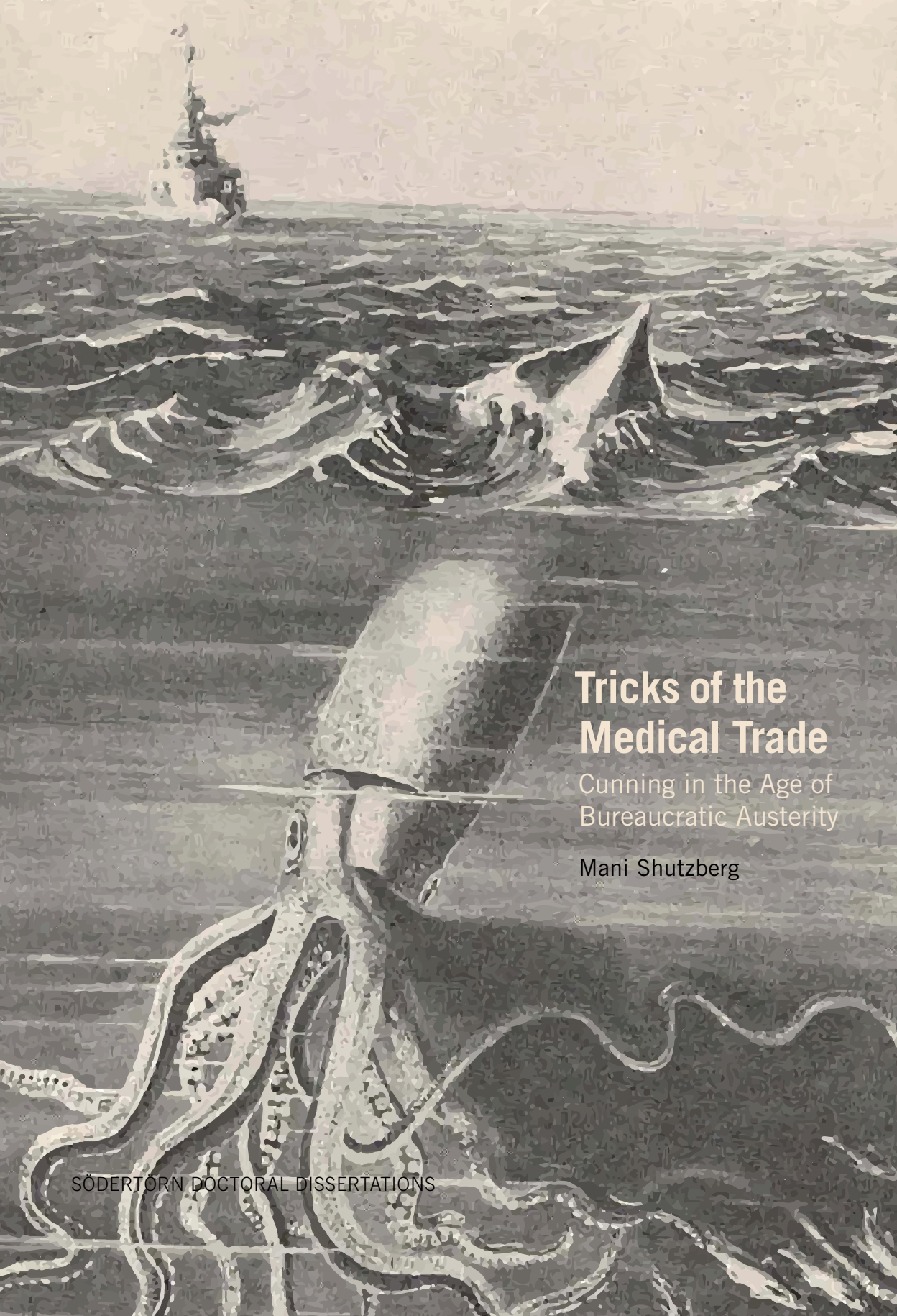

Tricks of the Medical Trade

Cunning in the Age of Bureaucratic Austerity

Mani Shutzberg

SÖDERTÖRN DOCTORAL DISSERTATIONS

Tricks of the Medical Trade

Cunning in the Age of Bureaucratic Austerity

Mani Shutzberg

Södertörns högskola

Subject: Studies in Practical Knowledge
Research Area: Critical and Cultural Theory
School of Culture and Education, and the Baltic and East European Graduate School

(CC BY 3.0)

Södertörns högskola
(Södertörn University)
Library
SE-141 89 Huddinge

www.sh.se/publications

© Mani Shutzberg

Cover image: *Giant Squid of the Newfoundland Banks*, 1905, Herbert B. Judy,
Freshwater and Marine Image Bank
Graphic form: Per Lindblom & Jonathan Robson

Printed by Elanders, Stockholm 2021

Södertörn Doctoral Dissertations 194
ISSN 1652–7399
ISBN 978-91-89109-78-0 (print)
ISBN 978-91-89109-79-7 (digital)

It can be frustrating, to have heard from the patient about panic attacks, that they don't get out of bed, and lots of other stuff that reinforces my conviction that this patient is unable to work. But the Swedish Social Insurance Agency ["Försäkringskassan"] is basically not interested in what the patient says at all. That's when, perhaps [...] you gotta use some street-smart phrasing.

"Alexia", physician

[I]n the post-totalitarian system, the real background to the movements that gradually assume political significance does not usually consist of overtly political events of confrontations between different forces or concepts that are openly political. These movements for the most part originate elsewhere, in the far broader area of the "pre-political."

Václav Havel, Power of the Powerless

Abstract
Being a "good" doctor nowadays involves more than having virtues and capacities conducive to the content of encounters between physicians and patients. Physicians can and must be able to act on the surrounding conditions of the doctor-patient encounter, and sometimes do so on an informal level to keep external interests, such as austerity and efficiency, at bay. Hence, the patient-related virtues and capacities of physicians, such as compassion, prudence, temperance and the like might not constitute sufficient cause for "good" doctoring. Resistance against the invasion of external interests requires another set of capacities. In this compilation thesis, one such capacity and form of action is explored: cunning. While certainly not part of the repertoire of useful or appropriate skills in relation to the patient, cunning intelligence is an indispensable "virtue" of good doctoring insofar as doctors must cleverly navigate institutional structures that block off paths toward the ultimate ends of healthcare. The role of cunning is examined through a particular case, namely, the struggle over social insurance, especially sickness benefits ("sjukpenning"), and the complex relationship between physician, patient and the *Swedish Social Insurance Agency* ("Försäkringskassan"). As the importance of non-medical goals has surged in social insurance matters, physicians have honed skills, such as authoring the sickness certificates in a certain way, retaining thereby good medical practice, and by extension also maintaining the integrity of the patient-related virtues of medicine. The empirical material for this study consists of thematically analyzed qualitative interviews with physicians working in primary care. Eight techniques were identified, particularly with respect to the way in which the sickness certificate is written to ensure approval by the SSIA. The identified techniques were usually employed when the patient's case was perceived to be at high risk for rejection by the SSIA (such as psychiatric illnesses, chronic pain, etc.). Based on these findings, the ambiguities, contradictions and possibilities inherent in the cunning resistance of physicians are analyzed and problematized. In terms of *resistance*, three dimensions of ambiguity are addressed: the multiple motives and shifting target of resistance; the complex blend of power and powerlessness which defines the situation of physicians and their resistance, and, finally, the fundamental ambiguity of the act of resistance itself, i.e. the tactical issuing of sickness certificates, which entails a particular mix of compliance and resistance. Understanding the action and skills underlying this form of resistance in terms of *capacity* or *virtue*, the present study demonstrates the role cunning intelligence—the ability of the weak to "outsmart" a stronger adversary—plays in the practice of medicine. Cunning intelligence is not merely a defective form of prudence (*phronesis*), nor is it simply an instance of instrumental reason (*techne*), but rather an ability that occupies a distinct place among the intellectual abilities generally ascribed to professionals. Finally, I explore if the use of these capacities indicates a change in the structure of the doctor-patient relationship. I argue that both doctor and patient are conditioned by an equality in powerlessness—the hallmark of "the age of bureaucratic parsimony", which can be appropriately described in terms of *solidarity* between *comrades.*

Keywords: physician, practical knowledge, everyday resistance, social insurance, medicine

Sammanfattning
(Summary in Swedish)

Ändamålsenligt läkararbete omfattar inte bara dygder och förmågor relaterade till innehållet i patientmötet. Läkare kan och måste också kunna förhålla sig till mötets grundläggande villkor, och gör det ibland på ett informellt sätt för att hålla yttre intressen (såsom åtstramning, effektivitet, rationalisering och politisk kontroll) stången. Läkares traditionella patientrelaterade dygder och färdigheter, såsom medkänsla, klokhet, måttfullhet, med flera, är således inte alltid tillräckliga villkor för en god läkargärning. Motstånd mot yttre intressen kräver en annan uppsättning förmågor. I denna sammanläggningsavhandling utforskar jag en sådan förmåga och typ av handling: slughet. Slugheten, som är en olämplig färdighet i själva patientmötet, kan vara en oundgänglig dygd för det ändamålsenliga läkararbetet när läkaren måste kunna ta sig förbi institutionella hinder som blockerar sjukvårdens grundläggande ändamål, hälsan. Jag utreder särskilt slughetens roll i ett fall, kampen of sjukpenning, och den komplexa väv av förhållanden mellan läkaren, Försäkringskassan och patienten. Eftersom vikten av icke-medicinska mål har ökat i socialförsäkringsärenden har läkare tvingats förfina färdigheter, exempelvis att skriva sjukintyget på ett särskilt sätt, som syftar till att bibehålla god medicinsk praktik och i förlängningen även läkaryrkets sedvanliga dygder. Det empiriska materialet utgörs av tematiskt analyserade kvalitativa intervjuer med läkare i primärvården. Åtta tekniker har identifierats, de flesta relaterade till hur sjukintyget författas, som alla syftar till att öka chansen för beviljad sjukpenning. Teknikerna används oftast när risken för avslag bedöms vara hög, vilket är fallet i samband med exempelvis psykisk sjukdom, kroniskt smärta med flera tillstånd. På basis av dessa fynd analyserar och problematiserar jag de tvetydigheter, motsägelser och möjligheter som slugheten och vardagsmotståndet mot Försäkringskassan är behäftade med. Att förstå ovanstående handlingar i termer av motstånd blottlägger tre dimensioner av tvetydighet som adresseras: de flerfaldiga motiven och motståndets flytande mål; det komplexa samspelet mellan makt och maktlöshet som kännetecknar läkarnas situation och vardagsmotstånd; samt handlingens fundamentala tvetydighet i sitt iscensättande av både motstånd och underordning. Genom att begripa handlingarna och färdigheterna som grundlägger motståndet i termer av kapacitet eller dygd syftar undersökningen till att utvisa den roll slugheten – förmågan hos den svage att utmanövrera en starkare motpart – spelar i läkargärningen. Slughet är varken en defekt form av klokhet (*fronesis*) eller en sorts instrumentellt förnuft (*techne*), utan snarare en förmåga i egen rätt jämte de intellektuella förmågor som vanligtvis tillskrivs skickliga yrkesutövare. Slutligen utreder jag ifall bruket av slughetens kapacitet indikerar ett skifte i förhållandet mellan läkare och patient. Hypotesen är att både läkaren och patienten villkoras av en ömsesidig maktlöshet – kännetecknet för "den byråkratiska åtstramningens tidevarv" – och som adekvat kan beskrivas som en sorts *solidaritet* mellan *kamrater*.

Acknowledgements

One great thing about believing in the collective nature of human existence is that others can be blamed for one's own faults. Here, then, is a list of contributors to the shortcomings of the dissertation and the flaws of my character. My supervisor Fredrik Svenaeus and assistant supervisor Jonna Lappalainen: Thank you for your intellectual and moral guidance during these years. Your bourgeois-Gadamerian and marginally-less-bourgeois-Sartrean outlooks (respectively) have been a tremendous help. Patrick Seniuk, my fellow PhD-student and officemate, thank you for years of rewarding conversations and corrections of my Swenglish. Your wisdom in matters of life is on a par with your baffling ability to get us both killed in The Division. I also want to thank all participants in higher seminars for their helpful feedback on my work, all colleagues at the Centre for Studies in Practical Knowledge, as well as the philosophy and aesthetic departments down the hall: All of you have made vital contributions to my inferiority complex. All except Martin Gunnarson. The beacon of methodological light. I have no scathing remarks for you. One particular person, whose annoyingly brilliant remarks made this dissertation better, is the opponent of the final seminar: Erik Malmqvist. Comrade Majsa Allelin, I am grateful for your astute remarks on earlier drafts that made me feel like a real academic—inadequate. Thank you Leila Brännström for getting me in this mess in the first place by helping me out with the PhD-application. Shabane Barot, the Great Proletarian Counterweight in my life: I expect this epithet to land me a prominent seat in the acknowledgment section of your future dissertation. Furthermore, I am deeply thankful and indebted to my informants. I will refrain from roasting you. Apparently, it is ethically and legally "inadvisable" to do so (the supervisors said). Mom, dad and sis: midonam ke mayoos hastin, motassefane doktore pooldar nashodam. Herman Geijer, thank you for teaching me that "it is never too late to give up." Paradoxically, it enabled me to carry on. Many thanks to David Payne, who despite his severe handicap (being British) managed to harness and domesticate my American English. Li Eriksdotter Andersson, my love. Thank you for being the genius, the wise, the kind, the loving, the principled one in our relationship. I love you. Thank god Mir has at least one serviceable guardian. Reviewer 2, always a pleasure. There are many many more I should thank and/or blame, but I shall stop here.

Contents

List of papers 15
Abbreviations 17

1. Introduction 19

1.1. Cunning in medical practice: a particular case (and its generalizability) 22
1.2. Situating cunning in the theory of practical knowledge 26
1.3. Remarks on the structure of the dissertation 30
1.3.1. The weave of normative and descriptive strands: moral and immanent critique 31

2. Aims and research questions 33

3. Context: developments of welfare and the doctor-patient relationship 35

3.1. Strains between healthcare and welfare administration 35
3.1.1. Framing the disconnect between lifeworld and system in healthcare 39
3.1.2. Rationalization of the lifeworld: colonization 42
3.1.3. Resistance "along the seams between system and lifeworld" 46
3.1.4. Resistance in severely constrained circumstances 51
3.1.5. Strategies of domination and tactics of evasion 54
3.2. Epochs of the doctor-patient relationship: fathers, partners, providers, comrades? 58
3.2.1. "Egalitarianism of the condition of being threatened": The new solidarity of the doctor-patient relationship 59
3.2.2. The breakdown and revival of solidarity 61
3.2.3. Old solidarity of integration, a brief overview 61
3.2.4. The new solidarity of the shaken 63

4. Materials and methods 65

4.1. Interviews and interviewees: Peculiarities in the field of practical knowledge 65
4.1.1. What interviews can and cannot capture 67
4.1.2. The collegial relationship 67
4.1.3. The collegial interview 70
4.1.4. Naive realism? A remark on a potential weakness of (my) interviews 75
4.1.5. Concluding remarks on the peculiarities of interviews in the field of practical knowledge 76
4.1.6. Remarks on analysis and interpretation of the interview material 77
4.2. Philosophical heuristics 78
4.2.1. Heuristic of inversion: reversals without sublation 80
4.2.2. Heuristic of multiple referents 83
4.2.3. Heuristic of productive temporal distance 84
4.3. Ethical considerations 86

5. Conclusions and a look ahead 89

6. Summary of articles 93

6.1. Article I: *Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners* 93
6.2. Article II: *Literal Tricks of the Trade: The Possibilities and Contradictions of Swedish Physicians' Everyday Resistance in the Sickness Certification Process* 93
6.3. Article III: *Doctors that "Doctor" Sickness Certificates: Cunning Intelligence as an Ability and Possibly a Virtue Among Swedish GPs* 94
6.4. Article IV: *The Doctor as Parent, Partner, Provider... or Comrade? Distribution of Power in Past and Present Models of the Doctor-Patient Relationship* 94

7. References 97

Paper I 105
Paper II 117
Paper III 151
Paper IV 165

List of papers

Article I. Shutzberg, M. (2019). Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners. *Scandinavian Journal of Primary Health Care. 37*(1), 10-17.

Article II. Shutzberg, M. (2020). Literal tricks of the trade: the possibilities and contradictions of Swedish physicians' everyday resistance in the sickness certification process. *Journal of Resistance Studies. 6*(1), 8-39.

Article III. Shutzberg, M. (2020). Doctors that "doctor" sickness certificates: cunning intelligence as an ability and possibly a virtue among Swedish GPs. *Medicine, Health Care and Philosophy. 23, 445-456.*

Article IV. Shutzberg, M. (2021). The doctor as parent, partner, provider... or comrade? Distribution of power in past and present models of the doctor-patient relationship. *Health Care Analysis*. Advance online publication. https://doi.org/10.1007/s10728-021-00432-2

Abbreviations

GP	General Practitioner
SSIA	Swedish Social Insurance Agency [Försäkringskassan]

1. Introduction

The *medical encounter* is the immediate and true core of clinical work. Or so they say. This belief often goes unquestioned in the fields of medical epistemology, medical ethics, and medical ideology in general.[1] Assuming that the immediate medical encounter between doctor and patient is the point of departure for matters pertaining to the medical profession has consequences: medical knowledge is reduced to knowledge of drug dosages, suturing techniques, of how to communicates with one's patients; and the practice of medicine is equated with understanding, comforting and treating one's patients (the number of examples of medical knowledge and praxis is, of course, infinite). One caveat: To distill and fixate on questions, virtues and capacities in medicine "that arise [directly] from the caring bond" risks depreciating other aspects of medical praxis. Edmund Pellegrino and David Thomasma, although influential representatives of their field of medical ethics, have the unusual courtesy to admit the pitfalls of such an approach: "There are many other virtues, of course. Our examination does not take all of them into account. Rather, the ones selected arise from the focus of our philosophy of medicine on the relation of doctor and patient" (Pellegrino & Thomasma, 1993: xii). But as Theodor Adorno once wrote, "[h]e who wishes to know the truth about life in its immediacy must scrutinize its estranged form, the objective powers that determine individual existence even in its most hidden recesses" (2005[1951]: 15). He could just as well have been talking directly about contemporary professional life and the current state of medical epistemology, ethics and ideology.

Healthcare without direct encounters between healthcare workers (among them, doctors) and patients is indeed unthinkable and impossible. While this claim might be formally correct, it is nonetheless false and misleading to declare it as the sole essence of healthcare. In the rush to isolate some essential, immediate, true or authentic core of healthcare, its contemporary essence is paradoxically lost, banished as inessential; this "contemporary essence" of the doctor-patient relationship is not the isolated dyadic relationship it once was (if it ever was). The medical encounter is really an ecology of encounters between patients and a considerable number of healthcare workers, such as medical interns, specialists in different branches of medicine, nurses, physiotherapists, occupational therapists, as well as other staff and people, such as cleaners, janitors, technicians, administrators, managers, statisticians, researchers, architects, politicians, and so on. The medical encounter is mediated through other persons and other things, through other staff reporting on the background of the patient, through institutions such as social insurance agencies, through simple and advanced tools such as stethoscopes and CT scanners. Mark

[1] For a representative example in medical epistemology, see Svenaeus, 2000: vii; for a representative example in medical ethics, see Pellegrino and Thomasma, 1993: xii; for a representative example in medical ideology, see the often regurgitated concepts of patient-centered and/or person-centered care, Håkansson Eklund et al., 2018.

Siegler noted already in 1982 that a hospital visit resulted in around seventy-five unique retrievals of the patient's medical records; an indicator of the number of people involved in the care for the patient (Siegler, 1982).

An important corollary of this basic point is that medical praxis is not reducible to the actions directly targeting, or carried out together with, the patient. Medical praxis is not limited to the activities within the confines of the examination room. It is carried out with and toward other individuals than patients in healthcare: colleagues, managers, subordinates and superordinates, janitors, relatives, and so on. In addition and obliquely related to these two aspects of medical praxis—the individual one-to-one and collective many-to-many relationships that constitute healthcare—there is something, *made of* men and *made out of* men, in and around healthcare that has *made itself* a relatively independent entity. This independent entity can be called "bureaucracy" or "institution", which while emerging from the totality of these social relations, becomes an operative force in its own right. It is abstract, yet real to the highest degree. While immediate face-to-face encounters are essential to healthcare in a generic ahistorical sense, the many-to-many encounters and worker-bureaucracy encounters are equally essential to actual contemporary healthcare.

Bureaucracies and institutions as such are certainly not recent entities by any means. Neither is their influence over healthcare particularly new. Over time, however, the accrued small changes to the hull, rudder and sail of medical bureaucracy have resulted in a new ship. From within, the change has been slow and obscure, but more visible in retrospect. At any rate, the objectives of the bureaucratic framework have come to diverge from the goals of medicine and medical professionals, to the extent that they appear at times contradictory. Whereas medical professionals strive *primarily* for the ends of medicine (that is, health: "prevention of disease [...] relief of pain and suffering [...] care and cure of those with a malady [...] avoidance of premature death." Hanson and Callahan, 1999: xi), the institutions, bureaucracies and their systems of control primarily strive for efficiency (and austerity).[2] The logic of instrumental economic rationality and its precedence over non-economic rationality have become the rule, and as such the former indirectly influences the way the latter operates. That is also the case in spheres not directly subject to a monetary profit motive, such as public administration. Management "philosophies" that arose in the early and mid-1980, such as *New Public Management*, operate with the explicit belief that public entities should be administered *as if* they

[2] Granted, medical professionals strive for a multitude of *secondary* goals besides health (such as remuneration, status and allegedly power, Illich, 1976). However, the intrusiveness of secondary interests of medical practitioners is a *function derived from* the divergence between the primary ends of professionals and institutions. For example, the intrusive secondary interest of making money off the backs of patients becomes an issue if the wage of doctors is tied to the medical encounter (directly, if the healthcare sector is privatized and deregulated, such that cash flows directly from patient or pharmaceutical companies to the physician; or indirectly, if professional behavior is tracked and managed by administrative performance indicators). The medical professionals are not the driving force behind (or main profiteers of) reification in healthcare, at least not anymore (see for example, Conrad, 2005).

were profit-oriented, even though they are not. These "philosophies" may have fallen out of fashion but only because their tenets have become generally accepted (Pollitt and Bouckaert, 2017: 6, 11).

Following philosophers Georg Lukács and Jürgen Habermas, I will try to make sense of this new configuration of relations between healthcare and the bureaucratic strictures and structures surrounding it in terms of *reification.* That the relationship between bureaucracy, on the one side, and the patients and workers in healthcare, on the other, is reified means that

> a relation between people takes on the character of a thing and thus acquires a "phantom objectivity", an autonomy that seems so strictly rational and all-embracing as to conceal every trace of its fundamental nature: the relation between people (Lukács, 1971[1923]: 83)

A human relationship between a doctor and patient becomes a machine, perhaps with "relations" between its moving parts, but withdrawn from the sphere of human action, nonetheless. Insofar as the "relation" between physician and patient becomes "so strictly rational" that it disallows improvisation and discretion, it ceases to be a human relationship. Lukács' understanding of this preliminary definition of reification as "phantom objectivity" is replete with ambiguities (as is his theory of reification in general), of which the most important is whether reification takes place in essence or appearance, in objective reality or in the minds of its subjects. The most damaging effect of reification for Lukács is that it hurls subjects into a passive "contemplative attitude," in which workers accept becoming "mechanical part[s] incorporated into a mechanical system [...] already pre-existing and self-sufficient, it functions independently of [them]" (Lukács, 1971[1923]: 100, 89). Rather than understanding reification as a label of our mistaken ideological reduction of "relations between people" to "a mechanical system," in which the latter only *seems* (but *is* not) strictly rational and law-bound, I will follow Habermas' "materialist" emphasis on reification as the name for an objective configuration of relations in the world. If the common structuralist pitfalls are successfully avoided, this alternate route enables one to identify a *relatively* unaffected subject, in the midst of a reified system, who is equipped with both the knowledge and capacity to navigate and survive. In the context of the present study, this subject is the physician who, out of necessity, has developed ways of operating to evade the harms and wrongs of bureaucratic reification, for the sake of herself and for her patients. Interestingly, this "phantom objectivity" of reification has been turned into a useful (albeit not unproblematic) tool in the struggle against that very same reification. It is to this knowledge, capacity and practice I will now turn.

1.1. Cunning in medical practice: a particular case (and its generalizability)

I was made acutely aware of the possibility (and necessity) of expanding the scope of medical knowledge and praxis during my medical internship ("AT-tjänst") at a primary healthcare center in Stockholm in 2017. I had already enrolled as a PhD-student in the *Theory of practical knowledge* with a rough idea about my direction of research. But it was during my clinical work that I encountered what would concretize its content: the challenge and art(s) of sickness certification. I realized that sickness certification in fact consists of two distinct arts united in one and the same activity. First, it involves insurance medicine, which is itself an art that is honed over time by experience. For the treating physicians, it involves disability evaluation as well as issuing a pedagogical and clear sickness certificate (de Boer et al., 2018). But then there was another *minor art*. I had certainly experienced it to some degree before, at the hospital as well as the psychiatric clinic I had worked in. It was a response to recently imposed conditions of medical work. During the previous decade and a half, the eligibility criteria for sickness benefits had narrowed significantly. In order to enforce the invasive logic of austerity, the power of the *Swedish Social Insurance Agency*[3] (henceforth, SSIA) over the sick listing process had increased. In some cases, physicians experienced that the ends of medicine were being supplanted by the ends of austerity, to the detriment not only of physicians themselves, but more significantly their patients, whose recuperation could be hampered and their vulnerability to poverty and distress amplified. We felt that the SSIA was attempting an informal power grab over the sickness benefit system and devaluing the judgment of treating doctors. The SSIA frequently questioned and rejected sickness benefit claims due to the "poor quality" of sickness certificates issued by doctors. For example, the SSIA could question how the physician had verified that a patient really was depressed, demented, in pain, etc., and how it could be ascertained that these things are really impeding the patient's ability to work. Sometimes, there were just quarrels about details.

It was on such occasions that the second art entered the picture: The minor art of not being governed. The doctors seemed to cunningly resist the attempted power grab of the SSIA by developing an art of writing sickness certificates in a particular way, in order to retain their medical influence over the eligibility for sickness benefits. For example, as physicians knew they had to produce "objective findings" for depression, they did so by transforming the patient's narrative (e.g. feelings of worthlessness not considered sufficiently "objective" by the SSIA) into "findings" made in the examination room (such as "observations of the patient's lowered mood"), which they then documented in the sickness certificate. The discovery of this object of study

[3] The *Swedish Social Insurance Agency* is the official translation of "Försäkringskassan." It is the governmental agency responsible for the administration of the publicly funded social security systems, of which the sickness benefit system is part. It will henceforth, for the most part, be abbreviated as the SSIA.

was truly an epiphany for me. It was the point of entry into a level of knowledge and activity among professionals hitherto undervalued and understudied: everyday forms of resistance and the knowledge coupled with it. The everyday resistance of physicians against the SSIA was a formidable and potentially generalizable archetype of professional everyday resistance against the logic of austerity. In this light, my dissertation's point of departure is an exploration of the techniques physicians employ in their interaction with the SSIA. However, it must be further added that this sphere of knowledge and action has relevance beyond this particular interaction. As this dissertation will thematize, this *relatively new layer of knowledge and praxis* is directed against the bureaucracy and institution in an age of bureaucratic parsimony. Other names for the same epoch are neoliberalism or New Public Management. Put in a slightly different way: this form of activity targets the conditions, rather than the content, of clinical work. Whereas the first art of sickness certification and layer of knowledge is mainly cooperative, this latter, second art of not being governed in the sickness certification process, is mainly antagonistic and engenders a form of resistance; and while the first layer of knowledge and praxis of *insurance medicine* can be understood in terms of classical Aristotelian categories of *skill* (*techne*) and *prudence* (*phronesis*), this new layer has more to do with *cunning* (*panourgia*, or *metis*). The latter has received scant attention in the *theory of practical knowledge*, the research area within which this study is to be located.

I have experienced the possible generalizability of this phenomenon from the patient's point of view as well. At the beginning of 2020, while working on this PhD-thesis, our child was born. He was perfect, but his intestines were not. They were malrotated, entangled, and they denied him the ability to absorb nourishment. Less than a hundred years ago this condition would have meant certain death. Luckily, he was saved by the brilliant intervention of a team of physicians, nurses, surgeons at both *Söder Hospital and* the *Karolinska University Hospital*. After surgery and a couple of days at the intensive care unit, we were transferred to a pediatric ward where our son—Mir—could return to this world from the fog of dehydration, surgery and anesthesia. In the space of a couple of days, we had welcomed our child into the world and almost lost him. There was much to cope with, and naturally we both wanted to stay with Mir around the clock during his recuperation. We soon heard from one of the nurses that the pediatric ward at *Karolinska University Hospital* was not built or planned to accommodate two parents. In fact, similar to all other wards housed in the most expensive hospital building in the world, the rooms had been constructed as generic modules. All rooms, for example, were equipped with expensive patient lifts, but which staff had used only once—in training. None of their (pediatric) patients had ever been heavy enough. The hospital had been planned by architects and consultants with little input from those working in hospitals. The arrangement of the building was ideologically justified in terms of its "flexibility"; every space can potentially be converted to suit future needs. The unfortunate outcome is that rooms and the activities conducted therein are simply not designed for the actual needs of

healthcare workers, patients and relatives, but rather for some vaguely imagined future (Ennart and Mellgren, 2016: 170–171). The leadership and administration of the hospital had apparently—and rather paradoxically, given that "flexibility" was their ruling principle—decided that the needs of patients should be adapted to the capacity of the rooms, rather than the other way around. Thus, they were reluctant to make exceptions. One child should be accompanied by one, and only one, parent. The architectural solutions of *Nya Karolinska* embody the broader tendency and drive towards a dizzying disregard for particularity.

It is here where things became interesting. The staff working on the hospital floor had of course realized the impossibility of enforcing the rule. In secret, or what felt like a semi-open secret, they did all they could to accommodate two parents per child, with extra beds, and so on. I soon realized how hospitals really work in this age of bureaucracy: an informal infrastructure, and set of practices and knowledges, run parallel to the everyday functioning of a hospital. These informal practices and knowledges are *simultaneously* a form of *resistance* against the inflexible administrative rules, *and* the constitutive basis for the survival of the institution. I realized that this is the case not only for the way doctors issue sickness certificates, but for healthcare labor in general.

This very same hospital has also been subject to managerial experimentation. Consultants from the *Boston Consulting Group* were hired to rationalize the workflow in the name of organizational efficiency. The aggressive implementation of their management techniques has been widely criticized by both patients and workers at the hospital. Instead of enabling quality care, managerialism has rather become its main obstacle (Gustafsson and Röstlund, 2019). In a newspaper interview, a senior cardiologist working at the hospital explained with uncommon frankness how she and her colleagues acted amid managerial chaos, which was designed for purposes other than aiding healthcare workers and helping hospital patients:

> I believe that people are like ants; they carve out paths wherever they are needed. I notice that we try to work the way we did before, with cooperation and collegiality. I engage in a lot of *civil disobedience* at work myself. I ignore some things and do it the way I did before [the managerial intervention] (Röstlund, 2019, my italics)

Apparently, this aspect of the interactional dynamics between doctors and the SSIA is no exceptional occurrence. As mentioned above, it is precisely these ant trails, commonly occurring but not often talked about, that I will trace in this dissertation. Everyday labor becomes a site or setting for this strange form of quotidian "civil disobedience." Furthermore, securing the actual use value of the labor process (that is, care) is conversely dependent on this "civil disobedience" as well.

Finally, no text today should be written without mention of the COVID-19 pandemic. Indeed, the pandemic actually reinforces one central theme of the present

study. SARS-CoV-2 brought the world to a standstill. At the time of writing this introduction, several cycles of full and empty streets and hospitals have passed. People are dying in numbers that some liken to *a conflict situation*. In an interview with the *JAMA network* about the ICU management of COVID-19 patients, professor of critical care medicine Derek Angus compared the experience to "a long horrendous war. The metaphors in my mind are trench warfare from the First World War" (Bauchner, 2020). Fiona Godlee, editor in chief of *The BMJ* wrote that families of healthcare workers "(my own included) are parceling up masks and scrubs and sending them by post, reminiscent of the parcels fondly sent to soldiers in the trenches in the first world war" (Godlee, 2020). The main metaphor used during the Covid crisis has been *trench warfare.* The prevalence of war metaphors has, for this dissertation, partially warranted the critical comparison of healthcare to war, at least in certain respects and at certain times.[4] Indeed, a central concept has been borrowed from the experiences of the First World War. In certain circumstances, adversity can give rise to a *solidarity of the shaken*: that strange feeling of togetherness with the "enemy" that follows from having a shared fate, of being "subject to the [same] crack of the whip" (Patočka, 1996[1975]: 133). But who, exactly, are the combatants of this war, and where are the lines of conflict drawn? In the case of Covid, one line obviously separates humans from the viral pathogen. But just like the First World War, it is a battle with multiple fronts. Other perhaps false and unjust, yet real, lines of conflict have been drawn between healthcare workers and patients: the sicker and more numerous the patients, the more fatigued the chronically overworked healthcare workers become. Additionally, an equally unjustifiable, but expected and real, line of conflict runs between states competing for resources, such as personal protective equipment and vaccines. This at least is how the austerity logics of the market have dug deep trenches within the healthcare system. Solidarity between doctors and patients has, in turn, shown a redrawing of the frontlines, and a refocus of the war efforts. A war that has the potential of becoming a "war against war" (Patočka, 1996[1975]: 127). In some respects, the relationship between doctor and patient in the Swedish sickness certification process, and the resistance against it, share a few traits both with the horror in the literal trenches on the Western Front, as well as with the metaphorical trenches of the current pandemic. Pitted against each other, doctors and patients find ways to relate to one another under the condition of mutual powerlessness.

Just as the increasingly austere sickness benefit system can tie together doctors and patients in distress, so may COVID-19 also help direct productive anger against the austere system that has reduced staffing levels, slashed funding for ICU beds, for personal protective equipment and jeopardized the lives of both healthcare workers

[4] The superabundance of war tropes in healthcare and biomedicine, especially the unreflected adoption of them (such as the talk of "eradicating" or "combating" disease, patients' "war" or "struggle" against cancer, etc.), can be extremely problematic and bring about undesirable side effects in care (Nie et al., 2016). It should be noted therefore that the use of such metaphors cannot be legitimated simply owing to their widespread occurrence.

and patients. The Covid crisis might be a "crisis" in all senses of the word: undeniably a disaster, but possibly also a turning point towards a better and more just health care and social insurance system.

1.2. Situating cunning in the theory of practical knowledge

Broadly speaking, as a field of research, the theory of practical knowledge is an interdisciplinary approach to professional life, and is principally comprised of the social sciences, humanities and philosophy. Beyond that, though, it lacks any clear itinerary or program. Rather, the theory of practical knowledge changes its theoretical as well as thematic direction in accordance with the specific research context and questions under investigation. In many respects, the heterogeneity of the field can be considered a benefit, not least because it prevents dogmatic ossification. Consequently, more often than not, attempts at mapping the field proceed by way of negation, as will become apparent below. What follows is not an attempt at summarizing the field as a whole, but rather to situate the dissertation in relevant subareas of the theory of practical knowledge.

If one were forced to summarize the research field of the theory of practical knowledge in one single sentence, the phrase coined by the philosopher Michael Polanyi would be a good (albeit non-exhaustive) pick: "We can know more than we can tell" (Polanyi, 2009[1966]: 4). The expression elegantly captures the conditions of the domain of practical knowledge, and how it differs from propositional knowledge. Even if the traditional definition of propositional knowledge has been contested, I will for the sake of simplicity understand it as justified true belief put forward in a proposition (Gettier, 1963). The central relevant point in this context is that propositional knowledge can be expressed without any difficulties by whoever possesses it. My true and justified belief in the proposition "the Swedish Social Insurance Agency is a Swedish agency" is an example of such knowledge. It is obvious that I have no difficulties in (verbally) expressing this proposition. In addition to everything we know that can be verbalized without hindrance, there is a sort of knowledge that, for different reasons, evades precise and exhaustive description. In the Swedish language it has often been called *silent knowledge* ("tyst kunskap"), or *practical knowledge*. According to the Norwegian philosopher Kjell S. Johannessen this silent knowledge accommodates a number of subcategories: *skill* ("färdighetskunskap") (for example, a nurse's skill to swiftly and painlessly draw blood samples from a patient); *intuition* ("förtrogenhetskunskap") (for example the ability to intuitively recognize a medical state on the basis of symptoms and clinical findings), and *judgment* (such as the doctor's ability to identify which patients benefit from sick-listing and those who do not) (Johannessen, 1999: 80). All three are subtypes of practical knowledge that can be difficult to articulate. A practical example from healthcare, which falls under the category of intuition, and which highlights the difficulties of articulating silent knowledge, is when the nurse responsible for the postoperative care of a patient

becomes worried without stating exactly why. At first sight, the patient seems healthy and has acceptable vital parameters. Yet, the nurse feels that something is wrong. She reports to the doctor, who examines the patient without finding anything alarming. A couple of hours later, the patient dies.[5] The nurse felt something was amiss but could not transform this knowledge into communicable language. It would be difficult to gain a deeper understanding of what had happened in this case only by means of interviews. Of course, interviews can be useful in studying such cases, but perhaps as a complement to other ways of exploring that which eludes exhaustive articulation: participant observation or autoethnographic exploration could serve as the first steps into these principally silent fields. Insofar that tacit and silent knowledge eludes full and direct expression, but only visualized and verbalized through an extensive reflective and figurative labor, it might be more appropriate to enable the research participants to explore it themselves—for example through so-called "dialogue seminars" (Ratkic, 2006), or through collective process writing and similar research strategies (Bornemark, 2019), so that professionals can explore a professional phenomenon together and/or with an external researcher.

Silent knowledge, the way it has been conceived by Johannessen, is knowledge that "*principally* eludes articulation by verbal means" (Johannessen, 1988: 86). But there are other forms of minor or low-key knowledge that are silent, not because of their fundamentally inexpressible nature, but for other external, circumstantial reasons. Forms of knowledge that *in principle* are verbally expressible—sometimes even with a high degree of precision—but have been silenced by external forces and interests, are known as *silenced knowledge*.[6] This concept is often associated with knowledge pushed aside by forces that are disinterested in or inimical to it. For example, the boss or manager of a medical facility who shows little interest in and undervalues the practical knowledge of nursing assistants and other healthcare workers besides nurses and doctors. Recognizing their knowledge could possibly disturb the (im)balance of power in favor of the workers in future salary negotiations. We can also think of a situation where management avoids the safety representative's grievances about working conditions. Both examples are silenced knowledge. However, knowledge can be silenced for other additional reasons. Sometimes, it can be intentionally muted in order to maintain its value. Trade secrets for example, are instances of this kind of voluntarily silenced knowledge. Another is the detailed knowledge of loopholes used in forms of everyday resistance against maladministration and to compensate for systemic organizational defects. Silenced and secret forms of knowledge are safe-

[5] The example is borrowed from Ingela Josefson's *Kunskapens former: det reflekterade yrkeskunnandet* (1991: 28), with some modifications. A similar case is recounted in Dreyfus and Dreyfus, 1986: 34–35. There is of course a good chance that the apprehension of the nurse and the death of the patient were purely coincidental, and possibly also reinforced by hindsight bias. Furthermore, it is completely understandable and reasonable that people refrain from acting on the hunch of others. These reservations notwithstanding, similar cases are all too common to completely dismiss the problem. Dreyfus and Dreyfus, for example, talk about those whose intuition has been repeatedly tested and, as it were, "validated" by a number of preceding events.

[6] See for example Molander, 1996: 44; Eliasson, 1992: 28; Svenaeus, 2009: 15.

guarded by lower epistemological, but by higher political and social, barriers. That is, while not principally impossible to articulate, such knowledge remains tacit for tactical purposes.

The theory of practical knowledge has hitherto mainly focused on knowledge that remains *principally* silent. With this dissertation, I want to expand the operative field of my discipline by exploring professional knowledge and practices that remain *tactically* silent. The way Swedish physicians act in relation to authoring sickness certificates is a perfect case of this kind of knowledge and action.

It should be recognized that Polanyi's elevator pitch of practical knowledge and the concepts of tacit and silent knowledge fail to encompass the entire research field. Although overlapping to a high degree, another notable current in the theory of practical knowledge looks to human activities that are anything but tacit or silent. In one way or another, this line of inquiry can be traced back to Aristotle's conjoined concepts of prudence (*phronesis*) and performance (*praxis*).[7] In the sixth book of the *Nicomachean Ethics*, Aristotle sets out to elaborate on the so-called intellectual virtues, the dispositions of reason and thought required for acting well, of which prudence enjoys a prominent place among all virtues of practical life. In order to do so, Aristotle contrasts prudence with craft, or technical skill (*techne*). Both craft and prudence belong to "what admits of being otherwise," namely, contingent and uncertain (Aristotle, 2011[350 B.C]: 119 [1140a1-5]). The difference is that techne belongs to the sphere of making and production (*poiesis*) in which the ends are fixed and external to the activities pursuing them. What Aristotle mainly had in mind was the making of products, artifacts, that were distinct from the making itself. For example, the joy and point of bread lies in eating it, not in its making. This disdain for manual work might seem foreign to us (some will rightly ask: who does not enjoy baking?). Nonetheless, it was a commonly held position in ancient Greece; the human sphere of *poiesis* was assigned to slaves and people of lower standing. Yet, this category of skill can be understood as an aspect of all human action, even those that do not directly involve the making of physical artifacts. In the case of medical practice, for example, the medical encounter is replete with such technical skills: using a stethoscope to auscultate the heart, knowing which heart valve is best heard at what point on the sternum, for example. As no one patient is like another, every diagnostic event is somewhat unique and requires some degree of improvisation. The end goal is predetermined: to examine the heart, and the purpose of examining the heart is in turn fixed as well (to promote health). However, someone truly capable in their professional field must not only be in possession of technical skills. In order to act well in complex and singular situations, which lack both clear-cut universal guidelines as well as identical precedents, one must be *prudent*. It is so because the universals (laws, principles, precepts, etc.) are unable to truly and exhaustively say everything about particular cases. A *prudent* person is capable of precisely that (Aristotle, 2011[350 B.C]: 124 [1141b15-20]). In this sense,

[7] *Praxis* is usually translated as "action." In this paragraph I feel it is more appropriate to translate it as "performance", thereby further highlighting the confluence of means and ends.

prudence is not so different from the tacit knowledge discussed above. Although, prudence is more besides. It involves good judgment in choosing the adequate means for reaching specific ends, but ultimately also in deciding which ends are relevant and appropriate in particular situations. This is the case because the field in which prudence operates is performance (*praxis*), to which both means and ends belong as an inseparable whole. The perceptiveness for and readiness to deliberate on the ends of performance, together with the fact that complex situations often have several potential ends and outcomes, some of which may be contradictory, makes the virtue of prudence *ethical*. Furthermore, prudence for Aristotle is a profoundly intersubjective virtue, always perceptive of the opinions and predicaments of others. It pertains to deliberation, communication and coordination, none of which can be reduced to the silence and automatism of tacit knowledge.[8] Both tacit knowledge and prudence can be considered as "knowing how", even if they are of two different orders. Prudence is a higher-order know-how that brings together all components (both skills and other moral and intellectual virtues) into a totality. To prudently decide whether the patient is better off with curative or palliative care would here be an appropriate example: In order for a cure to be pursued, what must the chances for survival first be? What about my colleagues? Do they have anything to say about the case? In this situation, the proper course of action is not only dictated by the biomedical status of the patient (which is sufficiently complex in itself), but equally so by the wishes, fears and thoughts of the patient (Gawande, 2014). As a consequence, knowing *how* to comport oneself toward the patient as a person and knowing *when* precisely to do so are issues that equally belong to the sphere of prudence: for example, ascertaining the opportune time for action and the necessary time for restraint; identifying when to comfort and when it is time for truth, when it is the right time to follow protocol and when to break with it.

Although the *political* nature of prudence (*phronesis*) and performance (*praxis*) was already highlighted by Aristotle himself, and has been pointed out by others after him (such as Arendt, 1998[1958]), the political aspect has in the field of the theory of practical knowledge been relatively neglected. Part of the aim of this dissertation, then, is to remedy this shortcoming, by exploring not only how political and institutional power impacts and conditions professional practice, but how professional practice also disrupts political power and those very same institutions conditioning it.[9] To do so successfully, I have pushed the boundaries of the field somewhat, by moving into the adjacent field of sociology. The extent of this pushing of boundaries will become evident below.

[8] Examples of works in this tradition are Bornemark (2018) and Svenaeus (2000). For an international overview, see Kinsella and Pitman (2012).

[9] I will return to Aristotle's political understanding of prudence (or lack thereof) in section 3.1.3.

1.3. Remarks on the structure of the dissertation

This dissertation is a compilation thesis, consisting of articles published or submitted to peer-reviewed scientific journals. The dissertation is comprised of four articles in total. Since the articles themselves are somewhat disparate, some additional contextualization and overarching points are necessary. The compilation thesis is dressed in what Swedes refer to as the "kappa": the "coat" of the dissertation. Writing the introductory sections, the kappa, of a compilation thesis is a difficult undertaking, and for several reasons. Those who write one, most often finish only one, and do not return to the genre again.[10] For the humanities, hitherto relatively unfamiliar with the compilation format, an additional difficulty lies in avoiding stifling formalism without losing stringency. A successful kappa for a compilation thesis in the humanities is one, I believe, that delicately balances between *summarizing*, *contextualizing*, *complementing* and *synthesizing* the articles of the dissertation, while keeping *repetitions* to a minimum. To some degree, these ends contradict each other. An exclusive emphasis on summary is perhaps the conventional approach and safest bet—but also boring. I have tried to also *contextualize, complement* and *synthesize* what I have written in the articles, perhaps at the cost of adequately *summarizing* them. Some may find the approach I have adopted confusing, but my hope is that this kappa will provide a more rewarding read than a summary ever could. In addition to all these difficulties, there is one further challenge, namely that the intended reader differs between the articles. The first article, published in a medical journal, is primarily written for physicians in general, and for primary care physicians in particular. The second and third article are interventions in the theory of practical knowledge and assume a theoretically oriented readership. The target audience of the fourth article are those interested in political transformation (which in no way contradicts the two previous groups of readers). This kappa, then, will have to strike a balance between these intended readers. However, given that the kappa ends up principally highlighting how the study as a whole contributes to the theory of practical knowledge, the content is slightly weighted towards satisfying readers active in this research field.

This first introductory section is succeeded by the aims and research questions (2). Then follows the main section of the kappa, labeled "context" (3). Although this section also partially summarizes the articles, its main purpose is (as its heading implies) to provide context. The context section is further subdivided. I begin with a short description of the changes over time in the relationship between physicians and the *Swedish Social Insurance Agency* (3.1). Thereafter I present a framework, borrowed from Jürgen Habermas, through which these changes can be understood in terms of reification (3.1.1. and 3.1.2). From there I identify a lack in Habermas'

[10] Most PhD-students write only one dissertation, which is the case for those authoring monographs as well. The dissertation monograph is arguably closer to a traditional book, and is often transformed into a commercially published volume. The so-called kappa, on the other hand, is a little more idiosyncratic.

thought (which is partially representative of some gaps in the theory of practical knowledge), the subject of which can be understood with the help of another theoretical tradition, namely, everyday resistance (3.1.3 to 3.1.5). In the ensuing subsection (3.2), which is meant to serve as a context for the fourth and last article, the investigation is partially reset as I embark on a quasi-historical tracing of the doctor-patient relationship (rather than the doctor-bureaucracy relationship) over time. This subsection converges at the same point as the previous one, that is, to make sense of professional activity in the age of bureaucracy. The contextualizing section is followed by a section on materials and methods used in the four articles (4).

Concerning the order in which the texts are to be read, I recommend that the reader starts with the first article (Shutzberg, 2019a) right after this introduction, then proceed with the rest of the kappa and finish off with the remaining three articles.

1.3.1. The weave of normative and descriptive strands: moral and immanent critique

Although intertwined, two (analytically) distinguishable critical standpoints underlie the entire dissertation: a normative critical standpoint, and a descriptive critical standpoint. These require some unpacking in order to project the trajectory of the dissertation as a whole. The normative standpoint articulates its critique, its value judgments, of the current configuration of the Swedish social insurance system from the outside. That is, the yardstick for measuring the harms and wrongs done to patients, physicians and other groups do not belong to the system itself. My position should be made clear. It is the case that harm is caused to patients and physicians (albeit in different ways, which will be demonstrated below). This harm qualifies as an act of injustice. Harm or the risk of harm becomes unjust when it affects some groups rather than others, and/or when some groups are left vulnerable (Young, 2011). In the case of the recent trends of the social insurance system, certain groups of patients are left exposed to sickness insecurity, while worsening labor conditions leave physicians more vulnerable than before to psychological distress. Furthermore, for harm to qualify as unjust, individual blame is not required. Philosopher Joel Feinberg notes that "there are some harms that are ascribable to group faults but not to the fault of every, or even *any*, individual member," which he calls collective non-distributive fault (Feinberg, 1968: 687). The philosopher Iris Marion Young takes Feinberg's idea of non-distributive fault one step further by proposing that the subject of justice is structure, or at least entities larger than individuals. Non-blameworthy (even commendable) actions by a range of actors, such as healthcare workers, case managers, lawmakers, etc., can still be structurally unjust, which I argue is the case with the Swedish social insurance system.[11]

[11] "Structure" is a notoriously elusive notion whose colloquial and technical uses depend on context, research field and values (Sewell, 1992). In lieu of a definition (and far too dualistic for general purposes) it is perhaps fruitful in this particular context to think of it as the production of effects that are independent of the motives

The point of the normative perspective adopted in this dissertation is twofold: firstly, it provides doctors with an objective reason for their actions of circumnavigating the stricter demands of the SSIA. Sensu stricto, this is not absolutely necessary for a proper exposition of their actions, as the physicians themselves motivated their own actions in the interview material. However, it felt scientifically irresponsible and unethical to abandon the informants and let them fend for themselves by only giving a descriptive account of their subjective motives without me passing judgment in this dissertation. Furthermore, for the sake of many patients and clients of the social insurance system, who have lost so much, it felt warranted to form a normative judgment about the present order of things, and how the status quo ought to be transformed. Secondly, the normative dimension adopted here should also clarify that I hope the future will be different. This forward-looking perspective (presented in the concluding section) enables a critical evaluation of the cunning skills and actions themselves: will they help or hinder the prospects for structural changes towards a more just social insurance system?

The core of the dissertation is nevertheless descriptive. Which is to say, irrespective of the justice or injustice one might believe to be inherent in the social insurance system, the aim of the study is to give a descriptive account of the motives, skills and actions of physicians at the intersection between healthcare and the social insurance system. Yet, a descriptive approach should not be mistaken for an uncritical approach. In the exposition, a number of contradictions appear, both in the structure and in the nature of the skills and actions depicted, as well as in the social insurance system itself. For example (as will be shown below), a main theme of article II is the contradiction that professional resistance against the stricter eligibility standards simultaneously enforces compliance with and the reproduction of the reified order. When it comes to systemic contradictions, the SSIA undermines its own "sovereignty" by engendering everyday acts of resistance by professionals. Also, the rule of law ("rättssäkerhet") in social insurance matters is threatened by the very same institutional changes that (allegedly) aspire to uphold it. Hence, despite the non-normative character of the descriptions provided, i.e. the fact that they are not principally oriented towards a concept of justice, these descriptions remain critical inasmuch that they constitute a kind of internal critique (as opposed to the external normative critique) of the contemporary configuration of the social insurance system.

of the actors involved with it. For a generally valid definition, that also incorporates rather than alienates agency, see Sewell, 1992.

2. Aims and research questions

It is always valuable to point out what studies are *not* about. The main aim of this dissertation is not to get to the bottom of the nature of reification in organizations as such. This is not mainly a dissertation about the loss of autonomy of the medical sphere, or its subjugation under the sphere of economic rationality; nor is it a dissertation about the loss of the medical discretion of physicians in the morass of bureaucracy. Neither is this dissertation about the obliteration of the shared lifeworld of the doctor and the patient.

Nevertheless, all these historically specific conditions constitute the point of departure for the main aim of the dissertation, namely, to explore a novel form of professional capacity and action. From this departure point, a series of questions are asked: how do physicians *retain* their autonomy in the medical sphere, *preserve* their professional discretion, and *guard* the lifeworld of medical practice against the destructive forces of reification? Can it reasonably be called *resistance*? Through this route, it is possible to understand the *forms of knowledge and actions* within the healthcare production process incited by the disconnect between the ends of healthcare and the ends of bureaucratic rationality. The focus on the immediate healthcare production process stands in contrast to other actions, such as organized union activity or attempts at persuading the public opinion or political parties through debate. A secondary aim of the dissertation is to contribute to the theory of practical knowledge by nuancing some of the conceptual distinctions between forms of knowledge and action.

Hence, to address the general aims and questions above, I will focus on the relationship between physicians and a specific institution that interacts with healthcare, namely, the *Swedish Social Insurance Agency* (SSIA). The specific questions guiding the four articles are:

1. What are the informal and unsanctioned techniques employed by general practitioners (GPs) as a means to increase the likelihood of sickness certificate approval, following the SSIA's consolidation of the gatekeeping role in sickness benefit evaluation? (Pursued mainly in Shutzberg, 2019a)

2. What possibilities, ambiguities and contradictions follow from framing the evasive actions of doctors *vis-a-vis* the SSIA as *everyday resistance?* (Pursued mainly in Shutzberg, 2020a)

3. Do the forms of capacity, knowledge and actions involved in cunningly navigating through bureaucratic systems constitute their own type, and if so, what are their main characteristics? (Pursued mainly in Shutzberg, 2020b)

4. What are the main characteristics of the doctor-patient relationship in the "age of bureaucratic parsimony"? What kind of solidarity, if any, can it accommodate? (Pursued mainly in Shutzberg, 2021)

3. Context: developments of welfare and the doctor-patient relationship

3.1. Strains between healthcare and welfare administration

In Sweden, the work doctors do is embedded in the welfare state. This means that a comprehensive social security system overlaps with healing apparatuses, both of which are primarily financed by public funds and are available for most Swedish residents. One of the key players in this system is the *Swedish Social Insurance Agency* ("Försäkringskassan," and henceforth SSIA). One important purpose of the government agency is the administration of sickness benefits ("sjukpenning"), which are part of a more comprehensive sickness insurance system. In short, the aim of this subsystem is to provide economic compensation for those who are temporarily unable to work due to sickness. Eligibility for sickness benefits requires a sickness certificate, issued by a medical doctor. In issuing the sickness certificate, the treating doctor enacts two roles. On the one hand, the doctor is one constitutive half of a healing bond with the patient. Within this framework, sickness benefits function the same way as other prescriptions and treatments. For example, the patient with a tibial fracture may need to have a metal rod inserted into the tibia to stabilize the fracture. Also, the patient may need the assistance of crutches and sick leave with economic compensation to ease the load on the leg. Measures of both types, i.e. therapy and rehabilitation, e.g. surgery and sick leave with compensation, are essential for recovering one's health. On the other hand, the doctor is at the same time a "gatekeeper" defending the resources of the Swedish state and the SSIA against fraudulent misuse. Consequently, the sickness benefit system is a border phenomenon between medicine and law, or between medicine and the state. Furthermore, the sickness certificate is the metonymic expression of this liminality. The doctor who embodies this liminality through the dual roles of patient advocate and resource gatekeeper must strike a balance in the act of issuing sickness certificates. The superimposition of the medical sphere and state bureaucracy in the way described above is not necessarily problematic in itself. The existence of a formal-rational bureaucratic apparatus, which examines and verifies sickness certificates, is ideally an integral part of ensuring an equal and predictable access to resources offered by the welfare state for all subjects.

