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Connective and Tactfully Tactical: Connective Tactics and Professional Authority in Doctor-Patient Relationships

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A B S T R A C T

Medical authority is often thought to be threatened by lay access to information, but how does professional authority work when citizens have more knowledge and choices? We seek to understand how professional authority works in doctor-patient relationships and what each side does to navigate medical encounters. Our abductive study is relational as it builds on qualitative interviews with both doctors and patients. While doctors and patients each try to steer the encounter towards their desired outcomes, they also employ a series of ‘connective tactics’ to maintain a good, professional relationship. These connective tactics are often draped in a ‘tactful’ and informal manner so as not to threaten the continuous authority relationship between professionals and citizens. Both sides have a repertoire of how to act on authority relations, often supported by courteous attempts to not insist on formal superiority or patient rights. Each side shifts between what may seem like traditional and connective ways to perform medical authority. Doctors can continue to act as knowledge authorities if they also at least appear to be equals with patients; and patients can use internet findings to get involved in medical decisions as long as they pretend to still respect medical authority.

1. Introduction

It is often debated whether professionals can still exercise knowledge-based authority towards lay citizens or whether their position has been compromised by individualisation and the spread of information (Epstein & Timmermans, 2021). The potential changes are not unidirectional, however, because while citizens have easy access to health information and often also a larger say in health decisions today, more information and choices can also appear ‘disturbing’ (Giddens, 1994: 87) and thus increase demand for professional guidance. This re-positioning also corresponds to the shift among professionals from a protective to a ‘connective’ professionalism (Noordegraf, 2020), for instance doctors who may need to use ‘connective’ practices towards patients rather than simply relying on a traditional knowledge hierarchy.

Medical encounters are classic examples of professional authority exercised through knowledge, but also an area where the classic roles may have been changed by patient rights and the spread of information. Empirical research shows that medical professionals experience being challenged by patients for example when patients request other treatments or tests than what doctors suggest (Fenton et al., 2015), which may lead to angry patients and unresolvable conflicts (Nilsen and Malterud, 2017). Research also suggests that doctors are not necessarily influenced by patients’ demands (Menchik & Jin, 2014) and may use various communication or persuasion strategies to overcome patient resistance (Paterniti et al., 2010; Timmermans and Stivers, 2020). What we seek to understand in this article is not so much who has the upper hand in doctor-patient encounters or whose word ultimately prevails. It is rather the means by which both doctors and patients approach their mutual relationship, a relationship of medical authority being renegotiated constantly during consultations about all sorts of medical problems. As explained and defined below, we label these means employed by both doctors and patients as ‘connective tactics’, a term that links both sides of the authority relationship. The research question is thus: How do doctors and patients use connective tactics to navigate their mutual relationship of professional authority? We investigate this question through an abductive in-depth analysis of qualitative interviews with doctors and patients in Denmark.

Our contributions lie mainly in four areas: First, much existing literature on authority in medical encounters focuses on outcomes such...
as medical compliance, patient resistance or persuasion. Our interest here is rather to understand how professional authority is maintained and acted upon by both sides of the professional relationship. As argued below, we may learn more about how professional authority works if we focus on the two-way relationship between doctors and patients rather than whether or not doctors ‘have’ authority. Second, compared to other studies we provide a different type of relational analysis with in-depth qualitative interviews from both sides. Many observational studies use conversation analyses or other approaches to great effect, but there is an additional value in interviewing parties separately and connecting them in the analysis. The unit of analysis in this study is thus not the interaction in itself, but rather doctors’ and patients’ perceptions and approaches to the authority relation.

Third, we elaborate the notion of connective tactics, theoretically in the next section, and empirically through an exploration of various examples. We find that while doctors and patients do cooperate in a connective relationship, they each do so in a tactical manner to steer the encounter towards their perception of the problem, their desired outcomes and their ideals for the authority relationship with the other side. The tactics are often draped in a tactful informality so as not to openly disclose the potential power differential between doctor and patient. Fourth, we adopt an abductive approach, which can be described as an iterative research process of moving back and forth between theory and empirical observations (Schwartz-Shea and Yanow, 2012; Tavory and Timmermans, 2014). The notion of connective tactics was not a preconceived theory or hypothesis, but a result of the abductive process. The study initially focused on challenges to professional authority, but the first coding then led us to introduce other work on connective professionalism and symbolic interactionism. The objective, however, is not an elaborate, comprehensive theory of connective tactics, but a more open theorization of how doctor and patients may engage in different types of relational and connective settings.

