the teacher, the psychologist, the physiotherapist; for a similar phenomenon during parent-teacher conferences, see Caronia, 2022, 2024). Although alliance between families and care professionals is deemed crucial in granting children’s safe and healthy upbringing (Contini, 2012; Epstein, 2001; Gigli, 2021; Kanizsa, 2013) through the spheres constituting the ecology of their development (Bronfenbrenner, 1979), caregivers’ voices may not always align. Affiliation or disaffiliation with a reported stance, alignment or disalignment with a suggested course of action as well as the management of possible conflictual professional visions are ordinarily at stake during pediatric visits (Caronia et al., 2023, 2026; Caronia & Ranzani, 2024; Stivers, 2007), influencing caregivers’ trajectories and therefore impacting on children’s wellbeing.

The management of knowledge and the interactional construction of (dis)alliances among the different voices are relevant phenomena to explore from a pedagogical perspective as they index the local hierarchy of expertise at stake, i.e., which voice prevails and is assumed by the parent as the epistemic and deontic authority.

Despite the relevance of these issues, little attention has been devoted to investigating the interactional management of expert and lay knowledge, the local constitution of epistemic authorities and the situated construction of (dis)alliance during pediatric consultations (but see Caronia et al., 2023, 2026). How the different expertise at stake in children’s growth and well-being are “talked into being” (Heritage, 1984, p. 290) and by whom? What forms of knowledge are treated as legitimate by participants during decision-making processes? Drawing on a corpus of 54 video-recorded pediatric visits and adopting a discourse analysis approach, this single-case study focuses on how a mother reports the teacher’s voice to resist the pediatricians’ advice on the management of a delicate topic (i.e., talking about death with the child). The article sheds light on how hierarchies of professional knowledge are locally negotiated and challenged: the teachers’ gaze and the pedagogical expertise it embodies are discursively treated by the parent as the legitimate epistemic and deontic authority over the pediatrician’s biomedical gaze (Foucault, 1963).

Background

From doctor-centered to patient-centered care

Over the past few decades, the relationship between doctors and patients has undergone a significant socio-cultural transformation. The paternalistic and doctor-centered model that characterized clinical practice until the late 1960s has increasingly been challenged and replaced by a more collaborative framework commonly referred to as “patient-centered care” (Mead & Bower, 2000; Zannini, 2008, 2023). In a nutshell, this approach stresses the ethical and clinical value of

recognizing patients' experiential knowledge and encourages the active involvement of patients and their caregivers in decision-making processes. Emphasis is placed on a biopsychosocial understanding of health and illness and on developing a therapeutic relationship grounded in shared power and responsibility. Overall, the aim is to improve the quality of care and adherence to treatment while safeguarding patients' autonomy, strengthening their sense of empowerment, and fostering patient agency. Clearly enough, the establishment of patient-centeredness as the gold standard of care is crucial from a pedagogical perspective as it sanctioned the need to acknowledge the patient's lived experience within clinical reasoning and therefore take care (also) of the subjective dimension of the illness (*to care*) rather than addressing only the biomedical component of the disease (*to cure*) (Bertolini, 1994; Bobbo, 2009; Zannini, 2004).

Not surprisingly, this sociocultural shift has impacted on the relationship between doctors and patients and the ways they communicate with each other in everyday institutional encounters. Research based on the analysis of video-recorded real-life medical consultations has extensively illustrated that contemporary patients behave as "engaged patients" (Timmermans, 2020): they propose their own interpretations of symptoms or even work to rule out potential diagnosis (Gill et al., 2001, 2010; ten Have, 2001), and increasingly more often they question and resist professional diagnoses and treatment recommendations (Costello & Roberts, 2001; Stivers & McCabe, 2021). At the same time, physicians appear to have become more inclined to make explicit and explain the reasoning behind diagnoses and treatment prescriptions, thereby orienting to professional accountability (Heath, 1992; Peräkylä, 1998).