But alas, ideality and reality seldom coincide. The Swedish sickness insurance system found itself in the firing line during the 2000s. Firstly, from the 1990s onwards Sweden was subject to a fluctuation of sickness absence over time, for which any single cause could not be identified (SBU, 2003: 22; Arbetsgivarverket, 2016: 19). In conjunction with these ebbs and flows in sickness absence the public discourse surrounding sickness absence changed, from considering it primarily a public health concern, to primarily a concern about runaway public expenditure due to overuse

and even fraudulent misuse of sickness benefits (Johnson, 2010). Finally, during the mid-2000s, the responsibility of physicians (or rather, their alleged lack thereof) for surging sickness absence numbers came under scrutiny. Some research has suggested that physicians too often passively yielded to patient demands, thereby extricating themselves from their role as gatekeepers, as seemingly independent medical experts rather than patient advocates (Arrelöv, Edlund and Goine, 2006; Hussey et al., 2004). The rising public costs of social insurance systems were partly attributed to the inability of physicians to curb them in accordance with governmental guidelines of austerity. This shift in public and research discourse led to some thoroughgoing legal and informal changes to the modus operandi of the SSIA: the introduction in 2008 of the so-called *rehabilitation chain* ("rehabiliteringskedjan"); the implementation of a model for reviewing sickness certificates, the so-called *DFA-chain* ("DFA-kedjan"), introduced in a public governmental report in 2009 and only informally adopted as a processing tool by the SSIA sometime thereafter, and, finally, changes over time in the governmental annual "appropriation directives" for the SSIA.[12] These reforms and "chains" all affected the relations of power between physicians and SSIA, fettering the former to the latter. All in all, the SSIA's power to "veto" sickness certificates issued by the patient's treating physician increased as a result of these reforms. The bars of the iron cage of the sickness insurance system hardened.[13]

These changes have caused considerable harm both to patients, who paradoxically have to "work" full-time by appealing denials, gathering paperwork, enduring questioning queries etc., in order to receive sickness benefits, as well as to those who are outright denied sickness benefits despite a doctor's certificate attesting their impaired ability to work. In 2019, almost 22,000 individuals were forced to turn to *social assistance* ("försörjningsstöd") because they were denied sickness benefits despite a doctor's certificate indicating an inability to work due to illness. Since at least 2010, the number of people belonging to this group has steadily grown over time both in

[12] For a closer look at the *rehabilitation chain* and the *DFA-chain*, see the first article of the dissertation (Shutzberg 2019a). Regarding changes to the annual appropriation directives ("regleringsbrev"), the question of "fraudulent" sickness benefit recipients (Socialdepartementet, 2005), "wrongful payments" (Socialdepartementet, 2008a) and the like have been addressed in government directives since the inception of the agency in 2005. However, these questions have continually risen in the priority rankings over time. In the directives for the fiscal year of 2008, the misuse of sickness benefits became the document's centerpiece (Socialdepartementet, 2008b). A noteworthy shift occurred in 2016 when the government changed their directives for the SSIA. The document set an explicit quantitative goal for the SSIA, namely, to lower the sickness absence rate to 9.0 days per person and per year by 2020. In 2018, the state agency that supervises the SSIA concluded that this rephrasing had restricted the eligibility criteria for sickness benefits. The problem was that this restriction came about indirectly, without any formal changes to the eligibility criteria (Inspektionen för socialförsäkringen, 2018b). After extensive internal and external criticism from both supervising governmental bodies as well as labor unions, this explicit quantitative goal of limiting the aggregate sick days to 9.0 days has since been removed (see Inspektionen för socialförsäkringen, 2018b; Senneby, 2016).

[13] In the second article I specify the meaning of "power" as the term comes to be used throughout the dissertation (Shutzberg, 2020a: 12–14). "Power", if not otherwise specified, should be mainly understood pretty straightforwardly as influence over decision-making as well as the capacity to withdraw a question from the negotiation table; Steven Lukes names these as the first and second dimension of power, respectively (Lukes, 1974: 12–13; 18–19).

absolute and relative terms: in 2010, social assistance claimants who trickled down from rejected sickness certificates constituted 5% of all such claimants. In 2019 this share had risen to 9% (Socialstyrelsen, 2020: Table 2). It is more than likely that these 22,000 are only the tip of the iceberg, since entitlement to social assistance requires that the entire household has zero assets. The descent from rejected sickness benefit claims to reaching rock bottom passes through a series of institutions. The Swedish public employment service and unemployment benefits, university and student loans and selling off any assets one may have, often precedes the final stretch towards social assistance—society's ultimate safety net (Altermark, 2020: 107–139). Many still try to get by, marking time in these other institutions or, worse, working despite debilitating illness. Some can lean on others: on spouses, relatives, friends. But many cannot do so. The consequences of being denied sickness benefits are not only purely economical, but also social and psychological . Socially, dependence on others hinders well-being, especially among women who are economically and socially tied to their spouses, making them vulnerable to abuse. The psychological cost can be colossal in the two-front war against illness and institutions.[14]

A case can be made that these harms are unjust. Since 2016, the concept of "rule of law" ("rättssäkerhet") has become one of the official guiding stars of the SSIA (Inspektionen för socialförsäkringen, 2018b) and has often been invoked to imply the just (or at least justified) nature of the recent changes made; however, the interpretation of what constitutes the rule of law has emphasized only some aspects of the formal procedure, mainly in terms of equal treatment and the standardization of decision procedures. Consequently, the differences in outcome depending on region (see for example Försäkringskassan, 2019) and dependent on who the case manager just so happens to be (Försäkringskassan, 2018: 18), are identified as the main obstacles to the rule of law. A system that allows for different outcomes for identical cases is unquestionably a serious obstacle to a proper rule of law. However, the rule of law is more than standardized, equal treatment. Firstly, as the name implies, it is rule in accordance with existing legislation. Yet, some of the central guidelines used by the SSIA to assess sickness benefits claims are not grounded in legislation, rather they are mere processing tools with little or no legal basis. Although these tools have indeed ensured equal treatment, they have failed to operate in accordance with law. One of those tools has been to match clients' impaired work ability to "normally existing work" on the labor market after 180 days of sick leave. The reasoning in a nutshell is that if there are jobs suitable for a client with a specific impairment, the client should be made available on the labor market. However, the SSIA has interpreted "normally existing work" as hypothetically existing jobs, rather

[14] For an excellent and moving depiction of the fate of those denied sickness benefits, see Altermark, 2020; especially pages 107–139; John Kaluza's dissertation explores the contemporary paradox of having to work in order to qualify for and keep sickness benefits (Kaluza, 2018); Further testimonies and illumination of the patient/client perspective can be found on the websites of grassroot initiatives such as #116omdagen (https://116omdagen.wordpress.com) and Solrosuppropet (http://solrosuppropet.se).

than actually existing jobs on the labor market, effectively elevating the threshold for sickness benefit eligibility. This lax interpretation of normally existing work as hypothetical work has since been rejected by the Supreme Administrative Court (HFD, 2018 ref. 51). Similarly, the legality of internal conceptual tools used by the SSIA to assess sickness certificates in sickness benefit claims (such as "objective findings" of illness and whether the certificate conforms to the so-called "DFA-chain") has been under scrutiny and criticized by legal scholars (e.g., Mannelqvist, 2019) and rejected in several instances by lower administrative courts (Arevik, 2019). Consequently, the SSIA modified its internal guidelines for sickness benefit assessment to clarify that neither "objective findings" nor the "DFA-chain" are necessary requirements for accepting sickness benefit claims (Försäkringskassan, 2021: 68; 247). The practical effects of these modifications are yet to be thoroughly investigated, but there are indications that not all court rulings are incorporated into the case assessments as soon as they appear (Altermark, 2020: 35–36). Another important caveat against the use of "rule of law" as synonymous to equal treatment, or even as synonymous to the merely *formal* aspect of rule of law (that is, the dimension that is supposed to guarantee predictability, and involves equal treatment, legality and objectivity), has been raised numerous times by the *Swedish Social Insurance Inspectorate* ("Inspektionen för socialförsäkringen"), which has an independent supervisory function for the Swedish social insurance administration. The formal aspect is but one (albeit important) aspect of rule of law. The other is "material" rule of law which, in a simplified sense, has to do with a proper evaluation of particular cases and involves "justice in an ethical sense" (Essen, 2010: 8).[15] Whereas the aim of the formal rule of law is a "correct" decision on paper, the aim of its material counterpart is a "good" one in reality (Bendz, 2010: 7). The realization of this material dimension requires a degree of discretion on behalf of the case managers at the SSIA (Inspektionen för socialförsäkringen, 2016: 10–11). As standardization and discretion are to some degree irreconcilable principles, the question of the rule of law becomes more complex. A recent report by the *Swedish Social Insurance Inspectorate* based on an independent follow-up of 455 rejected sickness benefit and activity compensation claims, concluded that the SSIA failed its obligation to procure sufficient information necessary to ensure that the decision is indeed "materially correct" in 11% of the cases. An additional 37% of the cases had room for improvement in this regard (Inspektionen för socialförsäkringen, 2021). Given the explicit goals set for and by the SSIA, as well recent modifications to the internal workflow—such as a more regular and close supervision of case management, less personal communication with both sickness benefit claimants (Altermark, 2020: 26–

[15] The distinction between formal and material rule of law probably overlaps with the distinction between formal and substantive rule of law in Anglo-Saxon juridical literature (see for example Craig, 1997). Here, I opt for translating the Swedish word "materiell" to "material" rather than "substantive" in order to confine the discussion to Swedish jurisprudence in general, and to the sphere of Swedish social insurance systems, in particular.

28; 87–90), pre-existing difficulties in the personal communication with case managers experienced by physicians (Alexanderson et al., 2018: 222)—the SSIA seems to prioritize the formal rather than the material, or ethical, aspect of a proper rule of law.

Questions of justice can also be addressed without making reference to the concept of the rule of law. Instead, one can observe the uneven distribution of changes to the rejection rates of sickness benefit claims among social groups: rejections rates are (generally) higher and increasing among those living in rural areas; those suffering from psychiatric disease; older persons; people with lower education; people born abroad; and (at least since 2017) women (Inspektionen för socialförsäkringen, 2018a). This uneven distribution says little about its underlying mechanisms. Regardless, it is clear that rejection rates correlate to pre-existing distributions of wealth, opportunity and vulnerability. Hence, the varying rejection rates, let us call it *sickness insecurity*, seem to be a kind of multiplier of vulnerability. Recalling Iris Marion Young's definition of (structural) injustice, this is no haphazard harm with uniform distribution. Sickness benefit recipients lose at different rates in this new arrangement (Young, 2011). *If* there are winners in the present rearrangement of welfare structures, they cannot be found among any (privileged) subgroup of sickness benefit recipients. Rather, the winner is (again, *if* there is such a thing) the abstract, healthy, taxpayer.

Although incomparable with the suffering experienced by many of their patients, the physicians' own interactions with the SSIA have mirrored the development towards austerity detailed above. One of the medical sectors affected most is primary care; they often process cases of illness whose underlying pathophysiology is not always clear, and for which the production of "objective" findings is difficult. Between 2004 and 2017, the proportion of Swedish general practitioners (GPs) reporting that their medical judgments were questioned by the SSIA rose from 10% to 57%. The number of GPs who had experienced the SSIA requesting unnecessary corrections to the sickness certificates increased from 48% to 72% between 2012 and 2017. In 2017, 72% of surveyed GPs expressed the view that the SSIA requested "objective signs" of illness in cases where objective signs are notoriously difficult to identify (e.g. psychiatric disability, chronic pain, etc.) (Alexanderson et al., 2018). This seems to indicate that the relationship between the sphere of medicine and the sphere of welfare administration is severely strained.

3.1.1. Framing the disconnect between lifeworld and system in healthcare

How does one make theoretical sense of the processes delineated above? The polarization of the content of care, on the one hand, and the form of delivery and administration of welfare provisions, on the other, seem to be part of physicians' and other health workers' general *loss of power*, and further evidence that there has been a *transfer of power* from the medical sphere to the administrative sphere. In the case of sickness benefits, the *de facto* power to decide on patient eligibility has been

transferred to the SSIA. This narrowing of sickness benefit eligibility, the loss of medical power, and the transfer of power away from healthcare practitioners is not unique to Sweden, but an international phenomenon.[16]

The struggle for power between healthcare and administration is not a traditional struggle between two symmetric entities. Rather, it is a friction between two aspects of society that are different in kind. The critical theorist Jürgen Habermas has theorized this friction through a "two-level concept of society" in his magnum opus *The Theory of Communicative Action*.[17] He is certainly not alone in doing so, which Habermas recognizes himself (1984: xl). Many thinkers throughout history have attempted to make sense of the social existence of man through a two-tiered conceptualization of the social whole. In sociology, the distinction between communities of common values and traditions ("Gemeinschaft") and associations of coinciding self-interests ("Gesellschaft")[18] can trace a long lineage beginning with Ferdinand Tönnies, linking together different thinkers such as Émile Durkheim (in whom the distinction takes the form of "mechanic" and "organic solidarity") and Max Weber (and his almost identical but slightly more processual concepts of "Vergemeinschaftung" and "Vergesellschaftung") (Tönnies, 2001[1887]; Durkheim, 1984[1893]; Weber, 1978[1922]: 40–43). In philosophy, the distinction between two kinds or aspects of power, "potestas" and "potentia"[19], as thematized by Spinoza and further developed more recently by Gilles Deleuze and Félix Guattari, Michel Foucault and Antonio Negri, echo a similar partition of social existence into two distinct, yet non-symmetric, counterparts.[20] Any of these thinkers could feasibly be used to make sense of the matter at hand. However, none of them speak of the friction between *lifeworld* and *system* with the same *empirical* utility and clarity as Jürgen Habermas. Furthermore, his reinvention of the idea of *reification* by way of these concepts is extremely helpful in contextualizing the research object of this dissertation.

Four key concepts should be mentioned and exemplified here before moving on: the couplet of *lifeworld* and *communicative action* on the one hand; *system* and

[16] For an overview of this disempowerment of healthcare workers, generally and internationally, see Shutzberg, 2020a: 10–12.

[17] In what follows, the primary focus will be on this specific *work* by Habermas, and not the author himself. The proper name "Habermas" is primarily a reference to *The Theory of Communicative Action*. Habermas the person revised some positions after completing that work, which is of secondary importance in this dissertation.

[18] "Gemeinschaft" is often translated as "community," while "Gesellschaft" is translated as "society" or "association" (which is the case in for example Tönnies, 2001[1887]).

[19] Michael Hardt and Antonio Negri note that the distinction exists in *most* European languages, except in English: "*potestas* and *potentia* in Latin, *pouvoir* and *puissance* in French, *poder* and *potencia* in Spanish, *Macht* and *Vermögen* in German" (Hardt and Negri, 2017: 70). They translate "potestas" as Power (with a capital P) and "potentia" as power.

[20] For example the controlling, limiting, capturing *potestas* of the state, versus the creative *potentia* of the multitude: "From the idealistic perspective of [Spinoza's] *Ethics* Power [potestas] is recognized as an illusion and subordinated to power [potentia]; but from the historical perspective, in Spinoza's world, power is continually subordinated to Power as political and religious authorities suppress the free expression of the multitude" (Hardt, 1991: xiv).

strategic/instrumental action on the other. For Habermas the *lifeworld* is "the horizon within which communicative actions are 'always already' moving" (1987[1981]: 119). Furthermore, "the lifeworld appears as a reservoir of taken-for-granteds, of unshaken convictions that participants in communication draw upon in cooperative processes of interpretation" (1987[1981]: 123). I would dare to claim that the lifeworld is filled with subjects; it is the sphere that structures "the forms of intersubjectivity of possible understanding" (1987[1981]: 126). The example Habermas uses to illustrate the concept is quite trivial: an older construction worker asks one younger and newly hired co-worker to buy some beer. He expects everyone to know that this means, namely: that it is time for a break; that German workers usually take breaks and drink beer; that there is a vendor down the street that sells alcohol, that the younger co-workers are expected to buy the beer, and so on. This is, in a nutshell, the lifeworld of the construction workers. Although a variety of different actions occur in this situation—for example one person orders another to carry out a task—the very condition of possibility of a lifeworld, of shared understanding, is *communicative action*; that is, the production of mutual understanding as well as pursuing mutually produced plans in a cooperative fashion.

What would this lifeworld amount to in healthcare? It is easy to think of an intersubjective communicative coexistence of medical colleagues in the clinic: the surgeon need only to open her hand for the correct tool to be placed there by her colleague. All participants are aware of what is going on and what is needed in that situation. Then there is the medical encounter between physician and patient. Fredrik Svenaeus has stressed in his work that the essence of clinical medicine is precisely what Habermas would call a construction of a lifeworld between doctor and patient: "The doctor must understand the patient as an understanding person, through projecting himself into the patient's understanding and vice versa; and what the doctor and patient say to each other must make sense for both parties. The discourse of the meeting must indeed take place through a shared language in the sense that both parties understand what the other is saying" (Svenaeus, 2000: 147). Although Svenaeus puts it in Heideggerian and Gadamerian terms, it amounts to roughly the same thing if "understanding" is replaced with "communicative action." Despite the radical asymmetry of the doctor-patient relationship, and even though the lifeworld of doctor and patient might be incompatible or differ in kind in some respects, Svenaeus claims that this interpretative mutuality and commonality is lodged at the very core of the relationship. Hence, medical practice is only *secondarily* a scientific endeavor in which a subject (the doctor) relates to an object (the body of the patient). It is mainly a relation between subjects, between doctor and patient.

An exhaustive description of the lifeworld of healthcare does not amount to an exhaustive description of healthcare in modern bourgeois societies. Lifeworld is but one aspect of Habermas' "two-level concept of society" (Habermas, 1984[1981]: xl), and hence only one aspect of healthcare as well. The other level is "system," a materialist complement to what Habermas calls the "hermeneutic idealism" of

lifeworld-centered approaches (1987[1981]: 148). Without this theoretical level, and the "rationalization of the lifeworld," none of the central pathologies of bourgeois society, such as the loss of meaning, anomie and alienation would make any sense. The challenge for Habermas is to "opt for a theoretical strategy that neither identifies the lifeworld with society as a whole, nor reduces it to a systemic nexus" (Habermas, 1987[1981]: 148). But what, then, is this system, which is key to understanding the rationalization of the lifeworld? While the lifeworld is filled with subjects, the system is devoid of them. "In one case [namely, in the lifeworld] the action system is integrated through consensus, whether normatively guaranteed or communicatively achieved; in the other case [system] it is integrated through the nonnormative steering of individual decisions not subjectively coordinated" (1987[1981]: 150). System is that which steers without direct involvement of values, norms, subjective intent or individual decisions. In bourgeois society, the *market* is the archetypical model of such a stabilizing and self-regulating system, not only for Habermas, but for the sociological tradition since Ferdinand Tönnies first elaborated on the distinction between *gemeinschaft* and *gesellschaft*.

That systems and markets are formally devoid of values, norms and subjective intent does not mean that they are without any direction. They can be put to work to obtain ends and goals. For example, the systemic dimension of the social insurance system has been put to use in order to lower the overall number of sickness benefit days allotted to the general population, as decreed by the Swedish government. Furthermore, the systemic dimension of sickness certification, embodied in the SSIA, is not directly regulated by the market, which is one of the archetypal forms of systemic regulation in bourgeois society according to Habermas. However, the bureaucratic administration of sickness benefit cases, which is the domain of the SSIA, is precisely that stabilizing mechanism or system that guarantees a reliable and rational processing of sickness certificates and sickness benefit cases. This internal differentiation and division of society into lifeworld and system is simply required by the sheer complexity of modern society. For Habermas this is not problematic in itself, so long as the stabilizing systemic mechanisms of the lifeworld are "anchored" in the lifeworld it regulates, which Habermas calls "institutionalization" (1987[1981]: 154).

3.1.2. Rationalization of the lifeworld: colonization

Somewhere along the road, the system of sickness benefit administration ceased to be institutionally anchored in the lifeworld of healthcare, that is, in the thoughts, beliefs, experiences, and forms of knowledge (etc.) of real existing patients and physicians. The ends of administration, namely, rationalization and efficiency, were dislodged from the true principles and ends they were supposed to serve (in this case of healthcare and public health, the end is *health*), and became ends in themselves. Habermas refers to this step as a further "uncoupling of lifeworld and system," which is basically a second-order differentiation of the structures that reproduce the material order of society. That is, not only have steering mechanisms differentiated

from the lifeworld, they have detached themselves from the immediate oversight of the lifeworld (1987[1981]: 155). In settings where the actual content of an activity and the forms of regulation have become detached from one another, there are two theoretical possibilities regarding in which direction power is exercised. Ideally, the lifeworld is the frame of reference that, in the last instance, provides the end for the bureaucratic steering system; that is, ultimately it is the lifeworld that exerts power over the system. As mentioned above, Habermas refers to this non-pathological relationship between lifeworld and system as "institutionalization". The second theoretical possibility is of course that, in the last instance, the system exerts power over the lifeworld: "In the one case, they function as an institutional framework that subjects system maintenance to the normative restrictions of the lifeworld, in the other, as a base that subordinates the lifeworld to the systemic constraints of material reproduction and thereby 'mediatizes' it" (1987[1981]: 185). If one would attempt to date when exactly the SSIA and the sickness benefit administration were decoupled from the lifeworld of doctors and patients, and mediatized it, it would perhaps be somewhere in the decade following the varied changes that took place within the social security system from 2008 onwards, as described above (in section 3.1). The aggregated effect of the reforms was that the needs and ends of patients and physicians were subordinated to the "systemic constraints" of austerity and the narrowing of the sickness benefit eligibility criteria.

This multi-step process of differentiation, the decoupling and mediatization of lifeworld and system, does not however capture the whole picture of reification in modern capitalism. For Habermas there is one further crucial step. The systemic constraints can do more than exert their power from afar. In the last devastating step of reification, systemic mechanisms return to *colonize* the flesh and substance of the lifeworld. The first tentative definition of this colonization is:

> In the end, systemic mechanisms suppress forms of social integration even in those areas where a consensus-dependent coordination of action cannot be replaced, that is, where the symbolic reproduction of the lifeworld is at stake. In these areas, the *mediatization* of the lifeworld assumes the form of a *colonization* (1987[1981]: 196).

As a first approximation, colonization is then simply the same mechanism of mediatization taking place "even in those areas where a consensus-dependent coordination of action cannot be replaced" (1987[1981]: 196). For Habermas, mediatization and colonization are similar insofar as they both regulate and steer the lifeworld. The only difference is that whereas mediatization is the legitimate subordination of lifeworld under systemic constraints, colonization is the illegitimate subsumption, and elimination, of the lifeworld. This imposition of a "quasi-ontological boundary" between normal and safe rationalization (mediatization) on the one hand, and pathological and dangerous rationalization (colonization) on the other, has

been criticized by Moishe Postone for eliminating meaning from "material life" and the sphere of "material reproduction" (Postone, 1993: 252). Habermas provides few concrete examples of spheres in which rationalization can be carried out "safely"; he merely posits that there are such places. Postone's point is, I think, that there are no such places. Symbolic and material reproduction, culture and economy, are too tightly integrated, if not one and the same thing.[21] Co-existing with the all too sharp distinction between material and symbolic spheres of reproduction, the question of *when* "consensus-dependent coordination of action" can and cannot be replaced, is (paradoxically) a bit too fuzzy. This implicit assumption that the difference between mediatization and colonization is a difference of degree rather than one of kind is clearer in other passages: "In order to locate, at least in analytic terms, the threshold at which *the mediatization of the lifeworld turns into its colonization*, I shall characterize more precisely the interchange relations between system and lifeworld in modern societies" (Habermas, 1987[1981]: 318). Consequently, I believe that Habermas' suggested way(s) of distinguishing between mediatization and colonization fails to clarify the internal nature of the two concepts. Habermas' position basically boils down to the idea that colonization is just "bad" mediatization, or too much of it, i.e. beyond a certain threshold. It is true that colonization entails the "suppress[ion]" of "social integration," that is, the form of communicative integration of people peculiar to the lifeworld. But then again, mediatization is a form of subordination and suppression too. Rather, the proper route, I believe, is to explore the distinct ways in which mediatization and colonization suppress the lifeworld. In the following, I will depart from Habermas' criteria for distinguishing between mediatization and colonization. In my reinterpretation, the difference between mediatization and colonization has more to do with the internal characteristics of the two mechanisms, and less with the characteristics (namely, the replaceability or non-replaceability) of *whatever is* mediatized/colonized. Whereas for Habermas, colonization is the "sociopathological" modus of mediatization (1987[1981]: 305), in my reinterpretation *both* mediatization and colonization are distinct sociopathological modes of disconnecting lifeworld and system.

Above, in previous sections, I have provided the reader with an example of what mediatization amounts to in the relationship between the medical practice of physicians and the SSIA. While doubtless more of a tendency than a binary phenomenon, the control of the SSIA and its ends of efficiency and reliability started to weigh heavy on the lifeworld of healthcare and sickness certification practices during the 2010s. Doctors and patients found themselves in a world in which the documents

[21] These sharp distinctions (between safe and unsafe rationalization, between strategic and communicative action, between the sphere of material and symbolic reproduction) are representative of the commonly occurring Aristotelian distinction between *techne* (art or craft) and *phronesis* (practical wisdom or prudence) that runs throughout the theory of practical knowledge and creates similar problems elsewhere. I will engage with these concepts and the problems they generate for the theory of the professional knowledge below.

of their encounters were inflexibly interpreted by the social insurance machine through which they were being fed.

Colonization, on the other hand, is not so much a mere suppression of the lifeworld as it is an *invasion* of it. While mediatization forces the lifeworld to respect the constraints of a bureaucratic system, though still at least allowing the lifeworld to preserve itself, colonization affects the core and content of the lifeworld in its entirety. The lifeworld is actively "*abstracted, in a manner suitable to the medium in question*" (Habermas, 1987[1981]: 322). In the case of the lifeworld of healthcare, the wisdom to judge well in particular situations, which is ideally embedded and expressed in professional care practice, is substituted by a "technicizing of the lifeworld" (1987[1981]: 182, 281). Habermas explicitly states that he is indeed talking about the relationship of the administrative structure of the welfare state and the lifeworld of its clients. As a matter of fact, this relationship is "even the model case for the colonization of the lifeworld" (1987[1981]: 322).

It does not take much effort to see that the colonization thesis is equally applicable to the invasion of the administrative system on the professional lifeworld of physicians who stand in between the clients/patients and the state insurance agency in sickness benefit cases. It is particularly visible from the viewpoint of the medical practitioners, something that helps in part to distinguish the theory of practical knowledge from other fields of empirical inquiry. The medical language of disease by which doctors make sense of the subjective illness of their patients, is an abstraction that can easily be criticized for all too often and all too violently reducing illness to disease. Regardless, the end of medical language is often still health, and to some extent is also motivated as such, insofar as it is a language shared with the patient. In relation to the SSIA, the underpinnings of the physicians' preferred language must be switched for another. This language is an abstraction in the sense that it prioritizes reliability over validity. Also, instead of health, the end is rather *eligibility*.[22] What the SSIA has demanded of physicians since consolidating the power over the sickness benefit system is precisely this: a more precise language, even though the object at hand might not allow for that level of precision. For depressed patients, for example, some physicians experience that the SSIA looks to quantify the attention span in minutes: "The patient can concentrate for no longer than 20 minutes," for example. Also, time and again, doctors, as we mentioned above, experience that the SSIA wants "objective signs," a kind of "objectivity" unfit for some of its objects. Taking the depressed patient as an illustrative case again, physicians experience that even standardized assessment forms, with validated high inter-rater reliability, do not

[22] This displacement of purpose and replacement of validity with reliability in professional practice (not least in healthcare) has been thematized in the theory of practical knowledge by Jonna Bornemark, albeit with a slightly different vocabulary. By salvaging the German renaissance thinker Nicholas of Cusa's understanding of reason, she addresses the contemporary disfiguration of it through an unrestrained growth of *ratio,* of ordering input, at the cost of *intellectus,* that is, the understanding of the *whatness* of that input. This is worth pointing out as the phenomenon is particularly visible from the viewpoint of the practitioners, which Bornemark shares (Bornemark, 2018).

always suffice to quench the thirst for "objective" proofs of depression. Sometimes, the kind of "objectivity" demanded in these cases are unclear. However, doctors internalize this language in order to appease the SSIA, mitigate the compulsion of work and enable the patient to recuperate (Shutzberg, 2019a). Hence, on this level, a kind of invasive colonization of the medical lifeworld "in a manner suitable to the medium in question" is evident.

What are the advantages of using Habermas' idea of a colonial invasion of administration and bureaucracy into the lifeworld? Can framing our problem in Habermasian terms shed new light on the phenomenon of reification in healthcare? Well, in addition to the descriptive clarity, which is valuable in itself, I think the Habermasian model can contribute on several levels, both by virtue of its possibilities, but also through its limitations and shortcomings. Habermas clearly states that Georg Lukács' original conception of reification was more *idealistic* than his, in the sense that it focused on the properties of the reified *consciousness*. In contrast, Habermas aspires to show how reification is a more objective and material condition, which he specifies as a disequilibrium, or cancerous invasion of systems into lifeworlds that suppresses and deforms the latter (Habermas, 1987[1981]: 1). As such, underneath the heavy weight of reification, a *relatively* unscathed subject exists, which can (as I will attempt to demonstrate below) mount resistance against the phenomenon of reification. Furthermore, Habermas' model shows how the antithetical relation between professions and bureaucracy is not ahistorical and universal. It is under specific circumstances that the two clash. Hence, Habermas' thesis does not contradict the idea that bureaucracy and the state can be the condition of possibility for professions and professionalism, as well as being an existential threat to them.

3.1.3. Resistance "along the seams between system and lifeworld"

In what ways did the interviewed physicians resist the colonization of the lifeworld in the sickness certification process? And how do we make theoretical sense of these ways? In order to ensure high rates of SSIA approval when they suspected a risk of a medically unwarranted rejection of the sickness benefit claims, physicians used eight clusters of mainly textual "techniques" when issuing sickness certificates. As a response to a perceived increased demand for *quantitative* data, two techniques were adopted: (1) *exaggeration* and (2) *quasi-quantification*. That is, either by exaggerating already existing quantities (such as how often a depressed patient contemplated suicide), or by inventing quantities (for example, the general inability to concentrate on menial tasks could be translated to an artificially exact duration of attention span). The physicians could also (3) *omit information* about, for example, leisure activities and remaining work ability. A slightly more complex way of dealing with the sickness certificate was through (4) *depersonalizing the voice of the patient*. Since the SSIA did not seem interested in the patient's own (indispensable) narrative, because it was not considered sufficiently "objective," physicians responded by objectivizing it in various ways. Some basic "cosmetic" changes to the written document could erase the

presence of the patient without losing key information retrieved from him or her. Physicians sometimes also (5) *adjusted the reported disease progression*, often by understating the rate of recovery when renewing sickness certificates. This technique corresponded with the belief that disease progression, which did not fit the standard expected timeframe for diagnosis, as well as any unexpected progression, could influence patients' eligibility for renewed sickness benefits. The use of standardized phrases or (6) *buzzwords* when writing sickness certificates was also reported by the physicians. They simply used a terminology they knew the SSIA case managers wanted (or needed) to hear, rather than employing terms that were medically more accurate. However, not all techniques were limited to the written content of the certificate. Some physicians would, when possible, also (7) *communicate off the record* with social insurance case managers in order to maximize the chance of a desired outcome. Through this mode of communication, often over the phone, a broader array of information could be conveyed, such as feelings, hunches, worries, and prospects regarding patients' abilities and their futures. Also, taking a further step beyond the mere textual composition of the sickness certificate, physicians could feel forced to (8) *produce redundant somatic data* beyond what was deemed medically motivated, in order to satisfy the demand for "objective signs." In these cases, they faced a difficult balance between expediting the sickness certification process through medically unnecessary examinations, on the one hand, and the potential damage of extensive medical examinations, on the other.[23] The use of these techniques constitute a form of resistance insofar as they aim to change the expected outcome of individual sickness benefit claims.[24]

In the model proposed by Habermas, the question of resistance against the colonization of the lifeworld is strangely present and absent at the same time. Formally, the question of resistance is technically present, with the concluding chapter of *The Theory of Communicative Action* serving as an attempt to understand the new and "different lines of conflict" drawn by the colonization of the lifeworld, as well as the "'new politics'" that "protest" this colonial condition (1987[1981]: 391–2). However, Habermas' examples of a "new politics" only focus on the shift in the *topics* of political contestation. Instead of questions of "economic and social security", the object of a new politics has "to do with quality of life, equal rights, individual self-realization, participation, and human rights" (1987[1981]: 392). Furthermore, the subject of Habermas' protests seems to be groups and individuals *qua* citizens, acting in the public sphere.[25] Hence, although the *substrate* of the new lines of conflict is clearly identified as the "seams between system and lifeworld," the political subject

[23] For further elaboration on the empirical findings, see article I and II (Shutzberg, 2019a; 2020a)

[24] For further elaboration on the theme of resistance, see article II (Shutzberg, 2020a)

[25] This is more explicit in later interviews where Habermas reflects on what he calls the "siege" model of democracy that permeated his position in *The Theory of Communicative Action*: "My purpose in proposing the image of a 'siege' of the bureaucratic power of public administration by citizens making use of communicative power was to oppose the classic idea of revolution—the conquest and the destruction of state power" (Habermas, 2002: 243–244).

Habermas considers stands and acts *outside* of that frontline (Habermas, 1987[1981]: 395). When taking political aim against "profit-dependent instrumentalization of work in one's vocation" Habermas is not thinking of it in terms of an everyday resistance in and through that vocation, but rather through the public display of political communication and contestation, be it inside or outside political institutions.

As a result, Habermas fails to properly account for the epistemological and action-theoretical structure of resistance in general, and everyday forms of professional resistance in particular, that occur "along the seams between system and lifeworld." On the one hand, Habermas puts much effort into theorizing "communicative practice of the everyday lifeworld," which is both the substrate of the lifeworld as well as the normative form of interaction (1987[1981]: 382); on the other hand, he also theorizes forms of social action in which the ends of the actor are fixed and non-negotiable: *strategic action*. In contrast to instrumental action, strategic action involves other subjects. They are, however, not treated as true interlocutors, but at best as people to be openly persuaded, and at worst as things to be forced or secretly manipulated (Habermas, 1984[1981]: 85, 294). Herein lies the cardinal problem of Habermas with respect to everyday resistance: the concept of strategic action casts all kinds of social manipulation, evasion, ruse, trickery and cunning in the same conceptual form. Hence, forms of everyday resistance aimed at evading or mitigating oppression and exploitation become conceptually indistinguishable from forms of everyday domination. For example, the cunning pilfering of grain by poor peasants, motivated by survival, is equatable with the dissemination of manipulative propaganda by military dictatorships; or to use examples more in tune with the theme of the dissertation, the open coercion and hidden manipulative strategies of systems and management (utilized by the *Swedish Social Insurance Agency)* are lumped together with the cunningly evasive acts of health workers *subjected to* those very same systems and managers.

Habermas is far from alone in losing sight of the practical knowledge of (and particularly the role of cunning in) everyday resistance. The roots of this presbyopia extend far in history. On the whole, both "uncritical" and "critical" thinkers share responsibility for the indiscrimination between the practical knowledge of domination and resistance. An example of an "uncritical" omission of the practical knowledge of everyday resistance is found in Aristotle. I say "uncritical" because both his virtue ethics and epistemology take for granted a social vantage point, the perspective of which is that of (political) power. Aristotle's viewpoint reveals itself (not exclusively) in discussions about the nature of prudence.[26] Aristotle seems convinced that the prudent have the choice to accept or reject certain laws and precepts. Or put differently, if the essence of prudence is to decide on making exceptions to the rule, then the freedom to make exceptions must be assumed. For

[26] See section 1.2 for a brief exposition of Aristotle's concept of prudence. Also see Shutzberg, 2020b.

example, in his discussion of justice and equity in the *Nicomachean Ethics*, Aristotle notes that the prudent individual needs to rectify what the law necessarily misses, since on its own the generality of law is unable to grip particular circumstances (Aristotle, 2011[350 B.C]: 112 [1137b10-b35]). Yet while this may very well be the case for the sovereign in power—this applies less to the ruled who are in a non-negotiable relationship with the law. Aristotle reiterates the intimate connection between prudence and power by presenting the powerful statesman Pericles as *the* role model of prudence (2011: 120–121 [1140b5-b15]). When Aristotle claims that "political art and prudence are the same characteristic", he understands politics from the point of view of rulers (2011: 124 [1141b20-b25]). In *Politics*, Aristotle even goes so far as to say that while many virtues can be common between rulers and those ruled, prudence is "the only virtue peculiar to a ruler" (Aristotle 1998[350 B.C.]: 73 [1277b25-30]). It is often remarked that Aristotle did not see the world from the viewpoint of the multitude of slaves populating Greek city states. Yet, it is equally clear that Aristotle not only deemed slaves as politically irrelevant, but at times he ignored the viewpoint of non-slave citizens. When discussing prudence, Aristotle takes an additional step and adopts the viewpoint of the pinnacle of political sovereignty, i.e. the rulers, the statesmen.It is from this perspective that Aristotle is careful to distinguish cunning and cleverness from true prudence. Aristotle makes the passing remark that

> [t]here is indeed a capacity that people call 'cleverness,' and this is of such a character as to be capable of doing what is conducive to the target posited and so of hitting it. If, then, the target is a noble one, the cleverness is praiseworthy; but if base, it is mere *cunning* [*panourgia*]
>
> (Aristotle 2011[350 B.C]: 131 [1144a25-30], my italics).

The passage may be too short to support any elaborate interpretation. Nonetheless, there is at least the hint that there is *something* similar to prudence in cunningness, even if they ultimately remain distinct from one another. This hint is quickly swept away again once Aristotle has settled on giving cunningness a privative definition (it is similar to prudence, but without an understanding of what is good and truly virtuous). And with that, he leaves the matter. This tendency to reduce ruse and trickery to something resembling prudence, though crucially no more than rule-bound and instrumental "binding," "trapping," "controlling" and "immobilizing" of instrumental knowledge (*techne*), is, to some degree, an assumption shared by neo-Aristotelians today (see for example Dunne 1993: 256–58[27]; Nussbaum 2001: 20; 310).

[27] Dunne's position is rather complex. In an attempt to nuance the view on *techne*, arguing that it also contains a creative element of sorts (*technai* also meant "device" or "ploy" for the pre-philosophical Greeks), it inadvertently reduces ploy to techne. This connotation has survived in the English use of the adjective "crafty," insofar as it refers both to instrumentality as well as cunning. Hence, by enriching techne Dunne simultaneously impoverishes the concept of cunning.

Then there is the "critical" attitude or tradition that critically and consciously examines the exercise and reproduction of power. The historian and critical theorist Martin Jay's work, *The Virtues of Mendacity: On Lying in Politics*, provides an overview of this tradition, and is simultaneously representative of this vein of thought. Although Jay claims to be interested in the "general role of mendacity in politics" (2010, x), the true object of the study is slightly less general than that: it is the role of mendacity in political *domination*. To be clear, my point is this: historically, attempts at thinking the art of dissimulation and cleverness, in politics and elsewhere, whether they have been dismissed as vice (by, for example, Aristotle) or lauded as virtue (by, for example, Machiavelli[28]), they all share the assumption that mendacity works in the service of domination. They are attributes of statesmen and princes, of the numerous Pericles and Medicis of this world. Neither extreme of this tendency have been able to think of deception as a *capacity of the ruled*. To be fair, Martin Jay does indeed—albeit in passing—mention the existence of another tradition of thought, that does precisely that:

> But before we turn our attention to [the contending concepts of the political], one other vital point needs to be made. In most discussions of political mendacity, the focus is on rulers who lie to those they govern or represent, or at best, on equals in an adversarial power struggle, either benign or lethal. But what if political lying goes in the other direction? What if it is used by the relatively powerless to protect themselves against those in authority? (2010: 133)

Despite such promises to thematize this kind of resistance, and a few examples ranging from the dissimulation in early modern Europe to evade religious persecution (borrowed from Zagorin, 1990) to the misogynistic and confused—but nonetheless interesting—reflections of Arthur Schopenhauer on women as "as the weaker [party], driven by nature to have recourse not to force but to cunning: hence their instinctive treachery, and their irremediable tendency to lying" (Schopenhauer, quoted by James C. Scott, 1990: 36, from which Jay also borrows), Martin Jay never returns with any rigor to the cunning of the weak. It remains, as it often does, a side note. It is to this minor tradition, this undercurrent of deception as the resistance of the weak, that I will now turn.

[28] "[H]e who has known best how to use the attributes of a fox has succeeded best. But a prince must know how to whitewash these attributes perfectly, to be a liar and a hypocrite" (Machiavelli, 2008[1532]: 281). There are alternative interpretations of the aims of Machiavelli. Antonio Gramsci for example, believed that Machiavelli's *The Prince* was intended not for those in power, who "acquire almost automatically the characteristics of the realistic politician." Rather, Machiavelli "intended to give political education to 'those who do not know' [i.e. who do not have political power], not a negative political education of hatred for tyrants [...] but a positive education of those who must recognise certain necessary means" (Gramsci, 1957[1949]: 142).

3.1.4. Resistance in severely constrained circumstances

What has been negatively described as a gap in the thought of Habermas and Aristotle (and by extension, in the theory of professional practical knowledge) has actually been thought in different ways by various thinkers: "Everyday resistance" (Scott, 1985); "infrapolitical resistance" (Scott, 1990); "covert resistance" (Hollander and Einwohner, 2004); "routine resistance" (Prasad and Prasad, 2000); "micro-resistance" (Kellner et al. 2011: 63; Mumby et al. 2017; Bornemark, 2018); "lines of flight" (Deleuze and Guattari, 1987[1980]; Deleuze, 2016[1994]: 226); "counter-conduct" (Foucault, 2007[1978]); "tactics" (Certeau, 2002[1980]); "metis" (Detienne and Vernant, 1991[1974]), and many more.[29] Despite significant differences between these concepts, they do indeed overlap to a surprising degree. There are some common denominators that I now want to go on to highlight.

Firstly, all these concepts try to capture a type of resistance that is carried out in immediate relation to that which is resisted. To use the conceptual apparatus of Habermas, it is a resistance enacted from within the "seams between lifeworld and system." To take my own study object as an example then, it is a resistance practiced in connection with the "production process" of healthcare. This immediacy of "everyday resistance" is usually contrasted with the more organized, formal, public and mediated forms of resistance carried out by *movements* that Charles Tilly and Sidney Tarrow have called "contentious politics" (Tilly and Tarrow, 2015). Regarding the case at hand, conceivable examples are forms of critique or actions that take place from outside of that production process, such as popular demonstrations, political mobilization of political parties, interests groups and trade unions (with the theoretical exception of actual labor strikes) to address problems surrounding the health benefit system. Forms of "everyday resistance" often precede the formation of any social and political movement that are constitutive of contentious politics. Traditionally, the word "resistance" has been associated with "contentious politics". For many, the word elicits mental images along the lines of "a lone man standing in front of a tank as it rolls onwards to Tiananmen Square", or "[f]rench men and women of the resistance fighting the Nazi occupation" (Pile, 1997: 1). The cluster of concepts above—i.e. those of "everyday resistance"—significantly widens the inclusion criteria of what counts as resistance. The positive consequence of this shift is the recognition of resistance where only submission and servitude was once seen, occasionally bracketed by bursts of rebellion and revolt that were "few and far between" (Scott, 1985: xvi). In his *Weapons of the Weak*, a seminal study of local everyday resistance among the peasantry in a Malay village, James Scott goes on to say that "[t]he rare, heroic, and foredoomed gestures of a Nat Turner or a John Brown are simply not the places to look for the struggle between slaves and their owners. One must look rather at the constant, grinding conflict over work, food, autonomy,

[29] In the following paragraphs I will, for the sake of simplicity, refer to this cluster of concepts as "everyday resistance."

ritual—as everyday forms of resistance" (1985: xvi). This is particularly important for this dissertation, as studies applying a narrow take on resistance give the impression that physicians "offer little resistance" against the neoliberal curtailment of their clinical autonomy (Harrison and Dowswell, 2002: 208).

Secondly, all of these notions of resistance are assigned to a kind of resistance that takes place amid severe constraints. Most commonly, the main constraint is a highly asymmetrical power differential. This is to say, the adversary to be confronted is so overpowering that an open display of force would be met by immediate defeat. This condition of "everyday resistance" is discussed by Scott:

> Most subordinate classes throughout most of history have rarely been afforded the luxury of open, organized, political activity. Or, better stated, such activity was dangerous, if not suicidal. Even when the option did exist, it is not clear that the same objectives might not also be pursued by other stratagems (Scott, 1985: xv).

Hence, covert and miniature forms of resistance take on such attributes by necessity. Historically, such asymmetries and correlating forms of resistance were studied in and associated with pre-liberal, non-liberal or illiberal societies, such as the deformed workers' states of the Eastern Bloc (see for example Havel, 1985[1978]). Although these extreme cases are valuable to study, their paradigmatic status certainly does not mean that similar forms of resistance are absent in liberal societies and subsystems.[30] In the case with doctors and their relation to the SSIA, the power differential is not even remotely close to the extreme domination of landlords over Malay peasants or the Eastern Bloc's domination of its citizens and "dissidents [...] a category of subcitizen outside the power establishment" (Havel, 1985[1978]: 23). Yet, in their everyday professional activities the individual physicians are formally almost powerless *in relation to* the SSIA. Also, the institutional channels have already been tried, to no avail. Swedish physicians have long travelled the high road by being good and obedient Kantian civil servants—arguing as citizens in the public sphere through petitions (Fjell et al., 2011), publicly declared resignations (Noterius, 2019), whistleblowing (Öhman, 2020) and debate articles (Zeba, 2020), while obeying in an official capacity—with little success. In addition to the relative powerlessness of physicians in relation to the SSIA, there is one very important factor that "weakens" healthcare workers in relation to the institutions they act within and against. Like

[30] Václav Havel recognized in his now classic essay, *Power of the Powerless*, that the political dynamics of the post-totalitarian Eastern Bloc should (and now indeed does) concern the "West": "And in the end, is not the greyness and the emptiness of life in the post-totalitarian system only an inflated caricature of modern life in general? And do we not in fact stand a kind of warning to the West, revealing to it its own latent tendencies?" (Havel, 1985[1978]: 38–39). Also, Steven Lukes notes that there are two possible readings of Havel's essay, one particular, addressing only the world beyond the Iron Curtain (that no longer exists), and another more general interpretation, concerning all social formations of technological civilization, state capitalist and liberal capitalist alike (Lukes, 2018).

many other interpersonal occupations delivering public services, healthcare work is characterized by the fact that the "raw material" of the production process happens to be real existing humans, namely patients. As a result, this severely restricts the tools available for exercising power, since disruptive acts such as strikes, sabotage and similar forms of resistance may be legally and/or ethically difficult (or impossible) to carry out.[31] Labor strikes in the healthcare sector, for example, are almost always partial, given that a total strike could lead to serious harm to patients in need of healthcare services, thereby making service disruption difficult to justify on ethical grounds (Thompson and Salmon, 2006). Consequently, partly for similar reasons as James Scott's landless peasants, but also for additional reasons too, which are more unique to the healthcare context, physicians resort to the same type of low-key non-disruptive resistance.

Thirdly, this conception of "everyday resistance" is founded on a series of related assumptions about domination and human nature that all boil down to the following principle: the compliance of subaltern groups is hardly ever absolute. In the case of dominance through different *coercive* means, the impossibility of absolute dominance is built into the medium and mechanisms of domination and controls themselves. The more layers of control, the more cracks there are to hide behind for those who wish to resist. Together they constitute what poetically can be described as "the anarchy of the chiaroscuro of the everyday" (Georg Lukács, quoted by Certeau, 2002[1980]: 199). For every spotlight of control casts a shadow to hide behind. A sociological way of stating the same thing can be seen in Ackroyd and Thompson's comprehensive work on organizational misbehavior: "When managerial persistence appears to produce some conformity, close inspection often shows that what has happened is that [mis]behavior has simply taken new (and perhaps less tractable) forms" (Ackroyd and Thompson, 1999: 4). But increasingly we have become aware that power and domination are not exclusively coercive. Compliance and the reproduction of social order is achieved through the active manufacturing of consent in various ways, understood in terms of *false consciousness*, or slightly less mechanistic (but to some degree beset with some of the same problems) as *hegemony*. It is how these concepts of (often structuralist) Marxism are employed that James C. Scott critiques: "The problem with the hegemonic thesis, at least in its strong forms as proposed by some of Gramsci's successors, is that it is difficult to explain how social change could ever originate from below" (Scott, 1990: 78). For Scott, taking compliance as a function of hegemony, mixes up the *appearance* of consent with *real* consent. Rather, subalterns that seem compliant are not always so; they may appear

[31] The otherwise rich tradition of post-World War Italian Marxism (e.g. Antonio Negri, 2005) which has thematized sabotage, wildcat strikes, refusal of work and other radically disruptive grassroot actions (both individual and collective), are therefore unfortunately not *directly* applicable to the conditions of healthcare. The use-value of healthcare cannot be flippantly dismissed.

like that for tactical purposes.[32] One of the more profound explanations for the existence of "everyday resistance" has to do not with the nature of domination or with the advantages of artificial consent, but rather with the nature of the subject. This is not the place to go into detail on subjectivity, but a common denominator among many theories of everyday resistance is that resistance is by definition part of what it means to exist, and that life is by definition unpredictable, indeterminate and fundamentally indomitable: "Conceptual engineers are familiar with this sort of movement, which they call 'resistance' and which disturbs functionalist calculations (an elitist form of bureaucratic structure)" (Certeau, 2002[1980]: 200). Similarly, for Gilles Deleuze "[r]esistance, in a sense, is built into [his] ontology [...] what is primary in any social formation are its lines of flight, its movements of deterritorialization, which are already movements of resistance. 'Far from lying outside the social field or emerging from it,' Deleuze writes, 'lines of flight constitute its rhizome or cartography'" (Smith, 2016: 278–79).

3.1.5. Strategies of domination and tactics of evasion

Although often suppressed, the second half of the 20th century has accommodated a rich subterranean tradition of thinking everyday forms of resistance. Any of the thinkers mentioned in the previous section could qualify as entry points into the tradition, providing as they do many unique perspectives. One of many possible entry points into this minor tradition is the philosopher Michel de Certeau. There are several reasons to enter the tradition by way of Certeau rather than any of the other thinkers. First and foremost, Michel de Certeau focuses on resistance as a capacity and a form of knowledge. He asks, what kind of knowledge and what kind of mental capacity is employed when people evade domination? Hence, his approach is slightly more epistemological than the more "sociological" perspective adopted by other thinkers. For this reason, Certeau can help nuance and slightly revise the Aristotelian distinctions between intellectual capacities and forms of knowledge that are popular in the theory of practical knowledge, and very useful for understanding the way doctors behave in relation to the SSIA, and the techniques they employ. The second reason to use Certeau is his compatibility with Habermas. The way they deal with "system" and the perspective of "everydayness" implies that they indeed occupy the

[32] This structuralist paradigm has been no stranger in critical medical sociology in explaining the behavior of medical professionals. Some (not all) works by sociologist Howard Waitzkin are representative of this tendency. Basically, Waitzkin's position is that the physician and the medical encounter *primarily* (and almost exclusively?) are entities which reproduce social order: "(a) that medical encounters tend to convey ideologic[al] messages supportive of the current social order; (b) that these encounters have repercussions for social control; and (c) that medical language generally excludes a critical appraisal of the social context" (Waitzkin, 1989: 220). Although it is certainly the case that doctors *do* reproduce the social order in the medical encounter (for example through conveying "ideologic[al] conceptions of work," Waitzkin, 1989: 222), assuming the above *a priori* excludes the possibility of *also* identifying and exploring the disruptive, emancipatory potential within everyday medical work and encounters.

same conceptual space, without necessarily being in agreement.[33] Most importantly for our purposes, however, are the similarities between Habermas' use of *strategic action* and Certeau's conceptualization of the same phenomenon. Where Habermas has only one concept under which all forms of manipulative, deceptive social action with a fixed end are lumped together, irrespective of power relations, Certeau has the distinct merit of having two: *strategy* and *tactics*. This important distinction is introduced in the first volume of *The Practice of Everyday Life* to help make sense of how the trickery of power and domination differ from the deception of resistance against domination. It should be noted that the meaning that Certeau gives to these concepts deviates from their colloquial use.

Strategy is the instrumental social action carried out by the "subject of will and power" in a very broad sense (Certeau exemplifies with "a proprietor, an enterprise, a city, a scientific institution") (2002[1980]: xix, 37). A central aspect of strategy is that it both presupposes and strives for securing a territory, a base of operation, which Certeau calls *place*. Again, this base or territory should be understood in a broad sense. Place can be literally geographical and spatial, but it may also be a metaphor for the playing field, the set of rules of an interaction. Hence the army of a nation, for example, waging war against a foe—say, a guerilla movement—acts strategically insofar as it has geographically fixed bases and a country from which it operates and protects. An entity such as the *Swedish Social Insurance Agency* (SSIA), on the other hand, may not operate on a physical territory, yet the standardized sickness certification forms, or the sickness benefit system as a whole, may be considered to be its abstract, metaphorical place that it designs and controls. The second important requisite of strategic action is that it relates to adversaries distinguishable from the actor (although any clear-cut distinction can sometimes be tricky to make), either literally or metaphorically. The examples provided by Certeau are "competitors, adversaries, 'clienteles,' 'targets,' or 'objects' of research" (2002[1980]: xix). Of these examples, the "clientele" is most relevant for this dissertation, as the way the SSIA operated towards its "clienteles," (both patients and physicians) can be precisely understood as a case of strategy, both in the way it is understood by Habermas as well as Certeau. Certeau's idea of strategy might not be entirely innovative, adding little to

[33] From what I can gather, the relationship between Jürgen Habermas and Michel de Certeau was indirect. Mainly mediated through the works of Henri Lefebvre, who basically established the everyday as a research field. Both Habermas and Certeau rely heavily on Lefebvre's conceptual world in various ways. For example, Habermas' idea of system colonization of the everyday lifeworld is very much inspired by Lefebvre, both because of the structural similarities between Lefebvre's concepts such as "abstract space" and "social space" deployed in the *The Production of Social Space* (1991[1974]) and Habermas' "system" and "lifeworld" (pointed out by for example Miller, 2000: xiii, 12. See also Elden, 2004: 119–20), but also by the fact that Lefebvre used *colonization* as a metaphor for the commodification and bureaucratization of social space of everyday life: "everyday life has literally been 'colonized'. It has been brought to an extreme point of alienation, in other words profound dissatisfaction, in the name of the latest technology and of 'consumer society'" (Lefebvre, 2002[1961]: 11). To my knowledge, Habermas never acknowledges his debt to Lefebvre. Meanwhile, Michel de Certeau acknowledges the fact that "the works of Henri Lefebvre on everyday life constitute a fundamental source" (Certeau, 2002[1980]: 205).

the understanding of how powerful entities operate and control territories and subjects. His use of strategy bears some semblance to Habermas' strategic action, as well as to Michel Foucault's concept of *dispositif*, i.e. a configuration of mechanisms of power with a "dominant strategic function" (Foucault, 1980[1977]: 195). However, Certeau's strength lies not in exposing strategies and dispositifs, the commands and panopticons of power. Rather, original contributions can be found in his exploration of "popular procedures (also 'miniscule' and quotidian) [that] manipulate the mechanisms of discipline and conform to them only in order to evade them, and [...] ways of operating form the counterpart, on the consumer's (or 'dominee's'?) side" (2002[1980]: xiv).