2. Scholarship on medical authority, encounters and connective professionalism

Much of the general sociological scholarship on authority is preoccupied with its status in contemporary society and more often actually with the alleged decline, erosion or crisis of authority (Bauman, 1987; Giddens, 1994; Sennett, 1980; Furedi, 2013). These broad debates tend to make sweeping claims about the status of knowledge authority, which are rarely examined empirically. They do, however, help us asking questions about how knowledge authority works in a contemporary setting where hierarchies are no longer taken for granted. This is also relevant for medical authority, which some argue is undermined by external factors such as formal state regulation or socio-cultural norms (Cecchini and Harris, 2022; Maynard-Moody and Musheno 2003). Similarly, patients may use various resources in their interactions with doctors or other frontline workers (Masood and Azfar Nisar, 2020). Timmermans and Stivers (2020: 62) show how physicians and patients each control some aspects of authority in both the epistemic (knowledge) and deontic (action) domains, a distinction somewhat similar to Starr’s divide between cultural and social authority (2017). Physicians typically exert epistemic authority on medical knowledge and diagnostics as well as deontic authority on access to prescriptions, tests and referrals. Patients also have some degree of epistemic authority because diagnoses are typically built on their preferences and perceptions of symptoms while they also may come with extensive research from the internet or through ‘lay referrals’ of what other patients have told them (Freidson, 1970: 292). Furthermore, patients have some control of actions, for instance in administering treatment and which information they choose to share or hide.

If we combine these insights with connective professionalism, both sides may re-enact the authority relationship as being entirely equal while still drawing on these resources and domains. The doctors may, for instance, pretend to be more interested in the patient’s internet searches than they really are as a sort of ‘noble oblige’ through which those of high status are expected to curb their power of embarrassing their ‘subordinates’ (Goffman, 1967: 28). The patient, in contrast, may pretend to respect the doctor’s knowledge and authority more than they really do to secure the desired referral or prescription, or they may do so simply to better connect and maintain a good relationship with their doctor.

The analysis below characterizes a series of ‘connective tactics’ employed by doctors and/or patients. We define connective tactics as the types of actions undertaken by professionals and citizens with the dual aim to achieve a desired result while simultaneously being able to maintain an ongoing connective relationship with the other party. These tactics may include acting understanding and sympathetic, making deals etc. in order to tactfully convert potential conflicts into a good connection. Hence, tactics are not only aimed at achieving a specific outcome, but at maintaining or building rapport. Connective tactics may manifest themselves differently in other institutional contexts, but outside of very uneven or traditional hierarchies, most professional-citizen encounters are likely to involve such a combination of approaches. The professional authority relationship can be understood as an arena where professionals and citizens play around the different expectations built into each role while constantly making sure to maintain a good, continuous relationship. Despite all this context-based variation, however, we argue that it is necessary for professionals and citizens today to be able to use connective tactics and shift between various roles rather than simply remain in one, traditional role as either a knowledge authority or the subject thereof. Calling the tactics ‘connective’ does not necessarily imply connective or cooperative spirit in the mutual facework of doctor and patient (Goffman, 1967: 27), but mainly that both sides seem destined to maintain the authority relationship through various actions in the encounter. We label these actions as ‘tactics’ rather than strategies, for example, because they appear to be chosen on the fly and thus shift depending on the situations.

The empirical inquiry begins with how each side understands the authority relationship between doctors and patients. This is an important first step, because doctors and patients will likely act based on how
they think doctor-patient relationships should be and whether the current status of medical authority is perceived as intact of fraught with problems. We then go on to characterize the different types of tactics that respondents apply to navigate in this relationship. In the following, we present the empirical background of the study and explain some of its core methodological choices and reflections.

3. Methods and data

We use a qualitative research design based on in-depth interviews with doctors and patients to explore how they ascribe meaning to their relationship and their actions. Interviews do not enable direct observations of where authority is negotiated ‘in action’ (Jerolmack and Kahn, 2014), but they can access emotions and reflections which are not always observable in behaviour (Lamont and Swidler, 2014). Interviewing parties separately brings out opinions, impressions and understandings that they would not share with each other in a direct conversation. Even if some of this is just talk, it shows their reflections on how to make medical encounters work.