Effects of this transformation are visible also in pediatric encounters, where scholars have identified a range of communicative resources through which pediatricians display accountability and work to secure parental acceptance of diagnoses and treatment plans (Caronia & Ranzani, 2024; Heritage & Stivers, 1999; Stivers, 2007), thereby ratifying their expertise-based authority. At the same time, parents are often found to perform as informed and competent participants (Ranzani, 2024; Prettner et al., 2024) as well as "surrogate decision makers" (Stivers & Timmermans, 2020, p. 63) for their children. By sharing their preferences, expectations, prior experiences, and first-hand knowledge of their children's daily lives to channel decision-making, parents make their epistemic and deontic rights relevant, while generally avoiding direct threats to pediatricians' professional authority.

As this article illustrates, among the communicative resources deployed by parents to make their voice count is reported speech.

The use of reported speech in social interaction

Research on the use of reported speech (RS) in social interaction has extensively illustrated how, by directly or indirectly quoting the words of an absent *persona*, speakers perform different activities and accomplish epistemic and moral work (Clift, 2007; Holt, 1996, 2000; Holt & Clift, 2007; Tannen, 1989)¹. First, they display their first-hand, privileged access to the form and content of the RS, thereby indexing their epistemic primacy. As a matter of fact, the recipient cannot contest the teller's quote, unless explicitly threatening their face by undermining their credibility. In this regard, previous studies have shown how RS is often used by a speaker to provide evidence and discursively support the truthfulness of her/his claim (Galatolo, 2015). In engaging in such epistemic work, the speaker can assume different stances with regards to the RS, ranging from taking the distance to assuming the enunciation by merging the voice of the speaker with the voice of the absent *persona* (Couper-Kuhlen, 2007; Holt, 2007). Furthermore, RS has been found to be used to orient the recipient: especially when mobilized as the climax of a narrative, it can channel the recipient toward what the speaker considers relevant information. Far from being a neutral report, the RS is a means for the speaker to display his/her stance toward - and therefore evaluating - the reported event and characters (Rae & Kerby, 2007).

After presenting the data and methods of this study, the next sections show the epistemic work carried out by a mother who acts as the "animator" (Goffman, 1981) of the teacher's talk during a pediatric visit.

¹ For space reasons, this section is not intended to be exhaustive. For a more detailed account on reported speech in social interaction see, among others, Holt and Clift (2007).

- 2 P **.h mhh::** ((with doubtful facial expression))
- 3 (0.5) ((M and P look at each other with doubtful facial expression))
- 4 M [eh-
- 5 P [lui (.) era già uscito?
[he (.) was out already?
- 6 M sno: lui non si è- non ha chiesto stamattina
yesno: he didn't not- didn't ask this morning
- 7 M [quindi io l'ho fatto andar via con mio marito,
[so I had him go with my husband,
- 8 P [ah (.) <no ha visto> (.)e
[oh (.) <he didn't see> (.) eh.
- 9 M e non ha visto,=
and he didn't see,=
- 10 P =ah.=
=oh.=
- 11 M =però adesso chiederà siccome quando era morta la (mamma)
=but now he will ask since when the (mother) died
- 12 M questo inverno non gliel'avevamo detto
last winter we didn't tell him
- 13 M >gli abbiám detto che è andata al parco<
>we said that she went to the park<
- 14 P ah::,
oh::,
- 15 M quindi lui tutti i giorni chiede perché () non torna
so everyday he asks why () does not come back
- 16 P ah.
oh.
- 17 (0.3)
- 18 M secondo me prima o poi gli dovrò spiegare
in my opinion sooner or later I'll have to explain to him
- 19 M che non tornano [que]sti: gatti.
that [the]:se cats do not come back.
- 20 P [eh.]
- 21 (3.5) ((M and P continue undressing the baby))