So, instead of looking at the Panopticon prison, Certeau looks to the creativity of those imprisoned there, and how they counter the strategies of power with *tactics*. The first and fundamental principle of tactical "ways of operating" is that it is carried out from a point of seemingly passive subordination. Once again, Certeau employs the literal and metaphorical meanings of the word simultaneously, such as when he calls the tactical subject a "consumer." On one level, he is literally talking about consumers and consumption society, but, on another level, he is also talking about subjects who have been rendered passive receivers, not only of commodities, but of instructions and rules. Hence, the doctor that does precisely what he or she has been told, in the precise way he or she has been instructed (by the SSIA), falls under this category of subordinated subject. Secondly, tactics operate on the minuscule and quotidian level; they move on dove's feet. It is the art of bringing on storms by standing still, of maximal effect with minimum effort. For those who do not control the playing field, maximizing effect is related to seizing the correct moment, waiting for the right opportunity, but also to use whatever materials might be lying around, namely, tools, ideas and things that belong to the master. Consequently, Certeau's position challenges varieties of political puritanism, expressed for example in the poet Audre Lorde's famous declaration that "*the master's tools will never dismantle the master's house*. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change" (Lorde, 1984: 112); that same tendency is evident in the situationist Guy Debord's dictum that one "must learn that it can no longer *combat alienation by means of alienated forms of struggle*" (Debord, 1994[1967]: 89). Granted, such cautionary claims make an important point in demanding vigilance, but for those who cannot afford their own pitchforks or a place of their own, nothing but the masters' tools remain for use, and nothing but the cracks in the master's house can provide hiding spots. Nothing but temporarily beating the master at his own game is possible (at least, at this particular moment). A tactical way of operating

> must vigilantly make use of the cracks that particular conjunctions open in the surveillance of the proprietary powers. It poaches in them. It creates surprises

> in them. It can be where it is least expected. It is a guileful ruse (Certeau, 2002[1980]: 37)

It should be noted that despite tactics (and strategy) being the most well-known aspect of Certeau's thought, their descriptions are rather thin on detail. They "[are] suggestive but not nearly as richly argued and exampled as was really needed to secure their conceptual future" (Buchanan, 2000: 86). One can, however, give the concept some thickness by juxtaposing it with the thought of other thinkers. First, and in order to deliver on the promise of throwing light on Habermas' colonization thesis through Certeau, one can say that a tactical way of operating is if the decolonial tendency is already operating from within the colonies themselves. In a way, the whole tradition of "everyday resistance" fills the gap in Habermas' project of a decolonial countertendency to reification from within reification itself. For Habermas the manipulative and deceptive actions he lumps together into the category of (hidden) strategic action, are always (onto)logically secondary to, and derivatives of, communicative action (Habermas, 1984[1981]: 288). Perhaps, the instrumentality of manipulation and deception might even undermine the open communication of the lifeworld. Simply put: in a world where everyone lies, manipulates and deceives, no one is ready to honestly communicate. While this is certainly true for the specific subtype of strategic action that Certeau calls strategy, I argue that this is not the case for tactics. Quite the opposite: *tactics are*, almost by definition, *the kind of strategic action that reproduces and defends the communicative action of the lifeworld*.

A second way to thicken the concept of tactics is to follow the historical traces that Certeau himself draws back to the mythology of Ancient Greece:

> Even though it is absent from the image that Greek thought constructed of itself, *metis* is extraordinarily stable throughout Hellenism. It is close to everyday tactics through its 'sleights of hand, its cleverness and its stratagems,' and through the spectrum of behaviors that it includes, from know-how to trickiness (Certeau, 2002[1980]: 81).

What, then, is this *metis*, this cunning intelligence, well known among the Greeks but scorned by their philosophers? As mentioned already in passing, Aristotle had little appreciation for this kind of intellect, which he dismissed as a defective form of prudence (*phronesis*). Marcel Detienne and Jean-Pierre Vernant's meticulous work on cunning intelligence in Greek mythology, *Cunning Intelligence in Greek Culture and Society* (1991[1974]), is an ambitious attempt to reconstruct the Greek appreciation of this intellectual capacity—*metis*. It is through their reconstructed concept of *metis* that I attempt to amend the Aristotelian distinctions between intellectual virtues. As I see it, some important aspects of medical practice in late modernity are reducible neither to the rule-following domain of *techne*, nor to the

rule-transcending sphere of *phronesis*. There is a third mode of relation to rules: rule-breaking or rule-bending (that is, everyday resistance/tactics) that for both epistemological and political reasons deserves, even demands, its own proper seat at the table of intellectual capacities. While *phronesis* helps one to deal with the ontological uncertainty of disease itself, with prognosis and treatment, *metis* aids in dealing with the organizational uncertainty of a bureaucratic system that tends to erase the particularities of this or that patient (Shutzberg, 2020b).

To conclude, all articles (particularly articles I and III: Shutzberg 2019a; 2020b) of the compilation thesis set out to explore this new kind of professional practical knowledge, capacity and mode of action that physicians employ when defending the shared medical lifeworld with their patients in the sickness certification process. That which emanates from this capacity, I have chosen to call "techniques" in the first article; Michel de Certeau would have called it "tactics." Detienne and Vernant talk more of the capacity from which "techniques" or "tactics" emanate, namely "cunning intelligence". This is something I develop in the third article.

3.2. Epochs of the doctor-patient relationship: fathers, partners, providers, comrades?

In the previous section I explored how the reified relationship between doctors and the SSIA forces doctors to develop a qualitatively new set of skills in order to defend their medical lifeworld and autonomy. The process of reification does not only affect conditions external to the medical encounter. The doctor-bureaucracy relationship pushes the doctor-patient interaction into new frontiers. Hence, directing attention to the changing dynamics of the doctor-patient relationship is warranted. Rather than assuming the immediate medical encounter as the starting point of the study, which is the common, and problematic, way of doing it (as pointed out in the introduction), I return here to the medical encounter, to the doctor-patient relationship, not as a starting point but as an endpoint that follows from what, up to this point, has been gathered in the dissertation. As a result, the essence of the medical encounter is significantly broadened and tied to the actuality of contemporary, reified (or to speak with the words of Adorno, the "estranged form" of) medical practice. In this section I want to look at roughly the same process of reification, but from the point of view of the doctor-patient relationship in terms of *power*. This requires a brief examination of the development of the doctor-patient relationship over time in order to make sense of what really is at stake today. The exposition overlaps somewhat with the fourth article and provides some background for it.

The mythical point of departure for many writings about the doctor-patient relationship is what is called "paternalism", which reigned supreme for a very long time. It has been claimed to have spanned between "many decades" (Charles et al, 1999: 780) to "thousands of years" (Siegler, 1985: 714). Although it can safely be assumed that the historical reality is more complex than this mythical departure

admits, it is nevertheless a common way of making sense of the evolution of the doctor-patient relationship historically. In the paternalist paradigm, the relation between doctor and patient was analogous to the relation between a benevolent father and his child. One of the fundamental characteristics of this relationship is the asymmetrical distribution of power. The doctor has all of it, and the patient has none. But, as the story goes, something happened in the sphere of culture (Thomasma, 1983), market (Callahan and Wasunna, 2006) or technology (Topol, 2015), resulting in a change of paradigm. The explanations differ on why, how and when, but often one of the following two scenarios is believed to have panned out: either the relationship became more equal, taking on attributes similar to the relationship between *partners* of a contract; or, the power relation flipped around: the patient became more powerful than the physician in the decision-making process; the patient as consumer and the physician more or less a passive *provider* of services. What we have, then, are three models of the doctor–patient relationship—doctor as *parent*, as *partner* and as *provider*—each represents one of three distinct distributions of power: in the first case power lies wholly with the physician, in the second it is roughly equally divided between doctor and patient, and in the third it mainly rests in the hands of the patient-consumer (Shutzberg, 2021).[34]

All these models have their own historical conditions of possibility, and none of them are any longer paradigmatic or hegemonic. Instead, as we enter what Mark Siegler calls the "age of bureaucratic parsimony" (Siegler, 1985), *a new type of doctor–patient relationship has become paradigmatic*. This new type is similar to the bourgeois liberal fantasy of the partnership model, insofar as power is distributed evenly between doctor and patient. However, there is one perverted twist and decisive difference: In the age of bureaucratic parsimony, both doctor and patient are equally *robbed* of power and influence by instances outside of the immediate medical encounter. This new situation enables doctor and patient to interrelate as two similarly exploited subjects—as *comrades*. I suggest that an appropriate word for this new bond is *solidarity*.

3.2.1. "Egalitarianism of the condition of being threatened": The new solidarity of the doctor-patient relationship

The contemporary ideals of the doctor-patient relationship are multiple, but one thing is clear: most, if not everyone, believes that the paternalist era is behind us, both descriptively and normatively. No longer is power concentrated in the hands of the physician, neither as an ideal nor in reality. The bourgeois ideals today are the partnership model, the consumer model or some hybrid in between; either the distribution of power should be equal, or rest in the hands of the patient.

[34] For similar subdivisions of the types of doctor-patient relationships, see for example Szasz and Hollender, 1956; Goodyear-Smith and Buetow, 2001.

Ideality is one thing, but reality is unfortunately quite another. Doctor and patient may stand on an equal footing today, unlike the unequal relationship during the paternalist epoch. However, there is a perverted twist to this formal equality of power: it is concentrated in the hands of neither doctor nor patient. Rather, power over healthcare is vested in entities outside of the doctor-patient relationship. This is not exclusive to, but particularly clear in, questions of sickness benefit eligibility in Sweden. De facto power over the sickness benefit system has been transferred to the SSIA, and thereby has qualitatively transformed the doctor-patient relationship. What, then, is the hallmark of this new type of relationship? As mentioned above, Mark Siegler declared the arrival of what he called the "age of bureaucratic parsimony" in healthcare, possibly a bit untimely in 1985. For Siegler, the distinctive feature of this age was that the relationship between doctor and patient had ceased to be the impenetrable dyadic bond it once was: "The physician will be accountable to multiple interests including employers (health maintenance organizations [HMOs], hospital corporations), hospitals, insurance companies, and government. The physician in the age of bureaucracy will have divided allegiances" (Siegler, 1985: 715). The condition of possibility for the equal disempowerment of doctor and patient is the multiplication of stakeholders in healthcare, which creates the possibility that *power can* (and does) *reside elsewhere*.

There is nothing new in this cultural logic of austere capitalism. Phenomena such as "freedom" and "equality" and "universality" are indeed realized in our contemporary mode of production, but always with a twist. Our present society is in general characterized by a "fine freedom" to choose between submission to wage-labor "or of starving, of freezing to death, of sleeping naked among the beasts of the forests!" (Engels, 1975[1845]: 376). Similarly, the freedoms of doctors and patients to pick and choose what kind of care they want to give or receive, are equally rigged, stripped of any real alternative. The same goes for "equality," as Theodor Adorno puts it in *Minima Moralia*: "Downfall is decided not by incompetence but by an opaque hierarchical structure in which no-one, scarcely even these at the very top, can feel secure: an egalitarianism of the condition of being threatened [Egalität des Bedrohtseins]" (Adorno, 2005/1951: 194/370). This is to say that while the economic development of late industrialism does indeed deliver on its promise of equality, it does so in the perverted form of an equal distribution of powerlessness and exposure to adverse social conditions.

In the last article of the thesis, metaphors of the doctor-patient relationship are understood in terms of their position on a two-dimensional field of physician empowerment along one axis and patient empowerment on the other (Shutzberg, 2021). That leaves us with *four* possible configurations of power rather than the more common tripartite division: 1. The paternalist model entails physician empowerment but patient disempowerment; 2. Conversely, the consumer model entails patient empowerment but physician disempowerment; 3. The partnership model empowers both physician and patient. The second (consumer) and third (partnership) models

constitute the realist and utopian variants of what could be called the contemporary liberal bourgeois medical fantasy. Both inadequately capture the essence of the new epoch of medical encounters. In some regards, the present doctor-patient relationship exists in another state of equality: 4. Neither physician nor patient has any real power. How should this distribution of power be characterized?

3.2.2. The breakdown and revival of solidarity

The fourth model—which today is becoming more prevalent, if not paradigmatic—does not only entail problems for the shared lifeworld of doctors and patients, but brings with it some possibilities as well. Although contemporary post-welfare society in many ways can be described in terms of its *loss of solidarity* and trust, the equal relationship between powerless doctors and patients can also be understood as engendering a new kind of solidarity, the form of which is also distinguishable from the more asymmetrical feeling of compassion (which, of course, is nonetheless part of the essential virtues of physicians). I have decided to call the new doctor-patient bond *comradeship*, following in the footsteps of the philosopher Rahel Jaeggi, who has identified a form of solidarity distinct from both other forms of solidaric ties, as well as from compassion, by tying it to the idea of *comrades* engaged in common struggle:

> We can see the significance of the distinction between solidarity and compassion when we look at the long history of oppressed groups calling for (and building on) solidarity. Obviously, being treated as a "comrade" as opposed to being treated as a helpless victim affects the self-esteem of those concerned (Jaeggi, 2001: 292).

In order to understand this breakdown and revival of solidarity it is necessary to briefly scout its conceptual history, which I will do below.

3.2.3. Old solidarity of integration, a brief overview

At first sight it might seem weird to talk of a resurgence of solidarity. Is not our time most of all known for the *erosion* of trust and solidarity, in society in general, but particularly with regards to the changing welfare arrangements of advanced economies in the west (Misztal, 1996; Ter Meulen et al, 2001)? In contemporary discussions (at least, in Sweden) on welfare and healthcare, two loosely interrelated uses of the word "solidarity" tend to dominate. Firstly, solidarity figures in a mostly intra-professional debate as one of the central ethical principles for priority setting within healthcare. The so-called need and solidarity principle stipulates that patients who are in greatest need of healthcare should be prioritized. Secondly, the concept of solidarity is also used in public and political debates concerning the structure of healthcare funding. It is often used in the phrase "solidaric financing of healthcare through tax," which implies that the financing of healthcare should be distributed

among Swedish subjects according to ability, and that this ability (or inability) to pay in turn should not affect their access to healthcare: "The rich cofinance for the poor (income solidarity) and the healthy cofinance for the unhealthy (risk solidarity)" (Maarse, 2006: 990). To some extent, this solidarity is a property of the institutional frameworks of welfare and healthcare (Michailakis and Schirmer, 2012). In Europe in general, the use of "solidarity" in this second sense (solidaric design and financing of welfare arrangements) is dominant too: "that everyone is assumed to make a fair financial contribution to a collectively organised insurance system that guarantees equal access to health and social care for all members of society" (Ter Meulen et al., 2001: 1).

What are the underlying assumptions of this colloquial use of the word "solidarity"? When talking about "solidaric financing of healthcare through tax", the community in question is not just any community, but society as a whole. There are of course many different takes on the particular characteristics that comprise this solidarity, this principle social cohesion. Whereas a Christian Democratic interpretation might emphasize that those who are stronger take responsibility for those who are weaker, a more Social Democratic interpretation would want to demarcate solidarity from charity, and thus emphasize the reciprocal character of solidarity. Either way, solidarity in this sense (and its varieties) stands firmly as a principle of social cohesion and social peace (Stjernø, 2005). This contemporary use of the word "solidarity" (shared by both Christian Democratic and Social Democratic parties in Europe) is more or less a continuation of the classical sociological use, epitomized by Émile Durkheim during the late 19th century. For Durkheim, solidarity is a descriptive category (although he recognized its normative roots) that is used to explain how societies cohere as a whole, how its members stick together. There are two distinct ways that members come together, based on similarity and difference, respectively. Firstly, members of society unite because of similarities and commonalities. These similarities—in values, taste and disposition—are actively produced, through repressive measures, at a cost of the individuality of particular members. One here could point to pre-capitalist villages when searching for examples of this kind of solidarity. Durkheim called this mode of solidarity *mechanical*, "in so far as they [the individuals] lack any movement of their own, as do the molecules of inorganic bodies" (Durkheim, 1984[1893]: 84). In contrast, modern capitalist society coheres as a whole, not because of the enforced similarity of its members, but rather for diametrically opposed reasons: society is a unit due to the structural necessity of the division of labor and because of the complementary interdependence of all its members. Not only does this form of solidarity tolerate difference, it is entirely predicated on it. In contrast to mechanical solidarity, Durkheim calls this type of sticking-togetherness *organic* solidarity, based on the biological structure of "higher animals" in which "each organ has its own special characteristics and autonomy, yet the greater the unity of the organism, the more marked the individualisation of the parts" (1984: 85). Although there is, evidently, a considerable latitude in the classical

sociological understanding of the idea of solidarity, there is something that remains constant and invariable throughout: solidarity is turned into the opposite of *conflict*, which in turn is banished from playing any part, either in the experience or the concept. According to Jacques Donzelot, the sociological co-optation of notions of solidarity in France around the time of the inception of the Third Republic, was no mere coincidence:

> Solidarity is the principle of government that makes it possible to convert the conflicting demands and fears generated by the proclamation of the Republic into a common faith in progress. At least, that is what is claimed by those who direct this new orientation in these closing years of the nineteenth century which are often represented as our Golden Age, when the Republic seems well on its way to a definitive triumph over its demons, wrenching itself free from the troubles of this closing century, and completing its self-realisation by creating the figure of the *State as guarantor of society's progress* (Donzelot, 1988: 395).

In the Durkheimian sense of the term, "solidarity" understood as the social integration among members of society is indeed currently placed in jeopardy, due to individualization, consumerism and the neoliberal dismantling (or at least, the fundamental restructuring) of the welfare state (Stjernø, 2005: 327ff). To borrow a certain Hegelian insight from the philosopher Rahel Jaeggi, the "crystallized solidarities" sedimented as institutions are subject to the shear stress being exerted from the outside, but also prone to cracking due to the brittleness of its own crystalline, institutionalized, state of matter (Jaeggi, 2001: 305). But just as high-level and "crystallized" solidarities have come to sublate or substitute lower-level solidarities between smaller groups and individuals, is it not possible that the *opposite* may today be taking place? Can a neoliberal de-institutionalization of welfare (through cutbacks) lead to a reactive strengthening of solidaric ties? Before answering that question, I want to circle back to the different types of doctor-patient relationships outlined earlier: one could perhaps say that the "old" type of solidarity, dependent on a strong welfare state, goes hand in hand with a specific doctor-patient relationship, namely *paternalism*. The question is whether the evidently new kind of doctor-patient relationship could correlate with another kind of solidarity; and if this question can be answered in the affirmative, what may the characteristics of such a new solidarity be?

3.2.4. The new solidarity of the shaken

The solidarity between doctors and patients are neither of the mechanical, *gemeinschaft* type (since today subject positions are too dispersed and differentiated with too little positive common content); nor is it the kind of complementary, organic or *gesellschaft* solidarity (on account of the fact that subject positions do not

constitute any happy symbiotic functional whole).[35] Rather, it is a type of solidarity that springs from the realization that nothing but the chains that fetter them, and the possibility of emancipating themselves from those chains, are in common. If one were to express this new kind of solidarity through the Habermasian conceptual apparatus of lifeworld and system presented above, it would perhaps amount to a solidarity that comes out of the mutual recognition that the systemic colonization of the shared medical lifeworld of physicians and patients affects them both in a destructive manner.

In the last article of this dissertation I suggest that the idea of a *solidarity of the shaken* (previously mentioned near the beginning of this introduction), which was developed by the Czech phenomenologist Jan Patočka, is particularly suited to help illuminate this new kind of ultra-negative solidarity made possible by a universal sense of distress (Shutzberg, 2021). To summarize, Patočka derived the idea of a *solidarity of the shaken* from the experiences of the horrors of the First World War. Having been shaken by the same horror of death, soldiers on both sides of the battle—who had nothing in common but the conflict itself—come together as "fellow participant[s] in the same situation." In whichever trench we happened to be stationed, German or British (or transferred to the context of medical practice: whichever role in the medical encounter, doctor or patient, we happen to occupy), we come to the insight that "ultimately, all are subject to the crack of the whip" (Patočka, 1996[1975]: 133). The shaking that Patočka talks of is operative on two levels of abstraction at the same time. Firstly, it is an experience of horror and absurdity that redraws lines of conflicts and distinctions between friend and enemy. Similarly, although thrown into the sickness benefit system as "adversaries," since doctors are formally expected to act as the gatekeepers of state resources, doctors and patients find each other as "comrades" in negotiating the absurdity of a social insurance system that prioritizes the effective rationality of its own functioning above the ends of health, which it is supposed to serve as well.

[35] The gemeinschaft/gesellschaft distinction has been briefly discussed above. See section 3.1.1.

4. Materials and methods

In line with the research tradition of the theory of practical knowledge, this dissertation attempts to approach its subject matter by both empirical and theoretical means. The material as well as methods (of data gathering, empirical analysis and a style of thinking) can thus be divided into two branches: materials and methods regarding the interviews conducted for this study (4.1), and theoretical procedure (4.2).

4.1. Interviews and interviewees: Peculiarities in the field of practical knowledge

In the first article I adopted a qualitative and descriptive approach for the purpose of exploring the informal practices of doctors who work with sickness certification at health care centers. The umbrella term I have used to designate this group is the *general practitioner*, GP. It should be noted that the English term and its Swedish counterpart, "allmänläkare," are not completely interchangeable. The latter more often designates a *specialist* in the field of family medicine, rather than any doctor who happens to work at a primary care center. A deliberate decision was made to include not only specialists, but also trainees and interns in order to ensure that the full breadth of physicians who work at primary care centers were represented in the collected data. Including only specialists would fail to reflect the "demographics" of those who actually work there. Twenty in-depth, semi-structured interviews were conducted with doctors working in primary care, between December 2017 and February 2018.[36] GPs were strategically sampled to ensure a balanced composition regarding gender, age, location, professional experience and educational background. All twenty interviews were conducted before thematic saturation was reached. Informants were recruited through direct contact with health centers, as well as through advertisement in Facebook groups and Internet forums for physicians. Additional informants were recruited through snowball sampling. Eleven informants were female, nine were male. Thirteen of the twenty informants worked in the Stockholm region, while the remaining seven worked in other Swedish regions. Those interviewed ranged between 29 and 65 years old. The average experience in primary care was nine years (ranging between 0.5 and 34). Thirteen had received their medical degree at Swedish faculties, and seven from Eastern and Central European countries. The proportion of doctors with an educational background from Eastern and Central European countries was therefore higher than pure randomness would allow for. The reason is that the first exploratory article was initially designed as a comparative study

[36] Prior to conducting the interviews, one calibrating pilot interview was undertaken in order to sharpen the research questions as well as the interview guide. This interview has not been included in the interview material I have analyzed.

between doctors educated in Sweden and Eastern Europe (the latter of whom constitute the largest cohort of doctors with a non-Swedish educational background in Sweden). There were some indications of differences between the groups, such as a relatively greater confidence, willingness and skill in using informal techniques to maximize the likelihood of having sickness certificates accepted by the SSIA among those physicians educated in Sweden, possibly attributable to their higher degree of experience (during their education) and awareness of the workings and critiques of the social insurance system. Another possible explanation (if one is allowed to speculate) is that the sample of those with a non-Swedish educational background were younger. I soon realized, though, that the similarities between these two groups were far more compelling, robust and open to qualitative inquiry than any comparative study. Thus despite some intriguing preliminary findings, the comparative approach was discarded.

A common assumption in manuals, guides, books and articles about qualitative interviews is that the interviewer often comes from outside with limited pre-understanding of the world of the informant(s).[37] It is also assumed that the informant is socially subordinate to the researcher/interviewer. However, in the research field of practical knowledge, the interviewing situation commonly deviates from the standard set-up. One reason for this is that interviews are often conducted by a researching colleague, and not by someone from outside a specific profession. This peculiar situation sometimes demands that the researcher adopts other strategies, skills and attitudes. Interviewer and informant often have much in common. This can bring the researcher both closer and further away from the informant during the interview, which I will elaborate below. Moreover, relations of power, which always manifest themselves between researcher and informant during the interview can take on slightly different forms: the interviewed colleague is more often an equal, or, in fact, s/he can in some cases even be institutionally "above" the researcher-colleague. Somewhere along the line, I realized that some of the questions and reflections, which arose during the interviewing process, were not unique for my own study, but potentially relevant and to some extent generalizable for the field of the theory of practical knowledge as a whole. The questions I will address in this section are the following: what sort of practical knowledge can be investigated with the aid of qualitative interviews? What key attributes define collegial interviews, and what further considerations are warranted on account of these unique attributes?[38]

[37] The concept of "informant" will in the following be used as a general signifier for the interviewee. Hence, "informant" in this context is generally interchangeable with other concepts such as "research participant" or "respondent."

[38] This section on the role of the interview in the field of practical knowledge is based on an earlier publication on interview methods (Shutzberg, 2019b).

4.1.1. What interviews can and cannot capture

According to sociologist Margarethe Kusenbach, the qualitative interview has the advantage of invoking what is otherwise not visible or observable. For example, through the interview, the past, future plans, desires, beliefs and secret activities of informants are made more accessible—at least if the informant to some extent is conscious of, and willing to disclose, these things. By contrast, regarding phenomena which precede or transcend the consciousness of the informant, and which for different reasons evade verbalization, the interview might be an inadequate mode of data gathering (Kusenbach, 2003: 462). The pros and cons of the interview can also be conceived in relation to the different forms of knowledge that together constitute the research field of the theory of practical knowledge. Some forms of knowledge are easier to verbalize than others, and are consequently easier to investigate with the aid of interviews.

In my own case, the praxis of resistance among physicians and their attempts to circumvent the stricter enforcement of sickness benefit eligibility of the *Swedish Social Insurance Agency* (SSIA), was clearly and distinctly a discursive practice. The challenge for the physicians was to express themselves in such a way (mostly formally in text, but also less formal in speech) to maximize the chance to have their sickness certificates accepted by the SSIA. To capture this already-literal, already-discursive activity by way of interview was, then, not difficult from a purely epistemological point of view. Had I, on the other hand, wanted to know and understand *how* doctors employ their judgment regarding which patients to sick-list (which is considerably harder, since the ability to judge in particular cases is ontologically "silent" or tacit or non-codifiable), interviews alone would probably have been an insufficient way of gaining relevant knowledge.[39]

4.1.2. The collegial relationship

As mentioned above, it is common in the research field of the theory of practical knowledge that the interviewer and the informant are colleagues. To determine how collegiality influences the interview, it is reasonable to begin by analyzing its foundational characteristics. As it is a non-technical term, the word "colleague" has no clear and stringent definition. In a broad sense, persons who *work with similar tasks* are colleagues, regardless of whether they do it at the same workplace or on different continents. The perceived feeling of community between "colleagues" on this abstract and general level varies between professions. Some professions within healthcare (for example nurses and doctors), can have a relatively strong sense of community, together with others in that profession, even though they might never have worked together or even met one another before. In many cases, this general relationship is also organizationally formalized and crystallized in different ways:

[39] For a closer look at the distinction between "silent" and "silenced" knowledge, see section 1.2 in the introduction.

"colleagues" in this sense can (but they do not have to) be joined together by membership in the same associations, unions, through taking the same oaths, or having their credentials certified by the same personnel certification body, etc. In a slightly narrower sense, the word colleague means *co-worker*. It denotes two persons who work at the same workplace. Even in this narrow sense, there is some variation in its meaning. One can be part of the same concrete organization without having ever met each other; or, perhaps the colleagues see one another daily and carry out tasks together. Perhaps, they are even friends. The relationship between colleagues is often, though with some reservations, one between equals. Two doctors are considered to be colleagues even if the more experienced doctor acts as supervisor and mentor for the other.

In both senses of the word, collegiality signifies some kind of proximity, doing so on several different levels: a linguistic community of technical jargon; a (potential) consensus regarding ethical foundations on which one's shared professional practice is based, as well as common (and perhaps shared) experiences. One might possibly have a similar historical understanding of the profession, know about the same historical pioneers in the field, or leading contemporary figures. One follows the same intraprofessional debates in specialized journals and mainstream media. Perhaps one also shares acquaintances. To be a colleague is thus the name for multiple layers of proximity and identity.

From an ethnographic point of view, the collegial interview relation can be understood as a species that is part of a genus of interview relations, characterized by the researcher's closeness and attachment to the object of research: the researching colleague is an *insider*. Research conducted by an "insider" (or "native" or "indigenous" person) is research "in which scholars conduct studies with populations and communities and identity groups of which they are also members" (Kanuha, 2000: 439). However, membership and insider status is not really an either/or question (Davies, 1999: 34). Belongingness ranges from *peripheral membership*, characterized by partial participation in, and support of, a group (without participation in core activities), to *full membership* which is understood as participation in central activities and to a certain extent also an adoption of the general *Weltanschauung* of the community in question. Struggling to move from being an outsider to (partial) insider is a common direction of travel in ethnographic research, for example.[40] Occasionally, this direction of travel reaches all the way to full membership. A famous example is the research of anthropologist Carlos Castaneda. What started out as a quite traditional anthropological field study of the use of medical plants by the American native population, metamorphosed into an intimate participation in a Yaqui shaman's worldview and spiritual rituals (Castaneda, 1990[1968]). Castaneda became a full member of the community, and never returned.

[40] For the role of participant observation in the field of the theory of practical knowledge, see Gunnarson, 2019.

The researching colleague, on the other hand, belongs to another species of the insider genus. The research process is not marked by a movement from naivety to nativity, since the colleague has been an insider from the outset. He or she is a full and active member of the very community being explored, in contrast to the researcher (such as Castaneda) who first decides to explore a field, and then proceeds to work their way into the "inside" (Adler and Adler, 1987: 69). Whoever is at the epicenter of a group and activity is perhaps more of an insider than an ethnographer or anthropologist could ever be. At the same time, this native insider position is fraught with its own unique obstacles. In order to write scientifically, it is necessary to stand at some distance from whatever is studied in order to achieve a level of acceptable objectivity and impartiality. The researcher, therefore, needs to return to a state of non-membership, to become an outsider. This can be difficult for those who are already insiders and natives from the beginning (or for those who go to irreversible depths, like Castaneda). The full member tends to favor the research object in conflicts of loyalty, and risks feeling uncomfortable in the research role. For those who move from the outside towards an inside, all these pitfalls may be easier to avoid. However, the main challenge for this traditional research position is that one might be barred from gaining entry and full membership in the first place (Adler and Adler, 1987: 73–74).

It should be stressed that group membership cannot be taken for granted, irrespective of how much on the inside the insider considers him or herself to be. Almost all human communities are heterogeneous, containing a multiplicity of subject positions, and perhaps several "sub"-communities. The experiences of one member are not identical to any other. Reducing the insider-outsider problematics to a one-dimensional scale can thus be misleading. After all, it is possible to be an insider and an outsider at the same time with respect to different dimensions of a context. It can be tempting to skip this necessary problematization of the insider role and to mistake a formal membership for a relation of greater intimacy, especially because group membership often can be abused as a false guarantee for the "validity" of research. The ethnographer Charlotte Aull Davies has referred to Stephanie Jones' dissertation on gender in a former mining town in south Wales as an example of the kaleidoscopic character of group membership and insider research. Jones problematizes and analyzes her own multiple layers of belongingness. On the one hand, she is Welsh, from a working-class family; on the other, she grew up in another part of Wales, has other experiences than those she is studying, and not forgetting that, she is on an academic career path (Davies, 1999: 34–35). I had some similar experiences during my interviews. For example, I realized the naivety of my own take on the specific challenges that general practitioners in *rural areas and small towns* could face. I had hardly any pre-understanding and experience of being acquainted and, even, friends with my patients; I had little insight into what it would mean encounter my patients in everyday settings, such as the supermarket or the local pub; even less, I understood its significance, especially for the decision to sick-list them.

Although I am a certified physician, and thus am able to talk with colleagues about common experiences, there are always particular experiences and positions that could not be shared.

There are additional reasons for not taking group membership for granted, or as an automatic proof of validity. Sometimes, membership of a group, that is being an insider, can be the very *cause* of distance. Although it is an omnipresent risk in relations between insiders in general, I believe that the phenomenon is accentuated when it comes to collegial insider relations. I have hitherto elaborated on the common assumption that *proximity and equality* are the main features of the collegial relation.[41] In addition to these characteristics, the relationship paradoxically carries the opposite within itself. The collegial community of the medical profession, to take but one example, exists in a rigid institutional hierarchy, the consequence of which is that relations between colleagues also become hierarchically ordered. Younger and less experienced colleagues are both formally and informally subordinated to older colleagues and are expected to both learn from and obey their "elders". In this sense the collegial relationship creates both closeness and *hierarchical distance* between its members. This hierarchized structure can often be mirrored in the interview relation. I will discuss this below. In the following, I shall focus on the peculiarities that distinguish this subspecies of insider—the colleague—in a specific element of qualitative research—*the interview*.

4.1.3. The collegial interview

Before I started conducting the interviews, I worried that the doctors would not be comfortable speaking about their practices and techniques of resistance. In order to avoid self-censorship as a result of perceived and/or real collegial condemnation, I opted for one-on-one interviews instead of gathering data through focus groups. In addition to the general challenges of interviewing, I realized that the collegial interview is afflicted by several special difficulties that had to be considered and negotiated. Below, I have divided these difficulties into three categories: *relational fusion and relational confusion*; *pre-understanding misunderstanding; the distance of collegial closeness—elitism and suspicion*.

The most salient peculiarity of the collegial interview seems to be the free shifting between, or fusion of, types of relations. This is a point that has also been noted by other researching general practitioners when conducting qualitative interviews. In one study on interviews between colleagues, the interviewed general practitioners switched back and forth between relating to the interviewer *as a professional colleague* at one moment, to, in the next, confiding in them almost *as friends* (Chew-Graham et al., 2002). I myself experienced this pendulum motion in my own interviews, both in conversations with the informants I knew before and those I did not know; in

[41] See for example Coar and Sim, 2006; Carolyn A. Chew-Graham et al., 2002; Platt, 1981.

particular, I was surprised by the willingness of those with whom I had no prior contact to switch to a personal tone. The collegial interview seems to carry with it a sense of closeness and assumed trust between two persons who have never met; this can, admittedly, feel quite artificial at times. Nevertheless, it can indirectly facilitate the discussion. For example, one of the informants and I built a rapport through our common interest in trade union activity. The widespread and commonly experienced frustration with the *Swedish Social Insurance Agency* and their handling of patient cases felt by most of the interviewed physicians also contributed significantly. An example of how quick a colleague can become a confidant was particularly evident in one of my interviews. Barely a couple of minutes had passed before she started to talk about how her own wellbeing was affected by the restricted sickness benefit eligibility criteria. It felt as if she related to me as a friend.

Relational switching and relational fusion in general are hardly unique to collegial interviews. Rather, they are expressions of a trust for which all interviewing researchers strive, to a greater or lesser degree. For researchers that begin as outsiders, these personal relationships need to be built over time, for example through participant observation. However, the collegial interview stands out because closeness and trust may be present from the outset, and may, even sometimes, precede personal relations between interviewer and the interviewee. Taking advantage of the fusion of different relations can be cast as a problem, as much as it can be construed as favorable. Instead of enumerating the limitations of interviews, Holstein and Gubrium choose a more productive path in their book *The Active Interview*, emphasizing the importance of the interviewer and the interviewee positions in enhancing the quality of the interview data. They show how an active and engaged interview technique can enrich, rather than impoverish, the material. All interviews and the data are to some extent produced by both the interviewer and the interviewee (Holstein and Gubrium, 1995).

Hence, switching between relationship types, and fusing them together, should, following Holstein and Gubrium, be encouraged and can have successful outcomes. Some of the risks of such an approach should nevertheless be addressed. When the roles and relationships of both parties of the interview switch and fuse, awareness of such occurrences is key. Otherwise, confusion and misunderstanding can lead to difficulties both during the interview itself, but also during the interpretative phase afterwards, which in turn can have consequences for validity. For example, interviewees may sometimes seem to contradict themselves. Informants can claim one thing, only then to switch their opinion regarding that very same topic a few moments later. According to Davies, this is a common experience (Davies, 1999: 96–97). Many doctors I interviewed demonstrated a contradictory attitude toward the SSIA. It is neither strange nor unusual for people to harbor ambivalent feelings, but I soon realized in the interpretative phase that it was not a question of pure ambivalence. One way of interpreting this contradictory attitude is that the informants had several different relations to and feelings about the SSIA, depending on the role they

enacted: as patient advocates; as representatives of state agencies, and finally as a regular citizen. They shared their "public" experiences (as patient advocates, and as representatives of state agencies) when the interviewing relation was more formal, and shared their private feelings once our relationship had become more personal. The researcher can, for example, miss that the informant suddenly switches from a public impersonal to a private and personal mode of relating to the researcher. Failing to adequately respond to this relational switching risks making the conversation stale and shallow. Consequently, the conversation is reduced to an arbitrary accumulation of superficial facts, with few qualitative elements (such as opinions, beliefs, lived experiences, etc.).[42]

The second category of difficulties relate to the tension between *pre-understanding and misunderstanding*. The sociologist Valli Kalei Kanuha recounts how interview transcripts she had made as an insider often contained phrases such as "Well, you know what I mean," or "I guess I don't need to tell you about that" (Kanuha, 2000: 442). Regarding research carried out by insiders in general, and through collegial interviews in particular, the interaction between researcher and informant is, as a rule, *saturated by a tacit and common pre-understanding*, of which the phrases mentioned above are markers. The informants assume that (native, insider) researchers know exactly what they mean. By the same token, the native researcher also tends to assume that the informants know what he or she means. It is a reasonable assumption, since it is often the case that they do know—by virtue of a shared professional lifeworld—what the other means by what they say, without having to make everything absolutely explicit. Often, however, is not always.

In addition to tension, *the pre-understood* and *the misunderstood* pose two types of challenges for the collegial interview. The pre-understood, the implicit and tacit mutual understanding, is the type of assumptions made about the other and their assertions (whether the interviewer or the interviewee) that are in principle true. The misunderstood, on the other hand, is my name for the type of false assumptions that one projects onto the other and assertions uttered by the other. Both pre-understanding and misunderstanding can pose problems for the interview for two different reasons. Firstly, it is easy to let the pre-understood remain implicit in an interview; the interviewer might choose to abstain from asking the interviewee to elaborate on any answers that may seem clear for a native or insider researcher. For example, when the informant says "Well, you know what I mean," it is easy to accept this mutual pre-understanding without further elaboration, even though it may negatively impact upon the later interpretative phase of the research process. There are moreover reasons why the interviewer, against better judgment, abstains from asking the interviewee to elaborate on such answers. It is because such assertions are more than neutral descriptions, and more than expressions of laziness or unwillingness to give elaborated answers. They are enactments and validations of the interviewer's

[42] During the course of a given qualitative interview there are additional ways that roles can become muddled. A point I have addressed elsewhere (2019b).

belonging to and membership in the group. It may therefore be tempting for the interviewer to play along, especially when he or she is convinced of what the underlying meaning is. When I read the transcripts of my pilot interview, as well as some of the initial interviews, I noticed myself saying "Yes, absolutely" instead of asking my informants to elaborate on their answers. I quickly learned to avoid doing so for the sake of the depth of the material. Secondly, mistakenly believing one has understood what the informant means can lead to misunderstanding, both further along in the interview, as well as in the later interpretative and analytical phases of the process. From my experience, the risk of misunderstanding was particularly high when the collegial relationship was abstract, that is, when we were both professional colleagues in the same line of work, but without any other personal ties. Such was the case in the previously mentioned example of my interview with the rural doctor. It is therefore important not to allow the mutual understanding to remain implicit, and to be ready to intervene in those moments of the interview when the pre-understood hints at its own existence. The gate marking the beginning of such areas might be phrases such as "you know what I mean" (or other markers, such as professional lingo, ironic or sarcastic inside jokes, etc.); such phrases were very important to unpack in the conversation, since they sometimes led me to trace out the most foundational assumptions we shared and reproduced during the interview process.

The third set of difficulties—*the distance of collegial closeness*—derive from the fact that all research relations also entail an asymmetric (im)balance of power. Notwithstanding certain exceptions, the relationship in itself gives the researcher the upper hand. It is often (in the last instance) the researcher who owns the project, phrases the research questions, has the advantage in terms of knowledge (of the research process). It is the researcher who asks the questions and draws up the general direction of the investigation, who lays the informants bare. After the data collection the researcher often has a *de facto* interpretative monopoly when writing up the scientific text in which the vulnerabilities of the participants are exposed. Therefore, it is the informants who may feel exploited, instead of heard. They may feel that they said too much or accidentally let things slip, and regret their participation. It is important to minimize the ethical and epistemological side effects of this imbalance of power, without sacrificing the relative autonomy of the research process.

Needless to say, the collegial interview relationship shares the abovementioned general traits. However, the dynamic of power also manifests in ways that are specific to the collegial interview relationship. I mentioned earlier that the collegial relation is not only a source of intimacy, but simultaneously a cause of distance. This is the case because occupational relations (some occupations more than others) are embedded in rigid hierarchical structures. Taking this fact as their point of departure, Chew-Graham et al. identify two roles that the informants (who in their study are general practitioners) can ascribe to the superordinate interviewer. The first is that the interviewer/researcher is assigned an expert role, in the same way that the older and more experienced colleague is an expert in relation to the younger apprentice at the

workplace. If this is the case, the answers provided by informants might become more hesitant and uncertain. It can also mean that the informants implicitly scope out what the researcher wants, and adapt their answers accordingly, in order to give, so to say, "correct" answers. Insofar as the (in this case, medical) community is also a moral community, the interviewer/researcher can also be ascribed a condemnatory and moralizing role. Consequently, the informants might become defensive and feel as if they need to explain and excuse a course of action in situations in order to avoid moral condemnation. At its worst, informants might even withhold information in order to evade rebuke (Chew-Graham et al., 2002). Being perceived as judgmental can be particularly devastating if the research aims to explore tough ethical questions within the selected professional field. During my interviews I noticed that a stiff distance could multiply if the interview took place at the workplace and/or if the interviewee wore a uniform. I see this as an empirical indication that the complex of hierarchy/bureaucracy/professionalism even affects the interview context. At the same time, hierarchical relationships do not have to be the sole cause of stiffness in these encounters. The time constraints of a heavily rationalized labor process could also be a factor for creating stressful interviews at the workplace.

In one of the first interviews I conducted with an experienced general practitioner, it was evident that the balance of power between us was more complex than me being simply superordinate (regarding the interview relationship, that is). This became evident at one point of the interview, when the informant (correctly) blamed me for asking a closed-ended question. I had asked whether she talks with her colleagues about sickness certification cases. "Now you're asking closed-ended questions," she answered. I laughed nervously. She felt I should ask it differently: "'How often' is a better way of putting it." When it comes to interviews with colleagues, the informant may (at least in some respects) be the superior party, counter to the common distribution of power in interview relationships. Sometimes, this is the case when interviewing older, more experienced, or more "successful" colleagues. Sometimes it is due to interviewing highly educated professionals who enjoy a respected social position. In the case of the latter, while informants may not be technically superior in direct relation to the interviewer, they can be so in a more general and global sense. It is important to know that an interview can sometimes take place with so-called *elites*. It can appear as counterintuitive to relate to colleagues as if they were members of an elite, especially given the fact that most qualitative studies of so-called elites have been carried out by outsiders, or outsiders who through the labor of research worked their way towards an intimacy with their informants.[43] At the same time, it is not uncommon that interviews with colleagues can take on a similar dynamic. To some extent the elite role of the informant entails an almost perfect inversion of the relational dynamics described above: in this case, it is the informant who spontaneously asks counter questions, who "tests" the knowledge level of the interviewer,

[43] See for example Mikecz, 2012; Neal and McLaughlin, 2009; McDowell, 1998.

or even (implicitly) condemns the research. The interviewer may have to prove himself (which in this case was me) "worthy" of continuing the interview.

Unsurprisingly, most studies of elites are reluctant to offer all too programmatic interview strategies. The platitude that every encounter is true, after all. The general recommendation, then, is that interviews of elites require even more attention to who the interviewee is, and to adapt the interview strategy accordingly (e.g. McDowell, 1998: 2138). At the same time, *if* it is possible to identify a specific tone and style that ought to be adopted when interviewing elites, it is one that allows the interviewer to come across confidently, actively presenting oneself as well-informed and serious, for example through the intentional use of complicated terminology and lingo (Mikecz, 2012: 484), and a choice of clothing to go with it (Richards, 1996: 202–203).

I thought the interview with the colleague above (who advised me to ask open-ended questions) went well, but it may have gone even better, had I been more confident. I think her comment was an implicit hint that she would have preferred that. When interviewing elites it can be a challenge to balance between "playing dumb" on the one hand, in order to get the informant to be as explicit as possible about their experiences, and on the other to make a confident impression and to be taken seriously. With some older and more experienced doctors, I noticed an expectation that I should be familiar with all the details of the Swedish social security system. In these interviews it was an advantage that to some degree I shouldered the expected "expert role" and demonstrated my knowledge in the field, if the opportunity to do so arose. Conversely, with younger colleagues, the opposite was generally the case. The logic of elite-style interaction was not as prominent, and accordingly, my approach was closer to strategically playing "dumb".

4.1.4. Naive realism? A remark on a potential weakness of (my) interviews

My research question aims at exploring and making sense of a form of professional practice. Given that the focus is on *practices*, rather than feelings, attitudes, beliefs and the experiences of them, a potential weakness of interviews in general is accentuated. On the one hand, as I have addressed above, researchers are always exposed to the risk of being kept in the dark by their informants: *Informants do not always say what they do*. Nevertheless, the opposite end poses a potential methodological problem as well: *Informants do not always do what they say*. Of course, the problems are present in phenomenologically oriented research questions as well (informants do not always say what they feel/experience/think, or feel/experience/think what they say), but in a way informants "own" a privileged access to their own feelings, experiences and thoughts in a way that is not the case with their actual worldly practices.

Yet, it would be severely and unnecessarily constraining to be overly cautious about what the interview can tell us about the objective world. In a way, believing in what the informant says about their world of practices is a leap of faith. The leap is

necessary. However, it is also important to reinforce the validity of the interviews by other means. In my case, the validity of the interviews was reinforced by my own experiences of engaging in the very same professional activities, but also through the documentation of physicians' attitudes toward the sickness certification process as recorded in nationwide surveys (such Alexanderson et al. 2018), as well as from the point of view of the bureaucracy itself. The SSIA, and other institutions, have long suspected that there is something amiss, that physicians not always do what they are told, that they misbehave in the sickness certification process. The interviews simply give an alternative framework for understanding this misbehavior, which most stakeholders already accept as fact. What is sometimes seen as "inadequate quality of sickness certificates" in the eyes of the *Swedish Social Insurance Agency* (Försäkringskassan, 2012: 8) contains more than simple errors, and may be the tip of the iceberg of everyday resistance in the eyes of others (such as Shutzberg, 2020a).

My assumption here could perhaps be identified as a form of *epistemological realism*. Whether or not this position conforms in detail with more fleshed out expressions of this epistemological approach, such as the *critical realism* of Roy Bhaskar (1998; 2011), is a sidetrack I will abstain from pursuing here.

4.1.5. Concluding remarks on the peculiarities of interviews in the field of practical knowledge

I have asked and developed and answered some methodological questions regarding the nature of research interviews relevant to my own interview study of the resistance of general practitioners against the SSIA. Many, if not all these questions, are relevant for the research field of the theory of practical knowledge as a whole. Therefore, the questions have been discussed with generalizability in mind. Emphasis has been on the relationship to informants who are also colleagues, the role of the insider researcher, and their consequences for the interview. This contribution is therefore particularly relevant for those who are insiders, colleagues or who carry out interviews with informants who occupy similar or superordinate social positions in relation to the interviewer and/or society in general. The aspects I have explored—relational fusion and confusions, the pre-understood and the misunderstood, the dialectics between closeness and distance, the multifaceted balance of power between interviewer and interviewee—is in no way unique to interviews with colleagues. Nevertheless, these same aspects are accentuated in interviews with colleagues, in a way that calls for a certain amount of reflective work on the part of the researcher. At the same time, research is not solely an infinite reflection, but to the highest degree also a practical activity. Hence, practical knowledge is not only the object of its research. The research itself has a practical and tacit dimension that evades articulation.

4.1.6. Remarks on analysis and interpretation of the interview material

Invariably, parts of the analysis and interpretation of data occur simultaneously with the gathering of data. Hence, gathering and interpretation of data are heavily intertwined, and are only analytically (not empirically) separable. Inevitably then, I have already touched on some analytical and interpretative dimensions of the interview data in the previous section. In this section I will refrain from repetition and only add what has not yet been said. For example, regarding the way I interpret and understand the contradictory nature of some answers from my informants, I refer the reader to the previous section. Some features of the analysis are easier to isolate than others, such as the *formal, procedural aspects of data analysis*, which I will focus on in this section.

The interviews were all transcribed in full. The first version "zero" of the transcript was, however, not verbatim, but cleansed of improper grammar, stammerings, etc. I allowed this, since I had assumed that I would not be analyzing the text on the micro-level of intonations, hesitations, slips, so on and so forth. Much of the interpretative work was carried out during the transcription phase, "forced as you are to *work slowly through a technical task* (writing down the words onto a piece of paper) while *your mind has time to think fast and widely about the material and the event* in which the material was gathered" (Wengraf, 2001: 209). Reflections that arose from transcription were documented as mainly unstructured shorter notes, but sometimes also as more coherent theoretical blocks of textual thought. These were saved in a separate document.

The interviews were exploratory endeavours on two levels: both an exploration of what the research question should be (more precisely), as well as an exploration of the content of the research question. During the course of the interview phase, I narrowed my scope slightly to focus on what I realized should become the main question of the first article. Besides exploring techniques for informally maximizing the likelihood of accepted sickness certificates (the research question for the first article), other topics were therefore discussed during the interviews: the collective aspect of everyday resistance; other types of everyday resistance; general attitudes to SSIA, etc.

Formally, a *thematic analysis*, as devised by Virginia Braun and Victoria Clarke, was used to interpret the data. This entailed an identification and explication of recurring patterns of meaning across the data set (Braun and Clarke, 2006). After a preliminary familiarization with the transcripts (through the transcription process itself and through reading the transcripts), coding of units of meaning relevant to the research question of this article was undertaken; this meant placing greater emphasis on the description of techniques adopted by GPs when issuing sickness certificates,

rather than, for example, focusing on GPs' beliefs and attitudes regarding the SSIA.[44] The preliminary coding was then checked by my supervisor to ensure fidelity to the transcripts. Categories were inductively developed on the basis of the codes. In the following phase of reviewing the categories, the secondary supervisor aided in sharpening distinctions and minimizing overlap. For example, the preliminary category of "generalization" was removed due to excessive overlap with other categories pertaining to technique.

Furthermore, regarding the encountered themes or categories, it is important to note that although the objective of the first article was exploratory, it was an exploration of a *specific* phenomenon in sickness certification practice (namely "informal and unsanctioned techniques employed [...] as a means to increase the likelihood of sickness certificate approval"). The material contains other potential themes regarding sickness certificate practice that were not explored, such as the decision to *abstain* from challenging the SSIA. These other themes were not taken up since they fall outside of the boundaries of the research objective.

4.2. Philosophical heuristics

The first article of the dissertation is the one most firmly based on the data gathered in the interviews. Describing procedures for how data are gathered and produced in empirical works is relatively straightforward. The procedures are standardized for good reason; it facilitates review by others. The three other articles in this dissertation are, on the other hand, more theoretical. Though, they too draw on, and are highly informed by, the qualitative data used in the first article. This does not mean that the subsequent articles are devoid of methodological considerations. Too often, theoretical works (especially philosophical ones) tend to reduce the question of method and methodology to the question of theoretical *background*. To some degree, theoretical background is an admissible substitute for the mode or procedure of thinking, because philosophical schools and traditions tend to overlap with specific thought styles and a set of cognitive devices that help to set propel one's thinking forward. To mention but one example (on which I will focus in more detail below), Hegelian Marxism (or rather Left Hegelianism in general) has a predilection for turning things on their head, and often proceeds to evaluate whether the reversed system, proposition or claim holds. Most famously (and by now very much a commonplace), Marx believed that Hegel's dialectics "must be *inverted*, in order to discover the rational kernel within the mystical shell" (Marx, 1976[1867]: 103). But then again, the device of inversions is not necessarily chained to the theoretical formation and method of Hegelian Marxism or to the dialectical method (which is,

[44] With that said, it is the intentions and motives informing the use of techniques that qualify them as more than simple errors and misbehavior, i.e. as resistance. For an elaboration on a contiguous topic, see subsection 4.1.4 above.

for better or worse, much more than a series of simple reversals). More about this later.

This section is based on my conviction that there is a phenomenon related to method that can be reduced to neither theoretical *background* (such as specific branches of Marxism or phenomenology) nor *higher-order guides of thought* (which could also go by the name "method proper"; if ill-defined or idiosyncratic, it is sometimes called "style." However, style is also reserved for the expressive, rhetorical aspect of thought). Alan Hájek has dubbed this elusive phenomenon "*philosophical heuristics*" (Hájek, 2016: 348). Heuristics are not merely sources of cognitive bias, a connotation attached to the word by the works of Amos Tversky and Daniel Kahneman (Kahneman, Slovic and Tversky, 1982). Importantly, they are contingent, experimental aids to learning, discovery, or problem-solving; *rules of thumb* that exist wherever complex tasks are at hand. Given that heuristic devices are indispensable for everything from "cooking, rock-climbing, photography, gymnastics, playing the xylophone, salsa dancing, taxi driving, taxidermy (I assume) [as well all branches of the natural sciences] [i]t would be odd if philosophy, one of the most complex activities of which we are capable, *didn't* have heuristics" (Hájek, 2016: 349). Philosophical heuristics are "recurring patterns of thought" in how the practice of "philosophy gets done" (2016: 348). Weirdly enough, despite their ubiquitous occurrence, these elements of a *practical knowledge* of philosophical thinking are usually not scrutinized or thematized with the same meticulousness as higher-order thought guides, such as logics (one could perhaps also include dialectics, genealogy, phenomenology, hermeneutics and deconstruction, which Hájek, who stands firmly in the analytic tradition, does not mention). In my case, the theoretical background is eclectic: Marxism, sociology and the theory of practical knowledge are perhaps the main three theoretical clusters, which I have presented previously (in section 3). The higher-order thought guide for this thesis is loosely informed by a Hegelian dialectic. At the very least, some of the themes of the dissertation have a certain Hegelian tone. Although these clusters do hint at the way arguments are advanced in the articles and the kappa, they fall short of accounting for *how* the thoughts are thought, or the mode of transportation, *after* one has departed from the theoretical background. In transdisciplinary works, such as this dissertation, these heuristic techniques often remain constant (besides the actual object of study), while the theoretical background and method varies between segments. Compared to monodisciplinary works, it is therefore all the more important and urgent to address heuristics here.

A valid objection against the relevance of surveying philosophical heuristics (as well as an explanation of the relative scarcity of works that attempt it) could be that a lucid description of philosophical heuristics is impossible (or futile). Another, that novelty takes precedence over reproducibility in the practice of philosophy which leaves questions of procedures less pressing. A third objection (or explanation) is that form and content are so entangled that attempts at distinguishing the two could do philosophy a great disservice. This said, I will insist that theoretical works owe both

readers and themselves the task of reflecting on the use of heuristic devices employed in the course of thinking. Perhaps it is an activity that should be carried out in retrospect (e.g. "these were the procedures and heuristics that propelled my thinking") rather than prospectively (e.g. "this is how I will order my thinking"), because heuristics are experimental and require several failed attempts before succeeding. In the following, I reflect on three of my own heuristic patterns, which recur throughout the three theoretical articles comprising the dissertation: *heuristic of inversion; heuristic of multiple referents* and, finally, *heuristic of temporal distance*. I will begin by identifying concrete instances of such patterns in my texts, explore if any of Alan Hájek's suggested heuristics are adequate descriptions of what happened, and identify potentially novel aspects left uncovered by Hájek's (admittedly non-exhaustive) list of heuristic devices.