We focus on medical encounters between physicians and patients because this type of relationship represents a generic type of knowledge-based authority that all citizens face from time to time, and where the internet offers citizens plenty of alternative information to potentially contest the physician’s authority.

The data consists of 37 in-depth interviews (20 doctors and 17 patients). Doctors were recruited through letters sent to a random selection of general practice clinics in a mid-size Danish city plus a few practices from a poorer, rural area. Most Danish general practices are privately owned by one or several doctors, but almost their entire revenue is based on fee-for-service payments from the regionally administered universal health care system (Larsen, 2020). Only in rare situations (e.g., flu or malaria vaccines) would patients have direct economic transactions with general practitioners. Aside from providing initial medical examinations and diagnoses, the general practitioner is the gatekeeper to referrals to hospitals or medical specialists and to drug prescriptions. We maximized the range of the sample to capture a variety of perspectives and achieve data saturation (Weiss, 1995) and thus include both male and female doctors with varying degrees of experience and with different patient populations (e.g. varied socioeconomic and ethnic backgrounds). Similarly, the citizens were sampled to secure variation in relation to gender, age, education and socioeconomic background. They were recruited among respondents to a previous survey. The interviews were conducted in Danish partly by one of the authors, partly by assistants. Research participants gave consent to participate and were informed about the aim of the research, data storage and potential withdrawal of consent. All interviews were completed in person before the COVID pandemic.

The interview questions focused on how physicians understood their role, potential challenges to medical authority, and finally how they handled such situations. We asked citizens about their perceptions of different kinds of professionals, including doctors, and their willingness to follow professional advice, and encouraged them to describe how they tried to handle concrete encounters with doctors. Both groups of interviews followed general guidelines for in-depth semi-structured interviews with open and concrete questions, adjusting language to the context of the participant, etc. (Kvale, 2008; Weiss, 1995). We used exemplifying probes to get interview participants to describe concrete experiences and thus to enhance analytical validity. The interview guides are included in full in the appendix.

All interviews were audio recorded and subsequently transcribed in Danish by assistants following a transcription guide to enhance the descriptive validity of the accounts. Afterwards, the data was coded in multiple phases to capture perspectives and insights overlooked in the initial coding, and thus also to achieve coding saturation. Inspired by first- and second-cycle coding (Miles et al., 2017), we coded the data twice using the NVivo software. In the first round, we coded two-thirds of the data openly, taking the data rather than theory as our point of departure with the research question in mind. The purpose was to not overlook important aspects not included in the initial theory. We tried to remain close to the data, for example by using in vivo codes and verbs to capture actions (Miles et al., 2017).

This led to two separate second-order coding schemes for doctors and patients, and with all codes defined to improve dependability (Miles et al., 2017). All data was then coded with either of these second-order schemes, but still with an openness to new aspects and an eye to negative or contradictory cases (Schwartz-Shea and Yanow, 2012). The second coding was done by one of the authors and two assistants, and it resulted in new subcodes due to new observations. The final coding schemes are available in the appendix.

To get an overview of the coded data and identify patterns in the material we made use of displays that is a visual format (in this case tables) that presents information systematically, so the user can draw valid conclusions and take needed action’ (Miles et al. 2017). We have worked with the original language (Danish) throughout the analysis to enhance the interpretive validity of the account by remaining closer to the wording of the interview participant. Only quotes presented in the article have been translated to English by the authors.

The analysis presents interview extracts as a form of power quotes, i.e. parts of data that most effectively illustrate analytical points and thus illustrate the overall findings (Pratt, 2009). We also incorporate matrix displays (tables) which illustrate the number of times and data sources that particular tactics appear in. These displays are not meant to offer quantitative evidence of our argument, but to show the breadth of the findings.

4. Analysis

The structure of the analysis reflects the iterative steps in the abductive process in the sense that the interview study began as an inquiry about authority relationships between doctors and patients, reported mainly in the first part of the analysis describing how doctors and patients understand their mutual authority relationship. Which factors do they emphasize as important in this relationship, and where, if at all, do they see medical authority challenged? After this introductory part, the second part goes on to characterize the different connective tactics that doctors and patients told us about when we asked about what they do when they approach each other in medical encounters, both the regular everyday meetings and the rarer, conflictual situations.