- 22 P eh quindi bisogna che gli dica che anche questo è scappato.
well so it is necessary you tell him that this one ran away too.
- 23 (0.3)((M opens her arms and assumes a doubtful facial expression))
- 24 M [(che è andato dalla mamma?)
[(that he went to his mom?)
- 25 P [magari che è stato- investito da una macchina,
[maybe that he has been- run over by a car,
- 26 P queste cose qua che son forse- cioè
these things that maybe- I mean
- 27 P son sempre traumi, però penso che sia meno peggio
they are always traumas, but I think it is less worse
- 28 P che se la:- viva la fiaba. sì.
that he:- leave the fairy tale. yes.
- 29 M **mh. ((nodding))**
- 30 M perché anche la maestra a scuola mi ha detto
because also the teacher at school told me
- 31 M guarda (0.2) prima o poi van preparati
listen (0.2) sooner or later they must be prepared
- 32 P **mh.=**
- 33 M =a certe cose della vita, eh::
=to certain things of life, eh::
- 34 M (c'è) non so quanto sia corretto inventargli:
(I mean) I don't know how right it is to invent for hi:m
- 35 M anche perché scappato lui rimane male
also because run away he will feel bad about it
- 36 M perché dice scap[pato perché è scappato?
because he'll say [run away why did he run away?
- 37 P [perché? eh.
[why? eh.
- 38 P perché è andato a cercar la mamma.
because he went to look for his mum.
- 39 M **eh.**

The mother's report of the teacher's talk occurs in lines 30, 31, and 33. However, before getting there, it is worth observing how the interaction develops until that point, in order to trace what makes relevant for the mother mobilizing the epistemic gaze of the teacher.

The excerpt begins with a report-formatted request for advice (Heritage & Sefi, 1992; Ranzani, 2024): in line 1, the mother voices her doubts about how to communicate the death of their cat to her elder (non-present) son. With this implicit request, the mother treats the pediatrician as an authoritative voice on the issue, making the delivery of advice sequentially relevant. However, the pediatrician does not answer the mother's request immediately. Rather, she multimodally conveys her uncertainty: she issues a response cry conveying her indecision ("mhh::", line 2; Goffman, 1978) and assumes a doubtful facial expression (lines 2 and 3). Such a mirroring of the mother's doubtful stance conveys that the issue is not easy to solve, legitimizing the mother's unsureness. Despite that, the pediatrician does not quit the role of advice-giver she has been attributed: in lines 5 and 8, she asks for further information, thus displaying her orientation toward helping the mother on the delivery of the bad news to the child.

In answering the pediatrician's questions, the mother declares the child has not seen the dead cat (line 8). This information may point toward an easy solution to the mother's problem, i.e., not telling the child about the cat's death. However, this potential solution is immediately ruled out by the mother, who clarifies that the child is likely going to ask about the cat ("but now he will ask", line 11). By pointing this out, the mother reiterates the request for advice, making relevant the pediatrician's help on how to handle the telling of the bad news. It is worth noting that the mother's turn (lines 11-13 and 15) subtly conveys her own orientation toward some 'unwanted' advice. Indeed, in making a case for why the child is likely going to ask about the cat, the mother narrates the negative experience she had when she did not tell him about the death of another cat ("last winter we didn't tell him >we said that she went to the park< so everyday he asks why () does not come back", lines 12, 13 and 15). In this brief narrative, the child is presented as distressed by the missing cat, always asking why the pet does not come home (see the use of the multimodally emphasized extreme case formulation "everyday", which conveys the pervasiveness of the child's requests; Pomerantz, 1986). By volunteering this incident, the mother suggests the problematic nature of any advice that entails not telling the child about the death of the pet and just telling that the pet 'went away' (on the pedagogical relevance of welcoming and legitimizing children's "big questions", see Demozzi, 2022).