4.2.1. Heuristic of inversion: reversals without sublation

As delineated above and as explored in the four research articles, research concerning sickness certification behavior of physicians tends to reduce unwanted behavior to an expression of ignorance. Doctors, it is claimed, write poor sickness certificates because they lack the knowledge of issuing proper ones. Articles I through III (Shutzberg, 2019a; 2020a; 2020b) turn this unquestioned postulate on its head: what has hitherto been understood as ignorance, as *privation of* knowledge (more specifically, as an inability to properly handle sickness certification cases), is more adequately understood as a concealed *form of* knowledge. The apparent ignorance of physicians is actually knowledge, while the apparent knowledge of the SSIA of their behavior is ignorance. To speak with the words of Georg Lukács, it is only from the viewpoint of a reified consciousness (which is the viewpoint of much research on the sickness certification behavior of physicians) that professional qualities and professional knowledge *falsely* appear "increasingly as *mere sources of error* when contrasted with these abstract special laws functioning according to rational predictions" (Lukács, 1971[1923]: 89).

This conceptual move of inversion recurs throughout the articles, mainly as variations of the above-mentioned topic of ignorance and knowledge, but also along other lines of reasoning. Article II (Shutzberg, 2020a) for example, elaborates on another possible inversion, namely whether the resistance carried out by physicians might, in the last instance, be an expression of its opposite, namely compliance with systemic demands. In a similar fashion, the last article (Shutzberg, 2021) investigates if the contemporary ideal that doctors and patients are equals, or equally empowered, is actualized in an inverted form in reality, namely, in the *equal disempowerment* of both doctors and patients. The question here is whether or not these inversions can be regarded as a heuristic of thinking. Hájek would possibly answer in the affirmative. In his list of heuristics, he glances over the "mini-heuristic" to "*do the opposite*" when approaching a problem:

> Take some approach to a problem, and follow the opposite approach, dual approach, or complementary approach. For example, replace universal quantifiers by existential quantifiers, necessities by possibilities, conjunctions by disjunctions, or replace parameter values by values that are in some sense complementary (Hájek, 2016: 358)

Unfortunately, Hájek remains in the realm of logic and does not thematize this heuristic in any deeper sense. All the same, the value of turning to Hájek lies in recognizing it as a heuristic at all. One objection might be that the thought style of reversals may be way too broad, too general a gesture, to be thought of as a heuristic. It is just too prevalent to be useful (almost as useless as "make an insightful point!" Hájek, 2016: 371). Nevertheless, I am going to entertain the idea that it might be nontrivial. Many philosophers-thinkers claim to turn taken for granted viewpoints or propositions on their heads as a productive way forward. The astronomer Nicolaus Copernicus famously proposed that the Earth revolves around the sun and not the other way around, which was the commonly held belief before him. Through this reversal Copernicus managed to solve many of the problems plaguing the geocentric model. Immanuel Kant co-opted the Copernican "revolution" as a metaphor to describe his own reversal of metaphysics (Kant, 1998[1787]: 112). Instead of positing that "cognition must conform to objects," Kant began his *Critique of Pure Reason* with "*assuming* that the objects must conform to our cognition" and explored the possibilities mapped out by this assumption (Kant, 1998[1787]: 110, my italics). Interestingly, Kant describes their common approach in very heuristic terms. The reversal is described in terms of an "experiment," a "procedure" and a "hypothesis." Copernicus "tried to see if he might not have greater success if he made the observer revolve and left the stars at rest" (Kant, 1998[1787]: 110). The history of philosophy is replete with similar critical reversals (although seldomly on the same scale), which I will refrain from cataloguing here.

As tempting as it may be to jump on the same old dialectical seesaw by finding parallels between the heuristic of inversion and the Hegelian dialectic (especially with Hegel's brief remarks on an "inverted [perverted] world" in the *Phenomenology of Spirit*, Hegel, 2018[1807]: 95), I do not think they are commensurable. Possibly, the moment of inversion is a component of dialectics, which is much more than one or a series of reversals. What I refer to as a heuristic is less than the iron necessity of the dialectical march in which worlds (or consciousness) implode under their own internal contradictory weights. Furthermore, the inversions I have engaged in during this study do not unite and resolve themselves with their opposites.[45]

[45] Interestingly, (among others) Georg Gadamer has identified a somewhat heuristic element in the trope of the "inverted world": "The *verkehrte* [inverted, but also perverted] world is thus a world in which everything is the reverse of the right world. Isn't that a familiar principle of literature, one which we call satire? [...] [T]his reversal in which everything is the opposite of itself makes visible in a kind of fun house mirror the covert perversion of everything as we know it. If this is so, the topsy-turvy world would be the perversion of perversity"(Gadamer,

Abandoning Hegel in the search for a heuristic of inversion should not entail the abandonment of all thinkers following in his footsteps. Karl Marx, a master of inversions, inherited the dialectical march of contradictions as properties of phenomena outside of the researcher's mind (whether it be spirit or society).[46] At the same time, I believe he *also* operationalized the use of inversions as a heuristic, as a tool for experimental exploration, that can be analytically disentangled from the system of dialectics. Marx's oeuvre, especially his early works, is replete with inversions on several levels of abstraction, from the underlying foundations of his thought[47] to the superficial rhetoric level of subject-predicate conversion.[48] Given that the language and operations of inversion occur on several levels and concern different topics, it can reasonably be inferred that it is a style of approaching a matter that is partially independent of its content. Then again, the condition of possibility of heuristic inversions is often that we inhabit a world that systematically distorts the relations between subjects and predicates; an inverted/perverted world. From what I can gather, Marx did not provide any commentary on this approach as an experimental technique. Another Young Hegelian, Ludwig Feuerbach did however describe something akin to a generalized procedure or heuristics of inversion, under the heading of "reformatory critique":

> The method of the reformatory critique of *speculative philosophy in general* does not differ from the critique already applied in the *philosophy of religion*. We only need always make the *predicate* into the *subject* and thus, as the subject, into the *object* and *principle*. Hence we need only *invert* speculative philosophy and then have the unmasked, pure, bare truth [...] The pure, unfalsified truth without contradiction is a *new truth* – a *new, autonomous deed* of humanity (Feuerbach, 1983[1842] 157, 171)

1976: 48). Satire is a purely negative movement of criticism. What I am trying to get at is rather the *positive* and *productive* aspect of inversion, which is why Gadamer's interpretation unfortunately is of little help.

[46] "Accumulation of wealth at one pole is, therefore, at the same time accumulation of misery, the torment of labour, slavery, ignorance, brutalization and moral degradation at the opposite pole" (Marx, 1976[1867]: 799). Not only is this quote methodically inspired by Hegel, it is almost a verbatim quote but in reversed order: "[§]244. When the standard of living of a large mass of people falls below a certain subsistence level the result is the creation of a *rabble of paupers*. At the same time this brings with it, at the other end of the social scale, conditions which greatly facilitate the concentration of disproportionate wealth in a few hands" (Hegel, 2008[1820]: 221).

[47] "To the vulgar economist who desires to represent capital as an independent source of value [...] M—M′ [money that begets more money] we have the incomprehensible form of capital, the most extreme inversion and materialisation of production relations" (Marx, 1971[1863]: 462).

[48] "The weapon of criticism cannot, of course, replace criticism by weapons, material force must be overthrown by material force" (Marx, 1975[1844]: 182). In 1986, the satirical art zine *Shoe Polish Week* published an article (in its first and only issue) titled *How to talk like a Situationist* which included the recommendation to "use Marxian reverse-talk. This is a sure-fire way of alerting people to the fact that you are a situationist or are eager to become one: [...] "separate production as production of the separate." Although easy to parody, I believe there is something worth holding on to in such inversions.

Putting to one side Feuerbach's brash and colorful style, here he seems to be on the brink of distilling a heuristic of inversion. Admittedly, the inversion is not an assumption subjected to testing and thereafter rejected or accepted. Neither is that really the case with Marx. It could however be understood as traces of an underlying, more modest—heuristic if you will—mode of reasoning.

To conclude, Alan Hájek has noted the heuristic of "do[ing] the opposite" in the field of analytic philosophy. Such a heuristic is also evident in Kant's critical project. Feuerbach and Marx have demonstrated that the scope of such inversions does not have to be confined to the realms of logics and metaphysics alone. The inversion is possibly a part of, but not identical with, dialectical reasoning.

4.2.2. Heuristic of multiple referents

In the fourth article of the dissertation (Shutzberg, 2021, and glanced over in previous sections), I map different types of doctor-patient relationships on a two-dimensional canvas of power distributions. Both the patient and the doctor can be endowed with much or little power, independently of each other. Four distinct possibilities arise: (1) the doctor has all the power and the patient has none, which has historically been called *paternalism;* (2) the patient has all the power and the doctor has none, which has historically been called *consumerism*; (3) doctor and patient are equally empowered, which historically has been called *partnership*. All these possibilities have *real* correlates. However, one formally conceivable possibility remains: (4) doctor and patient are equally *disempowered*. There is a certain symmetry within and between two of the possibilities, namely *partnership* (3) and *comradeship* (4). In both, the relationship between doctor and patient is one between equals. Whereas the former is often talked about and elevated to the status of an ideal, the latter is seldom discussed. Equality is preferably an equal share of power, not an equality of powerlessness. In the article, I notice this symmetry and pursue the latter possibility as the real condition of healthcare and describe some of its foundational characteristics. Here, again, there is a heuristic at work that propels the argument forward. Some examples in Hájek's batch of heuristics serve as good approximations surrounding what actually happened in terms of my own reasoning during the course of the research process. The heuristic mentioned in the previous section on inversions ("do the opposite") can give one account of what happens. However, some specific and additional traits are also captured by what Hájek calls "see definite descriptions in neon lights":

> A philosophical thesis or an analysis that involves a definite description "… *the F* …" typically presupposes that there is *exactly one F*. Ask:
>
> i) Are there, or could there be, *multiple F's*?
>
> ii) Are there, or could there be, *no F's*? (Hájek, 2016: 350)

The *F* in my case is *equality* in the doctor-patient relationship. I pursued both possibilities enumerated above, but in reverse order: are there, or could there be, no equality in the doctor-patient relationship. This question does not have a deductive answer, but an empirical one. Whether the newly evolved equality of the partnership model is indeed real or merely ideal and fictitious has been discussed by thinkers who have argued for the latter, namely the "*no F*" (no equality) position.[49] The problem was only that the position, possible indeed, did not generate any interesting or novel results. I then turned toward the possibility of "*multiple F's*" (multiple equalities). There are at least two conceivable scenarios in which doctors and patients are equals, one in which they have equal power and one where they are equally robbed of power. In article IV I pursued the latter. In contrast to Hájek's assumed natural habitat of philosophy, namely logics, my reasoning is not pure logic. Other areas outside of pure logic sometimes employ a similar heuristic. Could Friedrich Engels' ridicule of bourgeois "freedom" mentioned above count as such an instance?

> Fine freedom, where the proletarian has no other choice than that of either accepting the conditions which the bourgeoisie offers him, or of starving, of freezing to death, of sleeping naked among the beasts of the forests! A fine "equivalent" valued at pleasure by the bourgeoisie! (Engels, 1975[1845]: 376)

The question remains how to motivate choosing "*multiple*" over the "*no F's.*" While a noteworthy issue, it is not a particularly disturbing question demanding an answer. As stated above, following the "*multiple F's*" option was simply more productive, and a less travelled path. The criteria for a successful employment of a heuristic device is not primarily truth, but rather invention.[50]

4.2.3. Heuristic of productive temporal distance

When I turn to the concept of *metis*—cunning intelligence—developed in and through Greek mythological thought (in Shutzberg, 2020b), or salvage the "solidarity of the shaken" from the trenches of the First World War (in Shutzberg, 2021), in order to understand the mode of action of contemporary physicians, the objective is not primarily to understand Greek mythology or the sufferings of the First World War. These are vehicles and tools; the actual object of interest lies in *our time*.

Many branches of philosophy have a predilection for old concepts. This may not be very shocking, given that the same basic questions are repeatedly raised, and necessarily so. The philosophically informed research field of the *theory of practical*

[49] Something along these lines is followed by, for example Onora O'Neill, when she writes that "the doctor has set out the options, and is now telling the patient to sign, and where to sign. Look at that emphatically pointing finger! The patient is being told firmly that he is autonomous, that he is an equal partner in treatment and that he is about to give his free consent: but the reality, as his pained expression suggests, is quite different. [...] it illustrates a simulacrum of autonomy – and a simulacrum of trust" (2002: 26–27).

[50] Hájek lists a range of heuristics to aid in picking one F among several Fs. For the sake of brevity I will not discuss them here.

knowledge aims at making sense of concrete and contemporary phenomena: healthcare resistance; the nature of police work; the effect of managerial techniques on professions, etc. In these instances, the temporal distance between the concepts we employ and the phenomena we analyze can sometimes span centuries, if not millennia. However, "It's not a bug, it's a feature." To take an example from the field of practical knowledge, philosopher Jonna Bornemark returns to the concepts of a trio of Renaissance thinkers—Nicholas of Cusa, Giordano Bruno and René Descartes—in her study of the role (and abasement) of professional knowledge in late modernity (Bornemark, 2018). The reasons motivating this expedition back in time are several (or more precisely, three). Not only are these thinkers interesting in their own right, and not only is history a repository of good ideas waiting to be put back to work, but there is a methodological value in the temporal distance between concepts and the study object at hand. Firstly, Bornemark claims, the contemporary era is difficult to explore without using something else in which to ground oneself. The past is the leverage that allows the exertion of force, "that can provide a distance from that which encloses you" (Bornemark, 2018: 10). Secondly, Bornemark points out that the Renaissance was the birthplace of phenomena that have now become paradigmatic. Central to her endeavor is the idea of the measurability of all things and the mathematization of the world. Returning to the beginning, to Nicholas of Cusa, to Giordano Bruno and René Descartes, provides both a distance *and* proximity to the phenomena of interest. Thirdly, she specifies that although her "method" compares two historical periods, it is to some extent an ahistorical method, because it does not trace the historical development of the phenomenon in between the two periods. The interest lies in the contrast between two points, not the development of a phenomenon over a period (be it continuous or discontinuous) between two points in time. Although these reasons seem to be slightly contradictory (the epochs are compared because they are similar *and* different at the same time), they nonetheless constitute a solid argument for this particular type of investigation.

Bornemark is certainly not the only one to recognize the potential of (temporal) distance for the production of knowledge. All of science, that is both the natural sciences and the humanities, functions through establishing distance and detachment, a vantage point from which an impartial view is possible. Usually, the impartial distance does not include the historical, temporal, distance between concepts and their object, but rather between the researching subject and the object it investigates. Neither is the distancing impartiality of science considered to be productive in itself. In *Truth and Method*, Gadamer famously talks of the "temporal distance" between reader and the historically distant text not as an obstacle, but as the condition of possibility for meaning. This distance is a *productive* distance, in which our prejudgments add layers and depth to the text: "In fact the important thing is to recognize temporal distance as a positive and productive condition enabling understanding" (Gadamer, 2013[1960]: 308). This is certainly highly relevant, but what interests Bornemark (and I) is not the co-production of meaning between

reader and a work or the intent of an author, or to understand past cultures; we are interested in the inverse case: how to understand *our* time in and through the past. As such, Gadamer's discussion of the hermeneutic significance of temporal distance is the mirror image of our question.

Rather than the fusion of horizons and the productive temporal distance between reader and text, perhaps it is the concept of *Bildung* ("education") that should be acknowledged as a model for this kind of approach. Gadamer, along with many philosophers since the Enlightenment, tends to emphasize the self-transformative, self-cultivating dimension of learning and being. More specifically, for Hegel *Bildung* involved going outside of one's own taken for granted habits through knowledge of the past and "foreign land[s]," of the historical and geographical variability of beliefs (Odenstedt, 2008: 560). Whereas Hegel seemed to believe that the manifold of viewpoints decenters the subject in general, I am rather interested in the self-alienating effect of *one* specific collision with the past. In a way, this position is not all that different from the Hegelian position; it is perhaps a more specific and "heuristic" variety of it. Salvaging and reusing old (or foreign) concepts illuminates (specific elements in) the world we inhabit from a different angle. Going back in time to salvage old concepts in order to understand specific historical conjunctures is not simply about pointing out one's own *Bildung,* but to create a distance, leverage, a vantage point from which a new phenomenon can show itself.

To conclude, I have presented three heuristic devices at work in the theoretical parts of this dissertation. These tools are part of the practical knowledge of doing (something resembling) philosophy. Especially in transdisciplinary works, heuristics become more prominent than both theoretical background and higher-order thought guides, which is the rationale for focusing on heuristics in this section.

4.3. Ethical considerations

Questions regarding the general ethical challenges of interview research, such as securing confidentiality and informed consent of the participating informants, have been addressed in the ethical application reviewed and approved by the regional Ethical Review Board in Stockholm.[51] Given the content of the study, to explore everyday forms of resistance, there are some additional specific ethical challenges that call for discussion. I will mainly summarize the line of reasoning in the second dissertation article (Shutzberg 2020a) regarding ethical considerations, and add a few complementary comments. The main ethical question is if there might be any unintended effects of researching and producing publications on resistance? Is there a risk of betraying the very same subject I am attempting to understand and perhaps support, by revealing, hidden practices? These are questions that have repeatedly been asked and answered within the field of *resistance studies*. In article II, I partially lean on how Baaz, Lilja and Vinthagen have articulated that ethical risk (2018). The main

[51] Registration number of the ethical application is 2016/1162-31/5.

aim of my research is, however, not to *reveal*, but rather to *reframe* activities in which doctors engage. Hence, I understand these (already known and surveilled) activities in terms of *resistance* and *knowledge* rather than *ignorance*. Of course, that does not completely let the research "off the hook." Understanding these activities in terms of resistance may still project unwarranted culpability on the subject, not in a legal sense onto the individual study participants, but morally, onto the collective of physicians. This must, however, be weighed against the potential benefits (in terms of political consciousness raising, scientific value, and so on) of such studies. My judgment is that the benefits not only outweigh the risks, but that the research pushes the problematics of social insurance failures in the direction of the political, rather than the moral, sphere. I have also attempted to show that doctors are not the *cause* of the defects in the social insurance system; these problems are located elsewhere.

In addition, I have surveyed a highly fluid and turbulent area in which the techniques of control and evasion constantly fluctuate. As soon as a map is issued, many hallmarks of the terrain have disappeared or changed places. For example, at the time of writing this, many of the formal requirements on sickness certificates used by the SSIA to reject them have been legally challenged in one way or another. At least to some degree, this fluidity of the field protects the dissertation from being used and abused by forces interested in forging tools of control rather than strategies of emancipation.

5. Conclusions and a look ahead

As my thesis is comes to a close, both in time and in text, I find myself at the very beginning again. Just as my initial question when I first enrolled in Södertörn University was more oriented towards virtues of medicine, a premise I partially rejected in favor of assessing skills that are somewhat more ambiguous in their relation to "good" doctoring, I now return, once more, to the question of virtues of the medical profession. In sidestepping the pitfall of prematurely defining and beginning the search for medical virtues (or at least important skills) in the *immediate face-to-face medical encounter* between doctors and patients, and by looking instead for what physicians do in order to conserve the integrity of medical encounter, we find another set of skills and virtues. In this dissertation, I have attempted to name one of these skills and type of action: cunning (or *metis*). A cunning approach, nowadays deemed inadvisable as a rule in relation to the patient, is conversely *necessary* in relation to a reified bureaucracy, on the condition that the doctor wants to ensure a "good" medical encounter. The SSIA is but one cog in the bureaucratic machine of healthcare, and the cunning resistance employed in reaction to its logic of austerity are only part of the full set of extra-clinical skills with which physicians are equipped when working in the age of commodity. And yet while a part, it nonetheless is a representative and possibly generalizable part. The dissertation's point of departure of is empirical. Based on interviews with primary care physicians, I explored the use of informal techniques in order to maximize the chance of sickness certificate approval. In subsequent articles, I tried to understand it as a mode of resistance and a kind of skill, in terms of its basic features as well as its contradictions. Finally, I attempted (mainly on a conceptual level) to make sense of how the condition of austerity and the kind of reactions it engenders, also transfigure the immediate medical encounter between doctor and patient. I argue that we possibly stand on the brink of a new paradigm of the doctor-patient relationship, one founded on "comradeship" and mutual solidarity rather than the reigning paradigms of "partnership" and "provider/consumer."

In this conclusion I want to point toward some remaining research possibilities, but also to move further in the normative dimension implied in the last article, namely, the possible and desired future of a solidarity of the shaken in healthcare. After all, it would be nice to end on a high note, rather than to the pessimistic tunes of lamenting contemporary professional life as impossible and irreparably damaged. Regarding future research, the dissertation has generated more questions than it has been able to answer. I will recount some of the more fundamental ones here. Firstly, I have almost completely (and intentionally) bypassed the question of how power is exercised over the *content* of the medical sphere and medical judgment. Although physicians sometimes fight valiantly to keep extraneous interests (such as austerity and profit) at bay, some of those interests always find a way into the core of medical

judgment (not only in relation to sickness and disability evaluation). Although I have focused on the former (fending off external interests) rather than the latter (internalizing external interests), both can be true at the same time. A hypothetical research question derivable from the conjunctive relationship between resistance and internalization to external interests could be stated in the following way: how and in what ways has clinical medical judgment of physicians internalized reigning societal norms and values regarding work and employment, ranging from the general importance attributed to wage labor for the economy, social cohesion, etc. (visible in public policies and trickling down) to its perceived role for individual wellbeing? How does the impact of the social norms of work on clinical, medical judgment affect patients? It is a dizzyingly complex question, since the role of work and employment for health is not something exclusively imposed by ideology. However, there is certainly an ideological and discursive dimension at play (also in the historically determined and value-laden definitions of "work" and "employment" used in empirical research, as well in the operationalization and transposition of that research to clinical reality) which could be further explored.[52] Another possible direction of research is to explore the relationship between resistance to the SSIA and *medicalization*. Do well-intentioned doctors medicalize their patients' issues by "enforcing" acceptance of sickness benefit claims, making a medical problem out of a primarily political, economic, social (and possibly existential) one? For example, is occupational burnout only secondarily a medical problem, if at all? And if so, is medicalization necessarily bad? Can there be a kind of "emancipatory" or "strategic" medicalization (loosely analogous to what Spivak called "a *strategic* use of positivist essentialism," Spivak, 1996[1985]: 214) in defense of labor over capital, even though the patient's issues are misrecognized as "medical"? A third avenue of future research could be to develop and thicken the description of the suggested new paradigm of doctor-patient relationship, the comradeship model, by robust empirical research. In this dissertation I have explored it in a mainly conceptual fashion, with some (but rather weak) grounding in the interview material. There are many more research questions to address, but I will stop here and turn instead to hopes about the political future of healthcare.

In developing the concept of a solidarity of the shaken, Jan Patočka not only (or even primarily) had in mind the horror that could bring "enemies" together. He also contemplated a deeper quake in the foundation of meaning and politics, which I did not thematize in the fourth dissertation article. Patočka's burrowing into this deeper

[52] Perhaps a Swedish and refreshed version of what Howard Waitzkin's research once aimed for: "During their routine talk with patients, doctors inevitably convey attitudes about work, usually to encourage patients' continued performance on the job. In these instances and many others, the impact of the doctors' words is to define health as the capacity to work productively" (Waitzkin, 1989: 222). Another inspiring case is Moldvik et al., who have explored the interaction between "work ethics and societal norms" and the self-image of people on sick leave (2020). Similar research, in terms of methodology and themes, could prove fruitful in exploring the relationship between physicians' view on their medical judgment in sickness and disability evaluation and public norms of work.

level of inquiry may also unearth the role of shakenness and disorientation for *novel ways of conducting oneself politically*. They force us to broaden our scope, from the level of the state, institutions, more or less docile unions—from representative politics and politics as administration in the service of *status quo*—to include activities of those who are (relatively) disempowered: a politics underneath, and most importantly *against*, the political and administrative order. Patočka's reflections on the experiences of the First World War can be interpreted as a commentary on our time, in the light of political action and resistance of professionals against bureaucracy:

> The meaninglessness of life and war up to now bestows meaning on a new war, the war against war. Those who refused the front line which had been forced upon them, themselves force themselves to another front line for future years, no less hard and cruel. The war against war seems to make use of new experiences, seemingly acts eschatologically, yet in reality bends eschatology back to the "mundane" level (Patočka, 1996[1975]: 127)

What would it mean to think of politics as analogous to this "war against war"? A politics against politics? The idea is, as mentioned earlier, not far-fetched at all. Those who have been ejected from (or never even visited) the halls of power, who are disoriented and disenfranchised by it, take refuge to other arenas, forcing one to rethink what the substrate and extent of politics really is. As such, Patočka echoes the innovations of later thinkers: "infrapolitics of the powerless" as the "weapons of the weak" (Scott, 1990: xiii); "antipolitics" which is the dizzying free fall into the "void [and failure] of representation at the heart of the political institution" (Balibar, 2007: 64); the "pre-political events and processes that provide the living humus" for the organic growth of the "power of the powerless" (Havel, 1985[1978]: 50). The everyday resistance of physicians against the Swedish Social Insurance Agency is approximated by this set of prefixes: they are an infra-political, anti-political, pre-political rumble against the politics-cum-administration of a reified order.

One, perhaps the most important, riddle that remains unsolved in this dissertation is how disorganized and covert everyday resistance relates to organized resistance and transformative politics. In the second article (Shutzberg, 2020a) I paint in broad conceptual strokes the two possibilities from the point of view of everyday resistance: everyday resistance can either stimulate or inhibit political mobilization and organization on a large scale, such as progressive union activity, mass popular protests, and hopefully bring about positive structural change.[53] The question of the relationship between everyday resistance and organized resistance can probably

[53] Theoretically, a third (but unlikely) possibility remains: that the two levels are unrelated, that the sphere of law and state are just indifferent to what goes on at a micro-level, and that this micro-level has no effect on the sphere of laws and state. Furthermore, a reverse causal relationship may exist at the same time, such that organized resistance can either encourage or discourage acts of everyday resistance. An interesting overview of the possible set of dynamics (especially that organized resistance might stimulate everyday resistance) is provided by Lilja et al., 2017.

neither be answered generally nor theoretically, but demands empirical investigation of every specific case. The surveying of specific factors that could facilitate such a structural change to a better future (in the specific case of healthcare) is postponed for future research. However, empirical investigations are (by the unrelentingly unidirectional nature of time) tied to the past, and will only take us so far. Looking to the unknown future also involves hopes, wishes, desires, values. My personal hope is that the everyday resistance of physicians stimulates organized collective praxis, and helps to accomplish positive structural changes for the conditions of healthcare work and the social insurance system. *In what*, precisely, this more emancipatory and just system would consist, I cannot say. What I can say with some certainty, though, is that a return to the old way of doing things, to the paternalist "golden age of doctoring" is neither desirable nor possible. Perhaps, in a distant future the restoration of the truly progressive power of bureaucracy will be possible, of a just system that works without having to be carried on the shoulders of heroic and slowly crushing individuals; one that works despite individual shortcomings. When that time comes, we (even doctors) can all afford ourselves to be mediocre. Bertolt Brecht expressed this relationship between structure and virtue in *Mother Courage*:

> Whenever there are great virtues, it's a sure sign something's wrong [...] Why? When a general or a king is stupid and leads his soldiers into a trap, they need this virtue of courage [...] When he's tightfisted and hasn't enough soldiers, the few he does have need the heroism of Hercules—another virtue [...] All virtues which a well-regulated country with a good king or a good general wouldn't need. In a good country, virtues wouldn't be necessary. Everybody could be quite ordinary, middling, and, for all I care, cowards (Brecht, 1966[1941]: 39).

To some, this may sound more like a grim prediction of hell than heaven. But fear not. What they say about labor is also true for virtue: in the end, true freedom is freedom *from* (rather than *through*) both work and virtue. Even if the abolition of work and virtue proves impossible, it must nonetheless remain our regulative ideal—possibly unattainable but necessarily indispensable. The true indispensable virtue of good doctoring is the incessant thrust towards making heroic virtues dispensable.

6. Summary of articles

6.1. Article I: *Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners*

Abstract: Objectives: To explore informal and unsanctioned techniques that general practitioners (GPs) employ as a means to increase the likelihood of sickness certificate approval, following the *Swedish Social Insurance Agency's* (SSIA's) consolidation of the gatekeeping role in sickness benefit evaluation. Design: Qualitative semi-structured interviews with twenty GPs working in Swedish primary care. A thematic analysis of the transcribed material was carried out to map different techniques employed by the practitioners. Results: Eight techniques were identified, particularly with respect to the way in which the sickness certificate is written to ensure approval by the SSIA. The identified techniques were most commonly adopted when the patient's case was perceived to be at high risk for rejection by the SSIA (such as psychiatric illnesses, chronic pain etc.). Conclusions: The findings imply that the informal and unsanctioned techniques are complex and ambiguous. They are used intentionally and covertly. The study also suggests that, while the consolidation of SSIA's gatekeeping role may have resolved some sickness absence issues, a consequence may be that GPs develop unsanctioned techniques to ensure compliance.

Status: Published in Scandinavian Journal of Primary Health Care

6.2. Article II: *Literal Tricks of the Trade: The Possibilities and Contradictions of Swedish Physicians' Everyday Resistance in the Sickness Certification Process*

Abstract: This article deals with the ways Swedish General practitioners (GPs) informally deal with the stricter standards of sickness certification and the implications of understanding these ways in terms of "resistance." In recent decades, procedural and bureaucratic changes within the Swedish sickness benefit system have curtailed physicians' clinical discretion with regards to the sickness benefit approval for patients. By both formal and informal means, the *Swedish Social Insurance Agency* (SSIA) has consolidated its power over the decision-making process. Despite widespread dissatisfaction among physicians with the current system, acts of open defiance do not seem to occur. However, as shown in a recent qualitative study, Swedish General practitioners have developed informal 'techniques' (ranging from simple exaggerations in the certificates to complex constructions of apparent objectivity) for intentionally circumventing the stricter sickness certification stand-

ards. Taking that study as a point of departure, this article will consider the use of techniques as a form of everyday resistance. Three dimensions of ambiguity arise which require further attention, namely: (1) the multiple motives and shifting target of resistance; (2) the complex blend of power and powerlessness which defines the situation of GPs and their resistance, and (3) the fundamental ambiguity of the resistant act of issuing sickness certificates tactically, as a particular mix of compliance and resistance.

Status: Published in Journal of Resistance Studies

6.3. Article III: *Doctors that "Doctor" Sickness Certificates: Cunning Intelligence as an Ability and Possibly a Virtue Among Swedish GPs*

Abstract: The relations of power between healthcare-related institutions and the professionals that interact with them are changing. Generally, the institutions are gaining the upper hand. Consequently, the intellectual abilities necessary for professionals to pursue the internal goods of healthcare are changing as well. A concrete case is the struggle over sickness benefits in Sweden, in which the *Swedish Social Insurance Agency* (SSIA) and physicians are important stakeholders. The SSIA has recently consolidated its power over the sickness certificates that doctors issue for their patients. The result has been a stricter gatekeeping of sickness benefits. In order to combat the inroads made by state institutions into sickness certification, and into the sphere of medical practice, some doctors have developed cunning "techniques" to maximize the chance to have their sickness certificates accepted by the SSIA. This article attempts to demonstrate that cunning intelligence—the ability of the weak to "outsmart" a stronger adversary—plays an important role in the practice of medicine. Cunning intelligence is not merely a defective form of prudence (*phronesis*), nor is it simply an instance of instrumental reason (*techne*), but rather an ability that occupies a distinct place among the intellectual abilities generally ascribed to professionals.

Status: Published in Medicine, Health Care and Philosophy

6.4. Article IV: *The Doctor as Parent, Partner, Provider... or Comrade? Distribution of Power in Past and Present Models of the Doctor-Patient Relationship*

Abstract: The commonly occurring metaphors and models of the doctor-patient relationship can be divided into three clusters, depending on what distribution of power they represent: in the paternalist cluster, power resides with the physician; in the consumer model, power resides with the patient; in the partnership model, power is distributed equally between doctor and patient. Often, this tripartite division is accepted as an exhaustive typology of doctor-patient relationships. The main object-

ive of this paper is to challenge this idea by introducing a fourth possibility and distribution of power, namely, the distribution in which power resides with neither doctor nor patient. This equality in powerlessness—the hallmark of "the age of bureaucratic parsimony"—is the point of departure for a qualitatively new doctor-patient relationship, which is best described in terms of *solidarity* between *comrades*. This paper specifies the characteristics of this specific type of solidarity and illustrates it with a case study of how Swedish doctors and patients interrelate in the sickness certification practice.

Status: Accepted in Health Care Analysis

7. References

Ackroyd, S. & Thompson, P. (1999). *Organizational misbehaviour*. SAGE.

Adler, P.A. & Adler, P. (1987). *Membership roles in field research*. Sage.

Adorno, T. W. (1951). *Minima moralia: reflexionen aus dem beschädigten leben*. Suhrkamp Verlag.

Adorno, T. W. (2005[1951]). *Minima moralia: reflections on a damaged life*. Verso.

Alexanderson, K., et al. 2018. *Läkares erfarenheter av arbete med sjukskrivning av patienter: Resultat från en enkät år 2017 och jämförelser med resultat från motsvarande enkäter år 2012, 2008 respektive 2004. Huvudrapport 2018.* Stockholm: Karolinska Institutet. https://ki.se/sites/default/files/migrate/2018/03/08/huvudrapport_lakarenkat_2017_2012_2008_2004._ki.pdf

Altermark, N. (2020). *Avslagsmaskinen: byråkrati och avhumanisering i svensk sjukförsäkring*. Verbal förlag.

Arbetsgivarverket (2016). *Den ökande sjukfrånvaron: en studie av det statliga avtalsområdet mellan 2006–2015*. [PDF file]. https://www.arbetsgivarverket.se/globalassets/avtal-skrifter/rapporter/rapport-den-okande-sjukfranvaron_20160607.pdf

Arendt, H. (1998[1958]). *The human condition*. (2nd ed.). University of Chicago Press.

Arevik, N. (2019, October 3). Fler kan få sjukpenning efter nya domar. *Arbetet*. https://arbetet.se/2019/10/03/fler-kan-fa-sjukpenning-efter-nya-domar

Aristotle. (1998[350 B.C.]). *Politics*. Hackett Publishing Company

Aristotle. (2011[350 B.C]). *Nicomachean ethics*. University of Chicago Press.

Arrelöv, B., Edlund, C. & Goine, H. (2006). Grindvakterna i sjukförsäkringen: Samspel och motspel. In E. Palmer (ed.) *SKA-projektet: sjukförsäkring, kulturer och attityder* (pp. 479–530). Försäkringskassan.

Baaz, M., Lilja, M., & Vinthagen, S. (2018). *Researching resistance and social change: a critical approach to theory and practice.* Rowman & Littlefield International.

Balibar. É. (2007). Uprisings in the banlieues. *Constellations, 14*(1), 47–71.

Bauchner, H. [JAMA Network]. (2020, april 1). Coronavirus (COVID-19) Update: Critical Care Management [Video file]. https://youtu.be/c7s3fS6RTlQ

Bendz, A. (2010). *Rättssäkerhet som välfärdspolitiskt ideal: reformer av socialförsäkringens administration från 1955 till 2008*. Centrum för forskning om offentlig sektor.

Bhaskar, R. (1998). *The possibility of naturalism: A philosophical critique of the contemporary human sciences*. (3rd ed.). Routledge.

Bhaskar, R. (2011). *Reclaiming reality: A critical introduction to contemporary philosophy*. Routledge.

Bornemark, J. (2018). *Det omätbaras renässans: en uppgörelse med pedanternas världsherravälde*. Volante.

Bornemark, J. (2019). Att forska med skrivande praktiker. In M. Gunnarson (ed.) *Att utforska praktisk kunskap: undersökande, prövande och avtäckande metoder* (pp. 59–88). Södertörns högskola.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77–101.

Brecht, B. (1966[1941]). *Mother courage and her children: A chronicle of the Thirty Years' war*. Grove Press.

Buchanan, I. (2000) *Michel de Certeau: cultural theorist*. SAGE Publications.

Callahan, D. & Wasunna, A. A. (2006). *Medicine and the market: equity v. choice*. The Johns Hopkins University Press.

Castaneda, C. (1990[1968]). *The teachings of Don Juan: a Yaqui way of knowledge*, Washington Square Press.

Certeau, M.D. (2002[1980]). *The practice of everyday life*. University of California Press.

Charles, C., Whelan, T. & Gafni, A. (1999). What do we mean by partnership in making decisions about treatment? *BMJ*, *319*, 780–782.

Chew-Graham, C. A., May, C. R., & Perry, M. S. (2002). Qualitative research and the problem of judgement: lessons from interviewing fellow professionals. *Family practice, 19*(3), 285–289.

Coar, L. & Sim, J. (2006) Interviewing one's peers: methodological issues in a study of health professionals. *Scandinavian journal of primary health care*, *24*(4), 251–256.

Conrad, P. (2005). The shifting engines of medicalization. *Journal of health and social behavior*, *46*(1), 3–14.

Craig, P. (1997). Formal and substantive conceptions of the rule of law: an analytical framework. *Public Law*, (3), 467–487.

Davies, C.A. (1999). *Reflexive ethnography: a guide to researching selves and others*. Routledge.

Debord, G. (1994[1967]). *The Society of the spectacle.* Zone Books.

de Boer, W., Brage, S., & Kunz, R. (2018). Insurance medicine in clinical epidemiological terms: A concept paper for discussion. *TBV–Tijdschrift voor Bedrijfs-en Verzekeringsgeneeskunde. 26*(2), 97–99.

Deleuze, G. (2016[1994]). Desire and pleasure. In N. Morar, T. Nail and D.W. Smith (eds.) *Between Deleuze and Foucault* (pp. 223–231). Edinburgh University Press

Deleuze, G. & Guattari, F. (1987[1980]). *A thousand plateaus: capitalism and schizophrenia.* University of Minnesota Press.

Detienne, M. & Vernant, J. (1991[1974]). *Cunning intelligence in Greek culture and society*. University of Chicago Press.

Donzelot, J. (1988). The promotion of the social. *Economy and Society*, *17*(3), 395–427.

Dreyfus, H. & Dreyfus, S.E. (1986). *Mind over machine*. The Free Press.

Durkheim, É. (1984[1893]. *The division of labour in society*. Macmillan.

Dunne, J. (1993). *Back to the rough ground: Practical judgment and the lure of technique*. University of Notre Dame Press.

Elden, S. (2004). *Understanding Henri Lefebvre: theory and the possible*. Continuum.

Eliasson, R. (1992). *Egenheter och allmänheter: en antologi om omsorg och omsorgens villkor*. Arkiv förlag.

Engels, F. (1975[1845]) The condition of the working-class in England: from personal observation and authentic sources. In T. Yeremeyeva and L. Golman (eds.*) Karl Marx Fredrick Engels collected works, vol. 4: 1844–1845* (pp. 295–596). Lawrence and Wishart.

Ennart, H. & Mellgren, F. (2016). *Sjukt hus: globala miljardsvindlerier – från Lesotho till Nya Karolinska.* Ordfront.

Essen, U. (2010). Rättssäkerhet – inledning. In Inspektionen för socialförsäkringen *Rapport 2010:4 Rättssäker förvaltning?* (pp. 7–11). Inspektionen för socialförsäkringen.

Feinberg, J. (1968). Collective Responsibility. *The Journal of Philosophy*, *65*(21), 674–688.

Feuerbach, L. (1983[1842]) Provisional theses for the reformation of philosophy. In C. Taylor (ed.) *The young Hegelians* (pp. 156–171). Cambridge: Cambridge University Press.

Fjell, J., et al. (2011, March 30). Sluta straffa våra patienter. *Svenska Dagbladet.* https://www.svd.se

Foucault, M. (1980[1977]). The Confession of the Flesh. In C. Gordon (ed.) *Power/Knowledge: Selected interviews and other writings* (pp. 194–228). Pantheon Books.

Foucault, M. (2007[1978]). eight: 1 March 1978. In M. Foucault *Security, territory, population: lectures at the collège de France 1977–1978* (pp. 191–226). Palgrave Macmillan

Försäkringskassan (2012). *Kvalitetsgranskning av läkarintyg: en del av sjukskrivningsmiljarden år 2011.* Försäkringskassan. https://bit.ly/3tL1bGB

Försäkringskassan (2018). *Temperaturmätning: implementeringen av inriktning 2021 i försäkringskassans kärnverksamhet*. Försäkringskassan. https://bit.ly/3rNAuPX

Försäkringskassan (2019, February 21). *Försäkringskassan fokuserar på rättssäkerhet och enhetliga bedömningar* [Press release]. https://bit.ly/2NexQDK

Försäkringskassan (2021). *2015:1 Sjukpenning, rehabilitering och rehabiliteringsersättning, version 13*. https://www.forsakringskassan.se/omfk/dina_rattigheter_och_skyldigheter/vagledningar_rattsligastallningstaganden/vagledningar

Gadamer, H. (1976). *Hegel's dialectic: five hermeneutical studies*. Yale University Press.

Gadamer, H. (2013[1960]). *Truth and method*. Bloomsbury Academic.

Gawande, A. (2014). *Being mortal: medicine and what matters in the end*. Metropolitan Books.

Gettier, E.L. (1963). Is Justified True Belief Knowledge? *Analysis, 23*(6), 121–123.

Godlee, F. (2020) Protect our healthcare workers. *The BMJ*, *369*(m1324).

Goodyear-Smith, F., & Buetow, S. (2001). Power issues in the doctor-patient relationship. *Health care analysis*, *9*(4), 449–462

Gramsci, A. (1957[1949]). *The modern prince and other writings*. Lawrence and Wishart.

Gunnarson, M. (2019). Att utforska praktisk kunskap med deltagande observation. In M. Gunnarson (ed.) *Att utforska praktisk kunskap: undersökande, prövande och avtäckande metoder* (pp. 225–260). Södertörns högskola.

Gustafsson, A. & Röstlund, L. (2019). *Konsulterna: kampen om Karolinska*. Mondial.

Hájek, A. (2016). Philosophical heuristics and philosophical methodology. In H. Cappelen, T. S. Gendler and J. Hawthorne (eds.) *The oxford handbook of philosophical methodology* (pp. 348–373). Oxford University Press.

Habermas, J. (1984[1981]). *The theory of communicative action. Vol. 1, Reason and the rationalization of society*. Beacon Press.

Habermas, J. (1987[1981]). *The theory of communicative action. Vol. 2, Lifeworld and system: a critique of functionalist reason*. Beacon Press.

Habermas, J. (2002). A conversation about questions of political theory. In R. von Schomberg and K. Baynes (eds.) *Discourse and Democracy: Essays on Habermas's Between Facts and Norms* (pp. 241–258). State University of New York Press.

Hanson, M.J.& Callahan, D. (1999). *The Goals of Medicine: The Forgotten Issues in Health Care Reform*. Georgetown University Press.

Hardt, M. (1991). Translator's foreword: The anatomy of power. In A. Negri *The savage anomaly: The power of Spinoza's metaphysics and politics* (pp. xi–xvi). University of Minnesota Press.

Hardt, M. & Negri, A. (2017). *Assembly*. Oxford University Press.

Harrison, S., & Dowswell, G. (2002). Autonomy and bureaucratic accountability in primary care: what English general practitioners say. *Sociology of Health & Illness*, *24*(2), 208–226.

Havel, V. (1985[1978]). The power of the powerless. *International Journal of Politics, 15*(3/4), 23–96.

Hegel, G.W.F. (2008[1820]). *Outlines of the philosophy of right*. Oxford University Press.

Hegel, G.W.F. (2018[1807]). *The phenomenology of spirit*. Cambridge University Press.

Hollander, J.A. & Einwohner, R.L. (2004). Conceptualizing resistance. *Sociological Forum, 19*(4), 533–54.

Holstein, J.A. & Gubrium, J.F. (1995). *The active interview*. Sage.

Hussey, S., Hoddinott, P., Wilson, P., Dowell, J., & Barbour, R. (2004). Sickness certification system in the United Kingdom: Qualitative study of views of general practitioners in Scotland. *BMJ*, *328*(7431),

Håkansson Eklund, J., Holmström, I. K., Kumlin, T., Kaminsky, E., Skoglund, K., Höglander, J., ... & Meranius, M. S. (2019). "Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient Education and Counseling, 102*(1), 3-11.

Illich, I. (1976). *Medical nemesis: The expropriation of health.* Pantheon Books.

Inspektionen för socialförsäkringen (2021). *Rapport 2021:3. Försäkringskassans utredningsskyldighet: En granskning av Försäkringskassans tillämpning av utredningsskyldigheten i ärenden om sjukpenning och aktivitetsersättning där ansökan har avslagits*. Inspektionen för socialförsäkringen.

Inspektionen för socialförsäkringen (2016). *ISF kommenterar 2016:1. Att använda lagens bedömningsutrymme*. Inspektionen för socialförsäkringen.

Inspektionen för socialförsäkringen (2018a). *Rapport 2018:12. Ökning av antalet personer som får beslut om indragen sjukpenning: en redovisning av vad som kännetecknar gruppen försäkrade som får sin sjukpenning indragen.* Inspektionen för socialförsäkringen.

Inspektionen för socialförsäkringen (2018b). *Rapport 2018:16. Förändrad styrning av och i Försäkringskassan: en analys av hur regeringens mål om ett sjukpenningtal på 9,0 dagar påverkar handläggningen av sjukpenning.* Inspektionen för socialförsäkringen.

Jaeggi, R. (2001). Solidarity and indifference. In R. ter Meulen, W. Arts and R Muffels (eds.) *Solidarity in health and social care in Europe* (pp. 287–308). Springer.

Johannessen, K.J. (1988). Tankar om tyst kunskap. *Dialoger*, *6*, 13–27.

Johannessen, K.J. (1999). *Praxis och tyst kunnande*. Dialoger.

Johnson, B. (2010). *Kampen om sjukfrånvaron*. Arkiv.

Josefson, I (1991). *Kunskapens former: det reflekterade yrkeskunnandet*. Carlsson.

Kahneman, D., Slovic, P. & Tversky, A. (eds.) (1982). *Judgement under uncertainty: heuristics and biases*. Cambridge University Press.

Kaluza, J. (2018). *Sjukskrivnas arbetsbörda: arbetande medborgare möter en kundorienterad byråkrati.* Diss. Karlstads universitet.

Kant, I. (1998[1787]). *Critique of pure reason*. Cambridge University Press.

Kanuha, V.K. (2000) 'Being' native versus 'going native': Conducting social work research as an insider. *Social work, 45*(5), 439–447.

Kellner, D., Pierce, P. & Lewis, T. (2011). Introduction: Herbert Marcuse, Philosophy, Psychoanalysis and Emancipation. In D. Kellner, P. Pierce and T. Lewis (eds.) *Philosophy, psychoanalysis and emancipation: Collected papers of Herbers Marcuse* (pp. 1–100). Routledge.

Kinsella, E.A. & Pitman, A. (eds.) (2012). *Phronesis as professional knowledge: practical wisdom in the professions.* Sense Publishers.

Kusenbach, M. (2003). Street Phenomenology: The go-along as ethnographic research tool. *Ethnography, 4*(3), 455–485.

Lefebvre, H. (1991[1974]). *The production of space.* Basil Blackwell.

Lefebvre, H. (2002[1961]). *Critique of everyday life. Vol. 2, Foundations for a sociology of the everyday*. Verso.

Lilja, M., Baaz, M., Schulz, M., & Vinthagen, S. (2017). How resistance encourages resistance: theorizing the nexus between power, 'Organised Resistance' and 'Everyday Resistance'. *Journal of Political Power*, *10*(1), 40–54.

Lorde, A. (1984). *Sister outsider: essays and speeches.* Crossing Press.

Lukács, G. (1971[1923]). *History and class consciousness: studies in Marxist dialectics*. Merlin.

Lukes, S. (1974). *Power: a radical view*. Macmillan.

Lukes, S. (2018). Guilt-Tripping the Greengrocer. *East European Politics and Societies*, *32*(2), 294–300.

Maarse, H. (2006). The privatization of health care in Europe: an eight-country analysis. *Journal of health politics, policy and law, 31*(5), 981–1014.

Machiavelli, N. (2008[1532]) *The prince.* Hackett Publishing Company.

Mannelqvist, R. (2019) Kraven på läkarintyg för sjukpenning: en lagstridig begränsning av den allmänna sjukförsäkringen? In R. Mannelqvist, S. Ingmanson, C. Ulander-Wänman (eds.) *Festskrift till Örjan Edström* (pp. 337–344). Juridiska institutionen, Umeå universitet

Marx, K. (1971[1863]). *Theories of surplus-value: volume IV of Capital (Part III).* Progress Publishers

Marx, K. (1975[1844]). Contribution to the critique of Hegel's philosophy of law. Introduction. In V. Pospelova and L. Golman (eds.) *Karl Marx Fredrick Engels collected works, vol. 4: 1843–1844* (pp. 175-187). Lawrence and Wishart.

Marx, K. (1976[1867]). *Capital: a critique of political economy, vol. 1.* Penguin.

McDowell, L. (1998). Elites in the City of London: some methodological considerations. *Environment and planning A, 30*(12), 2133–2146.

Michailakis, D. and Schirmer, W. (2012). *Solidaritet som finansieringsform och som prioriteringsprincip*. Linköping University E-Press. http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-75196

Mikecz, R. (2013). Interviewing elites: Addressing methodological issues. *Qualitative inquiry, 18*(6), 482–493

Miller, B.A. (2000). *Geography and social movements: comparing antinuclear activism in the Boston area.* University of Minnesota Press.

Misztal, B.A. (1996). *Trust in modern societies: the search for the bases of social order*. Polity Press.

Molander, B. (1996) *Kunskap i handling*. Daidalos.

Moldvik, I., Ståhl, C., & Müssener, U. (2020). Work ethics and societal norms influence sick leave and return to work: tales of transformation. *Disability and rehabilitation*, 1–10. https://doi.org/10.1080/09638288.2020.1728398

Mumby, D. K., Thomas, R., Martí, I., & Seidl, D. (2017). Resistance redux. *Organization Studies*, *38*(9), 1157–1183.

Neal, S. & McLaughlin, E. (2009). Researching up? Interviews, emotionality and policy-making elites. *Journal of Social Policy, 38*(4), 689–707.

Negri. A. (2005). *Books for burning*. Verso.

Nie, J. B., Gilbertson, A., de Roubaix, M., Staunton, C., van Niekerk, A., Tucker, J. D., & Rennie, S. (2016). Healing without waging war: beyond military metaphors in medicine and HIV cure research. *The American Journal of Bioethics*, *16*(10), 3–11.

Noterius, M. (Reporter). (2019, July 16) Läkare säger upp sig i protest mot Försäkringskassan: ”Är ett systemfel”. In *TV4 Nyheterna*.

Nussbaum, M. (2001). *The fragility of goodness: Luck and ethics in Greek tragedy and philosophy*. (2nd ed.). Cambridge University Press

Odenstedt, A. (2008). Hegel and Gadamer on Bildung. *The Southern Journal of Philosophy*, *46*(4), 559–580.

Patočka, J. (1996[1975]). *Heretical essays in the philosophy of history.* Open Court.

Pellegrino, E. D., & Thomasma, D. C. (1993). *The virtues in medical practice*. Oxford University Press.

Pile, S. (1997). Introduction: Opposition, Political Identities and Spaces of Resistance. In S. Pile and M. Keith (eds.) *Geographies of Resistance* (pp. 1–32). Routledge

Platt, J. (1981). On interviewing one’s peers. *The British Journal of Sociology, 32*(1), 75–91.

Polanyi, P. (2009[1966]). *The tacit dimension*. University of Chicago press.

Pollitt, C. & Bouckaert, G. (2017). *Public management reform: a comparative analysis – into the age of austerity.* (4th ed.). Oxford University Press.

Postone, M. (1993). *Time, labor, and social domination: a reinterpretation of Marx's critical theory.* Cambridge University Press.

Prasad, P., & Prasad, A. (2000). Stretching the iron cage: The constitution and implications of routine workplace resistance. *Organization Science, 11*(4), 387–403.

Ratkic, A. (2006). *Dialogseminariets forskningsmiljö*. Dialoger.

Richards, D. (1996). Elite Interviewing: Approaches and Pitfalls. *Politics, 16*(3), 199–204.

Röstlund, L. (2019, May 10). Hjärtläkare på Karolinska: ”Jag ägnar mig åt civil olydnad på jobbet”. *Dagens Nyheter*. https://www.dn.se

SBU. (2003). *Sjukskrivning – orsaker, konsekvenser och praxis: En systematisk litteraturöversikt.* Statens beredning för medicinsk utvärdering.

Scott, J.C. (1985). *Weapons of the weak: everyday forms of peasant resistance*. Yale Univ. Press.

Scott, J.C. (1990). *Domination and the arts of resistance: hidden transcripts*. Yale University Press.

Senneby, J. (2016, September 9). LO: Försäkringskassan ska inte verka för att pressa ner sjuktalen. *Dagens Arena*. https://www.dagensarena.se

Sewell, W. H. (1992). A theory of structure: Duality, agency, and transformation. *American journal of sociology, 98*(1), 1–29.

Shutzberg, M. (2019a). Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners. *Scandinavian Journal of Primary Health Care. 37*(1), 10–17.

Shutzberg, M. (2019b). Om intervjuns säregenheter på den praktiska kunskapens forskningsfält. In M. Gunnarson (ed.) *Att utforska praktisk kunskap: undersökande, prövande och avtäckande metoder* (pp. 195–224). Södertörns högskola.

Shutzberg, M. (2020a). Literal tricks of the trade: the possibilities and contradictions of Swedish physicians' everyday resistance in the sickness certification process. *Journal of Resistance Studies*, *6*(1), 8–39.

Shutzberg, M. (2020b). Doctors that "doctor" sickness certificates: cunning intelligence as an ability and possibly a virtue among Swedish GPs. *Medicine, Health Care and Philosophy. 23, 445–456.*

Shutzberg, M. (2021). The doctor as parent, partner, provider... or comrade? Distribution of power in past and present models of the doctor-patient relationship. *Health Care Analysis.* Advance online publication. https://doi.org/10.1007/s10728-021-00432-2

Siegler, M. (1982). Confidentiality in Medicine-A decrepit concept. *NEJM*, *307*(24), 1518–21

Siegler, M. (1985). The progression of medicine: from physician paternalism to patient autonomy to bureaucratic parsimony. *Archives of internal medicine*, 145(4), 713–715.

Smith, D. W. (2016). Two Concepts of Resistance: Foucault and Deleuze. In N. Morar, T. Nail and D. W. Smith (eds.) *Between Deleuze and Foucault* (pp. 264–282). Edinburgh University Press

Socialdepartementet (2005). *Regleringsbrev för budgetåret 2005 avseende Försäkringskassan.* https://www.esv.se/statsliggaren/regleringsbrev/?rbid=8636

Socialdepartementet (2008a). *Regleringsbrev för budgetåret 2007 avseende Försäkringskassan.* https://www.esv.se/statsliggaren/regleringsbrev/?rbid=1057

Socialdepartementet (2008b). *Regleringsbrev för budgetåret 2008 avseende Försäkringskassan.* https://www.esv.se/statsliggaren/regleringsbrev/?rbid=11116

Socialstyrelsen (2020). *Försörjningshinder och ändamål med ekonomiskt bistånd 2019.* https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/statistik/2020-10-6965-tabeller.xlsx

Spivak, G. C. (1996[1985]). Subaltern studies: Deconstructing historiography. In D. Landry and G. Maclean (eds.) *The Spivak Reader: Selected Works of Gayatri Chakravorty Spivak* (pp. 203–235). Routledge.

Stjernø, S. (2005). *Solidarity in Europe: the history of an idea*. Cambridge University Press.

Svenaeus, F. (2000). *The hermeneutics of medicine and the phenomenology of health: steps towards a philosophy of medical practice.* Kluwer Academic Publishers.

Svenaeus, F. (2009). Vad är praktisk kunskap? En inledning till ämnet och boken. In J. Bornemark and F. Svenaeus (eds.) *Vad är praktisk kunskap* (pp. 11–34). Södertörns högskola.