4.1. Perceptions of the authority relationship

Almost all interview participants confirm that doctors are generally viewed as authorities. The interviewed doctors feel that patients usually listen to them and need their guidance and advice because of the medical knowledge and insight that patients do not have, as the following quote illustrates:

‘They’re much more prepared and they have searched around, but they cannot connect it, because they do not have the background knowledge. Not because they’re stupid, but because they do not have the professional background, they simply cannot select and they cannot evaluate [the facts] […] They are better prepared and you need to argue better […] for a given treatment, but I feel that I am still an authority. I really feel that I still have that.’

Doctor 12

This doctor has experienced patients showing up well-informed and well-prepared, which may require her to argue more. She still feels like an authority, however, because patients do not have the background knowledge from a medical education. Simply having information is thus perceived as different from the medical knowledge needed to analyse, diagnose, and prescribe treatment. The patients’ information is thus classified as being outside or below the domain of medical knowledge, a
sort of simple gathering of facts with no professional lens. This can be interpreted as an empirical manifestation of a knowledge hierarchy, where data and information are inferior to actual medical knowledge (Ackoff, 1989). Similarly, the interviewed patients also accept the doctor’s authority because of their medical knowledge. Some argue that they should listen to doctors and do what they recommend, because they have medical knowledge unavailable to ordinary citizens:

“If the doctor says “You really should eat more iron” or “You should exercise more” or “Not smoke”, etc. .. then I’ll say: ‘Ok, that’s what I’ll do then’.”

Citizen 8

However, the analysis also shows citizens who feel like they have no alternative but to accept the doctor’s authority, because as an ordinary citizen you ‘don’t have the expert knowledge to evaluate whether the doctor is right’ (citizen 4). Some patients find it almost impossible to question medical opinions in situations where the doctor appears more knowledgeable.

“It’s hard to sit face to face with an expert and say: You’re not right. Because I sit here with no expert knowledge and I do not actually know if the person is right or not. All I can come up with are my feelings.’

Citizen 12

Besides their knowledge, some doctors credit their authority in medical encounters to their own life experience:

‘I have some men both younger or older than me, and who come with lifestyle issues, relationship issues and talk to me about [them]...but it is in some way as an impartial [...] authority [...] It is not like it’s my sister or, you know, there’s nothing that gets in the way.’

Doctor 12

This doctor describes the authority relationship as going beyond expertise, as patients ask for and accept her advice on life issues besides the medical domain. Patients thus seek advice on non-medical problems, because they see the doctor as impartial and uninvolved in personal dilemmas or conflicts. Here, the doctor’s authority comes from being seen as impartial rather than from medical knowledge.

While the data mainly describes medical authority as intact, there are also situations where doctors feel their professional assessments challenged, for instance when patients are very knowledgeable about very specific conditions:

‘I had a patient recently, she was paralyzed in one side of the face, so her father is very active – she’s 40 and he’s 70, I have both of them. And then, damnit, he had found out about the Ramsay Hunt Syndrome with a chickenpox virus around the ear drum. And damnit, I had not heard about that.’

Doctor 15

If doctors feel they have less medical knowledge than the patient, it can be harder to act as the ‘expert’ and hence, a sense of loss of authority may set in. Patients also talk about situations where they have doubted the doctor’s assessments and instructions for example if something in the encounter raises doubt about the doctor’s professional competences as the following quote illustrates:

‘First, I called up the doctor, and then I wrote to her [...] Then I went there the next day to give a blood test, and then when I write her a few days later about the results, she wrote “All looks fine, just continue with the same dosage”. Then I wrote back “What dosage? [laughing] Did I get a prescription?” [doctor:] “God, no!” So, she had simply confused me with someone else, and there I was, like [...] well, how can I trust that it’s me she’s been looking at the next time she replies?’

Citizen 14

These are not challenges to the validity of medical knowledge as such, but to the specific doctor’s competence or efforts in the situation. Medical authority may also be challenged by patients behaving like ‘consumers’ and ‘demand[ing] specific treatments or tests’, as illustrated by this doctor:

‘It was someone whose girlfriend had caught a fungal infection, and they seemed to think that they had infected each other [...] And she had been to her doctor who had prescribed some pills for it [...] and then he wrote to me the other day ’Can’t you just write me a prescription for the same?’’ And there, I said ’No, you have to come, I have to see you’.’ But then he said “argh, I can’t do that. Can’t you just give me the pill?” I don’t think that is okay... him making this request, and I should have just told him that, but eventually I just prescribed him the pill.