At this point of the exchange, the pediatrician's advice is still missing: the mother's turns are followed by the pediatrician's news receipts and silence (lines 14, 16 and 17). The mother then offers a candidate advice: she advances the possibility of telling the child that "these cats do not come back" (line 19). With this turn, the mother proposes a potential solution; yet she also downgrades her certainty about it (e.g., the epistemic modalizing expression "in my opinion", line 18), thus further constructing the pediatrician as the epistemic authority on the matter. After a long silence (line 21), the pediatrician finally issues some advice: the mother must tell the child that this cat "ran away too" (line 22). Through the use of the impersonal deontic declarative ("it is necessary", "*bisogna*", line 22), the pediatrician makes a strong deontic claim: she presents the advice as unquestionable and 'absolute', i.e., as the "right thing to do for anyone in the current situation" (Rossi & Zinken, 2016: e321). However, this piece of advice is met with non-verbal, minimal resistance (Stivers, 2007; Caronia & Ranzani, 2024) by the mother: she makes a gesture conveying uncertainty and assumes a doubtful facial expression (line 23). Consistently with the mother's embodied demonstration of uncertainty, the pediatrician slightly modifies her advice trajectory: she suggests telling the child that the cat has been run over by a car (line 25), then accounting for this suggestion by describing this kind of telling as less traumatic than telling the child the truth (lines 27 and 28).

However, the mother's reply in the following turns conveys her disagreement with the advice she has just received (lines 29-31, 33-36). By using direct reported speech, she makes relevant the advice she has received from another institutionally sanctioned authority over childhood-related matters, i.e., the schoolteacher ("because also the teacher at school told me (.) listen (0.2) sooner or later they must be prepared to certain things of life", lines 30, 31, 33). This piece of advice is in clear contrast with the one just provided by the pediatrician as it indicates the need to 'prepare children to certain things of life', such as, arguably, death. By attributing this advice to the authoritative figure of the schoolteacher, the mother indicates telling the child the truth (rather than a "fairy tale", line 28) as another viable solution to her problem. The use of direct reported speech is particularly effective in resisting the pediatrician's advice. Indeed, through this report format, the mother can distance herself from the claim. In other words, the mother 'makes the teacher speak', thus mitigating her own

personal agency in disagreeing with the pediatrician's advice. Yet, at the same time, by attributing this claim to a socially sanctioned authority like the schoolteacher, the mother authorizes the advice, conveying it as reliable. In this case the mother evokes the 'voice of the school' and the epistemic gaze of education as an authoritative resource: the mother builds a conversational alliance with the teacher to resist the physician's advice.

After reporting the teacher's claim, and based on it, the mother further resists the pediatrician's advice. First, she expresses her doubts about the moral appropriateness of "inventing" a story for the child ("I don't know how right it is to invent for hi:m", line 34). Then, she makes relevant another problematic aspect: if she tells the child what the pediatrician suggested (i.e., that the cat "ran away", see line 22), he will "feel bad about it" and ask why the cat ran away (lines 35 and 36). By questioning the moral appropriateness of the pediatrician's advice and anticipating problems related to the child's feelings, the mother conveys her disagreement with the pediatrician's advice as well as her own orientation toward telling the child the truth – as reportedly suggested by the schoolteacher. However, note that she does so by avoiding threatening the pediatrician's face (Goffman, 1955). Despite the mother's disagreement, the pediatrician continues pursuing her advice trajectory. By answering the child's question anticipated by the mother ("why did he run away?", line 36, "because he went to look for his mum.", line 38), the pediatrician offers a solution to this specific problematic aspect, thus further conveying the suitability of her own advice, i.e., telling the child a "fairy tale", which the mother does not appear to sustain.

To sum up, through the unfolding of this long sequence, we have seen how the mother resorts to the pedagogical knowledge embedded in the teacher's reported talk to resist the pediatrician's advice trajectory and make her own voice count.

Conclusion

In contemporary knowledge society, professionals need to take into account "the many different ways of being an expert, the distribution of differing expertises among different groups, and the relations between these groups" (Collins & Evans, 2007, p. 4).

This single-case analysis has perspicuously illustrated how different expertises can be at play and are "talked into being" (Heritage, 1984, p. 290) during a pediatric encounter, where the need to consider the "many ways of being an expert" is even more relevant as different institutionally sanctioned caregivers (parents, healthcare professionals, nursery staff, preschool and schoolteachers) are responsible for children's wellbeing and healthy development.