Szasz, T. S. & Hollender, M. H. (1956). A contribution to the philosophy of medicine: the basic models of the doctor-patient relationship. *AMA archives of internal medicine, 97*(5), 585–592.

Ter Meulen, R., Arts, W. & Muffels, R. (2001). Solidarity, health and social care in Europe: Introduction to the volume. In R. ter Meulen, W. Arts & R Muffels (eds.) *Solidarity in health and social care in Europe* (pp. 1–11). Springer.

Thomasma, D. C. (1983). Beyond medical paternalism and patient autonomy: a model of physician conscience for the physician-patient relationship. *Annals of internal medicine*, *98*(2), 243–248.

Tilly, C. & Tarrow, S.G. (2015). *Contentious politics.* (2nd ed.). Oxford University Press.

Topol, E.J. (2015). *The patient will see you now: the future of medicine is in your hands*. New York: Basic Books.

Tönnies, F. (2001[1887]). *Community and civil society*. Cambridge University Press.

Veatch, R. M. (1972). Models for ethical medicine in a revolutionary age. *The Hastings Center Report*, *2*(3), 5–7.

Waitzkin, H. (1989) A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters. *Journal of Health and Social Behavior*, *30*(2), 220–239.

Weber, M. (1978[1922]). *Economy and society: an outline of interpretive sociology.* University of California Press.

Wengraf, T. (2001). *Qualitative research interviewing: biographic narrative and semi-structured methods.* SAGE.

Young, I.M. (2011). *Responsibility for justice*. Oxford University Press.

Zagorin, P. (1990). *Ways of lying: dissimulation, persecution and conformity in early modern Europe.* Harvard University Press.

Zeba, N. (2020, August 27). Läkare: Försäkringskassan förnedrar mina patienter. *Expressen.* https://www.expressen.se/debatt/lakare-forsakringskassan-fornedrar-mina-patienter

Öhman, A. (2020, February 18). Läkare fick bakläxa – sjukintyg om hjärtrusning dög inte: ”Man har tappat respekten”. *Sjukhusläkaren.* https://www.sjukhuslakaren.se

Paper I

Scandinavian Journal of Primary Health Care

ISSN: 0281-3432 (Print) 1502-7724 (Online) Journal homepage: https://www.tandfonline.com/loi/ipri20

Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners

Mani Shutzberg

T cite this article: Mani Shutzberg (2019) Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners, Scandinavian Journal of Primary Health Care, 37:1, 10-17, DOI: 10.1080/02813432.2019.1569426

T link to this article: https://doi.org 10.1080/02813432.2019.1569426

© 2019 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Gr up.

Published online: 28 Jan 2019.

Submit your article to this journal

Article views: 426

View Cr ssmark data

Citing articles: 1 View citing articles

Full Terms & Conditions of access and use can be found at https://www.tandfonline.com/action/journalInformation?journalCo e=ipri20

SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE
2019, VOL. 37, NO. 1, 10–17
https://doi.org/10.1080/02813432.2019.1569426

Taylor & Francis
Taylor & Francis Group

RESEARCH ARTICLE

OPEN ACCESS Check for updates

Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners

Mani Shutzberg

Centre for Studies in Practical Knowledge, Södertörn University, Stockholm, Sweden

ABSTRACT

Objectives: To explore informal and unsanctioned techniques general practitioners (GPs) employ as a means to increase the likelihood of sickness certificate approval, following the Swedish Social Insurance Agency's (SSIA's) consolidation of the gatekeeping role in sickness benefit evaluation.

Design: Qualitative semi-structured interviews with 20 GPs working in Swedish primary care. A thematic analysis of the transcribed material was carried out to map different techniques employed by the practitioners.

Results: Eight techniques were identified, particularly with respect to the way in which the sickness certificate is written to ensure approval by the SSIA. The identified techniques were most commonly adopted when the patient's case was perceived to be at high risk for rejection by the SSIA (such as psychiatric illnesses, chronic pain etc.).

Conclusions: The findings imply that the informal and unsanctioned techniques are complex and ambiguous. They are used intentionally and covertly. The study also suggests that, while the consolidation of SSIA's gatekeeping role may have resolved some sickness absence issues, a consequence may be that GPs develop unsanctioned techniques to ensure compliance.

ARTICLE HISTORY
Received 11 July 2018
Accepted 21 November 2018

KEYWORDS
Family practice; non-compliance; praxis; qualitative research; sickness certification; Sweden

Introduction

Since the 1990s, sickness absence in Sweden has fluctuated [1]. A surge in absenteeism beginning in the late 90s prompted public debate. In mid-2000, a discursive shift in the debate introduced new arguments for reforming the social insurance system: social security was overused, and perhaps even subject to fraudulent claims. It was argued that the controls intended to regulate eligibility for sickness benefits had failed [2]. In this old system, the physician was the *de facto* gatekeeper, deciding eligibility for sickness benefits. Research suggested that physicians themselves were dissatisfied as guardians of social resources, and that they had difficulties handling it. They took certain liberties when completing sickness certificates—exaggerations, ambiguous and vague wording, writing in favour of the patient etc.—partially due to pressure placed on them from the patients [3–5].

In response to the fluctuations, and the debates and research surrounding it, substantial changes to the social security system have been continuously implemented since the second half of the 2000s. Two changes stand out as fundamental to the shift in dynamics between the SSIA and physicians:

1. In 2008, the *rehabilitation chain* ('rehabiliteringskedjan') was implemented as a means to achieve sick leave process efficiency. It stipulates that the SSIA should conduct more rigorous assessment of a person's work ability after 90 and 180 days of sick leave. After 90 days, work ability is assessed with respect to possible assignments the employer might offer, and after 180 days, work ability is assessed in relation to any assignment or job on the labor market [6].
2. In 2009, an official governmental report introduced a model for evaluating work ability. This so called *DFA-chain* ('DFA-kedjan') highlights three essential dimensions for determining eligibility for sickness benefits on the basis of sickness certificates: *diagnosis (e.g. depression), functional*

CONTACT Mani Shutzberg mani.shutzberg@sh.se Centre for Studies in Practical Knowledge, Södertörn University, Stockholm, Sweden

© 2019 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

impairment (e.g. an inability to concentrate, impaired memory, tiredness and rating scale scores) and lastly how this affects *work ability (e.g. to be attentive or understand instructions)*. An acceptable sickness certificate should adequately describe these dimensions, as well as establish a reasonable link between them [7].

Sickness certificates are required after one week of sick leave. Physicians are expected to reason in accordance with the DFA-chain when issuing certificates, which are filled out with the use of a standardized form. At the time of conducting the interviews, the form explicitly requested a description of 'objective findings on an organ level', regardless of type of disease in question [8]. The form is then submitted to the SSIA for evaluation. The SSIA can accept the certificate, ask for further specification or reject it outright.

In recent years, the SSIA has become more rigorous in assessing eligibility in accordance with the DFA-chain and some aspects of the rehabilitation chain [1,9]. As a result, the task of controlling eligibility for social insurance has been further transferred from physicians to the SSIA. The reforms seem to have mitigated the potential conflicts between patient and physician during the sickness certification process. For example, disagreeing with patients who demand sickness certificates from their GPs is less of a problem when the SSIA are responsible for making the final decision [10]. However, the SSIA's more rigorous assessment of sickness certificates has, between 2014 and 2016, resulted in a threefold increase in the proportion of rejected sickness certificates [11]. The characteristics of GPs' working conditions (time constraints, the high number of complicated and unclear sickness certification cases, exclusively dealing with outpatients), make their relationship to the SSIA particularly vulnerable: between 2004 and 2017, the proportion of GPs who reported that their medical judgments were questioned by the SSIA rose from 10% to 57%. The number of GPs who experienced that the SSIA requested unnecessary corrections to the sickness certificates increased from 48% to 72% between 2012 and 2017. In 2017, 72% of all surveyed GPs felt that the SSIA requested 'objective findings' in cases where objective signs are notoriously difficult to identify in the clinical setting (e.g. psychiatric disability, chronic pain, etc.) [12].

Several overviews regarding physician sickness certification practices have been compiled during the last two decades. Aspects relevant to this study, such as managing conflicting roles as a practicing physician, and difficulties in cooperation with other actors, have spurred some research interest [13]; however, most of it has focused on GP *attitudes* concerning sickness certification rather than actual *praxis*. There are studies on the theme of conflict between stakeholders related to sickness absence, but they have to a large extent targeted conflicts between physician and patient, as opposed to conflicts between physician and external institutions [14–16]. Earlier research has hinted at the existence of ways for circumventing the expectations of insurance agencies. Emphasis has been placed on the physicians' views and attitudes towards sickness certification [10,17,18], rather than descriptions of the actions themselves, or in some cases focused on understanding the actions as textual incompetence [19] rather than as skillful goal-oriented activities.

The main assumption of this article is that the experienced difficulties of GPs' in their day-to-day interaction with the SSIA could in some way affect praxis, especially in terms of informal solutions to these difficulties. The purpose of this study is to explore the informal and unsanctioned techniques employed by GPs as a means to increase the likelihood of sickness certificate approval, following SSIA's consolidation of the gatekeeping role in sickness benefit evaluation.

Material and methods

Study design

A qualitative and descriptive approach has been adopted for the purposes of exploring the informal practices of GPs regarding sickness certification. 20 in-depth interviews constitute the data corpus for the study.

Participants

GPs were strategically sampled to ensure a balanced composition regarding gender, age, location, professional experience and educational background. Twenty interviews were conducted before thematic saturation was reached. Informants were recruited through direct contact with health centers, as well as through advertisement in Facebook groups and Internet forums for physicians. Additional informants were recruited through snowball sampling. Eleven informants were female, nine were male. Thirteen of them worked in the Stockholm region, while the remaining seven worked in other Swedish regions. The age range was 29–65 years. The average

experience in primary care was nine years (ranging between 0.5 and 34). Thirteen had received their medical degree at Swedish faculties, and seven from Eastern and Central European countries.

Data collection

The data were gathered between December 2017 and February 2018 through qualitative in-depth interviews with GPs working in primary care. The interviews were semi-structured, roughly following a preset interview guide. Topics covered during the interviewing process included: general attitudes towards, and difficulties regarding, sickness certification and the SSIA; examples of difficult sickness certification cases, and (both sanctioned and unsanctioned) ways of solving them; lastly, unsanctioned ways of solving difficult cases were broached with informants, through the use of both direct and indirect forms of questioning (see Appendix). The interviews were recorded and transcribed. One-on-one interviews were chosen over focus groups, as the topic was considered sensitive and that peer pressure could inhibit the informants' willingness to report compromising information [20]. Similarly, being a medical doctor myself was a double edged sword. GPs seem to be more open and spontaneous when interviewed by fellow professionals, switching between treating the interviewer as professional peer and a private confidante. However, respondents can also feel judged and distance themselves [21]. To the extent possible, I welcomed the two roles ascribed to me as interviewer, while avoiding judgmental reactions to the informants' accounts.

Data analysis

A thematic analysis, as devised by Braun and Clarke, was used to interpret the data. This entailed an identification and explication of recurring patterns of meaning across the data set [22]. After a preliminary familiarization with the transcripts, coding of units of meaning relevant to the research question of this article was undertaken; this meant placing greater emphasis on the description of techniques adopted by GPs, rather than, for example, focusing on GPs' beliefs and attitudes regarding the SSIA. The preliminary coding was then checked by the researcher's supervisor to ensure fidelity to the transcripts. Categories were inductively developed on the basis of the codes. In the following phase of reviewing the categories, the secondary supervisor aided in sharpening distinctions and minimizing overlap. For example, the preliminary category of 'generalization' was removed due to excessive overlap with other categories. Longer illustrative quotes were attributed to informants by letters between (A) and (T).

Results

Most informants reported that the last years of practice were marked by increasing difficulties surrounding the authoring of sickness certificates. The GPs were more often caught in a frustrating dilemma: either write transparent sickness certificates, thereby risking failure to satisfy SSIA standards, or complete them in a less transparent way in order to meet the standards set by the SSIA.

A minority of the informants were fine with any decision SSIA would reach. The majority was not, at least not in practice. Although a broad variation of views were found among them regarding the work of the SSIA, ranging from 'they do a great job' to the conviction that 'they make people sicker', most of them (with the exception of four) admitted that they occasionally adopted informal instrumental techniques when authoring sickness certificates for the purpose of securing SSIA approval. The GPs referred to the instrumental techniques with terms such as 'embellishment', 'uglifying', 'exaggerations', 'amplification in order to illuminate the total impression', which demanded 'street smartness', 'tactics' and 'maneuvering around'. The reasons for doing it varied, and often several interrelated reasons were given. The four categories of inductively developed reasons (*in the best interest of the patient*, *in defence of professional autonomy,* to *save time*, or simply to *bridge the gap between complex medical reality and the conceptual toolbox at their disposal)*, did not seem to affect preference for any particular technique.

A repertoire of techniques in dealing with the sickness certification process

Eight categories of techniques used to maximize the likelihood of having sickness certificates accepted by the SSIA were identified: *exaggeration, quasi-quantification, omission, depersonalization of the patient voice, adjustment of disease progression, buzzwords, communication off the record* and *production of redundant somatic* data.I define them as informal, and unsanctioned, ways of maximizing the likelihood of sickness certificate acceptance by the SSIA.

Dealing with quantities: exaggeration and quasi-quantification

A widespread conception among the informants was that *quantification* of patient symptoms is crucial when writing a successful sickness certificate. Consequently, informants feared that the SSIA case workers risked missing the overall picture and deny patients sickness benefit, sometimes solely due to insufficient quantification. The problem of insufficient quantity was informally resolved in mainly two ways: exaggeration and quasi-quantification. A young GP said the following:

> I have exaggerated. I exaggerate the problems, so it'll pass [...] I've even told the patient: maybe this wasn't exactly what you told me, but to be certain that you'll get your sick pay, I will have to write it like this. For example [...] wakes up ten times per night, although in reality maybe it is five times per night (I)

In this context, exaggeration seems to denote statements that represent quantities as more or less than they actually are. Yet, the informants who exaggerated were careful to differentiate exaggeration from lying or fabrication. One informant stated: 'I amplify to illuminate the total impression' (G).

Another way of solving the problem of insufficient quantity was to derive quantities from qualities, which I call *quasi-quantification*. This operation differs from exaggeration because there is no quantity to begin with. Instead, a quantity is created. One informant depicted the difficulties of assessing extent and frequency of a (psychiatric) patient's disabilities:

> [No patient] can answer that, no patients reason in those terms. So I ask a bit about what they do during the days, when do you wake up, when do you eat breakfast, what do you do after that. And then I transform it to minutes or hours or something like that (C)

Informant (C) felt that patients tend to have difficulties providing quantitative data directly, and therefore preferred to extrapolate them out of the patient narrative. Also, some informants felt that the encounter with the patient could become too inquisitorial when focusing on quantities, thereby undermining the patient–physician relationship.

Omission

Several GPs recounted how they sometimes deliberately excluded facts when issuing sickness certificates, in order to influence SSIA's decision. The cases could comprise of omitting references to small but remaining work ability, or not mentioning leisure activities. One GP gave the following example:

> For example, if the patient says that she's still active in her local sports club, and has occupational burnout, which actually was a case I had this week. It wasn't mentioned [in the sickness certificate]. She was being reintroduced to work at the time, but I didn't write it in the certification document [...] things that speak against sick listing tend to be omitted (B)

This GP felt responsible for ensuring that the sickness certificate went through after he had made the decision to issue it, and that the considerable risk of rejection mandated the use of this technique.

Depersonalization of the patient voice

Several informants reported that the SSIA did not seem to be interested in the patient's own narrative. This was particularly problematic in disability cases with few or no objective findings, when the patient's own narrative is the most important source of information. Consequently, a perceived devaluation of the patient's voice was sometimes circumvented by objectivizing it in various ways. On the most superficial level, some cosmetic changes made to the written document could erase the presence of the patient:

> [...] so you need to ask the patient, 'what is it you can't do?' You ask, but of course you don't write that you asked the patient, because it could lead to a rejection by the SSIA. I've seen this happen a number of times, that they motivate it: 'well, what the patient says doesn't mean a thing' (K)

On a deeper level it sometimes entailed transposing first person accounts onto something more tangible, such as objective clinical signs. For example, informant (J) recalled how he sometimes wrote that a depressed patient without visible signs of depression 'looks sad' or has a 'flat facial expression', rather than opting for a 'neutral mood'. The informant also expressed frustration with sanctioned ways of providing SSIA with objective data, such as rating scales. Other informants had also experienced that rating scales were not always accepted in isolation, particularly if they did not accord with the mental status examination.

Adjustment of disease progression

Some of the informants believed that both expected and unexpected disease progression could influence patients' eligibility for sickness benefit. To prevent premature termination, GPs could decide to either understate or overstate how fast the patient was recovering

when renewing sickness certificates. A GP gave an example of understating when sick listing a depressed patient:

> The first certification was easy, because she really had a flat facial expression and a monotone voice, [...] then we started treatment, she went to a psychologist, was given medication and started to feel better clinically, and she didn't have the signs anymore. But it was still out of the question that she should be exposed to work yet. So we see the progression in this patient, and other patients with these diseases. [...] That's when one has to tell white lies sometimes, such as 'she looks tired', although that's not the case (G)

At other times, informants felt compelled to overstate the rate of progress and ability. Another GP told the story of a recent patient he was dealing with, nearing retirement age with occupational burnout, and rather severe hypertension. Working part time was not going well.

> [H]e would actually need a total sick leave. But he is even more stressed out about being on total sick leave, because it increases the risk that SSIA just removes him from work and puts him in some goddam' vocational training programme. That would break him, totally. From a purely medical standpoint he needs to be totally off work (J).

Instead of insisting on 100% disability, the GP and his patient decided to lower his disability to 50%, in order to avoid putting the patient at the disposal of the whole labor market, as dictated by regulations.

Buzzwords

Standardized words and phrases were widely employed by the informants when writing sickness certificates. They did it reluctantly, worried that it partially dissociated the words from what they are supposed to signify, or what some GPs called 'catchwords', or 'code words, platitude'. One GP illustrated with using a particular phrase when describing her clinical findings in psychiatric patients:

> I write 'cognitively impaired', because I've learnt that they want to hear that particular phrase. It's not enough to write memory and concentration loss; for some reason the word 'cognitive' must be used. It has become such a routine, you use a few keywords (M)

The informants used buzzwords in two related ways: (1) As a device on a purely textual level, using words and phrases they know that the SSIA wants (as the case above); (2) As a way of directing the actual conversation with the patient. For example, one informant recounted how she could ask leading questions using buzzwords, in order to get an affirmative answer to it, just to be able to write it in the sickness certificate.

Techniques beyond the text: communication off the record

Techniques for conveying views of a patient's disabilities were not limited to techniques of *writing* the sickness certification document in a particular way. When requested to clarify sickness certification documents, some GPs would sometimes phone SSIA caseworkers. Beyond the completely sanctioned purposes of phone calls (such as giving a more thorough account of a patient, sorting out misunderstandings, and finding out what additional information the SSIA needs) it was a pathway for subjective and affective modes of persuasion. As one GP put it: 'If you have a caseworker you trust, [...] it could become a little "off the record", things you don't want to write' (E). This so called off the record communication concerned matters the informants both did not *want* to write, but also things they could *impossibly* write because it did not meet the standards of writing objective certificates. For example, the GP's subjective impressions could be communicated, as one of the informants explained:

> I don't write 'I was genuinely worried for the patient', but it is something I can say to the caseworker, and to add my thoughts and values to the whole, in a way I can't do [in text]. That makes it extra obvious for the caseworker, that the [patient's] narrative is very credible, and I think they are more inclined to [say] ... 'oh, was it that bad? Ok', and then you can cooperate a bit more. (G)

Another sub-category was to involve oneself rather than one's subjective impressions of a particular patient. It could involve talking about personal experiences of psychiatric disease, in order to make the caseworker understand the severity of the condition (one GP told a caseworker of his own depression, for example). It could also take the form of asserting one's own medical authority, for example through categorical statements about the state of the patient: 'sometimes I notice that it helps to say "there is no doubt about it"' (K). Occasionally, some informants could remind the caseworker of their superior medical knowledge.

Techniques beyond the text: production of redundant somatic data

The standards for establishing links between diagnosis, impairment, and disability was by some informants

considered inflexible to the degree that GPs must be redundantly clear about them. Hence, when attempting to make a solid case for sick listing, they could feel compelled to add information despite significant nuisance, or perhaps even potential harm, to the patient. An illustrative example was provided by one informant, who recounted a case of vertebral compression fracture. Although the GP did not believe that a radiological confirmation of the diagnosis was medically motivated, she ordered it anyway, solely to acquire objective findings. 'She will be exposed to unnecessary radiation for the sake of the SSIA' (D).

Discussion

This qualitative interview study has aimed to explore and thematize the informal and unsanctioned techniques GPs employ as a means to increase the likelihood of sickness certificate approval. The findings provide a non-exhaustive overview of these techniques used for meeting the stricter standards of sickness certification imposed by the SSIA. The eight categories of techniques identified were *exaggeration, quasi-quantification, omission, depersonalization of the patient voice, adjustment of disease progression, buzzwords, communication off the record* and *production of redundant somatic data*.

They were mostly utilized when GPs were convinced that a patient had a medically motivated work disability, but may have had a hard time satisfying the criteria of objective findings, as well as establishing links between the triad of diagnosis, (objective) impairments and work ability. Typical cases primarily involved patients with unclear prognoses that were on sick leave for longer periods (especially exceeding 90 and 180 days), and patients lacking objective findings to link their subjective illness with an objective disease (most often psychiatric problems such as depression and occupational burnout, but also patients experiencing chronic pain).

The techniques are quite heterogeneous, but a common denominator is their role in the struggle over objectivity. Some techniques aim at *producing quasi-objectivity* (for example when transforming the patient's narrative into an objective finding made in the examination room); others at *evading objectivity* (for example when trying to convince caseworkers over the phone); a few techniques *produce objectivity at a price* (for example when referring a patient to a redundant radiological examination to secure objective findings, at the price of unnecessary radiation exposure).

The distinction between sanctioned and unsanctioned ways of communicating with the SSIA is not always clear-cut. Rather, the techniques fit on a continuum. For example, when issuing sickness certificates (or any document, for that matter), physicians must always fish out relevant facts from the stream of unordered clinical impressions. Leaving out particular facts is essential in producing meaningful text. Yet, under some circumstances, the omissions of facts can be considered unsanctioned.

The techniques are intentionally used, and are therefore not simply mistakes. They display a certain level of sophistication, and go to great lengths to (at least superficially) comply with imposed rules and standards. Consequently, the techniques are difficult to identify as either compliant or non-compliant. Are they overzealous implementations of the standards of objectivity, or ways to wiggle out of them? That organizational misbehavior, even resistance, can straddle the line between compliance and non-compliance has been pointed out in earlier sociological research concerning 'everyday resistance' among airline pilots [23], office workers [24] as well as in spheres outside of the workplace [25]. This suggests that the use of informal techniques could be understood in similar terms. However, understanding GPs' informal sickness certification techniques through the lens of everyday resistance transcends the scope of this exploratory study.

According to Michael Lipsky, public policy does not simply encompass political and legislative stipulations, rather it is something made in every single street-level encounter between professionals and their clients [26]. The cunning use of objectivity can be understood as ways for GPs to control public policies by modulating their implementation, thereby retaining their own discretionary power. Needless to say, the discretionary powers of street-level bureaucrats (such as GPs) are not unproblematic. Advocacy of individual patients can be incompatible with an organizational perspective.

The mere existence of non-compliance might have implications from an organization perspective. Further research is needed regarding the prevalence of non-compliant actions, as well as potential causal links between the implementation of external control mechanisms and the development of sophisticated forms of non-compliance in the sickness certification praxis. The relation between them may be counterintuitive, in the sense that more control not always entails less deviation: interventions often produce an appearance of conformity, cloaking new and deeper

forms of misbehavior that can be even harder to identify and counteract [27]. Similarly, consolidating SSIA's gatekeeping role may have solved some sickness absence issues (revolving around patient-driven demands for sick listing [10]) at the cost of inadvertently stimulating new forms of underground praxes that are necessary to keep the head of clinical practice above water.

Strengths and limitations

There are some potential sources for bias in the collected data. Firstly, no informants have an educational background in countries outside of the EU. Secondly, a majority of the informants work in Stockholm. What problems does this pose for a qualitative study? Techniques that are unique for GPs outside of the EU and Stockholm could have been missed in this study. As this is not a quantitative study, the preference for one technique over any other is not sought for, and therefore the slight overrepresentation of one geographical area is a minor problem. Neither is the ratio between GPs that use techniques, and those who abstain from them, an overarching concern in this study.

Acknowledgments

The author thanks the GPs who participated in the study. The author also thanks the two PhD supervisors for their support and significant contributions to the analysis and interpretation of the data. However, the author and both supervisors are in agreement that neither supervisor alone satisfies all necessary criteria for the assignment of 'authorship', as it is defined by the International Committee of Medical Journal Editors (ICMJE), or as it is used colloquially. We acknowledge that, by tradition, the humanities (which our institution partially belongs to) tend to enforce a too strict delimitation of authorship. However, by assigning authorship to the supervisors in this particular article, we would rather succumb to another common and equally problematic cultural tendency in academia—the slightly too inflationary use of the concept of 'authorship'.

Disclosure statement

No potential conflict of interest was reported by the author.

Funding

The dissertation as a whole is funded by The Foundation for Baltic and East European Studies.

Ethical approval

The study has been approved by the regional ethical board of Stockholm (2016/1162-31/5).

References

[1] Försäkringskassan. Uppföljning av sjukfrånvarons utveckling 2018 [Follow up of the development of sickness absence 2018]. Försäkringskassan; 2018
[2] Johnson B. Kampen om sjukfrånvaron [The struggle over sickness absence]. Lund: Arkiv; 2010.
[3] Gulbrandsen P, Aasland OG, Forde R. Legeattester for å hjelpe pasienten [Medical certificates issued to help the patient]. Tidsskr Nor Laegeforen. 2004;124(2): 192–194.
[4] Hussey S, Hoddinott P, Wilson P, et al. Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland. BMJ. 2004;328(7431):88.
[5] Söderberg, E, Alexanderson K. Sickness certificates as a basis for decisions regarding entitlement to sickness insurance benefits. Scand J Prim Health Care. 2005; 33(4):314–320.
[6] Inspektionen för socialförsäkringen. Bedömningar vid 90 och 180 dagar i rehabiliteringskedjan [The quality of assessments for sickness benefit after 90 days and 180 days]. Stockholm: 2017;9
[7] Arbetsförmågeutredningen. Gränslandet mellan sjukdom och arbete: arbetsförmåga/medicinska förutsättningar för arbete/försörjningsförmåga: slutbetänkande [The borderland between disease and work: work ability/medical preconditions for work/self-provision ability: final report] (SOU 2009:89). Stockholm: Fritze.
[8] Inspektionen för socialförsäkringen. Försäkringskassans hantering av underlag för beslut om sjukpenning [The Swedish Social Insurance Agency's handling of information for sickness benefit decisions]. Stockholm: 2011;8. p. 37.
[9] Carlsson L. Healthcare and patient factors affecting sick leave: From a primary health care perspective [dissertation]. Uppsala: Acta Universitatis Upsaliensis; 2017
[10] Carlsson L, Lännerström L, Wallman T, et al. General practitioners' perceptions of working with the certification of sickness absences following changes in the Swedish social security system: a qualitative focus-group study. BMC Fam Pract. 2015;16(1):21.
[11] Försäkringskassan. Uppföljning av sjukfrånvarons utveckling 2017. Sjuk- och rehabiliteringspenning [Follow up of the development of sickness absence 2017. Sick pay and rehabilitation pay]. Försäkringskassan; 2017.
[12] Alexanderson K, Arrelöv B, Friberg E, et al. Läkares erfarenheter av arbete med sjukskrivning av patienter. Huvudrapport 2018 [Physicians' experiences of handling sickness certification of patients. Main report 2018]. Stockholm: Karolinska institutet; 2018.
[13] Sociala rådet. Läkares sjukskrivningspraxis: en systematisk litteraturöversikt [Physicians' sick listing practices: A systematic review of the literature] (SOU 2010:107). Stockholm: Fritze.

[14] Wynne-Jones G, Mallen CD, Main CJ, et al. What do GPs feel about sickness certification? A systematic search and narrative review. Scand J Prim Health Care. 2010;28(2):67–75.
[15] Nilsen S, Malterud K, Werner EL, et al. GPs' negotiation strategies regarding sick leave for subjective health complaints. Scand J Prim Health Care. 2015; 33(1):40–46.
[16] Nilsen S, Malterud K. What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway. Scand J Prim Health Care. 2017;35(2):201–207.
[17] Krohne K, Brage S. New rules meet established sickness certification practice: a focus-group study on the introduction of functional assessments in Norwegian primary care. Scand J Prim Health Care. 2007;25(3): 172–177.
[18] Swartling M. Physician sickness certification practice focusing on views and barriers among general practitioners and orthopaedic surgeons [dissertation]. Uppsala: Acta Universitatis Upsaliensis; 2008
[19] Aarseth G, Natvig B, Engebretsen E, et al. 'Working is out of the question': a qualitative text analysis of medical certificates of disability. BMC Fam Pract. 2017;18(1):55.
[20] Gill P, Stewart K, Treasure E, et al. Methods of data collection in qualitative research: interviews and focus groups. Br Dent J. 2008;204(6):291.
[21] Chew-Graham CA, May CR, et al. Qualitative research and the problem of judgement: lessons from interviewing fellow professionals. Fam Pract. 2002;19(3): 285–289.
[22] Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
[23] Ashcraft KL. Resistance through consent? Occupational identity, organizational form, and the maintenance of masculinity among commercial airline pilots. Manag Commun Q. 2005;19(1):67–90.
[24] Paulsen R. Empty labor: idleness and workplace resistance. Cambridge: Cambridge University Press; 2014.
[25] Hollander JA, Einwohner RL. Conceptualizing resistance. Sociol Forum. 2004;19(4):533–554.
[26] Lipsky M. Street-level bureaucracy: dilemmas of the individual in public services. 30th anniversary expanded ed. New York: Russell Sage Foundation; 2010.
[27] Ackroyd S, Thompson P. Organizational misbehaviour. London: SAGE; 1999.

Appendix

Interview guide, topics and a selection of questions

Background and participant information, building rapport

Sickness Certification

General

- Which aspects of the sickness certification process do you find most difficult? Examples?
- Which patients are difficult, regarding sickness certification?
- What changes have you experienced over time, concerning the sickness certification process?

Issuing sickness certificates

Direct questions:

- How has your way of issuing sickness certificates changed over time?
- Have you developed any strategies or rules of thumb when writing sickness certificates? Examples?
- Have you ever changed the content of the sickness certificate when the SSIA have requested clarification? How?
- Have you ever bent the truth when describing the state of a patient? How? Why?

Indirect questions:

- Are there differences between how you write sickness certificates and medical records? How do they differ? Why?

Relationship with the SSIA

- How would you describe your relation to the SSIA?
- Have you had any conflicts with the SSIA? Can you recount a time it happened?
- How did you solve it?

Other

- Is there anything concerning the sickness certification process that you have been thinking about, that we haven't discussed?

Paper II

Literal Tricks of the Trade

The Possibilities and Contradictions of Swedish Physicians' Everyday Resistance in the Sickness Certification Process

Mani Shutzberg, ***Centre for Studies in Practical Knowledge, Södertörn University, Stockholm, Sweden***

Abstract

This article deals with the ways Swedish General practitioners (GPs) informally deal with the stricter standards of sickness certification and the implications of understanding these ways in terms of 'resistance.' In recent decades, procedural and bureaucratic changes within the Swedish sickness benefit system have curtailed physicians' clinical discretion with regards to the sickness benefit approval for patients. By both formal and informal means, the Swedish Social Insurance Agency (SSIA) has consolidated its power over the decision-making process. Despite widespread dissatisfaction among physicians with the current system, acts of open defiance do not seem to occur. However, as shown in a recent qualitative study, Swedish General practitioners have developed informal 'techniques' (ranging from simple exaggerations in the certificates to complex constructions of apparent objectivity) for intentionally circumventing the stricter sickness certification standards. Taking that study as a point of departure, this article will consider the use of techniques as a form of ***everyday resistance****. Three dimensions of ambiguity arise which require further attention, namely: (1) the multiple motives and shifting target of resistance; (2) the complex blend of power and powerlessness which defines the situation of GPs and their resistance, and (3) the fundamental ambiguity of the resistant act of issuing sickness certificates tactically, as a particular mix of compliance and resistance.*

Introduction

Sickness benefit systems across various Western jurisdictions have witnessed fundamental reforms during the last couple of decades, effectively restricting access to sickness benefits. The effects of these reforms have been beautifully and painfully depicted in Ken Loach's feature film from 2016, *I, Daniel*

Blake. The film focuses on Daniel Blake, a carpenter nearing retirement who suffers a debilitating heart attack. Despite Blake's situation, the implementation of a 'Work Capability Assessment' deems Blake fit for work, which is in direct opposition to his physician's assessment that full time work would be detrimental to Blake's health. Dissatisfied with his capability assessment, Blake refuses to accept the situation laying down and resists, not only through explicit protest, but also by using subtle acts, such as sending out useless work applications to ensure eligibility for jobseeker's allowance. His resistance extends to the legal system as well, by appealing the decision determined by the *Work Capability Assessment*. The social worker assigned to Mr. Blake's case also finds ways to help Blake out of his predicament, and by doing so, puts herself at risk as a mediator between her client and the social security system of which she is representative.

I, Daniel Blake portrays Mr. Blake's physician as 'outraged' by the initial rejection of his claim. The absence of physician-led resistance in Loach's film underscores an important question. Why do we find countless examples of research addressing different forms of resistance among patients and social workers, yet so few (if any) that consider resistance practices in this context among physicians? Does that mean that physicians do not ever resist the reformed administration of social security systems? Or do physicians engage in resistance but in ways that are unrecognizable? If the latter is plausible, then how or at what level might resistance occur?

Because of circumstances peculiar to the healthcare sector and the nature of physicians' work (such as the fact that lives are at stake, which impedes the use of the labor strike weapon and other forms of disruptive resistance), cases of physician resistance may pass unnoticed and the physician might appear to 'offer little resistance' against the neoliberal curtailment of their clinical autonomy (Harrison and Dowswell, 2002: 208). Yet, when we look more closely at the sickness certification process that involves physicians, it seems to contain elements that are best understood in terms of (everyday) resistance against bureaucratic strictures that impinge the physicians' ability to properly provide optimal care for their patients. The fact that it is harder to engage in disruptive actions does not mean that resistance is impossible.

During 2017, I practiced as a medical intern at a primary care center for six months in Stockholm, Sweden. I realized that there is more to writing sickness certificates than mere technical skill. For my colleagues and I, the sickness certificate process was often experienced as adversarial, insofar as

claims made on behalf of sick patients sometimes failed to be approved by the *Swedish social insurance agency* (SSIA).[1] This was the rationale for setting out to explore the ways in which general practitioners (GPs) successfully appease the demands of the SSIA with experience-based knowledge that enables them to successfully navigate the increasingly stricter sickness certification protocols handed down by the SSIA. Using qualitative interviews with Swedish GPs, the collected and previously published data revealed eight 'techniques' used by physicians to ensure sickness certificate approval by the SSIA: exaggeration, quasi-quantification, omission, depersonalization of the patient voice, adjustment of disease progression, buzzwords, communication off the record and production of redundant somatic data (Shutzberg, 2019).[2] Based on these empirical findings, I will attempt to characterize how some Swedish GPs in primary health care 'resist' when completing sickness certificates on behalf of their patients.

Three levels of ambiguity will be the focal point of the analysis: The multiple motives and targets of this resistance; the peculiar mix of power and powerlessness that is a condition of possibility for this particular form of resistance; the ambiguous nature of the act as a combination of resistance and compliance. However, before proceeding to analyzing the use of techniques as a form of resistance, it is necessary to provide the reader with an account of how the situation arose. What were the reconfigurations of power relations that made it necessary for physicians to use these techniques?

How did we end up here? Reconfiguration of power relations and the curtailment of medical autonomy

Due to real and imagined scarcity of resources, through waves of governmental austerity measures, and because of ideological struggles, the last couple of decades have borne witness to fundamental reconfigurations of public administration in general, and social security systems and welfare delivery in particular. Part of a global trend (interchangeably called 'Neoliberal,'

[1] The Swedish name of the Swedish social insurance agency is "Försäkringskassan".

[2] For a more detailed description of the different techniques (as well as my methodological approach), see Shutzberg, 2019. As the errand of this article is to develop the implications of understanding the use of the techniques as resistance, I will not be delving into a systematic descriptive exposition of them here. Nevertheless, the empirical findings will be revisited organically when it is relevant to do so, below.

'New Public Management,' 'Managerialism'), affecting almost all welfare states of the Scandinavian countries, the Anglo-Saxon world, as well as some countries in continental Europe, the reforms of the publicly funded social security systems have entailed a number of things for its *clients*: Stricter eligibility criteria for 'disability' and 'sickness,' pressure to reintroduce unemployed 'sick persons' into the labor market, and rigorous control mechanisms to monitor patients with approved sickness benefits (Grover and Soldatic, 2012; Burström, 2015). On the level of public discourse, a person's inability to work has shifted from public health concern to concern with a person's unwillingness to work, with the implication that the latter reflects misuse of social benefit systems.[3] In addition to this discursive shift, an increased juridification and standardization of the way in which client cases are handled has extended institutional control over the professionals involved in case processing. Put simply, the work and professional discretion of healthcare workers (nurses and physicians), social service workers, and others involved with sickness and disability cases, are more tightly regulated than ever by performance indicators, scripts and routines, by organizational directives and governmental decrees (Broadbent and Laughlin, 2002; Beach, 2011; Hasselbladh and Bejeroth, 2017). Several Swedish studies have demonstrated that the 'possibility of expressing views and criticism has diminished in public organizations during the previous decade (Welander, 2017: 11). A comparative study has shown that doctors in general felt that their influence on management decisions, as well as (perceived) support from their employers, has diminished between 1992 and 2010 (Bejerot et al., 2011). There is little reason to doubt that this disenfranchisement has not dissipated, but only increased over the last decade.

For patients in need of economic assistance due to disability or sickness, physicians have clearly played a key role. Historically, the bureaucratic function of the treating physicians in a welfare state has been one of *gatekeeping*: That is, possessing and wielding the authority to approve or deny eligibility for sickness benefits. The physician was often caught in a dilemma, between the role of gatekeeper (representing the state) and the role of patient advocate (Wynne-Jones et al., 2007). From a governmental perspective, it has been claimed that (at least Swedish and British) physicians too often extricated themselves from the dilemma by passively yielding to

[3] For details on the discursive shift in a Swedish context, see Johnson, 2010. For similar processes in the UK, see McEnhill and Byrne, 2014.

patient demands, thereby eschewing demands associated with cost reduction and acting as independent medical experts on behalf of insurance agencies (Arrelöv, Edlund and Goine, 2006; Hussey et al., 2003). The rising public costs of social insurance systems have therefore in part been attributed to the inability of physicians to curb them in accordance with governmental guidelines of austerity.

Consequently, one of several ways of offsetting the costs has been to curtail doctors' professional discretion in social insurance matters. This has been done through a partial transfer of the gatekeeping function, from physicians into the hands of the social insurance agencies. All welfare countries carrying out the transition have done so through a combination of both informal and formal measures, albeit with different emphases on one of the two poles. In Sweden, the SSIA has consolidated control over the sickness benefit system during the last decade mainly by informal means. It has done so under the guise of a higher certification standard with respect to both the quality and quantity of paperwork doctors must administer in the sickness certification process, exemplified by increased requests for supplemental information from physicians, or outright rejection of sickness certificates (Försäkringskassan, 2017). In the UK, the transfer of the gatekeeping function has been more formal. The Welfare Reform Act in 2007 and the institution of the *Work Capability Assessment* has legally transferred decision of eligibility from physicians to the state administrative body (Grover and Soldatic, 2012: 220; Litchfield, 2013). Outside of Sweden and the UK, similar changes have been put in motion in Norway and Australia (Krohne and Brage, 2007; Grover and Soldatic, 2012: 218).

Hence, austerity and the intimately related discourse of suspicion towards both sickness benefit claimants and the physicians who issue certificates, the relations of power between the stakeholders in social security systems have undeniably changed in favor of the social insurance agencies. For patients, enjoying benefits are conditioned by fulfilling specific obligations. For physicians, the stricter implementation of legal or quasi-legal decision processes has thus curtailed their relative professional autonomy and discretion.

But what does it mean to claim that the social insurance agency has become more powerful over time, *vis-à-vis* physicians? What kind of power is at stake here? It seems to be the power over decision-making, or what Steven Lukes calls the first dimension of power (Lukes, 1974: 12-13). In

social insurance matters, increased power means that the judgments of the social insurance agency simply weigh more, and the judgments of physicians weigh less. To some extent, the power over physicians can also be understood in terms of the so-called second dimension of power: Whereas the first dimension of power deals specifically with influence over decision-making, the second dimension deals with what Lukes calls 'nondecision-making,' that is, the capacity to withdraw a question from the negotiation table (Lukes, 1974: 18-19). The decision process regarding sickness benefits is made to appear like a non-decision for the physician. That is, the social insurance agency sets the agenda, which effectively excludes the possibility to issue sickness certificates for some patients. In terms of these two dimensions, the power of the social insurance agency over physicians and their autonomy is strictly negative and repressive: the power has pushed back on the sphere of medical judgment. These two dimensions do not focus on the degree to which the content of the medical sphere may have been altered by the recent discursive and administrative changes. What I mean by this is that power also potentially has a productive dimension, that entails an active cultivation of the 'thoughts and desires' and 'preferences' of dominated groups, aligning them to suit the interests of a dominating group (Lukes, 1974: 23). Translated to the clash between the regimes of economic rationality and medical judgments, it means that the changed discourse on sickness absence could very well have trickled down to the minds and judgments of doctors. The question that must be asked, then, is if doctors voluntarily adopt strict views on sickness benefit eligibility with conviction. Do they accept and adopt the logics of austerity as part and parcel of a purely medical practice?

It seems as if the short answer to that question is 'no.' From a long-term perspective, this third dimension of power should certainly be taken into consideration. However, the changes that have occurred during the last couple of years, or perhaps a decade, do not seem to have created any kind of substantial acceptance among doctors, particularly not among GPs. Between 2004 and 2017, the proportion of Swedish GPs who reported that their medical judgments were questioned by the SSIA rose from 10% to 57%. The number of GPs who experienced that the SSIA requested unnecessary corrections to the sickness certificates increased from 48% to 72% between 2012 and 2017. In 2017, 72% of surveyed GPs conveyed that the SSIA requested 'objective signs' of illness in cases where objective signs are notoriously difficult to identify (e.g. psychiatric disability, chronic pain, etc.) (Alexanderson et al., 2018). These statistics suggest an increased

polarization between the social insurance agency and GPs, and consequently, that the power over them (in this particular regard) is more repressive than it is productive. That is, the power of the SSIA does not seem to include control over GPs' (professional) thoughts, desires and preferences.

Resistance in the new landscape of social insurance systems

Where power is exerted, resistance should be expected. Not surprisingly, then, resistance mounted by various subordinated stakeholders in the social insurance system has been documented. From the point of view of clients (patients, welfare recipients, and so on), the juridification of the approval process has made room for resistance such that clients use the legal system to fight unfavorable decisions. Vicki Lens has shown how (both disabled and able-bodied) welfare clients seek legal assistance and 'play with the rules, using their insider knowledge of the system to resist the unreasonable and the arbitrary' (2007: 312). That social workers go beyond protocol to assist clients, despite risking repressive measures by management, has also gained attention in research.[4]

From the perspective of the physician, administrative attempts at curtailing their clinical autonomy within their 'natural habitat' (the clinic) have not been without friction. Physicians have been observed to deploy different strategies for resisting or circumventing the impact of neoliberalism, new public management and managerialism on different aspects of clinical life (Waring and Currie, 2009; Numerato, Salvatore and Fattore, 2012). However, most studies focus on different forms of non-compliance directed against *healthcare* management, i.e. the management structure *within* a hospital, primary care center and so on. The theoretical lens of resistance studies has not yet thrown any illuminating rays on the sickness certification practices of physicians. This is certainly understandable, as physicians are not formally a part of the bureaucratic apparatus of the social insurance agencies in the same way that they are an integral part of the healthcare organization. Insurance agencies wield their power over GPs from afar, and GPs counteract them from an equally long distance.

[4] For a selection of the research concerning resistance in the line of social work, see Wallace and Pease, 2011: 138-139.

Current research on sickness certification behavior: A privative and depoliticizing understanding of GPs

How, then, is the non-compliant behavior of physicians in the sickness certification process currently understood in scholarly literature? There is a strong tendency to understand doctors' deviating behavior in privative terms, often attributed to the individual physician's: lack of professionalism, viewed as an inability to integrate and balance his/her dual roles as medical expert and patient advocate (Swartling, 2008: 33); lack of 'textual competence' (Aarseth et al., 2017); lack of knowledge of insurance medicine (Norrmén et al., 2006); lack of negotiation skills for fending off patients seeking sickness benefits (Nilsen et al., 2015). Sometimes, researchers recognize intentional resistance in the behavior of doctors, but seldomly thematize it. For example, a textual analysis carried out by Aarseth et al. investigating medical certificates issued by (Norwegian) GPs, noticed that doctors occasionally conflate several different voices (the patient's voice, the voices of relatives, the doctor's own voice), so that 'there are no speaking subjects or references and thus the utterances have no explicit source' (Aarseth et al., 2017: 7). Aarseth et al. do mention that ambiguities in the certificates cannot be wholly explained by a lack of textual skill, and that they could possibly be ascribed to some kind of 'strategic writing', aimed at producing an '"objectivised" [...] authorial voice to justify disability benefit' (2017: 7). However, they soon revert to a privative description of the phenomenon by calling it a 'textual failure' and that GPs 'show little consciousness of the ethics of the medical certificate as a juridical document' (2017: 10).

The implicit common denominator in this field of research is a structurally functionalist, non-conflictual, understanding of the relation between GPs and the organizations they interface with, whereas the dynamics between GPs and patients are readily understood in conflictual terms. The privative and individualized modes of understanding deviation may be warranted but provide only a simplified and incomplete understanding of sickness certification practices. Recommendations based on this way of problematizing the field will consequently focus on counteracting the individual lack of skills or virtues of GPs through educational measures, or minimizing their influence on the sick-listing processes. The overall ideological effect of a privative understanding of sickness certification that does not adhere to public guidelines is that the behavior is de-politicized.

Intermezzo: The ethical problem of 'revealing' everyday resistance through research

In addition to the general ethical challenges of dealing with consent, anonymity and transparency, researching resistance brings a specific set of ethical questions to a head: What are the potential unintended effects of research on resistance? Can I as a researcher inadvertently betray the very same subject I am attempting to understand and perhaps support? What if researching the weapons of the weak becomes but another weapon in the arsenal of the strong? What if, in this concrete instance, 'revealing' the techniques of physicians will ultimately serve the interests of the social insurance agencies and fuel repressive measures? These are pressing questions to ask, especially when dealing with covert and present (in contrast to overt and historical) instances of resistance. Baaz, Lilja and Vinthagen have thematized this contradiction and the ethical challenges facing those who conduct research on resistance:

> Exposing hidden forms or mechanisms of resistance effectiveness could increase repression. There is an inherent risk that making this type of research public betrays the very logic of this type of resistance, simply by exposing that which tries to be hidden. (2018: ch. 8, para. 3)

Knowledge has the peculiar ability to wiggle out of ownership and be used for unintended purposes (such as quelling resistance), and there is really no absolute solution to that risk (other than not doing research, which is a very real possibility that should be considered). The way forward suggested by Baaz et al. is 'self-reflection, discussions and professional work by a community of researchers who are continuously discussing these issues' (2018: ch. 8, para. 5).

The sickness certification behavior of physicians is a relatively well-researched area. Also, as shown above, these behaviors have already been identified as problematic (from a managerial point of view). The state and the social insurance agency already worry that doctors are not doing what they are told. This article, as well as its descriptively oriented predecessor (Shutzberg, 2019), operates more through reframing the 'problem' and less through revealing something hitherto hidden. Reframing the non-compliant behavior of physicians in terms of resistance rather than incompetence, as behavior based on knowledge rather than ignorance, is less susceptible to reproducing status quo than merely 'revealing' hidden practices. This

study also draws attention to the concept of resistance and its necessary relationship to the concept of power. A positive exposition of sickness certification behavior with emphasis on resistance practices is consequently an exposition of the power structure that engenders resistance in the first place. Although this strategy of 'reframing' does not make the research completely immune from being co-opted and used for repressive purposes, it can contribute to raising awareness among physicians of the conditions that make their resistance inevitable. The hope is that awareness increases the chance of further organized mobilization towards a humane social insurance (and healthcare) system.

Use of techniques for having sickness certificates accepted

It can prove challenging for patients who present with incapacitating sickness or disability to claim disability benefits. The sickness certificate issued by the doctor can be questioned or rejected due to lack of 'objective signs' that serve to prove a patient is sick and unable to work. Likewise, it may be difficult to establish a coherent and convincing link between diagnosis, (objective) impairments and work disability. This can be notoriously difficult in real life clinical practice, with multiple and overlapping diagnoses, diffuse psychiatric disabilities and so on. Nevertheless, the SSIA demands that reality conforms to the regulative matrix rather than the other way around, if sickness benefits are to be granted. How do GPs handle these cases?

To address this question, I conducted a qualitative interview study with 20 Swedish GPs. Based on their responses, eight techniques were identified, particularly with respect to the way in which sickness certificates are written to ensure high rates of SSIA approval. A widespread conception among the interviewed GPs was that *quantifying* patient symptoms is crucial when issuing sickness certificates. Consequently, they feared that SSIA case workers risked missing the overall picture and deny patients sickness benefits, sometimes solely due to insufficient quantification. This problem was informally solved in mainly two ways: (1) *exaggeration* and (2) *quasi-quantification*. That is, either by exaggerating already existing quantities (such as how often a depressed patient contemplated suicide), or by inventing quantities (for example, the general inability to concentrate on menial tasks could be translated to an artificially exact duration of attention span: 'So I ask a bit about what they do during the days, "when do you wake

up?", "when do you eat breakfast?", "what do you do after that?" And then I transform it to minutes or hours or something like that'). GPs could also feel forced to (3) *omit information* about for example leisure activities and remaining work ability, fearing that such information could increase the risk of unfounded rejection of the sickness certificate. A slightly more complex way of dealing with the sickness certificate was through (4) *depersonalizing the voice of the patient*. Several GPs reported that the SSIA did not seem to be interested in the patient's own narrative because it was not considered sufficiently 'objective.' In response, anticipating the SSIA's disregard for the patient's voice, physicians circumvented this problem by objectivizing it in various ways. Some basic 'cosmetic' changes made to the written document could erase the presence of the patient:

> So you need to ask the patient, 'What is it you can't do?' You ask, but of course you don't write that you asked the patient, because it could lead to a rejection by the SSIA. I've seen this happen a number of times, that they [the SSIA] motivate it: 'Well, what the patient says doesn't mean a thing.'

Some of the GPs believed that both expected and unexpected disease progression could influence patients' eligibility for renewed sickness benefit. To prevent premature termination, GPs could decide to (5) *adjust the reported disease progression*, often by understating the rate of recovery when renewing sickness certificates. The use of standardized phrases or (6) *buzzwords* when writing sickness certificates was widely reported by the GPs. They did it reluctantly, worrying that it partially dissociated the words from what they are supposed to signify. One GP illustrated with using a particular phrase when describing her clinical findings in psychiatric patients:

> I write 'cognitively impaired', because I've learnt that they want to hear that particular phrase. It's not enough to write 'memory and concentration loss'; for some reason the word 'cognitive' must be used. It has become such a routine, you use a few keywords.

Not all techniques were limited to the written content of the certificate. Some GPs would also attempt to (7) *communicate off the record* with social insurance case workers in order to maximize the chance of a desired outcome. In the direct communication between GP and case worker, they felt things could be conveyed that cannot be adequately expressed in quasi-

legal language, such as the total impression and intuitive feel of patients' abilities and disabilities. Also, GPs could feel forced to (8) *produce redundant somatic data* beyond what was deemed medically motivated, just to satisfy the demand for 'objective signs.' In these cases, the balance between expediting the sickness certification process through medically unnecessary examinations and the potential damage of extensive medical examinations was difficult. For example, one GPs recounted that she felt compelled to carry out an extra radiological examination to produce unambiguous proof of a vertebral compression fracture, even though it would not change the medical handling or outcome in any way. The alternative, to risk rejection of sickness benefit claims, would have been much more psychologically and economically stressful for the patient.

The techniques were defined as informal and unsanctioned ways of maximizing the likelihood of sickness certificate acceptance by the SSIA. Because the techniques are intentionally used it would be inaccurate to simply view them as mistakes. Their use displayed a certain level of sophistication, and the doctors went to great lengths to (at least superficially) comply with imposed rules and standards in order to circumvent them. They are *skills* acquired over the course of working clinically. Many GPs reported that they developed the skills as they realized that issuing certificates without tactical considerations was afflicted with rejections of sickness benefit claims by patients who needed them. Hence, the GPs drew the conclusion that the outcome could be partially influenced by how the certificate was written (Shutzberg, 2019). The underlying motives for utilizing the techniques provided by the interviewed GPs in these cases could be separated into four categories. The techniques were used: (a) for mending the gap between the complex reality of real patients and the coarse concepts provided by the insurance agency; (b) in the best interest of the patient; (b) in defense of professional autonomy; (c) for freeing up time for 'real' work, by using the techniques as shortcuts to minimize paperwork. I will return to the significance of the motives below.

The techniques are heterogeneous, but the common denominator is that they are used against externally imposed standards of objectivity upon the profession. To be clear, the physicians do not oppose the function of objectivity *per se*, i.e. that there are things in a human body that can be measured and verified independently of the individual physician. However, objectivity poses a problem for physicians when utilized as an inflexible bureaucratic criterion for accepting or rejecting sickness benefits for patients

whose diseases are difficult to prove through other means than listening to subjective reporting by the patient. For instance, there are currently no lab tests nor radiological modalities that can prove or disprove that a patient is depressed. The SSIA's demand for objective findings, when so-called objective data is absent, effectively casts doubt on the medical judgment of physicians. This is where the use of techniques enters the scene. Their use aims to generate *quasi*-objectivity (for example when transforming the patient's narrative into an objective finding made in the examination room); others at *evading externally imposed standards of objectivity* (for example when persuading insurance agency caseworkers over the phone); a few techniques *produce objectivity at a price* (for example when referring a patient to a redundant radiological examination to secure 'objective findings' and tangible data, which unnecessarily puts the patient in harm's way due to radiation exposure) (Shutzberg, 2019).

Understanding sickness certification in terms of (everyday) resistance: Three levels of ambiguity

Perhaps several decades worth of resistance studies has obliterated the connotative equation of the word 'resistance' to large scale, organized, collective and often public mobilization against some superior force — at least in the minds of specialists in the field. For many, the word still elicits mental images along the lines of '[f]rench men and women of the resistance fighting the Nazi occupation,' or 'a lone man standing in front of a tank as it rolls onwards to Tiananmen Square' (Pile, 1997: 1). But the tactical writing of sickness certificate is not like setting up tents and resistance in a public square.