Doctor 2

The doctor describes the patients’ self-diagnosis as something they ‘seem to think’, which needs to be verified by a medical professional, a process the patients skip by avoiding the consultation. The quote shows a doctor frustrated by attempts to circumvent her authority and negotiate another decision. The doctor eventually gives up and prescribes the medicine as requested. Patient challenges are thus not necessarily about medical knowledge itself, but also about specific outcomes.

Similar challenges come from well-resourced patients with private health insurance, who several doctors characterize as feeling entitled to a specific test, referral, or treatments because they ‘pay for them’ themselves. This makes the doctors feel their medical authority undermined, because professional evaluations are made irrelevant or reduced to a rubber stamp. These patients embarras the doctor by acting as if they were ‘above’ them, which clearly breaks the protocol for tactful conduct around the authority relationship.

A third type of challenge comes from patients whose information is not from conventional, but rather from alternative medicine or from questionable internet or media sources. A recurring example is parents who refuse to let their children be vaccinated.

‘They didn’t want their child vaccinated against measles, mumps and rubella, and it ended up where I asked them, sort of, why that was, and then she said [...], she came back with a totally stupid argument. I then asked where she had this knowledge from. Well, it was something she had read on Facebook. And there I accidentally said ‘blah!’ or something like that [...]. I just gave up, because I thought: my authority has no weight here [...] because what she reads on Facebook counts for more than what I say [...] And that can be hard to discuss, because they discuss emotions and we discuss facts […]’

Doctor 18

The patient refused child vaccinations after reading on Facebook, which made the doctor experience a loss of authority and utter a clear disapproval (‘Blah!’). The doctor simply gave up because it seemed too difficult to connect or align the patient’s ‘emotional’ vaccine hesitancy with the doctor’s medical reasoning based on ‘facts’. The situation also illustrates a break with the usual tact in these encounters because the doctor skipped any face-saving reactions and expressed direct contempt of the patient’s knowledge.

In summary, the first part of the analysis shows how both doctors and patients normally accept and reproduce the authority relationship. Doctors thus mostly experience their authority as unchallenged. Table 1 gives an overview of how often doctors and patients describe challenges compared to acceptance of professional authority in the medical encounter.

4.2. Tactics for negotiating authority: Avoiding conflict

Based on perceptions of the authority relationship, this second part of the analysis goes on to characterize what doctors and patients do both
Appearing understanding and listening can thus also be a platform for being better equipped to make correct diagnoses and treatment plans. Collaboration: being sympathetic undertaken to get an impression of the patient and patients what the problem might be, a sort of invitation to self-diagnose. The quote below shows a series of actions (listening, asking questions, uncover this right away) – [I ask them] what do they themselves think – with the patient and establishing a connection, which may involve making the patient identify with the doctor, but not everyone, and I also try to learn how to uncover this right away – [I ask them] what do they themselves think is the solution to a given problem, why so, and are they worried about something in particular? Because then I can disclose everything that’s behind it, and really, I can also better understand them. And when they feel understood, you already have a better connection, I think.’

‘Well, some people – but not everyone, and I also try to learn how to uncover this right away – [I ask them] what do they themselves think is the solution to a given problem, why so, and are they worried about something in particular? Because then I can disclose everything that’s behind it, and really, I can also better understand them. And when they feel understood, you already have a better connection, I think.’

Doctor 1

Communication and a good connection make it easier to get the patients onboard, which is also a way to manage interaction and avoid conflict or challenges. Sometimes it is more a tactic of giving the impression of listening rather than actually being interested in what the patient says, as the following quote shows:

‘I also remember a tutoring doctor who said sometimes when you’re looking at these sick children, then you can just pretend like you’re listening to them and that you’re listening super closely, because then they simply feel heard, and then they leave satisfied, and they’ve received the exact same treatment, but the way you act in it, or the little “act”, if we should call it that, it works. And just give yourself these 3 seconds extra to listen for a while, or to dare to have a moment of silence, so it can all just sink in.’