The example analyzed here has shown how a mother seeks the pediatrician's advice on the management of a delicate issue, namely how to talk about death with her 5-year-old child. By the very act of asking for advice and voicing her doubt, the mother not only displays a certain degree of uncertainty and concern (Heritage & Sefi, 1992), but she also treats the pediatrician as an authoritative voice on a topic that arguably lies beyond the pediatrician's biomedical domain of expertise. Interestingly, this request for support attests to the (often invisible) educational role played by pediatricians, who, especially during well-child visits (Ranzani, 2025), are ordinarily asked by parents to provide guidance on non-medical issues. However, in the case examined in this article, we have seen how the pediatrician's advice is met with some resistance. By skillfully resorting to reported speech, the mother mobilizes the piece of advice she has (said to have) received from another institutionally sanctioned authority in childcare, i.e., the schoolteacher. The advice evoked through the teacher's reported words stands in clear contrast to that offered by the pediatrician, as it stresses the need to 'prepare children to certain things of life', such as, arguably, death. By subtly merging her own voice with the teacher's voice and endorsing the teacher's reported stance (i.e., telling the child the truth), the mother brings the epistemic gaze of education into the pediatric clinic to resist the pediatrician's advice trajectory (i.e., telling the child a "fairy tale"). In other words, the mother discursively constructs the teacher and the pedagogical knowledge embedded in her reported voice as the epistemic and deontic authority in this domain of childcare. In doing so, she projects a privileged role to the epistemic gaze of education over the biomedical gaze. This is particularly salient from a pedagogical perspective for several reasons. First, it indexes the legitimacy of pedagogical knowledge in healthcare settings and how it can make a difference in decision-making processes. Second, it sheds

light on the crucial role of parents' participation in pediatric visits and on the legitimacy of their experiential, lay knowledge. Furthermore, it empirically illuminates how hierarchies of professional knowledge are locally negotiated and challenged in interaction rather than fixed and predetermined.

It is noteworthy that, while exerting her agency and making her voice count, the mother still appears to avoid overtly threatening the professional's face, thus orienting to maintaining a form of social solidarity and alliance not only with the invoked teacher but also with the co-present pediatrician, despite their contrasting perspectives on the issue at hand.

Zooming into everyday professional (communicative) practices, this study casts light on how hierarchies of knowledge and (dis)alliances among children's caregivers are a situated accomplishment, realized moment-by-moment in and through the details of interactions. Aware of the limitations typical of any single-case analysis, insights from this study are nonetheless particularly suited to video-based, medical education programs (Parry et al., 2024) aimed at maximizing practitioners' reflective thinking (Schön, 1987; Mortari, 2003; de Mennato, 2012) and awareness of the educational role they (are called to) play in everyday practices, which goes far beyond the "mere" biomedical dimension (*caring* and *curing*). Furthermore, in-service and pre-service medical training based on real-life events and empirical data may help practitioners navigate the challenges they face in daily professional life: how to deal with the consequences of the frequent parental challenges and epistemic tensions in pediatrician-parent interactions on the healthcare professionals' "emotional life" (Bruzzone, 2020); how to manage the compassion fatigue often resulting from their recurrent exposure to service users' difficulties and suffering, and possibly transform it into compassion satisfaction (Bobbo, 2015); how to take into account parents' lay knowledge and build alliances among children's caregivers without ceding the epistemic and deontic responsibilities inherent in professional expertise.

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Appendix

Jeffersonian transcription conventions

WORD	louder talk
[word]	overlapping talk
(.)	pause shorter than 0.2 seconds
(1.5)	pause measured in seconds and tenths of a second
=	absence of any discernible silence between two turns
>word<	rushed talk
<word>	slow talk
(word)	uncertain hearing
((word))	description of nonverbal events (e.g., gestures)
wo:rd	prolongation of the sound
^	point where the nonverbal event begins
<u>word</u>	talk uttered with emphasis
.	falling intonation
,	slightly rising intonation
?	strongly rising intonation (typical of questions)
()	incomprehensible words
°word°	talk that is markedly quiet or soft
-	prior word or sound is cut off

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