Yet, the use of techniques identified from the interviews appears to satisfy the two criteria in common for almost all implicit and explicit definitions of (everyday) resistance (according to Hollander and Einwohner, 2004: 538, and Johansson and Vinthagen, 2016: 418): Instances of resistance are (1) acts (as opposed to a thought, an attitude, or any other static internal attribute of the actor), and they (2) oppose something. Tactically designing sickness certificates involves actually issuing the certificate and are therefore acts, and when acting in this way, GPs also indirectly oppose and challenge the insurance agency's right to accept or reject patient claims for sickness benefits. However, they are more than generic oppositional acts. They differ from the large scale, organized, collective and public forms of mobilization

that also fit into this catch-all definition of resistance. Perceiving what doctors do in the sickness certification process as resistance is more in line with the works of Michel de Certeau, James Scott, Asef Bayat, Judith Butler and Antonio Negri, who all have significantly widened the conceptual breadth of resistance in the second half of the 20th century (Baaz, Lilja and Vinthagen, 2017: 16). The positive consequence is that it has made visible a plenitude of resistance where we once saw only submission and servitude, occasionally bracketed by bursts of rebellion and revolt that are 'few and far between' (Scott, 1985: xvi). In his seminal work, *Weapons of the Weak*, James Scott argues that '[t]he rare, heroic, and foredoomed gestures of a Nat Turner or a John Brown are simply not the places to look for the struggle between slaves and their owners. One must look rather at the constant, grinding conflict over work, food, autonomy, ritual—at everyday forms of resistance' (1985: xvi). Here Scott captures why it is crucial to examine how GPs handle the sickness certification process, if it is indeed the case that resistance is not exclusively grand gestures of defiance.

The use of techniques by GPs who issue sickness certificates is something done routinely, covertly and contains a considerable amount of actively feigned (and sometimes perhaps real) consent and compliance. Acts of traditional (explicit) resistance are usually not characterized by these traits.[5] Three intimately interconnected dimensions of ambiguity and contradictions present themselves as fundamental challenges to be worked through when applying this broadened concept of 'resistance' to what doctors do when they employ techniques while issuing sickness certificates. These dimensions, dealt with below, are multiple motives and a shifting target of resistance; the complex blend of power and powerlessness which defines the situation of the GP, the fundamental ambiguity of the resistant act of issuing sickness certificates tactically, as a particular mix of compliance and resistance.

Intent, multiple motives and the ambiguous target of resistance

As mentioned earlier, the physicians had several motives for utilizing the techniques when issuing sickness certificates. Often, they had several motives

[5] I will abstain here from more precise contrastive definitions of traditional and everyday forms of resistance. Such definitions have a way of creating more problems than solutions, and stand in the way of understanding the actual case.

simultaneously. The motives could be analytically disentangled into four main categories: The techniques were used (a) for mending the gap between the complex reality of real patients and the coarse concepts provided by the insurance agency; (b) in the best interest of the patient; (c) in defense of professional autonomy; (d) for freeing up time for 'real' work, by using the techniques as shortcuts to minimize paperwork.

Firstly, it is questionable if acts that are driven solely by the first motive (a), provided above, (that is, just making do with whatever concepts the social insurance agency wants physicians to use), qualify as resistance at all. One GP explained his motive for using techniques when issuing sickness certificates in the following way:

> It is a feeling out process. One tries to meet both the patient and the insurance agency half-way, and make both parties satisfied, and try to use as much evidence-based medicine as possible in the process. But it's a balancing act that is difficult to manage.

This motive is difficult to reconcile with the idea that the GP has an intent to resist, given that nothing appears to be *opposed*. Rather than resistance, it seems more suitable to characterize it as *coping*. That said, the remaining motives do appear to entail opposition and conflict. But between which parties? Two of the four motives given by GPs (namely motive (b) that they use techniques when issuing sickness certificates for the wellbeing of their patients, and motive (c) that they do it to defend their medical/professional autonomy) frame the field as a dualistic conflict between the GP and the social insurance agency, even though three actors seem to be involved (because the patient is a part of it as well). It is either a matter of doctor versus insurance agency, or a form of 'proxy resistance' in which the doctor resists on behalf of (or in solidarity with) the patient (Lilja and Baaz, 2016). In both cases, the GP is the resisting subject and the scenarios are hardly different in kind. Interestingly, many GPs spoke of a fourth motive (d): mitigating the load of administrative paperwork. Getting caught up in a back and forth correspondence with the insurance agency can be quite time-consuming. GPs circumvented the hassle by issuing 'warped' certificates that fit the requirements of the insurance agency. The already overburdened working conditions at the clinics consequently means that, as one GP put it: 'there is simply no time for [paperwork]. You've already met the patient, and then [the insurance agency] asks you to provide them with additional information. It is supposed to be done on time we don't have.'

It seems as if the additional paperwork becomes a problem only when it is put in relation to the amount of administrative time set by the employers and the performance compensation models (which is often not enough). The question is then if GPs are resisting the insurance agency, or if they are resisting the conditions and pace of work set by their direct employers and the performance compensation models they implement (or perhaps both at the same time)? The number of actors expands to four: the GP, the patient, the insurance agency—and the employer. Skillfully shirking paperwork in a bureaucratic structure that operates at a distance is easier than contesting one's direct employer. Is this a case of what one might call *mediated resistance*, in the sense that resistance against the insurance agency is only a necessary intermediate target, with the end-goal of the resistance being the mitigation of the total burden of paperwork? Or should it rather be called *displaced resistance*, in the sense that doctors are merely coping with (and in the last instance, consenting to) the high pace of the labor process at the clinic/workplace, by resisting the additional workload imposed by the insurance agency? In the latter case, what may be viewed as resistance between one set of actors (doctor versus insurance agency), is simultaneously submission in terms of another set (doctor versus employer).

The topic of *intent* — a concept similar to, but not identical with, motive — has sparked a cluster of debates in resistance studies (Courpasson, 2016: 5-7; Hollander and Einwohner, 2004: 542-544). Is intent required for something to qualify as resistance, or is there indeed something that can be called 'unwitting resistance'? What makes resistance significant; is it the intent or the outcome? I claim that many have taken a stance in favor of one or the other side thereby reducing intent to a formal and dichotomous concept, that must either be present (e.g. Scott, 1985) or may be absent (e.g. Certeau, 1984/2002) in resistance. Absent from these discussions is a distinction between intent(ion) and motive. I will present why I believe the distinction is relevant. Although the colloquial uses of 'intention' and 'motive' often overlap, some philosophers have suggested that they be kept apart. G. E. M. Anscombe, for example, proposed the following to be a common philosophical position: 'A man's intention is what he aims at or chooses; his motive is what determines the aim or choice' (Anscombe, 2000: 18). In the context of resistance, it could be said that the 'what' that is chosen is resistance. In some of the cases, physicians deliberately decide to oppose the insurance agency's right to decide who is eligible for social benefits. Underlying all this are the motives, that is, the answer to 'why?' an

intended action is carried out. While intent in this sense is often one thing, the underlying motives for acting can be multiple. Twisting Anscombe's quote slightly for the purpose at hand, one could say that the GPs' intent to resist the sovereignty of the insurance agency with the use of techniques is overdetermined by several motives. To reiterate, the point of this distinction between intent and motive is that the *target* of the (intended) resistant act varies depending on motive. As many of the interviewed GPs noted, there may be several motives for one act of resistance, meaning that one act may affect several targets simultaneously.

The distinction between intention and motive is by no means sharp, and they are certainly not independent of each other. One could for example object that any of the so-called motives could just as well be called intentions. Yet, I think this is a useful distinction for approaching some of the ambiguities that present themselves when physicians circumvent the social insurance agency.

Positioned between power and subjugation: the condition of possibility of resistance

The multiplicity of motives seems to undo the possibility of a simple dualistic understanding of the lines of conflict. What initially appeared as a line of conflict between GP and insurance agency, is a complicated interplay between GP, patient, insurance agency and the GP's employer. Another property of the conflict that similarly challenges the simple character of the conflict is the fact that doctors can hardly be considered to be 'subaltern,' 'weak' or 'subordinates' in a global sense.

Certainly, the role of the doctor in deciding on eligibility for sickness benefits has weakened considerably, and the doctor's power is subordinated to the increasing power of the social insurance agency, as shown above. This process is a subset of a broader set of transformations of the nodes of power in medicine; power over health has partially diffused over a range of 'powerful actors from the state to drug companies to "other" health occupations' since the mid-20th century (Coburn, 2006: 441). Furthermore, both the form and content of medical labor are becoming increasingly proletarianized (in terms of form), through a higher share of doctors being employed by others, and (in terms of content) through a routinization and standardization of the labor process (McKinlay and Marceau, 2002). At the same time, doctors still wield considerable power over their patients, healthcare staff and other

individuals (such as individual caseworkers at insurance agencies), not to mention that the profession is still held in high regard by the public and by the healthcare organizations they work in (relative to other categories of staff).

To complicate things even further, work in the healthcare sector (similar to many other interpersonal occupations delivering public services) is characterized by the fact that the 'raw material' of the production process happens to be real existing humans, namely patients. As a result, this severely restricts the tools available for exercising power, since disruptive acts such as strikes, sabotage and similar forms of resistance may be legally and/or ethically difficult (or impossible) to carry out. Labor strikes in the healthcare sector, for example, are almost always partial, as a total strike could lead to serious harm to patients in need of healthcare services, thus making service disruption ethically difficult to justify (Thompson and Salmon, 2006).[6]

The use of all the techniques are to varying degrees evident of the fact that physicians are both the subject and object of exerted power. Even though the SSIA has rendered the physician relatively powerless in social insurance matters, their opinion and authority still matter. Above all the techniques I have addressed, what I call 'communication off the record' illustrates this. When requested by the SSIA to clarify sickness certification documents, some GPs may sometimes phone SSIA caseworkers directly in order to persuade them to accept the sickness certificate. It could take the form of asserting one's own medical authority, for example, using categorical statements about the state of the patient: 'Sometimes I notice that it helps to say, "there is no doubt about it",' said one GP. Occasionally, some GPs might remind the caseworker of their superior medical knowledge. This authoritarian form of persuasion works only because the doctor's authority in medical matters is acknowledged, if not by the SSIA as an institution, then at least by individual caseworkers working within the institution.

Hence, the relatively powerful role of the doctor (in terms of general social status as well as in relation to other groups, as delineated above) seems to be at odds with two fundamental assumptions which I take to be the standard position of resistance studies iterated by Scott (1985), namely that forms of everyday resistance are somehow reserved for those without formal

[6] Even though it is probably a result of postponed elective medical interventions, it is an amusing side note that patient mortality rates seem to remain constant or even decrease when doctors strike (Cunningham et al., 2008).

or institutional power, and that everyday resistance is necessary when explicit and organized forms of contentious politics are difficult or impossible to pursue.[7] However, forms of everyday resistance do not seem to be exclusive to the absolutely powerless. Structurally superordinate agents such as pilots, white army men, and white power movement activists have been shown to engage in such infrapolitical (and at times extremely reactionary) activities as well (Ashcraft, 2005; Miller, 1997; Simi and Futrell, 2009). The second assumption made by Scott, which I contest, is that the dominated and dominant positions in a conflict are clearly distinguishable from one another (if not in a real sense, at least analytically). But in some cases of everyday resistance, this distinction is muddled because subordination in one given power structure is fought by means of superordination in another. For example, David Collinson's study of manual workers notes that humor is used as a way to resist managerial authority. Jokes and banter predominantly revolved around consolidating their masculine identities and ridiculing the perceived lack of masculinity of their superiors (1988). The use of humor in the English lorry-making factory elicits a double effect, both (micro-) emancipatory (in terms of class relations) and reproductive (in terms of patriarchy); or put in terms of the position of the joking working class men, the subordinate position in a class system was fought by means of patriarchal superiority.

Although physicians do not regularly fight their subordination to the SSIA by superordination in terms of gender, Collinson's case illustrates a mechanism that takes place when GPs resist SSIA's decisions. It is through their superordination in relation to the individual caseworkers (most often superordination in terms of medical authority, but occasionally in terms of gender as well) that they resist the SSIA as an institution. Occasionally, the communication off the record with individual caseworkers could take on this very form. One younger GP expressed some frustration with the way older, male colleagues made use of their power: "I never fall into a bullying position, in the way that some old-mannish chief physicians can be, when they call [caseworkers] and say: 'What do you mean, sweetie?'" In

[7] This first assumption is to some extent shared by other canonical literature in the field, such as Certeau, 1984/2002 (see especially xvii). Here, everyday resistance is presented as almost inversely proportional to the degree of marginality of the actor, symbolized by the ideal type of the "immigrant worker" who becomes even more creative resistance-wise, because he does not master language etc.

the cases the GPs happened to be men, the question is whether the use of communication off the record is purely emancipatory and progressive, or if it might also reproduce a patriarchal order. The individual caseworker is, as it were, a chink in SSIA's institutional armor. Hence, resistance is rather enabled through the medical authority vested in GPs by the healthcare organization that is intertwined with, but distinct from, the insurance agency.

The point is that the specific form taken by GPs' resistance, as routine and covert, is not solely explained by their powerlessness, or that it is possible despite their power. Rather, it is because they do have some kind of power and influence over the sickness certification process to begin with, that they resort to such means.

Resistance through, underneath or within compliance? Active production of compliance and its relation to resistance

Parallel to the contradictory positions of the doctor, and the ambiguity of his or her relation to the social insurance agency, the act of issuing a sickness certificate is itself ambiguous and contradictory. To evade the regulatory conditions set by the insurance agency, GPs go to great lengths to *appear* as if they are closely adhering to these regulatory conditions. Not only do they prefer to do it secretly, but the short-term success for both GP and the patient is dependent on its secrecy. The secret character of this resistance is an acquaintance between strange bedfellows: *resistance* and *compliance*. One could easily make valid arguments both for why it fits into compliance rather than resistance, and vice versa. It may be tempting to treat some human actions as something that belong to one of these two categories: 'Is it resistance *or* compliance?', one might ask. Consequently, disappointment ensues when the phenomenon refuses to conform to the question. The result is that the analysis risks getting bogged down in frustrating antinomies. If it is indeed resistance, it cannot possibly be compliance; but if it is compliance, it cannot possibly be resistance. Dennis K. Mumby has suggested that this 'dichotomic' approach has produced research on opposite sides of the divide: either research that reduced some forms of everyday resistance to being complicit with the reproduction of a dominant order (in the last instance) or works that 'often romanticize employee efforts to resist organizational control' (Mumby, 2005: 21). Instead, he proposes a dialectical approach, less preoccupied with pigeonholing acts either as resistance or compliance, and

more interested in how resistance and compliance may co-exist 'dialectically.' Mumby is not alone in his attempt to defend the dialectic between resistance and compliance (see Ashcraft, 2005; Ybema and Horvers, 2017; Paulsen, 2014).[8] The claim that some activities can be interpreted simultaneously as both resistance *and* compliance does however not absolve research from investigating how they relate to each other in particular and concrete cases. Hence, depending on circumstance, the contradictory coexistence of resistance and compliance in one act takes on particular forms. I will present some possible logical relations between resistance and compliance below, and look where the practices of GPs might and might not fit.

Some activities constitute resistance merely by meticulously adhering to rules and regulations. An archetypal example of resistance *through* compliance is what has been called 'ca'canny,' 'foot-dragging' and 'work-to-rule.' By following all rules and regulations to the letter, workers can slow down production output. This can either be an end in itself, or employed in order to create leverage against employers, pressuring them to yield to workers' demands (see for example Scott, 1998: 310; Paulsen, 2014: 113). In these cases, whether intent is openly declared or not, whether it is a tactic implemented after other actions (such as traditional strikes) fail or not, the logical relation between compliance and resistance remains the same: in order to resist, one complies, and the compliant act is itself a constitutive element of the resistant act. Hence, the compliant element is put to work directly in the service of resistance. One could object against this view on work-to-rule by pointing out that workers historically resorted to work-to-rule actions when traditional strike action failed. Work-to-rule could then be understood as a way of dealing with an already existing and enforced compliance. The pioneers of union work-to-rule action, the *National Union of Dock Labourers*, for example, resorted to slowing down labor in Glasgow during the late 19th century as means for wage negotiation, only after they realized that their traditional strike actions were being crushed by the use of scab labor (Brown, 1977: 3-8). Even if the reason for adopting work-to-rule strategy is reactive, it nevertheless constitutes a case of compliance that is resistance in and of itself.

[8] Mumby is, of course, not the first to point out the complicated interplay between resistance and control/compliance/consent. However, a systematic genealogy of the phenomenon lies beyond the scope of this article.

When doctors circumvent and resist the social insurance agency by tactically warping sickness certificates, the compliant element does not relate to resistance in the way mentioned above. The compliant element is neither identical to the resistant act, nor does compliance automatically work in the service of resistance. It more resembles a facade that enables resistant activities to continue undisturbed in the background. Hence, it is more appropriate to call it 'resistance underneath compliance,' which differentiates it from the first case of resistance through compliance. Workplace time theft provides many examples of this kind of covert resistance. Sometimes, time theft does not require a substantial active production of compliance: In its simplest case, avoiding work is just a matter of arriving late and/or leaving early, making personal telephone calls, taking long lunches and breaks, or excessively socializing with other workers. None of these activities necessarily require anything other than just doing them without notifying the boss. They are simply covert. However, many workplaces use strict regimes of 'surveillance and control' that may be trickier for workers to circumvent (Stevens and Lavin, 2007: 41). Making up a story about an illness to justify sick leave, or falsifying time sheets, for example, require something more than not telling the boss, but involves an active production of ostensible compliance. The French have a very fitting metaphor for this logical relationship between compliance and resistance: La perruque, 'the wig.' According to Michel de Certeau, 'La perruque is the worker's own work disguised as work for his employer' (1984/2002: 25). Compliance is a covering layer beneath which resistance can thrive. The question, then, is whether GPs' use of techniques is a form of resistance or autonomy, underneath a wig of actively produced compliance? The use of some techniques is. The most salient technique that qualifies as resistance underneath compliance is 'communication off the record.' The written sickness certificate itself is the compliant surface that functions as a public stamp of legitimacy, whereas the communication off the record works behind or underneath it, as an additional underlying layer of communication with, or influence on, individual caseworkers. Although the written sickness certificate itself is a precondition for the resistance, it is not identical to the resistant act.

While communication off the record is a technique that is distinct from the written sickness certificate itself—which is why it can be called resistance underneath compliance—this spatial metaphor of resistance underneath compliance fails to fully capture the logical relation between compliance and resistance in some of the other techniques employed within the actual

written sickness certificate. When exaggerating symptoms or clinical findings, or using certain buzzwords that the social insurance agency may like, or cunningly transforming the narrative of the patient into 'objective' clinical signs, there is no distinction to be made between a compliant surface and some underlying level of resistance. The resistance against the social insurance agency is, as it were, mounted from within the compliant surface itself. Using techniques when issuing sickness certificates is one single act, containing both compliant and resistant elements. How is resistance within compliance any different from resistance *through* compliance? In the case of resistance within compliance—which is what I am dealing with here—the compliant element is on a more equal footing with the resistant element. Neither is necessarily in the service of the other. This intimate interconnectedness of resistance and compliance is not a unique occurrence.

GPs' acts of resistance against the social insurance agency are not passive. They are not merely carried out through tacit consent, nor through empty lip service to the hegemonic ideological conviction that (waged) labor miraculously heals the sick, but through an active participation in producing documents that quantify, in minute details, a human life. Acts of resistance that depend heavily on the active construction of compliance (which does not unambiguously work in the service of resistance) have a limit. At some point, the construction of apparent compliance might turn into real compliance. Perhaps it is not even a point but something that happens parallel to the enactment of resistance. A non-dialectical approach would perhaps reduce it to compliance. There are in fact several solid arguments for calling the phenomenon compliance in the last instance, especially if the benchmark is centered on outcome. Asef Bayat, for example, points out that some activities that have been identified as resistance, such as household centered survival strategies among low-income Egyptians and use of informal networks in popular classes in Cairo, 'may actually contribute to the stability and legitimacy of the state' by 'shift[ing] some of [the state's] burdens of social welfare provision and responsibilities onto the individual citizens.' In fact, these activities may in some cases even be encouraged by the state apparatus, he claims. It is therefore more appropriate to call them 'coping strategies' rather than resistance (Bayat, 2000: 545). Bayat's position raises two questions that are pertinent to the matter at hand: (1) Can the systematic use of the techniques available to GPs in any way contribute to the stability and legitimacy of the social insurance agencies? (2) Does the social insurance agency in any way encourage or benefit from the use of techniques?

Regarding the first question, there are two ways in which this could be the case: a) physicians willingly use overly positivistic biomedical terminology to describe complex medical states that do not admit to such a description. There is, for example, no reliable test (beyond checklists) to objectively prove the presence of a depressive disorder. Still, GPs do their best to do so as they are instructed by objectifying and quantifying their findings. The secrecy then turns into active complicity with an inappropriate operationalization of scientific terms; b) there is the risk that refusal and resistance (if identified as such by the actor) merely play a comforting role. Resistance could itself be a way of coping. It has been suggested by Alessia Contu that diluted forms of resistance, cleansed equally from risk as well as transformative rewards, can have such a psychological function:

> In this decaf resistance, we receive a payment in the form of the illusion that we are still having the thing (resistance). However, we do not have to bear the cost that is associated with having the thing itself, which is the danger of radically changing things as we know them. (Contu, 2008: 374)

This so-called 'decaf' resistance thereby defuses actual resistance. The activities characterized as 'decaf' resistance rather than real resistance are mainly acts of parody, irony, satire, and cynicism; acts that rely on and are understood in terms of discourse, subjectivity and identity (Mumby, 2005; Collinson, 2003). Does this criticism apply to tactically choosing how to write sickness certificates as well? Authoring a sickness certificate with the use of techniques is a discursive activity in a very literal sense, but less symbolic than that of parody, irony, satire and cynicism. The effects of authoring a certificate in a particular way have direct economic consequences for the patient, and the aggregated sum of them have a significant impact on the distribution of societal resources. Furthermore, it saves actual time for the doctor. It also restores a professional autonomy in a very 'real' sense. Yet, is it possible that the use of techniques gives GPs only a feeling of professional autonomy without giving them the actual thing? Possibly. But as shown above, there are several motives driving physicians to act, among which the defense of professional autonomy is but one. For the individual patient, being granted sickness benefits, when he or she could just as well have been refused, the resistance does more than elicit a feeling—it influences the course of events in a very real sense.

Regarding the second question that Bayat imposes one to ask (whether the insurance agencies in any way encourage or benefit from the use of techniques), it has—to my knowledge at least—never been openly admitted by insurance agencies. However, the absence of open encouragement does not exclude the possibility that the Swedish social insurance agency may benefit from the ad hoc solutions to complex patient cases, nor does it exclude the possibility that they might implicitly encourage light cosmetic changes to sickness certificates. For example, Michael Lipsky notes that although the American criminal justice system publicly denounces police brutality and transgression of law in crime fighting, it:

> Allows police recruits to presume that they can approach with impunity young people hanging out in certain neighborhoods to see whether they are in possession of guns or drugs, even if they have no evident cause for suspicion other than the coincidence of age, race, and neighborhood. Young police officers learn that judges will back them up if the young people claim that the officers planted evidence or made up their own descriptions of the encounters. (Lipsky, 2010: xv)

Although the scenarios may appear as diametrically opposed (GPs defend their patients, while police oppress their 'clientele'), Lipsky's case raises some important and relevant points: The state apparatus allows some degree of professional discretion for their street-level bureaucrats, even when that discretion straddles (or at times violently transgresses) the border between legality and illegality. Furthermore, the street-level implementation (or non-implementation) of bureaucratic regulations (such as police brutality, but also physicians' resistance to the sickness certification process) can be publicly denounced and implicitly encouraged at the same time. Analogously then, what appears as resistance could be interpreted as the smoothing out of the rough edges of a social security system that, by and large, works according to its design and purpose. Hence, the so-called resistance is nothing but the weak contours of a human face artificially plastered onto a progressively stricter social insurance system. Nevertheless, there is no evidence to suggest that the SSIA encourages GPs to distort sickness certificates. In fact, as I have attempted to illustrate, social insurance agencies in welfare states actively push back against individual GPs.

Conclusion

What GPs do when they influence the decision process regarding sickness benefits can be understood in terms of everyday resistance. GPs resist the social insurance agency by employing subtle techniques within and beyond writing sickness certificates, in order to maximize the chance of having them accepted by the social insurance agency. These techniques are in the most literal sense 'tricks of the trade.' The resistance constituted by using techniques is fraught by ambiguities and contradictions: The target of resistance is not always clear-cut; the motives are not always altruistic and supererogatory; the distinction between resistance and compliance is not always simple. It is difficult to know whether it challenges the power relations between patients and professionals on one hand, and the social insurance agency's policies of austerity on the other. In short, everyday resistance is messy—at least in the form it has been observed to take among GPs in relation to the Swedish social insurance agency. The main point is this: Despite its ambiguities and contradictions, despite its dangerous proximity to consent and compliance, GPs who employ informal techniques to circumvent the social insurance agency are resisting. Despite its messy character, it is still what stands in between sick patients and the neoliberal juggernaut of austerity. This is what resistance looks like in the clinical everyday life of a Swedish GP. It is resistance adapted to the concrete circumstances and constraints of the healthcare sector, and more importantly to (and against) the recent wave of curtailed medical autonomy. There are certainly many other ways to resist in the healthcare sector when traditional modes of resistance are partially off the table. The use of techniques in the sickness certification process is but one example.

Although the interview material is limited to Swedish GPs in primary care, it is reasonable to assume that the findings are generalizable to other countries with similar publicly financed sickness benefit systems in which the state is a powerful stakeholder. This assumption is supported by earlier research on the similarities in sickness certification praxis in Norway and the UK (Aarseth et al., 2017; Hussey et al., 2004). Whether the findings are further generalizable to social insurance systems that are privately financed is an open question, but the lines of conflict are probably different. There is also a possibility that the findings are generalizable to the topic of resistance in the healthcare sector as a whole.

Furthermore, one needs to ask what has been gained by understanding what GPs do in terms of (everyday) resistance. As I see it, there are three advantages: Firstly, there is a *descriptive* advantage; what doctors do in the sickness certification process simply makes more sense when understood in terms of resistance. The common hypothesis that GPs 'fail' to issue sickness certificates in accordance to bureaucratic guidelines, and that they are not susceptible to educational measures because of personal ineptness, is more unlikely. Resistance, and the conflict of interests it presupposes, explains why this phenomenon subsists. Secondly, there is also what I would call an ethical advantage; recasting the behavior in terms of resistance counters the conception presented in scholarly literature that doctors do not comply because of moral shortcomings. Through resistance, which is situated in a complex set of power relations, the naive idea that doctors are simply immoral may be done away with. It is, as it were, an ethical defense through politicization. The third point is political; too often (and not only regarding the topic of sickness benefits), it is assumed that the main line of conflict runs in between the physician and patient. I hope to have shown that an equally constitutive (if not the main) line of conflict regarding the question of sickness benefits runs in between the bloc of patients and healthcare workers (whose interests converge) on the one hand, and a bureaucracy of austerity on the other.

References

Aarseth, G., Natvig, B., Engebretsen, E., and Lie, A. K. (2017). 'Working is out of the question': a qualitative text analysis of medical certificates of disability. *BMC family practice*, *18*(1), 55.

Alexanderson K., Arrelöv B., Friberg E., Haque M., Lindholm C., Lytsy P., et al. (2018). *Läkares erfarenheter av arbete med sjukskrivning av patienter. Huvudrapport 2018* [Doctors' experiences of handling sickness certification of patients. Main report 2018]. Retrieved from Karolinska Institutet Website: https://ki.se/sites/default/files/2018/03/08/huvudrapport_lakarenkat_2017_2012_2008_2004._ki.pdf

Anscombe, G. E. M. (2000). *Intention*. (2. ed) Cambridge, Mass.: Harvard Univ. Press.

Arrelöv, B., Edlund, C., and Goine, H. (2006). Grindvakterna i sjukförsäkringen: Samspel och motspel [The gatekeepers of social insurance: cooperation and adversity] in E. Palmer, (Ed.) *SKA-projektet: sjukförsäkring, kulturer och attityder* [SKA project: sickness benefits, cultures and attitudes]. Försäkringskassan, 479-530.

Ashcraft, K. L. (2005). Resistance through consent? Occupational identity, organizational form, and the maintenance of masculinity among commercial airline pilots. *Management Communication Quarterly*, *19*(1), 67-90.

Baaz, M., Lilja, M., and Vinthagen, S. (2017). Resistance studies as an academic pursuit. *Journal of Resistance Studies*, *3*(1), 10-28.

Baaz, M., Lilja, M., and Vinthagen, S. (2018). *Researching resistance and social change: a critical approach to theory and practice* [EPUB version]. Blue Ridge Summit: Rowman & Littlefield International. Retrieved from https://www-dawsonera-com.till.biblextern.sh.se/abstract/9781786601186

Bayat, A. (2000). From 'Dangerous Classes' to 'Quiet Rebels': Politics of the Urban Subaltern in the Global South. *International Sociology*, *15*(3), 533-557.

Bejerot, E., Aronsson, G., Hasselbladh, H., and Bejerot, S. (2011). Läkarkåren en profession med allt mindre stöd och inflytande: Enkätstudie av svenska läkares arbetsmiljö 1992 och 2010 [The medical profession, a profession with diminished support and influence: Survey of Swedish doctors' work environment 1992 and 2010]. *Läkartidningen, 108*(50), 2652-2656.

Broadbent, J., and Laughlin, R. (2002). Public service professionals and the New Public Management In K. McLaughlin, S. P. Osborne, and E. Ferlie (Eds.), *New public management: Current trends and future prospects* (pp.95-108). London: Routledge.

Brown, G. (1977). *Sabotage: a study in industrial conflict*. Nottingham: Spokesman.

Burström, B. (2015). Sweden—Recent Changes in Welfare State Arrangements. *International Journal of Health Services, 45*(1), 87–104.

Certeau, Michel de (2002). *The practice of everyday life*. [New ed.] Berkeley: University of California Press. (Original work published 1984)

Coburn, D. (2006). Medical dominance then and now: Critical reflections. *Health Sociology Review, 15*(5), 432-443.

Collinson, D. (1988). "Engineering humor": Masculinity, joking and conflict in shop-floor relations. *Organization Studies, 9*, 181-199.

Collinson, D. L. (2003). Identities and insecurities: Selves at work. *Organization, 10*(3), 527-547.

Contu, A. (2008). Decaf resistance: On misbehavior, cynicism, and desire in liberal workplaces. *Management Communication Quarterly, 21*(3), 364-379.

Courpasson, D. (2016). A Critical Introduction. In D. Courpasson and S. Vallas *The SAGE Handbook of resistance* (pp. 1-28). London: SAGE Publications Ltd

Cunningham, S. A., Mitchell, K., Narayan, K. V., and Yusuf, S. (2008). Doctors' strikes and mortality: A review. *Social Science & Medicine, 67*(11), 1784-1788.

Försäkringskassan (2017). *Uppföljning av sjukfrånvarons utveckling 2017. Sjuk- och rehabiliteringspenning* [Follow up of the development of sickness absence 2017. Sick pay and rehabilitation pay]. Försäkringskassan.

Grover, C. and Soldatic, K. (2013). Neoliberal restructuring, disabled people and social (in) security in Australia and Britain. *Scandinavian Journal of Disability Research, 15*(3), 216-232.

Harrison, S., and Dowswell, G. (2002). Autonomy and bureaucratic accountability in primary care: what English general practitioners say. *Sociology of Health & Illness, 24*(2), 208-226.

Hasselbladh, H. and Bejerot, E. (2017) Performative policy: the case of Swedish healthcare reforms, *Critical Policy Studies, 11*(3), 291-310

Hollander, J. A., and Einwohner, R. L. (2004). Conceptualizing resistance. *Sociological forum, 19*(4), 533-554. Kluwer Academic Publishers-Plenum Publishers.

Hussey, S., Hoddinott, P., Wilson, P., Dowell, J., and Barbour, R. (2004). Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland. *BMJ, 328*(7431), 88.

Johansson, A., and Vinthagen, S. (2016). Dimensions of everyday resistance: An analytical framework. *Critical Sociology, 42*(3), 417-435.

Johnson, B. (2010). *Kampen om sjukfrånvaron* [The struggle over sickness absence]. Lund (Sweden): Arkiv förlag.

Krohne, K., and Brage, S. (2007). New rules meet established sickness certification practice: a focus-group study on the introduction of functional assessments in Norwegian primary care. *Scandinavian Journal of Primary Health Care, 25*(3), 172-177.

Lens, V. (2007). In the fair hearing room: Resistance and confrontation in the welfare bureaucracy. *Law & Social Inquiry, 32*(2), 309-332.

Lilja, M. and Baaz, M., (2016). Resistance, rupture and repetition: civil society strategies against intimate partner violence. *Global Public Health, 11*, 95–107.

Lilja, M., Baaz, M., Schulz, M. and Vinthagen, S. (2017). How resistance encourages resistance: theorizing the nexus between power, 'Organised Resistance' and 'Everyday Resistance', *Journal of Political Power, 10*(1), 40-54.

Lipsky, M. (2010). *Street-level bureaucracy: Dilemmas of the individual in public services.* (30th anniversary expanded ed.) New York: Russell Sage Foundation.

Litchfield, P. (2013). *An independent review of the Work Capability Assessment: year four*. London: Stationery Office.

Lukes, S. (1974). *Power: A radical view*. London: Macmillan.

Marx, K. (1972). *The eighteenth brumaire of Louis Bonaparte*. Moscow: Progress Publishers. (Original work published 1852).

McEnhill, L., and Byrne, V. (2014). 'Beat the cheat': portrayals of disability benefit claimants in print media. *Journal of Poverty and Social Justice, 22*(2), 99-110.

McKinlay, J. B., and Marceau, L. D. (2002). The end of the golden age of doctoring. *International Journal of Health Services, 32*(2), 379-416.

Miller, L. L. (1997). Not just weapons of the weak: Gender harassment as a form of protest for army men. *Social Psychology Quarterly, 60*, 32-51.

Mumby, D. K. (2005). Theorizing resistance in organization studies: A dialectical approach. *Management Communication Quarterly, 19*(1), 19-44.

Nilsen, S., Malterud, K., Werner, E. L., Maeland, S., and Magnussen, L. H. (2015). GPs' negotiation strategies regarding sick leave for subjective health complaints. *Scandinavian Journal of Primary Health Care, 33*(1), 40-46.

Norrmén, G., Svärdsudd, K., and Andersson, D. (2006). Impact of physician-related factors on sickness certification in primary health care. Scandinavian *Journal of Primary Health Care, 24*(2), 104-109.

Numerato, D., Salvatore, D., and Fattore, G. (2012). The impact of management on medical professionalism: a review. *Sociology of Health & Illness, 34*(4), 626-644.

Paulsen, R. (2014). *Empty labor: Idleness and workplace resistance*. Cambridge University Press.

Pile, S. (1997). Introduction: Opposition, Political Identities and Spaces of Resistance, in S. Pile and M. Keith (eds) *Geographies of Resistance*, pp. 1-32. London: Routledge

Scott, J.C. (1985). *Weapons of the weak: Everyday forms of peasant resistance*. New Haven: Yale Univ. Press.

Scott, J.C. (1998). *Seeing like a state: How certain schemes to improve the human condition have failed*. New Haven: Yale University Press.

Shutzberg, M. (2019). Unsanctioned techniques for having sickness certificates accepted: a qualitative exploration and description of the strategies used by Swedish general practitioners. *Scandinavian Journal of Primary Health Care,* 1-8.

Simi, P. and Futrell, R. (2009). Negotiating white power activist stigma. *Social Problems, 56*(1), 89-110.

Stevens, A., and Lavin, D. O. (2007). Stealing Time: The Temporal Regulation of Labor in Neoliberal and Post-Fordist Work Regime. *Democratic Communique, 21*(2), 40-61.

Swartling, M. (2008). *Physician sickness certification practice focusing on views and barriers among general practitioners and orthopaedic surgeons* (PhD dissertation). Acta Universitatis Upsaliensis, Uppsala.

Thompson, S. L., and Salmon, J. W. (2006). Strikes by physicians: a historical perspective toward an ethical evaluation. *International Journal of Health Services, 36*(2), 331-354.

Wallace, J., and Pease, B. (2011). Neoliberalism and Australian social work: Accommodation or resistance? *Journal of Social Work, 11*(2), 132-142.

Waring, J., and Currie, G. (2009). Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession. *Organization Studies, 30*(7), 755-778.

Welander, J. (2017). *Trust issues: welfare workers' relationship to their organisation* (Doctoral dissertation, Mälardalen University).

Wynne-Jones, G., Mallen, C. D., Main, C. J., and Dunn, K. M. (2010). What do GPs feel about sickness certification? A systematic search and narrative review. *Scandinavian Journal of Primary Health Care, 28*(2), 67-75.

Ybema, S., and Horvers, M. (2017). Resistance through compliance: The strategic and subversive potential of frontstage and backstage resistance. *Organization Studies, 38*(9), 1233-1251.

Paper III

Medicine, Health Care and Philosophy
https://doi.org/10.1007/s11019-020-09954-3

SCIENTIFIC CONTRIBUTION

Doctors that "doctor" sickness certificates: cunning intelligence as an ability and possibly a virtue among Swedish GPs

Mani Shutzberg[1]

© The Author(s) 2020

Abstract
The relations of power between healthcare-related institutions and the professionals that interact with them are changing. Generally, the institutions are gaining the upper hand. Consequently, the intellectual abilities necessary for professionals to pursue the internal goods of healthcare are changing as well. A concrete case is the struggle over sickness benefits in Sweden, in which the *Swedish Social Insurance Agency* (SSIA) and physicians are important stakeholders. The SSIA has recently consolidated its power over the sickness certificates that doctors issue for their patients. The result has been a stricter gatekeeping of sickness benefits. In order to combat the inroads made by state institutions into sickness certification, and into the sphere of medical practice, some doctors have developed cunning "techniques" to maximize the chance to have their sickness certificates accepted by the SSIA. This article attempts to demonstrate that cunning intelligence—the ability of the weak to "outsmart" a stronger adversary—plays an important role in the practice of medicine. Cunning intelligence is not merely a defective form of prudence (*phronesis*), nor is it simply an instance of instrumental reason (*techne*), but rather an ability that occupies a distinct place among the intellectual abilities generally ascribed to professionals.

Keywords Metis · Cunning intelligence · Phronesis · Practical knowledge · Medical practice · Sickness certification

> *[T]he sepia [cuttlefish] is the most cunning, and is the only species that employs its dark liquid for the sake of concealment as well as from fear.*
> – Aristotle, History of Animals (1910: p. 621)

Introduction

Aristotle's *History of Animals* certainly demonstrates his knack for biology. However, with respect to the quote above, Aristotle was wrong. In addition to the cuttlefish, there is at least one more species that cunningly employs its ink for the sake of concealment: *the modern physician*. Recent observations indicate that members of this species write sickness certificates in a way that *appears* to comply with the stricter eligibility criteria for sickness benefits, but in order to evade them (Shutzberg 2019, 2020). This omission should not reflect badly on Aristotle. Healthcare and doctors were simply different in ancient times. Firstly, the use of ink for writing was not yet invented. Secondly, and probably much more important, the framework for medical practice was somewhat different back then.

Healthcare in late modernity is a different milieu, populated by other animals. Today, due to the rise of hospitals, welfare and management systems, massive healthcare enterprises etc., the multiplicity of stakeholders and actors in any given clinical situation modulates the clinical power of the physician. The last decades have borne witness to a negative modulation of clinical discretion, through audits and managerial techniques (Numerato et al. 2012; Power 1997). For better or for worse, the physician is less a subject of power, and more subjected to it. While oversight and control are not bad per se, the proliferation of goods and goals that are external to medical practice might misguide highly complex healthcare organizations.

As healthcare is different today, so too are the virtues ascribed to its practitioners. The practical situatedness and historical mutability of (professional) moral concepts and virtues certainly is not a new idea (see for example

✉ Mani Shutzberg
mani.shutzberg@sh.se

[1] Centre for Studies in Practical Knowledge, Södertörn University, Stockholm, Sweden

Published online: 09 May 2020

MacIntyre 2007, pp. 27–28; Pellegrino and Thomasma 1993, pp. 31–40). Cunning intelligence (or what the ancient Greeks referred to as *metis*), the ability of the weak to overcome a stronger adversary, makes its entrance as an important professional trait in a time when highly complex healthcare organizations are increasingly (mis)guided by external rather than the internal goods of healthcare.

Such is also the case in a facet of society that borders on healthcare, law and politics: social insurance, and the sickness benefit system in particular. The publicly financed social insurance system of Sweden has recently set off down the same path of austerity as insurance systems in many other welfare states. In an attempt to cut the costs of sickness absence, eligibility criteria for "disability" and "sickness" has narrowed, pressure to reintroduce unemployed "sick persons" into the labor market has intensified, and rigorous control mechanisms to monitor patients with approved sickness benefits has been put in place (Grover and Soldatic 2013; Burström 2015). The work and professional discretion of healthcare workers (mainly physicians), social service workers, and others involved with sickness and disability cases, are more tightly regulated than ever by performance indicators, scripts and routines, by organizational directives and governmental decrees (Broadbent and Laughlin 2002; Hasselbladh and Bejeroth 2017).

Physicians, however, do not seem to acquiesce to the reconfigured relations of power. They have demonstrated that the worn Foucauldian cliché—"where there is power, there is resistance"—holds at least some truth. Although weakened by the bureaucratic fabric of increasingly austere sickness benefit systems, doctors find discreet ways to navigate through them, in defense of their patients, their clinical autonomy, and to mitigate workload. In previously published qualitative studies, it has been shown that at least Swedish general practitioners (GPs) do so with "street-smart" stratagems, when writing sickness certificates to the *Swedish Social Insurance Agency*[1] (SSIA; Shutzberg 2019). This street-smart comportment and set of "techniques" can be understood as a form of "everyday resistance" that functions through mounting an appearance of compliance (Shutzberg 2020). Hence, the less quoted subclause of the Foucauldian cliché is also true in this case: "[…] and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (Foucault 1978, p. 95).

In this article I will explore the epistemological underpinnings of these "street-smart" stratagems. How does this bundle of intellectual ability, knowledge and practices employed in these situations relate to the traditional Aristotelian distinctions between the intellectual virtues? Is it warranted to introduce a new category? Can the category of cunning intelligence (*metis*)—well known among the Greeks but scorned by their philosophers—play a distinct but complementary role to the other "indispensable virtue for medicine", namely prudence, or what the Greeks called *phronesis* (Pellegrino and Thomasma 1993, p. 90)?[2]

Clinical judgment and prudence in sickness certification: the relation between the universal and particular

> Maria is not feeling well. Neither sleep nor weekends help with recovering from the fatigue. Even minor physical and mental exertion leaves her drained for the rest of the day. Work has demanded a lot lately, and being available through e-mail around the clock does not help. She feels down. A perceptive colleague of her suggests that Maria visit her doctor. So she does. After a thorough check-up, her GP identifies the problem as a depressive episode and/or burnout syndrome. The GP determines that Maria's ability to work is impaired. The observations, examination and judgment is written down on a form and submitted to the Swedish social insurance agency.[3]

The case above is a pretty routine case in Swedish primary care. The typical "difficult" sick listing case patient is usually presented as female, working in a socially demanding field (teacher, nurse, social worker, project manager, etc.), and suffering from a psychiatric condition (Shutzberg 2019; Engblom et al. 2008). In Sweden, patients who are unable to work due to medical conditions are economically compensated by the publicly financed sickness benefit system. Patient eligibility for sickness benefits requires that the treating doctor issues a sickness certificate, detailing the patient's diagnosis, functional impairment (through observations, clinical examinations and tests) and the limitations to activities in relation to work. Based on the information in this standardized form, the SSIA makes the final call to approve or deny the patient's claims (Riksrevisionen 2018, p. 22).

From the doctor's point of view, insurance medicine and sickness certification has never been easy. All the general challenges of medical practice are relevant in this subset of medical practice as well. One is confronted by

[1] Official translation of the Swedish government agency "Försäkringskassan".

[2] In this article, *prudence* is used as the English equivalent of the Greek concept of *phronesis*. Another common translation is *(practical) wisdom*. Opting for prudence rather than wisdom is purely arbitrary.

[3] The case of "Maria" is fictional, but based on examples of difficult sick-listing cases recounted by Swedish GPs in an interview study (Shutzberg 2019).

epistemological and ethical uncertainty within the four walls of the examination room that can be difficult and potentially dilemmatic to handle. Engblom et al. have proposed that most such difficulties, often fueled by conflicting interests between doctor and patient, fall within eight different categories: 1. Is the patient's problem really medical in nature, and if not, will sick-listing solve the problem?; 2. Is the doctor the authority, or merely a servant yielding to the patient's demand for sick-listing?; 3. What should the doctor do with discrepancies between what the patient says and the doctor finds?; 4. Should the doctor conduct exhaustive assessment of remaining working capacity that delays treatment and risks medicalization?; 5–6. May sick-listing itself cause (reversible or irreversible) harm?; 7. Should the doctor sick-list the patient despite personal doubts about its efficacy?; 8. May rehabilitative measures following sick-listing do more harm than good? (Engblom et al. 2008).

It is interesting to note that ethical and epistemological questions are tightly conflated in the difficulties and dilemmas enumerated above. Many things pertaining to the practice of medicine are not known, and many known things are imprecise: the ambiguity of what health means for this or that particular patient; the unpredictability of disease; the uncertainty of diagnosis and prognosis; the imprecision of diagnostic tools; the limits of human medical knowledge. In short, medicine is suffused with uncertainty on multiple levels—"moral, metaphysical and epistemic" (Tonelli and Upshur 2019, p. 507). Many of these general moral, metaphysical and epistemic challenges have been relatively constant since the inception of medicine as a profession.

Attempts to understand how doctors navigate in moral and epistemic uncertainty often make reference to *clinical judgment* (see for example Kienle and Kiene 2011; Montgomery 2005). As the literature in this field is too vast to deal with without some kind of selection, I will turn to a philosophical framework that has gained considerable traction in philosophy during the last 50 years, and in professional theory in general and medical theory in particular during the last 20 or so years: virtue ethics and Aristotelianism (Anscombe 1958; MacIntyre 2007; Pellegrino and Thomasma 1993; Banks and Gallagher 2009; Kinsella and Pitman 2012). In fact, Aristotle was one of the first to develop some kind of idea of judgment that tied together the moral and epistemic aspects of human action. From an Aristotelian point of view, "good clinical judgment is the end product of the use of prudence" (Pellegrino and Thomasma 1993, p. 90). What then is this "prudence" that Aristotle talks so highly of? As I see it, there are two essential dimensions to the intellectual virtue of prudence: 1. Prudence is the ability to bring together scientific and moral reasoning into a whole: "Anyone who has had to unravel the intricacies of clinical choices in a concrete case knows that the decision is the product of an intimate dialogue between the clinical facts and the moral principles, values, or virtues" (ibid: 90); 2. Prudence is at the same time a way of bringing the universal in dialogue with the particular case, such that the universal is put in the service of the particular (Aristotle 2011, p. 124 [1141b15-20]). Returning to the concrete case of Maria's medical encounter can perhaps put things in perspective:

> Maria's GP knows that there are national guidelines for sick-listing patients. According to the so-called "insurance medical decisions support"[4] provided for doctors by the *National Board of Health and Welfare*,[5] sick-listing "mildly depressed" patients should be avoided. This certainly makes sense generally. But in Maria's particular case, the fatigue seems to be partially caused by an unbearable workload. It is a difficult decision, as being off work could both exacerbate Maria's condition, or help with recuperation. The experienced and prudent GP decides to make an exception in Maria's particular case and sick-list her.

The way the GP acts in this situation is a mundane yet telling example of professional prudence. It is relevant in areas of clinical life where simple rule-following is inadequate. Someone truly capable in their professional field must be able to deliberate and act well in singular situations that lack both clear-cut universal guiding rules as well as identical precedents. It is so because the universals (laws, principles, precepts, etc.) never truly and exhaustively can say everything about the particulars.[6] This is not to say that universals, principles, have no place in judgments. On the contrary, they give a necessary sense of general direction, a rule of thumb. Hence, it is *generally true* that depressed patients (such as Maria) are not helped by staying away from work. Yet, there may be particular circumstances that warrant sick-listing. Furthermore, that universals cannot give a full account of the to the particular case does not mean that rule-bound, productive and instrumental action has no place in medical practice.[7] Quite the contrary. This logic of *techne* is operative on

[4] Unofficial translation of the Swedish "Försäkringsmedicinskt beslutsstöd".

[5] Official translation of the Swedish government agency "Socialstyrelsen".

[6] "And prudence [*phronesis*] is not concerned with the universals alone but must also be acquainted with the particulars: it is bound up with action, and action concerns the particulars" (Aristotle 2011, p. 124 [1141b15-20]).

[7] To what extent "*techne*" itself is knowledge of the particularity of a situation, or closer to the universal, has been debated. On one end stands for example Bent Flyvbjerg, who sees in *techne* a focus on "that which is variable and particular", similar to prudence (2008: p. 492). On the other hand there is the almost opposite tendency, in for example Joseph Dunne, to emphasize its proximity to *episteme* (1993, p. 251) and with reference to Aristotelians such as Aquinas as something that proceeds "according to fixed and classical methods which is the rule of *ars* rather than of *prudentia*" (Aquinas, quoted

two distinct levels in cases such as Maria's. Firstly, the *production of data* is precisely a *techne*: to interview the patient (perhaps with the aid of surveys), to physically examine her and order lab tests, and then to correctly translate those findings to text on the sickness certificate. Secondly, following existing guidelines and precepts in an instrumental manner is also a form of *techne*, insofar as the guideline is the universal which is mechanically translated onto the particular case. In Maria's case, a doctor can look up the recommended duration of sick-listing in the national guidelines for a particular diagnosis. This way of passively relating to guidelines is perhaps more salient among less experienced practitioners. In complex cases, this instrumental relation to guidelines might lead to mistakes, but are nevertheless an important propaedeutic stage for developing proper prudence, i.e. an ability to act wisely in the particular case.[8] Empirically this also seems to hold true, as less experienced non-specialists report more appreciation for the "*insurance medical decisions support*" (Svärd et al. 2018, p. 2).

New challenges to sickness certification practice: age of bureaucratic austerity and the limits of prudence

The importance of prudence (in the Aristotelian sense) in sickness certification matters has not changed dramatically over time. The metaphysical relationship between the universal and the particular, that is, the challenges of *applying* what one knows and the principles one holds on the particular and unique case is principally the same today as it was twenty years ago. Clinical prudence still demands years of experience to perfect.

At the same time, the institutional setting of sickness certification in Sweden has changed dramatically since the early 2000s; these changes, mainly the reconfiguration of the relations of power between physicians and the institutions, have had far-reaching consequences for the exercise of prudence. Once, the role of the SSIA in determining patient eligibility for sickness benefits was less prominent. The doctor was the main de facto "gatekeeper" of access to sickness benefits (Sundquist et al. 2007). Due to ideological and political pressure, the power over sickness benefits has gradually shifted from the physicians to the government and the SSIA. In the 1990s the Swedish public discourse on how work disability was being problematized started to shift: it went from being mainly a public health concern to concern with patients' unwillingness to work, with the implication that the latter reflects misuse of social benefit systems (Johnson 2010). Doctors working in different jurisdictions, not only in Sweden, were accused of aiding in this alleged overuse of sickness benefits by passively yielding to patient demand (Arrelöv, Edlund and Goine 2006; Hussey et al. 2004). Consequently, on the level of public policies, changes came creeping from the late 2000s and onwards. For example, the government stipulated an upper limit to the duration of sickness benefit eligibility in 2008 (which has since been partially rolled back), effectively pushing the boundary between medicine and law towards the latter. Since then, the SSIA review process of sickness certificates have gradually become more rigorous (Larsson et al. 2017). In summary, the SSIA has established itself as the *gatekeeper of the gatekeepers*.

Nationwide surveys have shown that doctors, especially GPs, are not pleased with these reforms. Between 2004 and 2017, the proportion of Swedish GPs who reported that their medical assessments were questioned by the SSIA spiked from 10 to 57%. The number of GPs who experienced that the SSIA requested unnecessary corrections to the sickness certificates increased from 48 to 72% between 2012 and 2017. In 2017, 72% of GPs believed that the SSIA requested that doctors provide "objective signs" of illness in their sickness certificates in cases where such objective signs are difficult to identify (e.g. psychiatric disability, chronic pain, etc.) (Alexanderson et al. 2018). Finally, a very important and telling complaint has been reported by the national surveys with doctors: "doctors perceive that the SSIA does not implement the *insurance medical decision support* as guiding recommendations, but as 'laws'" (Svärd et al. 2018, p. 2). The so-called *insurance medical decision support* that was implemented on a national level to help guide doctors in their sickness certification practices, have been hijacked by the SSIA to exert power over the behavior of doctors.

When guides turn into imperative lawlike structures in this way, the relationship between prudence and the universal is altered. This new situation reveals one conceptual limit to Aristotle's concept of prudence. Aristotle seems convinced that the prudent have the choice to accept or reject certain laws and precepts. Or put differently, if the essence of prudence is to decide on making exceptions to the rule, then the freedom to make exceptions must be assumed. In his discussion of justice and equity in the *Nicomachean Ethics*, for example, Aristotle notes that the prudent needs to rectify

Footnote 7 (continued)

by Dunne 1993, p. 253). Dunne also explicitly takes *techne* to be the antithesis of the particular: "once we descend to particular cases of dealing with *this* or *this*, we are no longer securely within the governance of the *techne*, which always remains limited to *general* rules" (Dunne 1993, p. 259). Devereux also equates *techne* with the universal (1986, p. 493). In this article I will stick to this second interpretation of *techne*.

[8] Hubert and Stuart Dreyfus famously articulated the acquisition of skill as necessarily beginning in rule-following and progressing toward something akin to prudence (Dreyfus and Dreyfus 1986, pp. 16–51).

what the law necessarily misses, because the generality of law cannot capture particular circumstances (Aristotle 2011, p. 112 [1137b10-b35]).[9] This may very well be the case for the sovereign in power—but not so much for the ruled who are in a non-negotiable relationship with the law. Aristotle reiterates the intimate connection between prudence and power by presenting the powerful statesman Pericles as *the* role model of prudence in the sixth book of the *Nicomachean Ethics* (Aristotle 2011, pp. 120–121 [1140b5-b15]). When Aristotle claims that "political art and prudence are the same characteristic", he understands politics from the point of view of rulers (Aristotle 2011, p. 124 [1141b20-b25]). In *Politics*, Aristotle even goes so far as to say that while many virtues can be common between rulers and those ruled, prudence is "the only virtue peculiar to a ruler" (Aristotle 1998, p. 73 [1277b25-30]).[10]

Hence, although it is reasonable to claim that doctors need to be prudent in relation to their patients, over which they "rule" to some extent, it is problematic to say that the relationship between doctors and institutions in this age of bureaucracy is adequately understood through the lens of prudence. This is because doctors are "ruled" by institutions more than they are their rulers. It is also important to note that the relationship between universals and particulars is not only solely a metaphysical issue. It is at the same time political, in the sense that the universal (in the form of standardized guidelines, rules, laws, precepts, etc.) may force itself on the particular cases to varying degrees. In sickness certification matters, the universal throws a dark shadow on the particular patient cases, and the degree of freedom of the individual medical practitioner to prudently establish a dialogue between them is smaller than before. The challenge for doctors is, then, not how to rule well but rather, how *not* to be ruled. How *not* to be ruled requires another intellectual capacity altogether, to which I will now turn.

Beyond the examination room: cunning intelligence in sickness certification

> The GP tells Maria that he needs to be "street-smart" when issuing the certificate. Sure, Maria can still laugh occasionally, and her affects are not completely blunted. Yet, the doctor tells Maria that it is better to actually write that her affects are blunted, in order to match the "ideal" depressed patient. The doctor explains that the Swedish Social Insurance Agency has been ordered by the government to keep down the total number of granted sick days. Even patients with serious disabilities are deemed unqualified for sickness benefits, sometimes due to some minor detail in the sickness certificate. In order to circumvent additional paperwork, defend the autonomy of medical practice, and last but not least, to guarantee adequate treatment for the patient (in this case, Maria), her doctor "doctors" the sickness certificate.