Doctor 11

The doctor describes a ‘little act’ performed to satisfy patients. When disagreement does occur, they may try to find common ground or make informal ‘deals’ with their patients to reach an agreement:

‘Sometimes I say already in my introduction that “With these tests we have here […] I’m quite sure there is nothing wrong with you, but I think we should have an alliance about getting it checked” […] So if it can be part of what I sense is an alliance with the patient about saying that we’re working to find out what this is and we’ll make some sort of plan.’

Doctor 16

The doctor seeks to find common ground with patients or make ‘deals’ with them. This particular doctor emphasizes forming an alliance with the patient and establishing a connection, which may involve giving in to some of the patient’s wishes. Moreover, doctors also place the blame for non-popular decisions on the formal rules and regulations. Some explain to patients how they must follow certain procedures and rules, which means they cannot accommodate the patient’s wishes.

‘I say “Well, that’s how the rules are, just like there’s red, yellow and green, there are rules, and this is how the rules are”. I didn’t make the rules, so there, I just lean on that.’

Doctor 2

This is a way to avoid conflict with patients and keep a positive connection by deflecting blame away from one’s own decisions onto an outside system of abstract rules and regulations (Schmidt Hansen, 2021). Saying ‘I don’t make the rules, I just follow them’, however, mainly appears as a connective tactic to get a desired outcome without damaging the relationship.

Doctors also use anecdotes to make issues more relatable and to connect with patients on a more human level, even though the anecdotes are used in a tactical and not in a friendly sense.

“When people come, they have already made up their mind. Because...and it’s often the mother who comes and says “My child is supposed to be vaccinated soon [...] these stories have been running around, and what do you think about that?” [...] And then I’d say “Well, it’s true there can be side effects, but it’s much more dangerous not to be vaccinated [...] and I have vaccinated my own children and wife”’

Doctor 10

The example above shows a doctor trying to connect with patients sceptical of the HPV vaccine. Here, it is not sufficient to just provide medical information about benefits and possible side effects; it helps to also explain why he personally chose to have his family members vaccinated, i.e. placing himself in the patient’s situation. The doctor seeks to connect with the patient and whichever doubts they may have in a specific situation and perhaps also to downplay the implied professional authority relationship.

Another doctor does not use personal narratives, but rather tells ‘horror stories’ from their professional experience about individuals who were not vaccinated:

‘People who refuse to have their children vaccinated, to be part of the vaccination program […] I can be outraged about that, also because I had this [...] grown man who had the mumps, which turned into meningitis, and who became sterile from that [...] so there, I try to tell them these stories [...], and it does become a bit of a scare campaign, it’s not only something you read about, it’s also something you experience.’

Doctor 2

The aim here is not to make the patient identify with the doctor, but to illustrate and connect the doctor’s professional opinion with a relatable story.

Patients also seek to establish a collaborative relationship and avoid conflict in the medical encounter. Some patients explain that they simply follow the doctor’s advice:

‘If the doctor says “You really should eat more iron” or “You should exercise more” or “Not smoke”, etc. .. then I’ll say: “Ok, that’s what I’ll do then”.’

Citizen 8

This tactic can be labelled complete acceptance, which means that patients choose to follow the doctor’s advice without reservation. It is debatable whether this type of pure obedience to authority really constitutes a tactic, but it nevertheless appears to be a clear choice.

Whereas the citizen in the quote above express complete acceptance and compliance with the doctors’ professional advice, the analysis also shows citizens who seek to avoid conflict and keep a positive connection.
without actually complying to the doctor’s orders. An example is the following quote where the patient does not show the doctor that he disagrees, but instead ignores the advice in practice:

‘I had some pills against the cholesterol, but I couldn’t smell, or taste or anything when I took them, so I was not very good at taking those pills, they were left in the medicine cabinet, I really didn’t want to do that.’

Citizen 2

By keeping his non-compliance secret, the patient can appear tactful towards the doctor in the encounter and ignore the professional decisions without having to confront medical authority openly. This illustrates patients trying to exert control by keeping either actions or information secret from the doctor. Patients may also rely on another tactic to gain some control in the medical encounter. Some interview participants explain how they ask a lot of questions and require thorough and convincing explanations from the doctor:

‘Or I might ask to have it explained so I can understand it [...] I want a complete explanation until I have had it explained well enough and not a second [before]...I want an explanation that I understand.’

Citizen 1

We call this tactic inquiry, because the patient really examines the doctor’s professional opinion and seeks to obtain sufficient knowledge and control rather than relying on the professional’s judgement. This illustrates a very exhaustive type of patient involvement where the doctor is almost reduced to a consulting role. It is still, however, a sort of acceptance of the doctor’s professional knowledge, since the patient actively investigates and seeks to understand the medical explanations given by the doctor without questioning the validity of the knowledge. Moreover, the tactic is still connective in the sense that the patient seeks to build rapport and communicate with the doctor, but in a form where patient retains a final say over the ultimate decision.

4.3. Asserting power when connective tactics fail

Both patients and doctors also sometimes revert from the connective tactics and try a more defensive tactic of asserting power. Even though the doctors normally try to appear on equal footing with and offer patients a say in the consultation, their professional opinions are sometimes articulated explicitly in an attempt to take control and get the upper hand:

‘If people come in with a pain in their back, or their knee or something else, then even if I’m not 100% sure that it’s the mucous sac there or a strained tendon or something similar. So, I’d often have an idea about what it could be and I often use that to try to appear more certain and say “You know what, the thing you have is this: You have a runner’s knee, it’s the tendon right there” [...] And maybe they do not actually have a runner’s knee, but the treatment will almost always be the same.’

Doctor 10

The doctor here deliberately gives a very quick diagnosis without being sure, because it makes patients more willing to accept what he is saying. The patient may not even have a ‘runner’s knee’, but the treatment for these kinds of symptoms is almost always the same. This tactic is about avoiding having medical authority questioned when faced with uncertain diagnoses. Similarly, in cases where patients actually challenge medical decisions, the doctors can make their professional opinion clear and refuse to give in to the patient:

"Then I can say “If you choose to order the medicine online, then it is not with my approval and you must know that there is no documented effect of this medicine and you can get these and these and these side effects”.

Doctor 20

By presenting formal scientific medical knowledge about the issue, the doctor seeks to accentuate the boundaries of medical authority. Patients also sometimes challenge the doctor’s authority explicitly instead of using connective tactics:

‘Well, there was this doctor, or really it was a new one each time, right, who then says to me: “Yes, well, this might be a bit uncomfortable”. And it was a man, right, and there I got up on my elbows and said: “What the hell do you know about that? You don’t have a damn women’s abdomen, for god’s sakes!” And then he was like all astonished, right! Like “Well, I’ve been told”. I don’t want to be an object and they definitely shouldn’t talk to me like I’m just some piece of meat with no feelings and such. […] it’s when someone thinks they know more about me than I do, and I tell them: “This is no good, well if you think you can tell me my neck hurts instead of asking me how I feel, then it illustrates what kind of professional face you have decided to wear, right?” […] it sometimes happens that there are these people who think they know more about another person than the person does. I’m the expert on my body, my life, my mind, my soul, and everything that there is.’

Citizen 4 (bold indicates patient’s emphasis)

This patient questions the doctor’s knowledge directly. The patient claims to have knowledge and experience that the doctor does not, because he does not have a uterus. She may not be a health professional, but as a woman she employs knowledge of her own body as a tactic to confront medical authority. The patient understands herself as an expert on her ‘body, life, mind, and soul’, and has no respect for doctors who fail to acknowledge this. By redrawing the domain of relevant health knowledge in this way, the patient challenges the doctor’s position as the most knowledgeable person in the encounter. This appears as an attempt to partially reverse the authority relationship where the doctor is expected to acknowledge this type of ‘patient expertise’ where the professional will almost by default be the minor. This tactic may not seem very tactful or connective, but it is nevertheless a clear attempt to act on the authority relationship while debating a concrete medical issue. Moreover, the patient’s reaction is caused by what she experiences as the doctor not acting tactfully and being understanding, but treating her ‘like a piece of meat’ (Citizen 4).

Patients can also challenge the doctor’s authority by seeking different types of experts and expertise, either other doctors or from alternative medicine:

‘Well, I went to this naturopath and got this diagnosis, about how my body is. If I eat what I usually eat, live like I usually live, what is it my body will be deprived of so, there I go to the naturopath. I would certainly not go to my doctor there. They [doctors] have sort of sworn not to have anything to do with that sort of thing, right?’