The nationwide Swedish survey in which doctors reported that the SSIA use the national guidelines for sickness certification (the so-called *insurance medical decision support*) as an instrument of control over physicians. However, the report also hinted at the occurrence of an opposite phenomenon: Physicians admitted to using the insurance medical decision support in an "unintended way, for example as a basis for finding a diagnosis whose recommendations better correlate to the duration of sick-listing that the doctor deems adequate for the medical condition of the patient" (Svärd et al. 2018, p. 2). These doctors seem to *reverse engineer* the guidelines-turned-laws in order to use them against the SSIA themselves. It is not unreasonable to assume that these voluntary reports of unintended use of the guidelines is only the top of an iceberg of evasive actions.

One of the central criteria for sickness benefit eligibility that has caused many headaches for Swedish physicians and their patients is the way the SSIA understand the concept of "objective signs" of disease. In many cases of disease that affect the ability to work, there are no lab tests or radiological exams to independently verify the condition. Such is the case with psychiatric conditions, chronic pain, etc. In these cases, SSIA's increasingly narrow interpretation of "objective signs" has led to a higher degree of rejected sickness benefit claims, counter to the clinical judgments of the treating physicians. Because of this, GPs have developed a cluster of "techniques", that is, "informal, and unsanctioned, ways of maximizing the likelihood of sickness certificate acceptance by the SSIA." In an interview study with Swedish GPs on this matter, the doctors themselves labeled them expressions of "street-smartness", "tactics", "maneuvering around" (Shutzberg 2019). The common denominator of these "techniques" is that they in one way or another deal with the

[9] Although Aristotle does not explicitly mention prudence in conjunction with his discussion on equity and justice in this passage, I will follow Martha Nussbaum and Daniel Devereux in recognizing the proximity to prudence (Nussbaum 2001, p. 301; Devereux 1986, p. 496).

[10] Bent Flyvbjerg has also pointed out this lack of problematization of power in Aristotle's conception of phronesis, simply because it "may not have been a problem for practising *phronesis* among the elite in the Greek *polis*" (2008, p. 504). Furthermore, Richard Bernstein confronts Aristotle by proxy through a critical engagement with Gadamer concerning his omission of power when discussing *phronesis* (Bernstein 1983, pp. 157–159). Although both Flyvberg and Bernstein make very important points in this regard, neither directly address (political) power as the presupposed vantage point of *phronesis*.

SSIA's inflexible and narrow understanding of "objective signs" when deciding eligibility for sickness benefits. Some techniques aim at (1) producing *quasi-objectivity*: for example, GPs reported that the SSIA tended to dismiss patients' own accounts since it narrowed the eligibility criteria, as patient accounts do not qualify as "objective signs" that can be independently verifiable. Yet, in many medical conditions that limit the activity level of patients, what the patient says is all there is. Psychiatric conditions, chronic pain etc. *can* manifest themselves in the examination room, but not necessarily. Hence, the doctors reported that they would write the sickness certificate such that the patient's narrative appeared as an "objective finding" made in the examination room. A narrative account of suicidal thoughts, lowered mood and so on, could be written as something the doctor encountered in the consulting room (e.g. "patient appears with a lowered mood", rather that "the patient *says* that she usually suffers from lowered mood"). Other "techniques" aimed at (2) *evading objectivity*: for example, when SSIA requested supplemental information, GPs could phone SSIA case workers and "communicate off the record". In these conversations, doctors conveyed information that could not fit in the reified format of the standardized sickness certificate form, such as feelings, intuitions etc. about their patients' medical conditions. Sometimes the physicians could use other means of persuasion, such as pointing out their superior medical knowledge relative to the SSIA case workers. Thirdly, a few techniques (3) *produced objectivity at a price*: In order to satisfy the narrow view of "objective findings", they would be produced despite being medically unnecessary. For example, patients with conditions such as chronic back pain would be submitted to extra radiological examinations, although such examination would not alter the treatment strategies in any way.[11]

Not unlike Aristotle's cunning cuttlefish, doctors employ these techniques in order to *conceal* their resistance to the strict eligibility criteria enforced by the SSIA. They break the iron bars of bureaucracy precisely by pretending to follow them. But *what* are these new set of techniques that doctors utilize in order to navigate in a complex and increasingly inflexible bureaucracy? Are they just modifications of the same old prudence displayed by the seasoned doctor in relation to his or her patients? Or are they something else, epistemologically and ethically? Perhaps the Greeks, who astutely theorized prudence, did have something to say about the shrewdness of such a mode of thought and action as well?

[11] For a more detailed and empirical account of these "techniques", previously published, see Shutzberg (2019). For an account of the use of the techniques as a form of everyday resistance, and a closer look at the intent and motives of resisting physicians, see Shutzberg (2020).

Steps towards providing cunning intelligence its own space among the intellectual abilities

Despite Aristotle's fascination with the cunning cuttlefish, he scorned that very same ability in the life of humans. In discussing prudence in the sixth book of the *Nicomachean ethics*, Aristotle made the passing remark that "[t]here is indeed a capacity that people call 'cleverness,' and this is of such a character as to be capable of doing what is conducive to the target posited and so of hitting it. If, then, the target is a noble one, the cleverness is praiseworthy; but if base, it is mere *cunning* [*panourgia*]" (Aristotle 2011, p. 131 [1144a25-30], my italics). Although there is not much in this passage to interpret, it does at least hint at the existence of *something* similar to, yet distinct from, prudence in cunningness. Aristotle settles for giving cunningness a privative definition (it is similar to prudence, but without an understanding of what is good and truly virtuous) and leaves it at that. This tendency of reducing ruse and trickery to something resembling prudence, but in the end being nothing more than rule-bound and instrumental "binding", "trapping", "controlling" and "immobilizing" of instrumental knowledge (*techne*) is also to some degree repeated among the neo-Aristotelians of our days (see for example Dunne 1993, pp. 256–58; Nussbaum 2001, pp. 20, 310).

Yet, outside of philosophy, in the universe of myth, the Greeks did indeed demonstrate a deep appreciation for cunning intelligence. Marcel Detienne and Jean-Pierre Vernant's meticulous work on cunning intelligence in Greek myth, *Cunning Intelligence in Greek Culture and Society*, is an ambitious attempt to reconstruct the Greek appreciation of this intellectual capacity—*metis*—from the myths of the Gods. More a "semantic field" than a unified concept, it encompasses everything from navigating ships across shifty seas, to gods outsmarting other gods. Given the vast amount of different examples of *metis* provided by Detienne and Vernant, a broad interpretation of metis would evidently have it overlapping with the practical intellectual capacities and virtues of Aristotle, with *techne* and *phronesis*, also in a very literal sense: Both *techne* and *phronesis* are are at different points in the book fused together with the category of *metis* (Detienne and Vernant 1991, pp. 43, 138).

However, some fundamental characteristics ascribed to *metis* by Detienne and Vernant seems to warrant its presentation as a *particular sub-species* of practical knowledge, somewhat distinct from both productive instrumental knowledge (*techne*) and practical-ethical knowledge (*phronesis*). If one attempts to isolate this aspect of *metis*, five tightly interrelated features stand out as unique, or at least helpful for contrastive purposes. *Firstly*, metis comes in play in antagonistic circumstances, in a race or contest, a conflict,

a rivalry or the like. The first example of *metis* presented by Detienne and Vernant is the chariot race recounted in the 23rd book of the *Iliad*, which I will return to below. *Secondly*, more specifically, metis is crucial for the subjugated part in this antagonistic conflict. One could even claim that metis is almost exclusively the weapon of the weak, circumventing the advantage of pure strength of a more powerful adversary. Instead of pure strength, *metis* is "the use of methods of a different order whose effect is, precisely, to reverse the natural outcome of the encounter and to allow victory to fall to the party whose defeat had appeared inevitable" (Detienne and Vernant 1991, p. 13). In the chariot race, Antilochus beats Menelaus to the finish line despite having slower horses. He does so through taking "advantage of a sudden narrowing of the track, which has been worn away by storm rains, and drives his chariot obliquely across in front of that of Menelaus at the risk of causing a crash: the manoeuvre takes his adversary by surprise and he is forced to rein in his horses" (Detienne and Vernant 1991, p. 12). *Thirdly*, cunning intelligence is that form of thought and movement brought about by being completely interior to power. What I mean by this is that metis becomes necessary when there is nowhere outside of the terrain of power to run or hide, and when the setting of the potential confrontation between antagonistic forces is structurally "rigged" and set. The myth of Metis—wife of Zeus and mother of Athena—is itself a metaphor of the particular *type* of subjugation that necessitates *metis*: In order to cheat his own fate which was to be overthrown by his own future son, Zeus swallows Metis who is pregnant with their child (1991, p. 60). Metis is, then, literally *inside* of rule and power. This aspect of cunning intelligence is perhaps more obvious in the comportment of the trickster god Prometheus, the most cunning of all. "Hesiod and Aeschylus are at one in recognising in Prometheus that very type of wiley intelligence, that same power of deception which the Greeks called *metis*" (1991, p. 58). Detienne and Vernant highlight the myth of how Prometheus outwitted Zeus when a huge ox was to be slaughtered and divided between the humans and the gods. Prometheus divided the ox into two portions for Zeus to pick from, knowing that gods have the first pick. "The first looks extremely appetising but in reality consists only of the animal's bare bones. The second conceals beneath the skin and stomach—which are inedible—all the best pieces" (1991, pp. 125–126). Zeus of course picks the first, getting only bones, while the humans were allotted the edible parts. As the hierarchical order between humans and gods were set, as well as the order in which the meat was distributed, Prometheus had to trick Zeus. However, it was a trick that on a superficial level still "respects" the order of things. Being completely swallowed up by power also means that the subjugated must seize whatever tools and opportunities that the situation or the master presents. Doing so successfully is the essence cunning. In the case of Prometheus, it was the picking order that was cunningly exploited. *Fourthly*, deception and disguise are indispensable components of metis. "In metis appearance and reality no longer correspond to one another but stand in contrast, producing an effect of illusion, *apate*, which beguiles the adversary into error and leaves" (Detienne and Vernant 1991, p. 21). In addition to this fourth feature, it follows—*fifthly*—that metis is first and foremost a *social* skill. This fifth interpersonal and social dimension is not unique for *metis*. *Phronesis*, being intimately related to action (*praxis*), is an activity between humans, which has been emphasized by for example Hannah Arendt (1998), but also by Phillippe Baumard, who calls *phronesis* "social wisdom" (1999, p. 53). However, this fifth aspect does to some degree distinguish *metis* from *techne,* which expresses itself in the *fabrication* of things (*poiesis*), that is, as a relation between a subject and an object, rather than *acting* in relation with others.

That the ancient Greeks did demonstrate appreciation for the capacity of cunning does not automatically make it a virtue. Nevertheless, the *ontologically* positive exposition of cunning intelligence gives the phenomenon substance, instead of reducing it to the mere shadow or defective version of some other human capacity (such as in Aristotle's case, prudence).

Metis in the age of bureaucracy: resistance of practice and practice of resistance

At first glance, the concept of *metis* seems very distant from practice in the world of modern organizations and institutions. Yet, the concept has been mobilized by several thinkers in order to make sense of practice within and against bureaucracy. Among them, political scientist and anthropologist James C. Scott has been the most empirically oriented in attempts to shed light on the complicated interplay between cunning intelligence and institutions.[12] In his highly influential work *Seeing Like a State,* Scott asks why authoritarian high-modernist projects (such as scientific forestry in the late eighteenth century, forced agricultural collectivization during the Soviet era, centralized urban planning projects influenced by Le Corbusier in the mid twentieth century, etc.) often ended in terrible failures. The argument is that these projects are destined to simplify reality in the name of efficiency and control

[12] Philippe Baumard (1999) and Michel de Certeau (1984) are two others who pursued a similar interest in the concept of *metis* (as it has been understood by Detienne and Vernant) and its relation to organization, institution and bureaucracy. For the sake of clarity and brevity, I will stick to James C. Scott's more empirical engagement with the concept.

and are therefore, by design, incapable of appreciating the particularity of "*this* forest, *this* revolution, *this* farm" (Scott 1998, p. 318). This extends to an inability on behalf of the bureaucratic state structure to recognize particular and local forms of tacit and approximative knowledge of local farmers, artisans, physicians and what have you. Taking Detienne and Vernant's work as a point of departure, Scott adopts the Greek word *metis* to designate this dimension of practical knowledge inherent (albeit to different degrees) in all human activities, ranging from riding a bicycle and local farming to diplomacy, politics, and just about everything in between. His explicit thesis is that failure of high-modernist projects is due to the fact that *metis* "*resists* simplification into deductive principles which can be successfully transmitted through book learning, because the environments in which it is exercised are so complex and nonrepeatable that formal procedures of rational decision making are impossible to apply" (Scott 1998, pp. 315–316, my italics). The explicit thesis is, then, that practical knowledge *passively* resists due to its ontological refusal to be codified. It is simply impossible to codify highly contextualized and particular forms of practical knowledge.

This broad take on practical knowledge and the resistance it engenders, certainly overlaps with established concepts such as "practical knowledge", "procedural knowledge", (Gilbert Ryle's) "knowing how", (Michael Polanyi's) "tacit knowledge", (Aristotle's) "*phronesis*", or any of the other alternatives mentioned by Scott himself ("indigenous technical knowledge", "folk wisdom", "practical skills"). All these concepts—irrespective of the radical differences between them—denote knowledge that to some degree requires context and person, and that refuse complete codification or conversion to propositional knowledge. Their total subjugation to centralized systems is, almost by definition, epistemologically impossible. What Scott says of the passive resistance of *metis*, is also the case with practical knowledge in many of the varieties above. By their very nature, they all passively "resist simplification" and reduction to "mechanical application of generic rules" (1998, p. 318).

An alternative reading of some of the central examples Scott provides the reader is possible, with the implication that there is more to *metis* than the mere passive irreducibility, survival and resistance of practical knowledge itself. This alternative reading focuses on the *kind of professional practices whose intended objective is resistance against institutions*, rather than the resistance that passively follows from the exercise of professional practice. So, for example, Scott mentions a study of how East German factory workers dealt with meeting the production quotas set by the central government. As access to necessary spare parts and raw materials were scarce and unreliable, some of the workers also acted as dealers on the black market:

> the factory routinely used its funds to stock up on such valued nonperishable goods as soap powder, cosmetics, [...] and fashionable clothes. When it seemed that the plant would fall short of the quota [...], these knowledgeable dealers would set off across the country [...], to secure what was needed. Neither of these roles was provided for in the official table of organization, and yet the survival of the factory depended more on their skills, wisdom, and experience than on those of any other employee. A key element in the centrally planned economy was underwritten, always unofficially, by metis. (Scott 1998: pp. 350-351)

The shrewdness of the workers moonlighting as dealers in this case is not a simple return to old ways of producing goods, which would be impossible. Neither is it the passive resistance of older forms of practical knowledge that have managed to survive incorporation into centralized planning. Rather, the quota system and its unavoidable imperfections gives rise to a higher-order and a new form of knowledge and practice that aims at circumventing the quota system itself. It has few or no links to old ways farming, woodcutting or mining, although it might at times function as a bulwark against their extermination. The relation between this cunning intelligence and the institutions it acts against involves a series of contradictions: it simultaneously *resists and consolidates* the centralized systems, which simultaneously *produces and represses* these types of disposition, knowledge and action.

Let's recall the trick at Mecone, mentioned earlier, for a second. Prometheus tricked Zeus into picking the pile of bones, leaving the edible flesh of the ox for the humans. But who tricked whom, really? Vernant suggests that Hesiod's *Theogony* can be interpreted such that the ultimate trickster was Zeus himself, letting Prometheus believe he was tricked, while in fact he was not. Zeus wanted the bones of the ox, the substrate of immortality. He wanted a reason to condemn humans to mortality, and Prometheus gave him an opportunity to do so by his insubordination (Detienne and Vernant 1989, pp 224–225, n. 6). The same potential inversion of who profits (in the long run) from the cunning intelligence of employees in organizations is the implicit theme of Scott's case, and relevant in the case of cunning GPs. Whom does it really serve that GPs cunningly outsmart the SSIA by subtle means, by creating an apparent compliance with the new stricter rules of sick-listing? Is it possible that the resistance of *metis* is an inadvertent but life-sustaining feature of the sickness certification system?

Synthesis and concretion: *phronesis* and *metis* as complementary abilities in sickness certification practice

Let's return to the sickness certificates. When issuing sickness certificates, two complementary modes of knowledge are mobilized by the GP. Firstly, in terms of the content, *this* particular patient before the GP calls for a professional judgment to be made. Is sick leave beneficial for this particular patient? How much, in what way? Are other medical measures necessary? These kinds of judgments exist in the realm of *phronesis*. They are fundamentally *unmanageable*, in the sense that they refuse submission to universal categories. Or put differently: when universal categories are confronted by a particular case, judgment is needed and cannot be wholly supplanted by flowcharts and algorithms. Still, the sphere of medical judgment is continuously encroached by external goods (such as economic efficiency) and control mechanisms (such as governmental decrees and guidelines, as well as extensive auditing of the sickness certificates), seeking to minimize professional discretion. The greater the encroachment, the more GPs grow another different and distinct sphere of knowledge and ability: *metis*. As understood in the previous section, this is the ability to create a space for judgment and action through disguise. This ability is partially independent of the knowledge, ability and virtue of prudence (*phronesis*) in relation to the patient. That is, it is easy to imagine a doctor who is prudent in relation to his or her patients, but incompetent with regards to outsmarting social insurance agencies or other forms of bureaucracy (when it is legitimate to do so). Yet, these two abilities (of *phronesis* and *metis*) are indirectly related. The "function" of *metis* is to keep fundamentally unmanageable space unmanaged. It is closely related to prudence, but different in kind. While *phronesis* deals with the content of a unique situation that must be handled wisely, *metis* creates the conditions under which that unique situation *can* be dealt with wisely. While *phronesis* may be called the "tricks of the trade (in a nondeceptive sense)", only metaphorically as Scott did (1998, p. 330), *metis* is the "tricks of the trade" in the highest possible literal sense of the phrase. Doctoring is an essential component of being a doctor.

Hence, *phronesis* and *metis* differ from each other with regards to their area of interest: *phronesis* deals with the clinical content, while *metis* deals with (some aspects) of the clinical context. They also differ with how they relate to rule. Grossly simplified *techne*, or instrumental knowledge, is the ability to follow rules; *phronesis*, or prudence, is the ability to act where the domain of rules end; *metis*, or cunning intelligence, is the ability to act in between, or against, rules. Consequently, they differ in their relation to uncertainty: While prudence deals with the ontological uncertainty of disease itself, with prognosis and treatment, *metis* deals with the organizational uncertainty of a bureaucratic system that tends to wipe out the particularities of *this* or *that* patient.

The ambiguous ethical and political status of *metis*: Why lumping *phronesis* and *metis* together is a bad idea

Many scholars of medical philosophy have identified the challenge of acting well in a bureaucratic structure in medical practice. A common position for the scholars in the field influenced by Aristotle's intellectual virtues is to subsume the creatively evasive skills involved in sickness certification under the category of prudence (*phronesis*). Saraga et al., for example, identify both rule-breaking in general (and "gaming the clinical context" in particular), as well as "creating the magic bubble" (i.e. a temporary space, shielding the clinical encounter from external interference) as essential aspects of "*phronesis* enacted in medicine" (Saraga et al. 2019, p. 49). In a similar vein, Bontemps-Hommen et al. arrive at the conclusion that the definition of professional prudence needs to be updated to account for the complexity of "late modernity". Consequently, their proposed updated definition of *phronesis* reads as follows:

> practical wisdom [prudence] is the capability which emerges in acting jointly in medical practices, consisting of knowing how to remain focused on achieving the good for every individual patient, within the context of the practice and its telos, in ever changing situations, and how to accomplish this through the most appropriate means, *while operating complexity and institutional and systemic pressure.* (Bontemps-Hommen et al. 2019: p. 103, my italics)

The last subordinate clause (italicized above) is of central interest here: "operating […] institutional and systemic pressure" is identified not as distinct from, but as a part of professional prudence in late modernity. Both formal and informal, both rule-following, rule-bending and rule-breaking ways of dealing with this pressure is implicitly incorporated in this refusal to differentiate between different ways of dealing with institutional and systemic pressure.

The importance of identifying the novel challenges of "late modernity," "bureaucracy," "institutions" etc. to good doctoring and the *skills* they require cannot be overstated. Both Bontemps-Hommen et al. and Saraga et al. have successfully done so. However, highlighting their importance by elevating them to the realm of prudence (*phronesis*) in the Aristotelian sense, risks obfuscating some essential differences between prudence and the cunning ability

to maneuver in bureaucracies. Most importantly, some of these differences are related to the ethical and political status of *phronesis* and *metis*. They emanate from three central characteristics of metis: its *oppositionality*, its *secrecy* and its *enactment from subordination*. While phronesis to some extent always can be institutionally recognized and sanctioned as an important part of professional activity, metis cannot. At best, *metis* can be institutionally *tolerated* (as acknowledged by James C. Scott) but never accepted. Consequently, attempts can be made to deliberately and publicly facilitate the learning of phronesis, but because metis in its very essence is the ability to counter institutions, it cannot enjoy the same privilege. Metis can be taught horizontally only, whispered between colleagues, but never vertically, as part of a public curriculum.

The million-dollar question: Is *metis* a virtue?

I have hitherto talked about *metis* as form of knowledge and/or capacity pertaining to the physician's professional role. In this regard, *metis* is similar to *phronesis*, which also can be understood as a kind of (ethico-practical) knowledge possessed by doctors, and/or as a kind of capacity belonging to that professional role. But prudence is not merely an attribute like any other—it is a *virtue.* The attempts at differentiating *metis* from *phronesis* above may boil down to one question that is simple to ask, but difficult to answer: Is *metis* a virtue? It would certainly be easy to dismiss cunning intelligence as a defective mode of *phronesis*, as Aristotle did, or dismiss it on the basis that it collides with Alasdair MacIntyre's idea that honesty is one of (at least) three central virtues of modern human practices.[13] Is cunning intelligence not simply the intellectual capacity for dishonesty, the necessity of which might be excused because of pressing circumstances, but never acclaimed as a virtue? In order to answer this question, I believe a turn to MacIntyre's neo-Aristotelian framework (in the form it has been presented in *After Virtue*) can be helpful, as he has expanded on the relevance of virtues in modern society in which human practices are both supported and suppressed by institutions (such as a "hospital" in which the practice of medicine takes place, which MacIntyre himself uses as an example). MacIntyre defines virtue in the following way:

> A virtue is an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods. (MacIntyre 2007: p. 191)

This (preliminary) definition of virtue brings its relation to "practice" to the foreground, which in this context has a semi-technical meaning, close to, but slightly different from the broader colloquial use of the word. A practice is.

> any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity (MacIntyre 2007: p. 187).

Again, MacIntyre is helpful by giving examples of practices: medicine is a practice (MacIntyre 2007, p. 194). The good internal to the practice of medicine has been considered to be health, which is the essential goal and reward of this practice. However, there are other goods contingently tied to the practice of medicine, that are external to it: fame, status, money, etc. The dual nature of goods, as it were, are also applicable in the case of sickness benefits: on the one hand sickness benefits are something to be used with the health of the patient in mind. Or better yet, medically informed sickness certification practice manages to put external goods (economic compensation) in the service of health. Unfortunately, on the other hand, the opposite relationship between the inner good of health and the external good (of bureaucratic efficiency) is not only thinkable, but a rule in contemporary Swedish social security arrangements. Narrow and strict eligibility criteria for sickness benefits have turned social security from an aid to health to a tool for forcing sick patients back to the labor market.

To repeat the chain of reasoning of this article, but with a MacIntyrean vocabulary, and in terms of virtue rather than intellectual capacity, *metis*, then, is a virtue, because "without them [the virtues], practices could not resist the corrupting power of institutions" (MacIntyre 2007, p. 194). *Metis*, the cunning aspect of medical practice, is that which guarantees that sickness certification practice (which is a part of medical practice) operates in accordance with the inner good of health, rather than the external good of efficiency and austerity. It is the covert way to "resist" the external goods of institutions gone adrift.

The preliminary answer to the question is then: yes, *metis* is a virtue. However, there are some serious reservations to be made. Firstly, Macintyre's idea of virtue is much more complex and relates not only to practice. In addition to practice, virtues are tied to a good life as a whole (which may be hard to reconcile with the idea of *exclusively* professional virtues); furthermore, virtues are intimately connected to the inheritance of a living tradition. A second type of reservation to calling *metis* a virtue has been raised by other

[13] The other two being justice and courage (MacIntyre 2007, p. 191).

philosophers. The neo-Aristotelian philosopher Lisa Tessman, who has contributed to understanding virtues under non-ideal conditions and making virtue ethics relevant for emancipatory projects, has noted that there are some important differences between traits that are virtues both in ideal and non-ideal circumstances, and traits that "deserve praise only in the qualified sense of being the best that is possible under awful conditions" (Tessman 2005, p. 7). Clearly, *phronesis* belongs to the first category, and *metis* to the second. If one chooses to call the second category of traits "virtues", it should be with the qualification that they are "burdened" or "burdening" virtues, Tessman suggests.

For these reasons, a *definitive* answer to the question of whether *metis* is a virtue should be postponed for future study.

Conclusions

This paper has argued that the recently changed relations of power between medical practitioners and the SSIA has forced Swedish GPs to develop a new type of ability. This ability, cunning intelligence, is sufficiently different from technical instrumental rationality (*techne*) and prudence (*phronesis*) and therefore deserves its own category: *metis*. There are reasons to assume that this intellectual ability is generalizable. Firstly, the concept has a far-reaching history, delineated by Detienne and Vernant, and by James C. Scott. Secondly, the factors that necessitated *metis* are not limited to the Swedish social insurance system. Rather, the logic of austerity and the bureaucratic control over professionals have become paradigmatic in healthcare (Siegler 1985; Power 1997).

Prudence is considered to be "[m]edicine's indispensable virtue" (Pellegrino and Thomasma 1993, p. 84) because those who bear it are able to take into consideration which other virtues, which ends and goals are relevant in situations fraught with uncertainty. Prudent conduct of physicians in the domain of sick-listing is certainly a challenge in itself: what benefits *this* particular patient? In the setting of bureaucratic austerity, there is the additional obstacle to effectuate these judgments. The ability to cunningly circumvent the heteronomy of rules and regulations, the external goods of institutions that force themselves on the sphere of medical practice, is a distinct intellectual capacity. It is a capacity necessitated by subordination.

The unique place of *metis* in the repertoire of intellectual capacities can be expressed in its relation to rules: instrumental reason is the ability to *follow rules*; prudence is the ability to move and act *where rules do not apply*; cunning intelligence is the ability to move and act *despite rules*. Cunning complements prudence.

Cunning intelligence is more than mere defective prudence. Nevertheless, the ontologically positive status of cunning intelligence does not automatically make it a virtue. This investigation paves the way for asking whether it might be. A preliminary answer is that cunning intelligence perhaps is a virtue, or at least that it is tightly interwoven with professional virtues and the internal goods of healthcare. A definitive answer to this question lies in the future.

Acknowledgements Open access funding provided by Södertörn University.

Funding The author received no financial support for the research, authorship, and/or publication of this article.

Compliance with ethical standards

Conflict of interest The author declares no potential conflicts of interest.

Open Access This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/.

References

Alexanderson, K., et al. 2018. Läkares erfarenheter av arbete med sjukskrivning av patienter. Huvudrapport 2018. [Doctors' experiences of handling sickness certification of patients. Main report 2018]. Stockholm: Karolinska Institutet. https://ki.se/sites/default/files/2018/03/08/huvudrapport_lakarenkat_2017_2012_2008_2004._ki.pdf.

Anscombe, G.E.M. 1958. Modern moral philosophy. *Philosophy* 33 (124): 1–19.

Arendt, H. 1998. *The human condition*, 2nd ed. Chicago: University of Chicago Press.

Arrelöv, B., C. Edlund, and H. Goine. 2006. Grindvakterna i sjukförsäkringen: Samspel och motspel [The gatekeepers of social insurance: cooperation and adversity] in SKA-projektet: sjukförsäkring. In *kulturer och attityder [The SKA project: sickness benefits, cultures and attitudes]*, ed. E. Palmer, 479–530. Stockholm: Försäkringskassan.

Aristotle. 1910. *The works of Aristotle. Vol. 4, Historia animalium*. Translated by D.W. Thompson. Oxford: Clarendon Press.

Aristotle. 1998. *Politics*. Translated by C.D.C. Reeve. Indianapolis: Hackett Publishing Company

Aristotle. 2011. *Nicomachean ethics*. Translated by R.C. Bartlett and S.D. Collins. Chicago: University of Chicago Press.

Banks, S., and A. Gallagher. 2009. *Ethics in professional life: Virtues for health and social care*. Hampshire: Palgrave Macmillan.
Baumard, P. 1999. *Tacit knowledge in organizations*. London: SAGE Publications Ltd.
Bernstein, R.J. 1983. *Beyond objectivism and relativism: Science, hermeneutics, and praxis*. Philadelphia: University of Pennsylvania Press.
Bontemps-Hommen, C.M.M.L., A. Baart, and F.T.H. Vosman. 2019. Practical wisdom in complex medical practices: A critical proposal. *Medicine, Health Care and Philosophy.* 22 (1): 95–105.
Broadbent, J., and R. Laughlin. 2002. Public service professionals and the new public management. In *New public management: Current trends and future prospects*, ed. K. McLaughlin, S.P. Osborne, and E. Ferlie, 95–108. London: Routledge.
Broadie, S. 1987. Nature, craft and phronesis in Aristotle. *Philosophical Topics* 15 (2): 35–50.
Burström, B. 2015. Sweden—Recent changes in welfare state arrangements. *International Journal of Health Services* 45 (1): 87–104.
Certeau, M.D. 1984. *The practice of everyday life*. Berkeley: University of California Press.
Detienne, M., and J. Vernant. 1989. *The cuisine of sacrifice among the Greeks*. Chicago: University of Chicago Press.
Detienne, M., and J. Vernant. 1991. *Cunning intelligence in Greek culture and society*. Chicago: University of Chicago Press.
Devereux, D.T. 1986. Particular and universal in Aristotle's conception of practical knowledge. *The Review of Metaphysics* 39 (3): 483–504.
Dreyfus, H., and S.E. Dreyfus. 2000. *Mind over machine*. New York: The Free Press.
Dunne, J. 1993. *Back to the rough ground: Practical judgment and the lure of technique*. Notre Dame: University of Notre Dame Press.
Engblom, M., et al. 2008. When physicians get stuck in sick-listing consultations: A qualitative study of categories of sick-listing dilemmas. *Work.* 35: 137–142.
Flyvbjerg, B. 2008. Aristotle, Foucault and progressive phronesis: Outline of an applied ethics for sustainable development. In *Political economy, diversity and pragmatism: Critical essays in planning theory*, vol. 2, ed. J. Hillier and P. Healey, 65–83. Hampshire: Ashgate.
Foucault, M. 1978. *The history of sexuality volume 1: An Introduction.* New York: Random House.
Gracia, D., and M.C. White. 1978. The structure of medical knowledge in Aristotle's philosophy. *Sudhoffs Archives* 62 (1): 1–36.
Grover, C., and K. Soldatic. 2013. Neoliberal restructuring, disabled people and social (in) security in Australia and Britain. *Scandinavian Journal of Disability Research.* 15 (3): 216–232.
Hasselbladh, H., and E. Bejerot. 2017. Performative policy: the case of Swedish healthcare reforms. *Critical Policy Studies* 11 (3): 291–310.
Hussey, S., P. Hoddinott, P. Wilson, J. Dowell, and R. Barbour. 2004. Sickness certification system in the United Kingdom: Qualitative study of views of general practitioners in Scotland. *BMJ* 328 (7431): 88.
Johnson, B. 2010. *Kampen om sjukfrånvaron [The struggle over sickness absence]*. Lund: Arkiv.
Kienle, G.S., and H. Kiene. 2011. Clinical judgement and the medical profession. *Journal of Evaluation in Clinical Practice* 17 (4): 621–627.
Kinsella, E.A., and A. Pitman (eds.). 2012. *Phronesis as professional knowledge: Practical wisdom in the professions*. Rotterdam: Sense Publishers.
Larsson, M., B. Hamrén, and H. Persson Schill. 2017. *Bedömningar vid 90 och 180 dagar i rehabiliteringskedjan [The quality of assessments for sickness benefit after 90 days and 180 days]*. Stockholm: Inspektionen för socialförsäkringen.
MacIntyre, A. 2007. *After virtue: A study in moral theory*. Notre Dame: University of Notre Dame Press.
Mongtomery, K. 2005. *How doctors think: Clinical judgment and the practice of medicine*. New York: Oxford University Press.
Numerato, D., D. Salvatore, and G. Fattore. 2012. The impact of management on medical professionalism: a review. *Sociology of health & illness* 34 (4): 626–644.
Nussbaum, M. 2001. *The fragility of goodness: Luck and ethics in Greek tragedy and philosophy*, Revised ed. Cambridge: Cambridge University Press.
Pellegrino, E.D., and D.C. Thomasma. 1993. *The virtues in medical practice*. New York: Oxford University Press.
Power, M. 1997. *The audit society: Rituals of verification*. Oxford: Oxford University Press.
Riksrevisionen. 2018. *Bedömning av arbetsförmåga vid psykisk ohälsa: en process med stora utmaningar* [Assessment of working capacity in cases of mental ill health—a process with great challenges]. Stockholm: Riksrevisionen. https://www.riksrevisionen.se/download/18.74e14d25162d3d1f14e4da83/1526286318651/RiR_2018_11_ANPASSAD.pdf.
Saraga, M., D. Boudreau, and A. Fuks. 2019. Engagement and practical wisdom in clinical practice: a phenomenological study. *Medicine, Health Care and Philosophy* 22 (1): 41–52.
Scott, J.C. 1998. *Seeing like a state*. New Haven: Yale University Press.
Shutzberg, M. 2019. Unsanctioned techniques for having sickness certificates accepted: A qualitative exploration and description of the strategies used by Swedish general practitioners. *Scandinavian Journal of Primary Health Care.* 37 (1): 10–17.
Shutzberg, M. 2020. Literal tricks of the trade: The possibilities and contradictions of Swedish physicians' everyday resistance in the sickness certification process. *Journal of Resistance Studies* 6 (1): 8–39.
Siegler, M. 1985. The progression of medicine: From physician paternalism to patient autonomy to bureaucratic parsimony. *Archives of internal medicine* 145 (4): 713–715.
Sundquist, J., A. Al-Windi, S.E. Johansson, and K. Sundquist. 2007. Sickness absence poses a threat to the Swedish welfare state: A cross-sectional study of sickness absence and self-reported illness. *BMC Public Health* 7 (1): 45.
Svärd, V., Haque, M., Friberg, E., and Alexanderson, K. 2018. *Läkares erfarenheter av Socialstyrelsens försäkringsmedicinska beslutsstöd och av digitalisering av läkarintyg*: Report 2018 [Doctors' experiences of the insurance medical decision support of the national board of health and welfare: Report 2018]. Stockholm: Karolinska institutet. https://ki.se/sites/default/files/migrate/2018/07/18/lakares_erfarenheter_av_forsakringsmedicinskt_beslutsstod_och_av_digitalisering_av_lakarintyg._ki_2018.pdf.
Tessman, L. 2005. *Burdened virtues: Virtue ethics for liberatory struggles*. New York: Oxford University Press.
Tonelli, M.R., and R.E.G. Upshur. 2019. A philosophical approach to addressing uncertainty in medical education. *Academic Medicine* 94 (4): 507–511.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Paper IV

DOI: https://doi.org/10.1007/s10728-021-00432-2

Health Care Analysis
https://doi.org/10.1007/s10728-021-00432-2

ORIGINAL ARTICLE

The Doctor as Parent, Partner, Provider… or Comrade? Distribution of Power in Past and Present Models of the Doctor–Patient Relationship

Mani Shutzberg[1]

Accepted: 8 April 2021
© The Author(s) 2021

Abstract
The commonly occurring metaphors and models of the doctor–patient relationship can be divided into three clusters, depending on what distribution of power they represent: in the paternalist cluster, power resides with the physician; in the consumer model, power resides with the patient; in the partnership model, power is distributed equally between doctor and patient. Often, this tripartite division is accepted as an exhaustive typology of doctor–patient relationships. The main objective of this paper is to challenge this idea by introducing a fourth possibility and distribution of power, namely, the distribution in which power resides with neither doctor nor patient. This equality in powerlessness—the hallmark of "the age of bureaucratic parsimony"—is the point of departure for a qualitatively new doctor–patient relationship, which is best described in terms of *solidarity* between *comrades*. This paper specifies the characteristics of this specific type of solidarity and illustrates it with a case study of how Swedish doctors and patients interrelate in the sickness certification practice.

Keywords Solidarity · Power · Doctor–patient relationship · Healthcare · Bureaucracy

Introduction: Metaphors and Models of the Doctor–Patient Relationship

This paper revisits the three main archetypes of the doctor–patient relationship. In them the doctor figures as *parent*, as *partner* and as (service) *provider*, respectively. The three clusters represent distinct distributions of power among the involved parties: in the first case power resides wholly in the role of the physician, in the second it is roughly equally divided between doctor and patient, and in the third it mainly

✉ Mani Shutzberg
mani.shutzberg@sh.se

[1] Centre for Studies in Practical Knowledge, Södertörn University, Stockholm, Sweden

rests in the hands of the patient-consumer. As we enter what the medical ethicist Mark Siegler calls the "age of bureaucratic parsimony" [54], a new type of doctor–patient relationship has become paradigmatic. This one is similar to the partnership model, insofar as power is distributed equally between doctor and patient. However, there is one perverted twist and decisive difference: In the age of bureaucratic parsimony, both doctor and patient are equally robbed of power and influence by instances outside of the immediate medical encounter. This new situation enables doctor and patient to interrelate as two similarly dominated subjects—as *comrades*. I suggest that an appropriate word for this new bond is *solidarity*.

This new medical bond is explored theoretically and with an empirical case, namely, the interaction and comportment of Swedish doctors and patients in the sickness certification process, which have changed drastically during the last years. The way doctors and patients act towards each other, and the way doctors resist the insurance agency, embodies this new kind of solidarity at the heart of the new doctor–patient relationship.

The Physician as Parent

The grand narratives of the evolution of the doctor–patient relationship almost always start with what philosophers have referred to as "paternalism" since the 1960s and 1970s [6, 18]. The age of paternalism has been claimed to span between "many decades" [14] to "thousands of years" [54]. Etymologically, paternalism derives from the Latin word for father. This metaphor, then, aligns the relationship between doctor and patient with the relationship between benevolent father and ignorant child. The patient-child is regarded as a dependent of the doctor-father; just like the child of the father, the patient-child is not really actively involved in deliberations about his or her medical encounter. Belonging to the same cluster of metaphors is the so-called "priestly model" of doctor–patient interaction, which has designated more or less the same thing [63]. In terms of ethical principles, a paternalistic stance implies that the principle of beneficence often, or always, trumps the principle of patient autonomy [8, 62]. Thomas Szasz and Marc Hollender's famous text about the doctor–patient relationship puts forth two distinct paternalist metaphors which correspond to two different types of doctor–patient interaction: the *parent-infant* and the *parent-adolescent* relationship. In the first, the doctor-parent is active, and the patient-infant is a completely passive recipient of the doctor's actions. It is even questionable if it can be called "interaction" at all, as the action goes only one-way. It is a completely appropriate orientation in the treatment of emergencies, but not much else. The second parental metaphor, between *adult and adolescent* roughly designates a form of paternalism that partially recognizes patient subjectivity. In contrast to the infant, the adolescent is conscious. The adolescent can cooperate, or at least obey. Although critical of this model, Szasz and Hollender admit that there are scenarios when also this mode of interaction might be warranted, or at least commonly occurring: "it is employed in situations which are less desperate than those previously mentioned […]. Although the patient is ill, he is conscious

and has feelings and aspirations of his own." Their own suggested example of this is "acute infections" [57].

Despite the heterogeneity of the attitudes that huddle under the umbrella of paternalism and familial metaphors, there is one feature that unites them, and which is important for the progression of the main argument in this article. The doctor is the one in charge, with power to influence the decisions. The main characteristics "pertains to power, and to its actual or potential use. The more powerful of the two (parent, physician, employer, etc.) will expect […] cooperation of the other member of the pair (child, patient, employee, etc.). The patient is expected to 'look up' and to 'obey' his doctor" [57].

The End of Paternalism, and the Start of Something New

The standard account of the doctor–patient relationship during the last century is a story of the abandonment of paternalism for something else [54, 57, 62]. The beginning of the end of the era of medical paternalism is often set around the end of the Second World War. Although the effective causes for the death of the hegemony of paternalism are notoriously difficult to pin-point, and separation between causes and effects are tricky, the changes in general attitudes are somewhat easier to follow. For example, an American survey in 1961 showed that 90% of the responding doctors preferred not to fully disclose a cancer diagnosis to their patients. About 20 years later, the response was completely reversed: 97% indicated a preference to tell their patients they have cancer [45]. For the medical ethicist Howard Brody, among others, this rapid change in information disclosure possibly represented a paradigmatic shift, leaving behind the "history of routine deception and withholding of information for fear that frank truth would frighten or harm the patient" [8].

The Physician as Partner

There are several suggestions as to what superseded medical paternalism. One category and cluster of metaphors used to designate the new relationship emphasizes its equal and cooperative character [2, 15, 19, 63]. Doctor and patient are more like parties of a contract of sorts, both in the form of a business contract but also as a holy covenant, a marriage [63]; Others have suggested that the bond is analogous to friendship [19]. The common denominator of these models and metaphors can be summarized in a few points: 1. The flow of information between doctor and patient is more symmetric; less an interrogation and more a conversation; 2. An open deliberative approach to whatever means and ends are appropriate for the treatment of the patient; the ends of medicine are not presupposed, as in the paternalist case. In terms of power, they are all identical, as Szasz and Hollender put it: "It is crucial to this type of interaction that the participants […] have approximately equal power" [57]. A crucial common denominator for many who employ the metaphor (some cited above) is the relative indifference to power structures outside of the doctor–patient dyad. The power vested in doctors and patients is assumed to entail a high degree of actual influence over the ends of the medical with negligible apparent involvement

by external forces. A corollary of this assumption is that the doctor and patient are the main (or sole) entities involved in deliberating and making decisions about the goals set in the confines of the doctor's office. The negotiation is, hence, directed inwards [2, 8, 14, 15, 19, 48, 57, 63].

The Physician as (Service) Provider

There is a third mode of doctor–patient relationship that has gained traction later than the partnership model: *the consumer model*.[1] In the United States it can be traced back to the 1960s [7]. In a European welfare state context, the transition might have occurred later, during the (re-)commodification, privatization and marketization of healthcare around the 1980s (with considerable individual differences between countries, of course) [27].

Even though the model can be categorized as a realist offshoot of the partnership model, they differ in terms of power. The autonomous and sovereign patient-consumer constitutes the essential core of the metaphor. The professional role correlating to the patient-consumer is more passive: a provider or "engineer" [63], or a "seller" [7] of a service. At its most reified extreme, physicians *are* the services or objects they provide: mere products. Hence, the relationship is more asymmetrical than the partnership model, and can in some respects be conceived as the "polar opposite" of the paternalist model [7]. Analee and Thomas Beisecker have elegantly summarized the consumer metaphor in the doctor–patient relationship in the following bullet points: "Consumerism focuses on rights[;] consumerism assumes the doctor is self-centered[;] consumerism replaces trust with accountability[;] consumerism presumes that the patient's health care values dominate[;] consumerism may require third-party supervision" [7]. The fundamental assumption that forms the base of the consumer model is that the interests of the physician and the patient diverges, and the only person genuinely interested in the health of the patient is the patient. Most importantly, for the aims of this article, the specific distribution of power rests in the hands of the patient: "In a consumerist relationship, the seller has no particular authority; power rests in the buyer who can make the decisions to buy or not to buy as he or she sees fit " [7].[2]

[1] Other models suggested are quite similar, if not identical, to this so-called consumer model. For example, what has been called the *informed model* [14] shares many of the attributes of what I will discuss below.

[2] The idea that consumerism empowers consumers (patients) requires one important qualification. Whether or not it really empowers the consumer depends on which "dimension" of power one is referring to. If power is to be understood as "decision-making" (which I do throughout the article), then it is indeed possible to say that consumers wield the formal power and freedom to choose this or that commodity as they see fit (given that the market functions in the way it is supposed to by providing the consumer several alternatives to choose between). However, power can also be understood as a multidimensional phenomenon (as suggested by for example Steven Lukes), constituted not only by "decision-making", but also by power as "control over the agenda", as well as control over the "perceptions, cognitions and preferences" of others [37]. The agenda of (or the scope of options on) the market is less directly controlled by the consumer. That power in consumer society resides elsewhere than it may appear at first sight, in the sense that it might entail power in the first dimension (freedom of choice), but disempowerment in the second and third, has been thematized by for example scholars in the tradition of

Ordering the Metaphors

In working through the different metaphors of the doctor–patient relationship, I have implicitly ordered them in two ways. Firstly, there is the question of historical order in which the metaphors of the doctor–patient relationship appeared. Although there is good reason to be critical of grossly oversimplifying statements, I believe there is some truth to the specific order in which the paradigms are assumed to have appeared: that is, during the twentieth century in the West, paternalism was superseded by other models for the doctor–patient relationship, namely the partnership model and the consumer model.

Then there is the question of ordering the models and metaphors in terms of the specific power distribution they each represent. This categorization of models and metaphors is by no means an unprecedented endeavor. For example, Felicity Goodyear-Smith and Stephen Buetow have suggested something similar. In their metamodel, there are mainly three unique distributions of power: In paternalism power resides with the doctor, in consumerism with the patient, and in contemporary society both doctors and patients are empowered, but with "each exercising different but equally important sources of power". They then proceed to problematize this last position of "equality" or "mutuality" of power. Both doctors and patients can misuse their powers; doctors have multiple allegiances to other stakeholders outside of the doctor–patient relationship which adds a good deal of complexity to the partnership model [24]. However, there is one possible configuration of power they do not explore, namely, the *disempowerment of both physician and patient* and the peculiar interaction it engenders.[3]

The Equal Disempowerment of Physicians and Patients: Comradeship

The same historical and ideological conditions that brought forth the consumer model are also the ground for this fourth model: marketization, public sector cutbacks and a businesslike management of healthcare that remained public, all driven by a neoliberal frame of reference [38, 39]. The partnership model and the consumer model both presuppose that the unit of doctor and patient (regardless of the internal distribution of power) contains a high degree of control and power over the course of the medical encounter. Current conditions of power have in reality empowered neither doctor nor patient. Not only is the equal disempowerment of doctor and patient conceivable; in contemporary healthcare, I argue, the equal disempowerment of doctor and patient is becoming paradigmatic. As far back as 1985, and possibly a

Footnote 2 (continued)
critical theory during the twentieth century, such as Herbert Marcuse and Erich Fromm [33]. There are also studies of the aforementioned ambivalence of consumerism in healthcare, and the exercise of the third kind of power that shapes the very desires and preferences of patient-consumers [29, 51].

[3] Goodyear-Smith and Buetow hint at a particular experience springing forth from a "shared weakness" in the face of the clinical inability to cure a disease. This powerlessness is directed toward natural, rather than social, fact [24]. This article deals with the latter.

bit untimely, Mark Siegler declared the arrival of what he called the "age of bureaucratic parsimony" in healthcare. For Siegler, the distinctive feature of this age was that the relationship between doctor and patient had ceased to be the impenetrable dyadic bond it once was: "The physician will be accountable to multiple interests including employers (health maintenance organizations [HMOs], hospital corporations), hospitals, insurance companies, and government. The physician in the age of bureaucracy will have divided allegiances" [54]. The condition of possibility of the equal disempowerment of doctor and patient is this multiplication of stakeholders in healthcare, and that *power resides elsewhere*.

A warranted objection is that the doctor–patient relationship never existed in isolation, that external stakeholders and actors (such as family members or social insurance agencies) and more impersonal, abstract, power structures (such as class, culture, market, gender, etc.) always have conditioned and influenced the patient-doctor interaction [1, 35, 54, 58, 64]. These constitute a dimension of external force behind all the enumerated models, that can be large or small, depending on the circumstances. For example, does the partnership model not already contain the possibility of an even distribution of whatever power there is (be it a lot or very little), reducing a distinction between an even distribution of power and an even distribution of powerlessness to a category mistake? As mentioned above, characterizations of the partnership model usually exclude the possibility that powers of doctors and patients might be severely constrained by external forces. Secondly, the partnership model deserves a distinct category as its normative claims are laudable, despite its limited descriptive value in this particular conjuncture. Thirdly, although the partnership model and the model I propose both formally share an even distribution of power, the experiences they produce are qualitatively different. Whereas the partnership model mainly brings to the fore inward negotiation, my suggested equal disempowerment model is dominated by negotiation strategies directed towards the structures in which the doctor–patient interaction is embedded. Hence, another difference is that schematic partnership models allow a bracketing of outside forces without losing grasp of the interaction between doctor and patient as partners (be it for ideological or pedagogical reasons). The main characteristics of how disempowered doctors and patients act and interact, on the other hand, cannot even be comprehended without reference to its outside.

The novelty of my proposition, I believe, is that this relatively new condition of healthcare creates not only problems, but also possibilities. It is not *despite* the characteristics of this age, but *because of them*, that a new kind of bond can be established between doctors and patients. Following philosopher Jan Patočka (which I will return to below) one can also say that being on the receiving end of the cracking whip of domination creates a sentiment between former adversaries—a *solidarity of the shaken* [46]. Similar to philosopher Rahel Jaeggi, I will call the subjects of this new solidarity *comrades* in order to distinguish it from other forms of solidarity.[4] In

[4] "We can see the significance of the distinction between solidarity and compassion when we look at the long history of oppressed groups calling for (and building on) solidarity. Obviously, being treated as a 'comrade' as opposed to being treated as a helpless victim affects the self-esteem of those concerned" [30]. In Sweden in particular, and in Europe in general, one colloquial use of the word "solidarity" tends to dominate. It denotes a welfare arrangement in which "everyone is assumed to make a fair

the remainder of this text I will explore what this new kind of solidarity is and how it manifests in a concrete case.

Solidarity and the Struggle over Welfare Arrangements

Solidarity (in its more conventional form) and the welfare state are tight-knit phenomena. It is therefore reasonable to assume that the dismantling of the welfare arrangements of European states also entails the weakening of solidarity as a principle. Yet, some have identified possible anomalies in this correlation. The Norweigan political scientist Steinar Stjernø, for example, hints at the intimate connection between the contemporary *decomposition* of the welfare state on the one hand, and the formation of solidarity-like bonds between some of its stakeholders that may seep out from the cracks of its neoliberal rearrangement. Firstly, he claims, welfare society has "created" occupational groups that "serve it",[5] and consumers that benefit from it, both of which will stand ready to defend the welfare society in times of crisis. Furthermore, alliances between the direct producers and consumers of welfare services may form when these arrangements are contested:

> In the struggle over welfare arrangements, strong alliances may develop between occupational groups and professionals serving the welfare state and the consumers of its services and the recipients of its transfers [56]

Nevertheless, Stjernø is quite pessimistic about the potential and stability of these "alliances". Although similar to solidarity in some sense, alliances fail to qualify as solidarity proper for a number of reasons:

> This possible new alliance is more difficult to stabilise and more vulnerable to internal disagreement [...] The professionals who serve the welfare state and its consumers are characterised by a high degree of fragmentation, organisationally and politically. They are not bound together by reciprocal feelings of empathy. They do not share a common vision of society. They do not experi-

Footnote 4 (continued)
financial contribution to a collectively organized insurance system that guarantees equal access to health and social care for all members of society" [61]; also see [38, 41]. When talking about solidarity in this way, the community in question is not just any community, but society as a whole. There are of course many different takes on the characteristics of this solidarity-cum-social cohesion. Despite a considerable heterogeneity, there is something that remains invariable throughout its use in classical sociology and the political discourse of both Social Democracy and Christian Democracy: solidarity is the opposite of *conflict*, which in turn is banished from playing any part in the concept [56]. Jacques Donzelot has written a short history of the co-optation of the concept of solidarity during the inception of the Third Republic in France that robbed it of its conflictuality [17]. David Lockwood has argued for abandoning the concept of solidarity, as it is hopelessly tied to sociological functionalism of Émile Durkheim [36].

[5] Among these "large number of occupational groups" that have been "created" by the welfare society are, according to Stjernø, physicians. Although the claim that the profession of medicine was outright *created* by the welfare state might be contested (it was for a long time independent from it), its social position was certainly regulated, modulated and consolidated in different ways by the welfare state. For a Swedish example of these processes, see [13, 21].

> ence a common adversary that can serve to unite them. As we have seen, these were important characteristics of the ideology of the labour movement in the heyday of working-class solidarity in Scandinavia [56]

There are three important points to be made with respect to Stjernø's claims. Firstly, Stjernø operates with the assumption that "working-class solidarity" of labor movements is qualitatively different from the "old" solidarity, whose main characteristics have been mentioned above. Secondly, I would like to argue, Stjernø is wrong to claim a priori that the newly formed bonds between (healthcare) professionals and consumers do not express any of the characteristics of what he calls "working-class solidarity". Thirdly, there is admittedly something special to the "new" solidarity I propose. There is a certain negativity to it, that paradoxically might both qualify and disqualify the phenomenon as solidarity. I will expand on these points.

This is where I turn to the other solidarity, the undercurrent of solidarity tied to emancipatory politics rather than retaining *status quo*. There is indeed a tradition of using the word in a slightly different way, rooted in the rhetoric of the European labor movements, before they followed the Social Democratic turn to a non-conflictual understanding of solidarity in the first half of the twentieth century.[6] In his monumental tracing of the conceptual history of solidarity in Europe, Stjernø terms this conflict-oriented type "working-class solidarity", or "Classic Marxist solidarity" [56]. In contrast to the (old) Durkheimian take on the concept of solidarity, whose main objective is social integration, the main objective of marxist solidarity is the realization of group interests. Most importantly, the "common interests" are articulated "against a third party" [56]. Many have noticed the distinctive nature of this "type of solidarity", and returned to its "permanent characteristic: […] that it involves a commitment *against* an opponent, from whom positive goals must be wrung […] This leads to a *negative* component significantly differentiating this type of solidarity from those mentioned previously" [5]. This type of solidarity has carried additional names (atop of those already mentioned): "oppositional solidarity" [32], "fighting solidarity" [34], "political solidarity" [50], or "solidarity of the shaken" [46]. For many thinkers mentioned above, the main negative component of this other solidarity lies in the way rebellion and conflict against an adversary is the constitutive basis of solidarity. It is through the negativity of rebellion that solidarity in turn is negative. According to Kurt Bayertz, this position has been elegantly summarized by Albert Camus in *The Rebel*: "Man's solidarity is founded upon rebellion, and rebellion, in its turn, can only find its justification in this solidarity". For Camus, rebellion is for collective and daily life what the cartesian dictum of "cogito" is for solitary being: "I rebel—therefore *we* exist" [10]. On closer inspection, however, the specific concept of solidarity relevant for our purposes consists of not one, but multiple negative components. Beyond the negativity of rebellion, there is the negative character of the common denominator between those who become part of this peculiar (non-)community of solidarity. In the beginning, they share no common vision

[6] Hence, it should be admitted that the term "new" might be misleading, as there are roots that go further back.

of society, nor do their "feeling of solidarity" derive from an "identity of class position", if one is to speak with the words of Friedrich Engels [20]. In order to develop this new concept of solidarity, I turn to a concrete case of what Stjernø would call "struggle over welfare arrangements": sickness certification behavior of Swedish doctors in austere times.

Case Study: New Solidarity Between Disempowered Swedish Physicians and Patients in the Sickness Certification Process

The Swedish social security system provides universal income protection in case of inability to work due to sickness. After one week of sick leave, patients are required to provide the Swedish Social Insurance Agency (SSIA) with a sickness certificate, which is compiled by their treating physician, often a general practitioner (GP) at a primary health center. In the last instance it is the SSIA that decides eligibility for sickness benefits. The SSIA can accept the certificate as is, ask for further specification or reject it outright [55]. In recent years, the SSIA has become more rigorous in assessing eligibility of patients, thereby limiting the clinical discretion of physicians in this regard [16, 22, 52]. For example, between 2014 and 2016 the proportion of rejected sickness certificates increased threefold [23]. The Swedish state is certainly not unique in narrowing the scope of social insurance in general, and sickness benefit systems in particular, in this way [25]. This restructuring of social insurance systems, often labelled "neoliberal", is a subset of the rearrangement of the welfare state as a whole (discussed above).

This cluster of reforms has had far reaching consequences for both patients and doctors. For the patients, rejected sickness benefit claims can have serious economic consequences, not to mention the negative health related consequences of the two undesired outcomes of being forced to work despite debilitating sickness, or having no income because of a debilitating sickness. Doctors have reported numerous problems with this rearranged determination of eligibility for sickness benefits. GPs belong to one of the medical specialties that deal with sickness certificates on an almost daily basis, and have been particularly vulnerable to the recent changes: between 2004 and 2017, the proportion of GPs who reported that their medical judgments were questioned by the SSIA rose from 10 to 57%. The number of GPs who experienced that the SSIA requested unnecessary corrections to the sickness certificates increased from 48 to 72% between 2012 and 2017. In 2017, 72% of all surveyed GPs felt that the SSIA requested "objective findings" in cases where objective signs are notoriously difficult to identify in the clinical setting (e.g. psychiatric disability, chronic pain, etc.) [3]. Hence, for doctors, the changes have resulted in two types of problems: their medical professional autonomy and discretion is questioned and curtailed, and their working conditions have deteriorated by the increased paperwork required by the SSIA.

The ideological and paradigmatic underpinning of these reforms has been visible both in the public debate as well as the research on sickness certification praxis. The Swedish public discourse on sickness shifted during the 1990s, and the problem of sickness absence was reframed from being mainly a public health concern,

to a problem of malingering patients and illegitimate overuse of a so-called "too generous" sickness benefit system [31]. Sick patients were hence implicated as malingerers taking advantage of their doctors, the healthcare system and the sickness benefit system. Similarly, the thematics emerged in European research on doctor–patient dynamics regarding sickness certification. People were forcing their will to receive sickness benefits on doctors, and the doctors were passively yielding to their demands [28]. In fact, the majority of studies conducted on sickness certification praxis focused on the doctor–patient relationship as *primarily conflictual* as well as *the primary conflict* in sickness certification [43, 44, 65].

Everyday Resistance Against the Sickness Benefit System

The processes delineated above could certainly be interpreted as expressions of a general loss of trust and solidarity, which have been superseded by a universal logic of suspicion [40, 61]. It could easily be assumed that doctors follow suit and act equally suspicious towards their patients and their sickness benefit claims. However, that does not seem to be the case. Physicians are not just standing idly by. Some of them mount elaborate forms of low-key everyday resistance against the attempted power grab of the SSIA, its stricter standards of sickness benefit eligibility, its logic of austerity and suspicion. One such way of resistance has been documented through interview studies with Swedish GPs. In writing the sickness certificate, they employ "techniques" aimed at making the certificate appear as if it adheres to the stricter standards. For example, as the SSIA demands documentation of "objective signs" for cases where such signs are hard to come by (such as psychiatric disease, some forms of chronic pain, etc.), the appearance of such data is fabricated on the fly. Hence, parts of the anamnesis (the patient's own account) might be presented *as if* it was an objective finding: an account of a depressed mood is "translated" to a clinical sign ("patient has a lowered mood" or "psychomotor retardation"). In the interview study, the motives declared by physicians for doing so were multiple: writing sickness certificates in an evasive fashion was not motivated solely by self-interest, nor by pure altruism. The doctors saved time, so they could do more clinical work instead of paperwork, and defended their medical autonomy and discretion. The patient could recuperate and enjoy income protection [52, 53].

In both the experience of and resistance against the bureaucratic disregard for professional judgment, the *absurdity*—that is, the contradictions and senselessness—of bureaucracy appeared in between the lines of the interview study of Swedish GPs. For example, one doctor lamented that the SSIA forced her to use buzzwords which paradoxically lowered the medical precision of their certificates:

> I write 'cognitively impaired', because I've learnt that they [the SSIA] want to hear that particular phrase. It's not enough to write memory and concentration loss; for some reason the word 'cognitive' must be used [52]

Furthermore, this perceived absurdity was commonly communicated between the doctor and patient. The doctor could be frank with the patient about the weirdly Kafkaesque and common predicament of theirs, exemplified here:

> I've even told the patient: "Maybe this wasn't exactly what you told me, but to be certain that you'll get your sick pay, I will have to write it like this." [52]

The "New" Solidarity of Disempowered Comrades

The dynamics between doctors and patients in the sickness certification process, the transition from adversaries to comrades in and through their common powerlessness, can be understood in terms of philosopher Jan Patočka's idea of a "solidarity of the shaken".[7] In an essay in his *Heretical Writings* ("Wars of the Twentieth Century and the Twentieth Century as War") Patočka develops the idea that the horrors in the trenches of the First World War revealed something very important regarding human coexistence. Through depictions of the front-line experiences, he highlights a special type of coexistence, enabled by the limit-experience of war, of death, and violent conflict. The experience was utterly destabilizing and frightening: "The first phase, which few can transcend, is the experience of meaninglessness and unbearable horror. The front line is absurdity *par excellence*". One of the main consequences of this fundamental shaking is that the "adversary"—the one with whom we have nothing in common but conflict—becomes a "fellow participant in the same situation", through the absurdity of war, and through the brush with death. This is what Patočka calls "the solidarity of the shaken for all their contradiction and conflict". Whichever trench we happen to crouch down in, German or British, in the role of doctor or patient, we come to the insight that "ultimately, all are subject to the crack of the whip" [46].

Likening mundane clinical encounters to life in the trenches of war may seem implausible, even tasteless. However, metaphors of war are commonplace in portrayals of healthcare, even though their use can be problematic. It has been claimed that they stigmatize the ill and shift focus "from fighting the disease to fighting the patient" [42]. Yet, there are some fundamental similarities between war and the clinical encounter that warrant a comparison aided by Patočka's *solidarity of the shaken*. The concept constitutes a *critique* of the senseless killing of war and is therefore less prone to reproduce the negative impact of warfare tropes; it might even counter such effects. The three fundamental similarities are the following: (1) Both war and the clinical encounter can involve severe suffering and death. Through illness as the reminder of the finitude of life, death figures at least to some extent in the background of many clinical encounters. Havi Carel, an influential thinker in the field of phenomenology of illness, goes further and establishes death as a transcendental-existential condition of illness as such: "Death is positioned on the existential

[7] This "solidarity of the shaken" is part of a greater, yet non-systematic, philosophical exploration the "three fundamental movements of human life" [46], which bear similarities both with Heidegger's existential analysis of time and Hannah Arendt's partition of the spheres of human life into labor, work and action [49, 59]. It should be admitted that I do not do justice to the totality of Patočka's thought. My aim is here not to expand on Patočka's thought in general, but to operationalize his interesting take on the idea of solidarity.

horizon of illness, and therefore makes up part of the illness experience" [12].[8] Furthermore, for the doctor, there is the limit-experience of being overworked to the brink of fatigue. It is a form of "self-sacrifice" and an "*endurance* in the face of death", not exclusively in relation to the patient, but also through an ever accelerating production process [46]; (2) Both war and clinical encounters in the era of bureaucracy are in some respects *absurd*: In war, the horror of death is its necessary condition. In healthcare, this may occasionally be the case. There is, however, another dimension of existential loss of meaning or ground that springs forth not from facing death in itself, but from confronting nightmarish bureaucratic inflexibility. This holds true for war as well: while the horror of death is necessary, it is not a *sufficient* cause of that specific type of absurdity. Rather, it is the horror of death *in conjunction with* the destruction of human bodies on an unprecedented industrial scale, initiated by impersonal state structures and carried out by opaque chains of command. Hence, the absurdity in question is not only of the transcendental Sisyphean variant, but simultaneously a worldly and historically specific subspecies often emphasized in the works of Franz Kafka.[9] When internal ends of healthcare are increasingly colonized and replaced by external goals of efficiency and austerity, a similar kind of absurdity emerges, that may lead to losing and being forced to find new ground. In the case of the absurdity of the sickness certification process (mentioned above), that new ground is the solidarity between physicians and patients; 3. There is a procedural similarity between the solidarity of soldiers in war and the encounters between doctors and patients in late capitalism. In contrast to the solidarity of, say, factory workers who start out from a relation of mutual *indifference* to showing solidarity with each other, the starting point of this other form of solidarity is not indifference, but *antagonism*, from which they transition over to solidarity.[10] In a way, the foundations of this new kind of solidarity were built by the metaphors and models of partnership and consumerism. The abandonment of the paternalist paradigm also meant that the interests of physicians and patient

[8] Havi Carel's claim is certainly controversial. It can be argued that there are healthcare encounters where suffering from illness, let alone death, is no more than a hardly distinguishable point in the distance. Medical encounters devoid of any suffering are difficult to imagine (perhaps routine check-ups, that nevertheless involve previous or potential future suffering). There are indeed cases where *serious* harm or death are not prominent at all: cosmetic interventions, routine check-ups, and an infinite number of benign health concerns. On the other hand, there are exceptions to the association between death and war as well (not everyone fought in the frontline). Nevertheless, I believe the *general* claim that war and healthcare are associated with death (specifically with the production and prevention of death, respectively) is valid.

[9] For Albert Camus, one of Kafka's great contributions consisted of identifying and presenting the absurd as encompassing *both* dimensions (the "metaphysical" or "supernatural" versus the secular, historical, worldly or "everyday" dimension) at the same time [9].

[10] Indifference and antagonism as points of departure for different kinds of solidarity should be understood as ideal types. Empirically, there is considerable overlap. Even in the case of factory workers, antagonism may be present from the very beginning: the race to the bottom of unorganized labor where each worker undercuts the other with lower wages, scabs replacing workers on strike, as well as the stratification of workers in terms of other axes of domination (gender, race, etc.). However, antagonism is not a necessary part of the type of solidarity of factory workers. They solidarize despite, not because, of the antagonism.

could not be assumed to automatically overlap. In the superseding framework of partnership their interests often appear as subject to negotiation, and in the framework of consumerism the participants even appear as mutually suspicious adversaries, whose interests must not only be negotiated, but sometimes even fought for [24]. Antagonism is essential to market mediated relations, even if they do not always appear as such. Irrespective of the use-value of whatever is changing hands, the goal is nevertheless for one to buy cheap and for another to sell high. However, the argument of a foundational antagonism between doctor and patient is independent of the conceptual content of the partnership and consumer models. For example, the relationship between doctors and patients in the sickness certification process does not embody any specific doctor–patient relationship model. Even if the logic of mistrust pervades the entire field, in Sweden it is not directly a commodity relation because the *Social Insurance Agency* is state-run and can only indirectly be understood in terms of the consumer model. Due to the institutional framework, the doctor and the patient have still been cast into the pit of sickness certification as adversaries, as "gatekeeping" the resources of the social insurance system is one of the main roles that the Swedish doctor is expected to assume [60]. Given current circumstances, that role unfortunately amounts to being the guardian of austerity [4].

In addition to these points, which make Patočka's (ontologically) negative take on solidarity relevant for our purposes, the concept is also distinctly negative in one further sense. Whereas Steinar Stjernø believes that the lack of "a common vision of society" between physicians and patients automatically disqualifies their relation as being solidaristic, this apparent lack is an essential feature of Patočka's solidarity: "The solidarity of the shaken can say 'no' to the measures of mobilization which make the state of war permanent. It will not offer positive programs but will speak, like Socrates' *daimonion*, in warnings and prohibitions" [46].

Hence, the Patočkean take on solidarity, a subspecies of non-Durkheimian oppositional solidarity, extends the negative character of the phenomenon. In *addition* to being negative by being grounded in rebellion and opposition to an adversary, it is also negative insofar as it unites through the negative experience of death and suffering; that the point of departure for those who solidarize with each other is discord; and finally that it does not offer a "positive program" or have a "vision of society" common to those who are shaken.

Solidarity of the Shaken Physician and Patient in the Sickness Benefit System

It is here time to critically revisit Steinar Stjernø's claim that the alliance between professionals serving the welfare state and their clients (in our case doctors and patients) fails to qualify as "solidarity" proper. It might be true that the phenomenon does not qualify specifically as "working-class solidarity", as physicians and patients do not necessarily "share a common vision of society". However, as seen above this should not automatically disqualify the phenomenon as solidarity. For Jan Patočka, this positive program is not required for a "solidarity of the shaken". Hence, the concept of solidarity might be salvaged if one reconfigures its meaning. It is also noteworthy that Stjernø's postulated lack of "a common adversary that can

serve to unite them" is simply not true in the case study. The common adversary, holding the whip of austerity, is the SSIA. Furthermore, it is the very same whip that redraws the lines of conflict. Doctors and patients start off as adversaries in the sickness certification process, their interests are pitted against each other. Nevertheless, being shaken, simultaneously by the whip of austerity and the encounter with the *absurdity* of bureaucracy, aligns them. The solidarity is evident in the forms and motives of covert resistance practices employed by the physicians. This latter form of negativity (of resistance) is not unique to Patočka's concept of solidarity but is common to the family of "solidarities" to which it belongs.

Conclusion and the Question of Generalizability

In terms of power, the many metaphors of the doctor–patient relationship can be clustered into three distinct groups: paternalism (in which the doctor wields power over the patient); partnership (in which doctor and patient shares the power); consumerism (in which the patient wields power over the doctor). By ordering the metaphors in terms of power and temporal ordinality, a *fourth* possibility arises: a situation in which *neither* doctor *nor* patient have any significant power.

This mutual powerlessness creates a special type of bond between doctors and patients. I have argued that they relate to each other as *comrades*, and that an adequate descriptor of the properties of this relationship is *solidarity* (of the shaken). Rather than social integration, solidarity signifies the unity of those who "are subject to the [same] crack of the whip" [46].

The case study demonstrates the dual effects of austerity: It alienates both doctor and patient, rendering them both powerless; at the same time, through the very same process, it creates the very conditions of its own potential undoing. In the Swedish case, the narrowed eligibility criteria for sickness benefits (a consequence of austerity logics) forces doctors to abandon the impossible task of reconciling their "dual roles" as patient advocates and representatives of the authorities, and side with their patients. The "horror" of being pitted against their patients turns them into allies, and even establishes a form of negative solidarity through this common experience of horror and stress brought about by austerity, bureaucracy and institutional powerlessness. This has warranted the introduction of the concept of "the solidarity of the shaken", devised by Jan Patočka.

An important question is if this "solidarity of the shaken" is generalizable. Can it really be considered somewhat paradigmatic? The idea and phenomenon of (infra-) political *solidarity* between doctors and patients that transcends the traditional therapeutic alliance between them has actually gained some traction in recent years. However, this kind of solidarity has almost exclusively been observed in times of intensified political conflict: On *Tahrir Square* in Cairo during the Arab Spring in 2011, doctors in makeshift tent facilities and protestors forged a deep form of alliance in and through the common adversary, repression and horror they faced [26]; In 2013, the infirmaries in *Gezi Park* in Istanbul "acted as new networks of solidarity and comradeship among doctors and protestors" [11]; Another recent but less militant example of the same phenomenon was observed in the battle against

privatization and market-based administrative ideologies of the British NHS, and the political attacks on the working conditions of junior doctors which culminated in a series of labor strikes in 2016 in the UK. Ranajit Pushkar observed that the "moral and practical logic" of NHS activists and doctors aligned the duties and interests of health care workers and health care users, effectively making possible the formation of a "new" type of "solidarity" between them, based on the recognition of their "mutuality of interests" [47].

What is really at stake in the choice of seemingly descriptive terms? Does it matter if the phenomena above are called "alliance" or "solidarity"? There is of course a normative aspect at play here. Alliances are fleeting and temporary. By arguing for solidarity, the depth and significance of the mutual interests and sufferings of doctors and patients are brought to the fore.

Funding Open access funding provided by Södertörn University. The author received no financial support for the research, authorship, and/or publication of this article.

Declaration

Conflict of interest The author declares that there is no conflict of interest.

Open Access This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/.

References

1. Angell, M. (1993). The doctor as double agent. *Kennedy Institute of Ethics Journal, 3*(3), 279–286. https://doi.org/10.1353/ken.0.0253
2. Árnason, V. (1994). Towards authentic conversations. Authenticity in the patient-professional relationship. *Theoretical Medicine, 15*(3), 227–242. https://doi.org/10.1007/BF01313339
3. Alexanderson, K., Arrelöv, B., Friberg, E., et al. (2018). *Läkares erfarenheter av arbete med sjukskrivning av patienter. Huvudrapport 2018* [Physicians' experiences of handling sickness certification of patients. Main report 2018]. Karolinska institutet.
4. Altermark, N. (2020). *Avslagsmaskinen* [The rejection machine]. Verbal förlag.
5. Bayertz, K. (1999). Four uses of "solidarity." In K. Bayertz (Ed.), *Solidarity.* (pp. 3–28). Kluwer Academic Publishers.
6. Beauchamp, T. L. (1977). Paternalism and biobehavioral control. *The Monist, 60*(1), 62–80. https://doi.org/10.5840/monist197760132
7. Beisecker, A. E., & Beisecker, T. D. (1993). Using metaphors to characterize doctor-patient relationships: Paternalism versus consumerism. *Health Communication, 5*(1), 41–58. https://doi.org/10.1207/s15327027hc0501_3

8. Brody, H. (1997). The physician/patient relationship. In R. M. Veatch (Ed.), *Medical ethics.* (pp. 75–102). Jones and Bartlett Publishers.
9. Camus, A. (1975). *The Myth of Sisyphus*. Penguin Books.
10. Camus, A. (1991). *The rebel: An essay on man in revolt*. Vintage Books.
11. Can, B. (2016). The criminalization of physicians and the delegitimization of violence in Turkey. *Medical Anthropology, 35*(6), 477–488. https://doi.org/10.1080/01459740.2016.1207641
12. Carel, H. (2016). *Phenomenology of illness*. Oxford University Press.
13. Carlhed, C. (2013). The rise of the professional field of medicine in Sweden. *Professions and Professionalism*. https://doi.org/10.7577/pp.562
14. Charles, C., Whelan, T., & Gafni, A. (1999). What do we mean by partnership in making decisions about treatment? *BMJ, 319*, 780–782. https://doi.org/10.1136/bmj.319.7212.780
15. Childress, J. F., & Siegler, M. (1984). Metaphors and models of doctor-patient relationships: Their implications for autonomy. *Theoretical Medicine and Bioethics, 5*(1), 17–30. https://doi.org/10.1007/BF00489243
16. Carlsson, L. (2017) *Healthcare and patient factors affecting sick leave: From a primary health care perspective.* diss. Acta Universitatis Upsaliensis.
17. Donzelot, J. (1988). The promotion of the social. *Economy and Society, 17*(3), 395–427. https://doi.org/10.1080/03085148800000016
18. Dworkin, G. (1972). Paternalism. *The Monist, 56*(1), 64–84. https://doi.org/10.5840/monist197256119
19. Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician–patient relationship. *JAMA, 267*(16), 2221–2226. https://doi.org/10.1001/jama.1992.03480160079038
20. Engels, F. (1970). On the history of the communist league. In K. Marx & F. Engels (Eds.), *Selected works.* (Vol. 3, pp. 173–190). Progress Publishers.
21. Eklöf, M. (2000). *Läkarens ethos: Studier i den svenska läkarkårens identiteter, intressen och ideal 1890–1960* [The ethos of the doctor: Studies of the identities, interests and ideals of the Swedish medical profession, 1890–1960]. diss. University of Linköping.
22. Försäkringskassan. (2018). *Uppföljning av sjukfrånvarons utveckling 2018* [Follow up of the development of sickness absence 2018]. Försäkringskassan.
23. Försäkringskassan. (2017). *Uppföljning av sjukfrånvarons utveckling 2017*: Sjuk- och rehabiliteringspenning [Follow up of the development of sickness absence 2017: Sick pay and rehabilitation pay]. Försäkringskassan.
24. Goodyear-Smith, F., & Buetow, S. (2001). Power issues in the doctor–patient relationship. *Health Care Analysis, 9*(4), 449–462. https://doi.org/10.1023/A:1013812802937
25. Grover, C., & Soldatic, K. (2013). Neoliberal restructuring, disabled people and social (in) security in Australia and Britain. *Scandinavian Journal of Disability Research, 15*(3), 216–232. https://doi.org/10.1080/15017419.2012.724446
26. Hamdy, S. F., & Bayoumi, S. (2015). Egypt's popular uprising and the stakes of medical neutrality. *Culture, Medicine, and Psychiatry, 40*(2), 223–241. https://doi.org/10.1007/s11013-015-9468-1
27. Harrison, M. I. (2004). *Implementing change in health systems: Market reforms in the United Kingdom, Sweden and the Netherlands*. SAGE Publications.
28. Hussey, S., Hoddinott, P., Wilson, P., Dowell, J., & Barbour, R. (2004). Sickness certification system in the United Kingdom: Qualitative study of views of general practitioners in Scotland. *BMJ, 328*(7431), 88. https://doi.org/10.1136/bmj.37949.656389.EE
29. Irvine, R. (2002). Fabricating 'health consumers' in health care politics. In S. Henderson & A. Petersen (Eds.), *Consuming health: The commodification of health care.* (pp. 31–47). Routledge.
30. Jaeggi, R. (2001). Solidarity and indifference. In R. ter Meulen, W. Arts, & R. Muffels (Eds.), *Solidarity in health and social care in Europe.* (pp. 287–308). Springer.
31. Johnson, B. (2010). *Kampen om sjukfrånvaron* [The struggle over sickness absence]. Arkiv.
32. Karagiannis, N. (2007). Multiple solidarities: Autonomy and resistance. In N. Karagiannis & P. Wagner (Eds.), *Varieties of world-making: Beyond globalization.* (pp. 154–172). Liverpool University Press.
33. Kellner, D. (1983). Critical theory, commodities and the consumer society. *Theory, Culture & Society, 1*(3), 66–83. https://doi.org/10.1177/026327648300100306
34. Laitinen, A., & Pessi, A. B. (2015). Solidarity: Theory and practice. An introduction. In A. Laitinen & A. B. Pessi (Eds.), *Solidarity: Theory and practice.* (pp. 1–28). Lexington Books.
35. Lipsky, M. (2010). *Street-level bureaucracy: Dilemmas of the individual in public service*. Russell Sage Foundation.

36. Lockwood, D. (1992). *Solidarity and schism: "The problem of disorder" in Durkheimian and Marxist sociology*. Clarendon.
37. Lukes, S. (2005). *Power: A radical view*. (2nd ed.). Palgrave Macmillan.
38. Maarse, H. (2006). The privatization of health care in Europe: An eight-country analysis. *Journal of Health Politics, Policy and Law, 31*(5), 981–1014. https://doi.org/10.1215/03616878-2006-014
39. McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies, 25*(2), 82–89. https://doi.org/10.1111/j.1470-6431.2001.00183.x
40. Misztal, B. A. (1996). *Trust in modern societies: The search for the bases of social order*. Polity Press.
41. Michailakis, D., & Schirmer, W. (2012). *Solidaritet som finansieringsform och som prioriteringsprincip* [Solidarity as financing form and as priority principle]. Linköping University E-Press. Retrieved October 31, 2019 from http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-75196.
42. Nie, J. B., Gilbertson, A., de Roubaix, M., Staunton, C., van Niekerk, A., Tucker, J. D., & Rennie, S. (2016). Healing without waging war: Beyond military metaphors in medicine and HIV cure research. *The American Journal of Bioethics, 16*(10), 3–11. https://doi.org/10.1080/15265161.2016.1214305
43. Nilsen, S., & Malterud, K. (2017). What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway. *Scandinavian Journal of Primary Health Care, 35*(2), 201–207. https://doi.org/10.1080/02813432.2017.1333309
44. Nilsen, S., Malterud, K., Werner, E. L., et al. (2015). GPs' negotiation strategies regarding sick leave for subjective health complaints. *Scandinavian Journal of Primary Health Care, 33*(1), 40–46. https://doi.org/10.3109/02813432.2015.1001943
45. Novack, D. H., Plumer, R., Smith, R. L., Ochitill, H., Morrow, G. R., & Bennett, J. M. (1979). Changes in physicians' attitudes toward telling the cancer patient. *JAMA, 241*(9), 897–900. https://doi.org/10.1001/jama.1979.03290350017012
46. Patočka, J. (1996). *Heretical essays in the philosophy of history*. Open Court.
47. Pushkar, P. (2019). NHS activism: The limits and potentialities of a new solidarity. *Medical Anthropology, 38*(3), 239–252. https://doi.org/10.1080/01459740.2018.1532421
48. Quill, T. E. (1983). Partnerships in patient care: A contractual approach. *Annals of Internal Medicine, 98*, 228–234. https://doi.org/10.7326/0003-4819-98-2-228
49. Ricoeur, P. (1996). Preface to the French edition of Jan Patočka's Heretical essays. In J. Dodd (Ed.), *Heretical essays in the philosophy of history.* (pp. vii–xvi). Open Court.
50. Scholz, S. J. (2008). *Political solidarity*. Pennsylvania University Press.
51. Shankar, A., Cherrier, H., & Canniford, R. (2006). Consumer empowerment: A Foucauldian interpretation. *European Journal of Marketing, 40*(9–10), 1013–1030. https://doi.org/10.1108/03090560610680989
52. Shutzberg, M. (2019). Unsanctioned techniques for having sickness certificates accepted: A qualitative exploration and description of the strategies used by Swedish general practitioners. *Scandinavian Journal of Primary Health Care, 37*(1), 10–17. https://doi.org/10.1080/02813432.2019.1569426
53. Shutzberg, M. (2020). Literal tricks of the trade: The possibilities and contradictions of Swedish physicians' everyday resistance in the sickness certification process. *Journal of Resistance Studies, 6*(1), 8–39
54. Siegler, M. (1985). The progression of medicine: From physician paternalism to patient autonomy to bureaucratic parsimony. *Archives of Internal Medicine, 145*(4), 713–715. https://doi.org/10.1001/archinte.1985.00360040147031
55. Söderberg, E., & Alexanderson, K. (2005). Sickness certificates as a basis for decisions regarding entitlement to sickness insurance benefits. *Scandinavian Journal of Public Health, 33*(4), 314–320. https://doi.org/10.1080/14034940510005798
56. Stjernø, S. (2005). *Solidarity in Europe: The history of an idea*. Cambridge University Press.
57. Szasz, T. S., & Hollender, M. H. (1956). A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship. *AMA Archives of Internal Medicine, 97*(5), 585–592. https://doi.org/10.1001/archinte.1956.00250230079008
58. Swartling, M. (2008). *Physician sickness certification practice: Focusing on views and barriers among general practitioners and orthopaedic surgeons*. diss. Uppsala universitet.
59. Strandberg, G. (2017). *Politikens omskakning: Negativitet, samexistens och frihet i Jan Patočkas tänkande* [The shaking of politics: negativity, coexistence and freedom in the thought of Jan Patočka]. diss. Södertörns högskola.

60. Söderberg, E., Lindholm, C., Kärrholm, J. & Alexanderson, K. (2010). *Läkares sjukskrivningspraxis: En systematisk litteraturöversikt* [Physicians' sick listing practices: A systematic review of the literature] (SOU 2010:107). Fritze.
61. ter Meulen, R., Arts, W., & Muffels, R. (2001). Solidarity, health and social care in Europe: Introduction to the volume. In R. ter Meulen, W. Arts, & R. Muffels (Eds.), *Solidarity in health and social care in Europe.* (pp. 1–11). Springer.
62. Thomasma, D. C. (1983). Beyond medical paternalism and patient autonomy: A model of physician conscience for the physician-patient relationship. *Annals of Internal Medicine, 98*(2), 243–248. https://doi.org/10.7326/0003-4819-98-2-243
63. Veatch, R. M. (1972). Models for ethical medicine in a revolutionary age. *The Hastings Center Report, 2*(3), 5–7. https://doi.org/10.2307/3560825
64. Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behavior, 30*(2), 220–239. https://doi.org/10.2307/2137015
65. Wynne-Jones, G., Mallen, C. D., Main, C. J., et al. (2010). What do GPs feel about sickness certification? A systematic search and narrative review. *Scandinavian Journal of Primary Health Care, 28*(2), 67–75. https://doi.org/10.3109/02813431003696189

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Södertörn Doctoral Dissertations

1. Jolanta Aidukaite, *The Emergence of the Post-Socialist Welfare State: The case of the Baltic States: Estonia, Latvia and Lithuania*, 2004
2. Xavier Fraudet, *Politique étrangère française en mer Baltique (1871–1914): de l'exclusion à l'affirmation*, 2005
3. Piotr Wawrzeniuk, *Confessional Civilising in Ukraine: The Bishop Iosyf Shumliansky and the Introduction of Reforms in the Diocese of Lviv 1668–1708*, 2005
4. Andrej Kotljarchuk, *In the Shadows of Poland and Russia: The Grand Duchy of Lithuania and Sweden in the European Crisis of the mid-17th Century*, 2006
5. Håkan Blomqvist, *Nation, ras och civilisation i svensk arbetarrörelse före nazismen*, 2006
6. Karin S Lindelöf, *Om vi nu ska bli som Europa: Könsskapande och normalitet bland unga kvinnor i transitionens Polen*, 2006
7. Andrew Stickley. *On Interpersonal Violence in Russia in the Present and the Past: A Sociological Study*, 2006
8. Arne Ek, *Att konstruera en uppslutning kring den enda vägen: Om folkrörelsers modernisering i skuggan av det Östeuropeiska systemskiftet*, 2006
9. Agnes Ers, *I mänsklighetens namn: En etnologisk studie av ett svenskt biståndsprojekt i Rumänien*, 2006
10. Johnny Rodin, *Rethinking Russian Federalism: The Politics of Intergovernmental Relations and Federal Reforms at the Turn of the Millennium*, 2006
11. Kristian Petrov, *Tillbaka till framtiden: Modernitet, postmodernitet och generationsidentitet i Gorbačevs glasnost' och perestrojka*, 2006
12. Sophie Söderholm Werkö, *Patient patients? Achieving Patient Empowerment through Active Participation, Increased Knowledge and Organisation*, 2008
13. Peter Bötker, *Leviatan i arkipelagen: Staten, förvaltningen och samhället. Fallet Estland*, 2007
14. Matilda Dahl, *States under scrutiny: International organizations, transformation and the construction of progress*, 2007
15. Margrethe B. Søvik, *Support, resistance and pragmatism: An examination of motivation in language policy in Kharkiv*, Ukraine, 2007
16. Yulia Gradskova, *Soviet People with female Bodies: Performing beauty and maternity in Soviet Russia in the mid 1930–1960s*, 2007
17. Renata Ingbrant, *From Her Point of View: Woman's Anti-World in the Poetry of Anna Świrszczyńska*, 2007
18. Johan Eellend, *Cultivating the Rural Citizen: Modernity, Agrarianism and Citizenship in Late Tsarist Estonia*, 2007
19. Petra Garberding, *Musik och politik i skuggan av nazismen: Kurt Atterberg och de svensk-tyska musikrelationerna*, 2007
20. Aleksei Semenenko, *Hamlet the Sign: Russian Translations of Hamlet and Literary Canon Formation*, 2007
21. Vytautas Petronis, *Constructing Lithuania: Ethnic Mapping in the Tsarist Russia, ca. 1800–1914*, 2007
22. Akvile Motiejunaite, *Female employment, gender roles, and attitudes: the Baltic countries in a broader context*, 2008

23. Tove Lindén, *Explaining Civil Society Core Activism in Post-Soviet Latvia*, 2008
24. Pelle Åberg, *Translating Popular Education: Civil Society Cooperation between Sweden and Estonia*, 2008
25. Anders Nordström, *The Interactive Dynamics of Regulation: Exploring the Council of Europe's monitoring of Ukraine*, 2008
26. Fredrik Doeser, *In Search of Security After the Collapse of the Soviet Union: Foreign Policy Change in Denmark, Finland and Sweden, 1988–1993*, 2008
27. Zhanna Kravchenko. *Family (versus) Policy: Combining Work and Care in Russia and Sweden*, 2008
28. Rein Jüriado, *Learning within and between public-private partnerships*, 2008
29. Elin Boalt, *Ecology and evolution of tolerance in two cruciferous species*, 2008
30. Lars Forsberg, *Genetic Aspects of Sexual Selection and Mate Choice in Salmonids*, 2008
31. Eglė Rindzevičiūtė, *Constructing Soviet Cultural Policy: Cybernetics and Governance in Lithuania after World War II*, 2008
32. Joakim Philipson, *The Purpose of Evolution: 'struggle for existence' in the Russian-Jewish press 1860–1900*, 2008
33. Sofie Bedford, *Islamic activism in Azerbaijan: Repression and mobilization in a post-Soviet context*, 2009
34. Tommy Larsson Segerlind, *Team Entrepreneurship: A process analysis of the venture team and the venture team roles in relation to the innovation process*, 2009
35. Jenny Svensson, *The Regulation of Rule-Following: Imitation and Soft Regulation in the European Union*, 2009
36. Stefan Hallgren, *Brain Aromatase in the guppy, Poecilia reticulate: Distribution, control and role in behavior*, 2009
37. Karin Ellencrona, *Functional characterization of interactions between the flavivirus NS5 protein and PDZ proteins of the mammalian host,* 2009
38. Makiko Kanematsu, *Saga och verklighet: Barnboksproduktion i det postsovjetiska Lettland,* 2009
39. Daniel Lindvall, *The Limits of the European Vision in Bosnia and Herzegovina: An Analysis of the Police Reform Negotiations,* 2009
40. Charlotta Hillerdal, *People in Between – Ethnicity and Material Identity: A New Approach to Deconstructed Concepts*, 2009
41. Jonna Bornemark, *Kunskapens gräns – gränsens vetande,* 2009
42. Adolphine G. Kateka, *Co-Management Challenges in the Lake Victoria Fisheries: A Context Approach*, 2010
43. René León Rosales, *Vid framtidens hitersta gräns: Om pojkar och elevpositioner i en multietnisk skola*, 2010
44. Simon Larsson, *Intelligensaristokrater och arkivmartyrer: Normerna för vetenskaplig skicklighet i svensk historieforskning 1900–1945*, 2010
45. Håkan Lättman, *Studies on spatial and temporal distributions of epiphytic lichens*, 2010
46. Alia Jaensson, *Pheromonal mediated behaviour and endocrine response in salmonids: The impact of cypermethrin, copper, and glyphosate*, 2010
47. Michael Wigerius, *Roles of mammalian Scribble in polarity signaling, virus offense and cell-fate determination,* 2010
48. Anna Hedtjärn Wester, *Män i kostym: Prinsar, konstnärer och tegelbärare vid sekelskiftet 1900*, 2010

49. Magnus Linnarsson, *Postgång på växlande villkor: Det svenska postväsendets organisation under stormaktstiden*, 2010
50. Barbara Kunz, *Kind words, cruise missiles and everything in between: A neoclassical realist study of the use of power resources in U.S. policies towards Poland, Ukraine and Belarus 1989–2008*, 2010
51. Anders Bartonek, *Philosophie im Konjunktiv: Nichtidentität als Ort der Möglichkeit des Utopischen in der negativen Dialektik Theodor W. Adornos,* 2010
52. Carl Cederberg, *Resaying the Human: Levinas Beyond Humanism and Antihumanism*, 2010
53. Johanna Ringarp, *Professionens problematik: Lärarkårens kommunalisering och välfärdsstatens förvandling*, 2011
54. Sofi Gerber, *Öst är Väst men Väst är bäst: Östtysk identitetsformering i det förenade Tyskland*, 2011
55. Susanna Sjödin Lindenskoug, *Manlighetens bortre gräns: Tidelagsrättegångar i Livland åren 1685–1709*, 2011
56. Dominika Polanska, *The emergence of enclaves of wealth and poverty: A sociological study of residential differentiation in post-communist Poland*, 2011
57. Christina Douglas, *Kärlek per korrespondens: Två förlovade par under andra hälften av 1800-talet*, 2011
58. Fred Saunders, *The Politics of People – Not just Mangroves and Monkeys: A study of the theory and practice of community-based management of natural resources in Zanzibar*, 2011
59. Anna Rosengren, *Åldrandet och språket: En språkhistorisk analys av hög ålder och åldrande i Sverige cirka 1875–1975*, 2011
60. Emelie Lilliefeldt, *European Party Politics and Gender: Configuring Gender-Balanced Parliamentary Presence*, 2011
61. Ola Svenonius, *Sensitising Urban Transport Security: Surveillance and Policing in Berlin, Stockholm, and Warsaw*, 2011
62. Andreas Johansson, *Dissenting Democrats: Nation and Democracy in the Republic of Moldova*, 2011
63. Wessam Melik, *Molecular characterization of the Tick-borne encephalitis virus: Environments and replication*, 2012
64. Steffen Werther, *SS-Vision und Grenzland-Realität: Vom Umgang dänischer und „volksdeutscher" Nationalsozialisten in Sønderjylland mit der „großgermanischen" Ideologie der SS*, 2012
65. Peter Jakobsson, *Öppenhetsindustrin*, 2012
66. Kristin Ilves, *Seaward Landward: Investigations on the archaeological source value of the landing site category in the Baltic Sea region*, 2012
67. Anne Kaun, *Civic Experiences and Public Connection: Media and Young People in Estonia*, 2012
68. Anna Tessmann, *On the Good Faith: A Fourfold Discursive Construction of Zoroastripanism in Contemporary Russia*, 2012
69. Jonas Lindström, *Drömmen om den nya staden: stadsförnyelse i det postsovjetisk Riga,* 2012
70. Maria Wolrath Söderberg, *Topos som meningsskapare: retorikens topiska perspektiv på tänkande och lärande genom argumentation*, 2012
71. Linus Andersson, *Alternativ television: former av kritik i konstnärlig TV-produktion,* 2012
72. Håkan Lättman, *Studies on spatial and temporal distributions of epiphytic lichens*, 2012
73. Fredrik Stiernstedt, Mediearbete i mediehuset: produktion i förändring på MTG-radio, 2013

74. Jessica Moberg, *Piety, Intimacy and Mobility: A Case Study of Charismatic Christianity in Present-day Stockholm*, 2013
75. Elisabeth Hemby, *Historiemåleri och bilder av vardag: Tatjana Nazarenkos konstnärskap i 1970-talets Sovjet*, 2013
76. Tanya Jukkala, *Suicide in Russia: A macro-sociological study*, 2013
77. Maria Nyman, *Resandets gränser: svenska resenärers skildringar av Ryssland under 1700-talet*, 2013
78. Beate Feldmann Eellend, *Visionära planer och vardagliga praktiker: postmilitära landskap i Östersjöområdet,* 2013
79. Emma Lind, *Genetic response to pollution in sticklebacks: natural selection in the wild*, 2013
80. Anne Ross Solberg, *The Mahdi wears Armani: An analysis of the Harun Yahya enterprise,* 2013
81. Nikolay Zakharov, *Attaining Whiteness: A Sociological Study of Race and Racialization in Russia,* 2013
82. Anna Kharkina, *From Kinship to Global Brand: the Discourse on Culture in Nordic Cooperation after World War II*, 2013
83. Florence Fröhlig, *A painful legacy of World War II: Nazi forced enlistment: Alsatian/ Mosellan Prisoners of war and the Soviet Prison Camp of Tambov*, 2013
84. Oskar Henriksson, *Genetic connectivity of fish in the Western Indian Ocean*, 2013
85. Hans Geir Aasmundsen, *Pentecostalism, Globalisation and Society in Contemporary Argentina*, 2013
86. Anna McWilliams, *An Archaeology of the Iron Curtain: Material and Metaphor*, 2013
87. Anna Danielsson, *On the power of informal economies and the informal economies of power: rethinking informality, resilience and violence in Kosovo*, 2014
88. Carina Guyard, *Kommunikationsarbete på distans*, 2014
89. Sofia Norling, *Mot "väst": om vetenskap, politik och transformation i Polen 1989–2011*, 2014
90. Markus Huss, *Motståndets akustik: språk och (o)ljud hos Peter Weiss 1946–1960,* 2014
91. Ann-Christin Randahl, *Strategiska skribenter: skrivprocesser i fysik och svenska*, 2014
92. Péter Balogh, *Perpetual borders: German-Polish cross-border contacts in the Szczecin area*, 2014
93. Erika Lundell, *Förkroppsligad fiktion och fiktionaliserade kroppar: levande rollspel i Östersjö-regionen*, 2014
94. Henriette Cederlöf, *Alien Places in Late Soviet Science Fiction: The "Unexpected Encounters" of Arkady and Boris Strugatsky as Novels and Films*, 2014
95. Niklas Eriksson, *Urbanism Under Sail: An archaeology of fluit ships in early modern everyday life*, 2014
96. Signe Opermann, *Generational Use of News Media in Estonia: Media Access, Spatial Orientations and Discursive Characteristics of the News Media*, 2014
97. Liudmila Voronova, *Gendering in political journalism: A comparative study of Russia and Sweden,* 2014
98. Ekaterina Kalinina, *Mediated Post-Soviet Nostalgia*, 2014
99. Anders E. B. Blomqvist, *Economic Natonalizing in the Ethnic Borderlands of Hungary and Romania: Inclusion, Exclusion and Annihilation in Szatmár/Satu-Mare, 1867–1944,* 2014
100. Ann-Judith Rabenschlag, *Völkerfreundschaft nach Bedarf: Ausländische Arbeitskräfte in der Wahrnehmung von Staat und Bevölkerung der DDR*, 2014
101. Yuliya Yurchuck, *Ukrainian Nationalists and the Ukrainian Insurgent Army in Post-Soviet Ukraine*, 2014

102. Hanna Sofia Rehnberg, *Organisationer berättar: narrativitet som resurs i strategisk kommunikation*, 2014
103. Jaakko Turunen, *Semiotics of Politics: Dialogicality of Parliamentary Talk*, 2015
104. Iveta Jurkane-Hobein, *I Imagine You Here Now: Relationship Maintenance Strategies in Long-Distance Intimate Relationships*, 2015
105. Katharina Wesolowski, *Maybe baby? Reproductive behaviour, fertility intentions, and family policies in post-communist countries, with a special focus on Ukraine*, 2015
106. Ann af Burén, *Living Simultaneity: On religion among semi-secular Swedes*, 2015
107. Larissa Mickwitz, *En reformerad lärare: konstruktionen av en professionell och betygssättande lärare i skolpolitik och skolpraktik,* 2015
108. Daniel Wojahn, *Språkaktivism: diskussioner om feministiska språkförändringar i Sverige från 1960-talet till 2015*, 2015
109. Hélène Edberg, *Kreativt skrivande för kritiskt tänkande: en fallstudie av studenters arbete med kritisk metareflektion*, 2015
110. Kristina Volkova, *Fishy Behavior: Persistent effects of early-life exposure to 17α-ethinylestradiol*, 2015
111. Björn Sjöstrand, *Att tänka det tekniska: en studie i Derridas teknikfilosofi,* 2015
112. Håkan Forsberg, *Kampen om eleverna: gymnasiefältet och skolmarknadens framväxt i Stockholm, 1987–2011*, 2015
113. Johan Stake, *Essays on quality evaluation and bidding behavior in public procurement auctions*, 2015
114. Martin Gunnarson, *Please Be Patient: A Cultural Phenomenological Study of Haemodialysis and Kidney Transplantation Care*, 2016
115. Nasim Reyhanian Caspillo, *Studies of alterations in behavior and fertility in ethinyl estradiol-exposed zebrafish and search for related biomarkers,* 2016
116. Pernilla Andersson, *The Responsible Business Person: Studies of Business Education for Sustainability,* 2016
117. Kim Silow Kallenberg, *Gränsland: svensk ungdomsvård mellan vård och straff,* 2016
118. Sari Vuorenpää, *Literacitet genom interaction*, 2016
119. Francesco Zavatti, *Writing History in a Propaganda Institute: Political Power and Network Dynamics in Communist Romania*, 2016
120. Cecilia Annell, *Begärets politiska potential: Feministiska motståndsstrategier i Elin Wägners 'Pennskaftet', Gabriele Reuters 'Aus guter Familie', Hilma Angered-Strandbergs 'Lydia Vik' och Grete Meisel-Hess 'Die Intellektuellen',* 2016
121. Marco Nase, *Academics and Politics: Northern European Area Studies at Greifswald University, 1917–1992,* 2016
122. Jenni Rinne, *Searching for Authentic Living Through Native Faith – The Maausk movement in Estonia*, 2016
123. Petra Werner, *Ett medialt museum: lärandets estetik i svensk television 1956–1969*, 2016
124. Ramona Rat, *Un-common Sociality: Thinking sociality with Levinas*, 2016
125. Petter Thureborn, *Microbial ecosystem functions along the steep oxygen gradient of the Landsort Deep, Baltic Sea*, 2016
126. Kajsa-Stina Benulic, *A Beef with Meat Media and audience framings of environmentally unsustainable production and consumption*, 2016
127. Naveed Asghar, *Ticks and Tick-borne Encephalitis Virus – From nature to infection*, 2016

128. Linn Rabe, *Participation and legitimacy: Actor involvement for nature conservation*, 2017
129. Maryam Adjam, *Minnesspår: hågkomstens rum och rörelse i skuggan av en flykt*, 2017
130. Kim West, *The Exhibitionary Complex: Exhibition, Apparatus and Media from Kulturhuset to the Centre Pompidou, 1963–1977*, 2017
131. Ekaterina Tarasova, *Anti-nuclear Movements in Discursive and Political Contexts: Between expert voices and local protests, 2017*
132. Sanja Obrenović Johansson, *Från kombifeminism till rörelse: Kvinnlig serbisk organisering i förändring, 2017*
133. Michał Salamonik, *In Their Majesties' Service: The Career of Francesco De Gratta (1613–1676) as a Royal Servant and Trader in Gdańsk,* 2017
134. Jenny Ingridsdotter, *The Promises of the Free World: Postsocialist Experience in Argentina and the Making of Migrants, Race, and Coloniality*, 2017
135. Julia Malitska, *Negotiating Imperial Rule: Colonists and Marriage in the Nineteenth century Black Sea Steppe,* 2017
136. Natalya Yakusheva, *Parks, Policies and People: Nature Conservation Governance in Post-Socialist EU Countries,* 2017
137. Martin Kellner, *Selective Serotonin Re-uptake Inhibitors in the Environment: Effects of Citalopram on Fish Behaviour,* 2017
138. Krystof Kasprzak, *Vara – Framträdande – Värld: Fenomenets negativitet hos Martin Heidegger, Jan Patočka och Eugen Fink*, 2017
139. Alberto Frigo, *Life-stowing from a Digital Media Perspective: Past, Present and Future*, 2017
140. Maarja Saar, *The Answers You Seek Will Never Be Found At Home: Reflexivity, biographical narratives and lifestyle migration among highly-skilled Estonians*, 2017
141. Anh Mai, *Organizing for Efficiency: Essay on merger policies, independence of authorities, and technology diffusion*, 2017
142. Gustav Strandberg, *Politikens omskakning: Negativitet, samexistens och frihet i Jan Patočkas tänkande*, 2017
143. Lovisa Andén, *Litteratur och erfarenhet i Merleau-Pontys läsning av Proust, Valéry och Stendhal*, 2017
144. Fredrik Bertilsson, *Frihetstida policyskapande: uppfostringskommissionen och de akademiska konstitutionerna 1738–1766*, 2017
145. Börjeson, Natasja, *Toxic Textiles – towards responsibility in complex supply chains*, 2017
146. Julia Velkova, *Media Technologies in the Making – User-Driven Software and Infrastructures for computer Graphics Production*, 2017
147. Karin Jonsson, *Fångna i begreppen? Revolution, tid och politik i svensk socialistisk press 1917–1924*, 2017
148. Josefine Larsson, *Genetic Aspects of Environmental Disturbances in Marine Ecosystems – Studies of the Blue Mussel in the Baltic Sea*, 2017
149. Roman Horbyk, *Mediated Europes – Discourse and Power in Ukraine, Russia and Poland during Euromaidan*, 2017
150. Nadezda Petrusenko, *Creating the Revolutionary Heroines: The Case of Female Terrorists of the PSR (Russia, Beginning of the 20th Century)*, 2017
151. Rahel Kuflu, *Bröder emellan: Identitetsformering i det koloniserade Eritrea*, 2018

152. Karin Edberg, *Energilandskap i förändring: Inramningar av kontroversiella lokaliseringar på norra Gotland*, 2018
153. Rebecka Thor, *Beyond the Witness: Holocaust Representation and the Testimony of Images - Three films by Yael Hersonski, Harun Farocki, and Eyal Sivan*, 2018
154. Maria Lönn, *Bruten vithet: Om den ryska femininitetens sinnliga och temporala villkor*, 2018
155. Tove Porseryd, *Endocrine Disruption in Fish: Effects of 17α-ethinylestradiol exposure on non-reproductive behavior, fertility and brain and testis transcriptome*, 2018
156. Marcel Mangold, *Securing the working democracy: Inventive arrangements to guarantee circulation and the emergence of democracy policy*, 2018
157. Matilda Tudor, *Desire Lines: Towards a Queer Digital Media Phenomenology*, 2018
158. Martin Andersson, *Migration i 1600-talets Sverige: Älvsborgs lösen 1613–1618*, 2018
159. Johanna Pettersson, *What's in a Line? Making Sovereignty through Border Policy*, 2018
160. Irina Seits, *Architectures of Life-Building in the Twentieth Century: Russia, Germany, Sweden*, 2018
161. Alexander Stagnell, *The Ambassador's Letter: On the Less Than Nothing of Diplomacy*, 2019
162. Mari Zetterqvist Blokhuis, *Interaction Between Rider, Horse and Equestrian Trainer – A Challenging Puzzle*, 2019
163. Robin Samuelsson, *Play, Culture and Learning: Studies of Second-Language and Conceptual Development in Swedish Preschools*, 2019
164. Ralph Tafon, *Analyzing the "Dark Side" of Marine Spatial Planning – A study of domination, empowerment and freedom (or power* in*,* of *and* on *planning) through theories of discourse and power*, 2019
165. Ingela Visuri, *Varieties of Supernatural Experience: The case of high-functioning autism*, 2019
166. Mathilde Rehnlund, *Getting the transport right – for what? What transport policy can tell us about the construction of sustainability*, 2019
167. Oscar Törnqvist, *Röster från ingenmansland: En identitetsarkeologi i ett maritimt mellanrum*, 2019
168. Elise Remling, *Adaptation, now? Exploring the Politics of Climate Adaptation through Post-structuralist Discourse Theory*, 2019
169. Eva Karlberg, *Organizing the Voice of Women: A study of the Polish and Swedish women's movements' adaptation to international structures*, 2019
170. Maria Pröckl, *Tyngd, sväng och empatisk timing - förskollärares kroppsliga kunskaper*, 2020
171. Adrià Alcoverro, *The University and the Demand for Knowledge-based Growth The hegemonic struggle for the future of Higher Education Institutions in Finland and Estonia*, 2020
172. Ingrid Forsler, *Enabling Media: Infrastructures, imaginaries and cultural techniques in Swedish and Estonian visual arts education*, 2020
173. Johan Sehlberg, *Of Affliction: The Experience of Thought in Gilles Deleuze by way of Marcel Proust*, 2020
174. Renat Bekkin, *People of reliable loyalty…: Muftiates and the State in Modern Russia*, 2020
175. Olena Podolian, *The Challenge of 'Stateness' in Estonia and Ukraine: The international dimension a quarter of a century into independence*, 2020
176. Patrick Seniuk, *Encountering Depression In-Depth: An existential-phenomenological approach to selfhood, depression, and psychiatric practice*, 2020
177. Vasileios Petrogiannis, *European Mobility and Spatial Belongings: Greek and Latvian migrants in Sweden*, 2020

178. Lena Norbäck Ivarsson, *Tracing environmental change and human impact as recorded in sediments from coastal areas of the northwestern Baltic Proper*, 2020
179. Sara Persson, *Corporate Hegemony through Sustainability – A study of sustainability standards and CSR practices as tools to demobilise community resistance in the Albanian oil industry*, 2020
180. Juliana Porsani, *Livelihood Implications of Large-Scale Land Concessions in Mozambique: A case of family farmers' endurance*, 2020
181. Anders Backlund, *Isolating the Radical Right – Coalition Formation and Policy Adaptation in Sweden*, 2020
182. Nina Carlsson, *One Nation, One Language? National minority and Indigenous recognition in the politics of immigrant integration*, 2021
183. Erik Gråd, Nudges, *Prosocial Preferences & Behavior: Essays in Behavioral Economics*, 2021
184. Anna Enström, *Sinnesstämning, skratt och hypokondri: Om estetisk erfarenhet i Kants tredje Kritik*, 2021
185. Michelle Rydback, *Healthcare Service Marketing in Medical Tourism – An Emerging Market Study*, 2021
186. Fredrik Jahnke, *Toleransens altare och undvikandets hänsynsfullhet – Religion och meningsskapande bland svenska grundskoleelever*, 2021
187. Benny Berggren Newton, *Business Basics – A Grounded Theory for Managing Ethical Behavior in Sales Organizations*, 2021
188. Gabriel Itkes-Sznap, *Nollpunkten. Precisionens betydelse hos Witold Gombrowicz, Inger Christensen och Herta Müller*, 2021
189. Oscar Svanelid Medina, *Att forma tillvaron: konstruktivism som konstnärligt yrkesarbete hos Geraldo de Barros, Lygia Pape och Lygia Clark*, 2021
190. Anna-Karin Selberg, *Politics and Truth: Heidegger, Arendt and The Modern Political Lie*, 2021
191. Camilla Larsson, *Framträdanden: Performativitetsteoretiska tolkningar av Tadeusz Kantors konstnärskap*, 2021
192. Raili Uibo, *"And I don't know who we really are to each other": Queers doing close relationships in Estonia*, 2021
193. Ignė Stalmokaitė, *New Tides in Shipping: Studying incumbent firms in maritime energy transitions*, 2021
194. Mani Shutzberg, *Tricks of the Medical Trade: Cunning in the Age of Bureaucratic Austerity*, 2021
195. Patrik Höglund, *Skeppssamhället: Rang, roller och status på örlogsskepp under 1600-talet*, 2021

Contemporary praxis of medical doctors entails more than just those capacities conducive to the content of medical encounters between physicians and patients. Physicians can and must be able to act upon the very conditions under which the doctor and patient encounter one another, sometimes doing so in order to keep external interests, such as austerity and efficiency, at bay. Increasingly, the patient-related virtues and capacities of physicians, such as compassion, prudence, temperance and the like, are exposed to be insufficient for "good" doctoring. Resistance against external interests requires another set of capacities. One such capacity and form of action is cunning. While certainly not part of the repertoire of useful or appropriate skills in relation to the patient, it is an indispensable "virtue" of good doctoring insofar as doctors must cleverly navigate institutional forms that block the ultimate ends of healthcare.

Mani Shutzberg carries out research in the theory of practical knowledge. He is a physician educated at Uppsala University, holds an M.A. in philosophy from Södertörn University, and this is his PhD thesis.

Studies in Practical Knowledge, Critical and Cultural Theory, School of Culture and Education, and the Baltic and East European Graduate School, Södertörn University.

ISBN 978-91-89109-78-0 (print) / 978-91-89109-79-7 (digital) | Södertörn University | publications@sh.se

SÖDERTÖRN UNIVERSITY | STOCKHOLM
sh.se