Citizen 4 (bold indicates patient’s emphasis)

Table 2 provides an overview of the tactics that citizens and doctors use to navigate the medical encounter. Most tactics aim to maintain a good relationship and avoid conflicts or explicit challenges to professional authority, although both doctors and patients also draw on fewer connective tactics to gain control in the encounter.

5. Discussion

The analysis shows how both doctors and patients draw on connective tactics aimed at building rapport and gaining control of the medical encounter at the same time. The doctors’ tactics include being understanding and sympathetic, making deals with patients, drawing on rules and regulations to deflect blame as well as drawing on personal anecdotes. For patients, connective tactics include complete acceptance and compliance, asking questions, but also hiding non-compliance, which is a way of taking control without damaging the ongoing authority relationship with the doctor. These tactics are ways to build a relationship
with the other part and tactfully convert potential conflicts into a good connection. At the same time, the analysis also shows doctors and patients who confront and challenge each other in attempts to renegotiate the epistemic domain.

The argument about connective tactics presented here can be tied to the ongoing debates about professional authority in both medicine (Menchik, 2021) and more broadly (Gauchat & Andrews, 2018). As recently discussed by Epstein & Timmermans (2021), more research is needed on the cultural authority of medicine in contemporary settings where patients have much more information available. Here, we see that patients may come with more facts about their specific conditions after hours of internet searching, but doctors handle patient encounters many times every day and also control how facts are made relevant in diagnostic decisions. Medical authority has not eroded here, it appears, nor has it been replaced by some sort of equal, open dialogue. Doctors often seem eager to level with their patients and integrate patients’ knowledge into the process, or at least they seem eager to present themselves this way here. Nonetheless, they take clear offense if patients challenge their domain, either with information from social media or in diagnostic decisions. Patients similarly seem to shift quickly between accepting and connecting with the doctor’s knowledge authority and yet still using various tactics to get their view of the situation accepted. Even if authority is thus not a ‘under siege’ here (Timmermans & Stivers, 2020), it is definitely not a ‘secure’ hierarchy either (Noordegraf, 2020).

Both sides of the relationship seem to use a repertoire of connective tactics that are almost always presented and performed very tactfully. Not in the sense of a very formal tone or of appearing impersonal, but a sort of tacit cooperation where each side only rarely needs to insist on appealing to rights or superior positions. Many of the points raised by informants in our analysis – both the challenges they experience and the connective tactics they use – may mirror similar examples in other studies of medical encounters. These individual tactics are given a more coherent meaning within the ‘connective’ professional relationship. For example, the importance of second opinions, private insurance, formal regulations, medical compliance, personalized trust and communicative strategies in medical encounters is well-known (Nilsen & Malterud 2017; Heritage and Maynard, 2006; Paterniti et al. 2010; Fenton et al. 2015). The most important contribution here is perhaps to place these elements in the context of a cooperation between professionals and citizens, which is both connective and tacit.

The broad repertoires of doctors’ and patients’ connective tactics illustrate how medical authority is not simply about whether medical knowledge leads to the right medical decisions and outcomes, or about who has the upper hand. They constitute an integrated connective relationship between professionals and citizens. Some of these tactics may seem mutually exclusive, for instance when doctors appear to shift seamlessly between levelling with patients in a personal and informal way at one moment and then taking a superior stance or ridiculing patients’ experiences at the next. Patients also seem to shift easily between a pure willingness to accept medical authority on one side and only sharing selective information with the doctor on the other. These dual roles look contradictory or insincere when placed side by side, but the ability to shift easily between them and connect with the other side in different ways is perhaps a necessary requirement in a continuous doctor-patient relationship, or for that matter in relationships between professionals and citizens more broadly. Encounters may be far more volatile and potentially conflictual when either doctors or patients seek a very specific outcome and thus care less about continuity. In most situations where citizens encounter professionals, however, both sides need to consider how an overt conflict may hurt their future relationship or reputation among others.

To return to the question of how professionals can still act as authoritative experts (Noordegraf, 2020), we argue that general practitioners can do so if they manage to do exactly that: Act like it. They need to be able to play dual roles, acting as a traditional knowledge authority while also at least appearing to connect on equal terms with patients’ views. Patients, on the other side, can get much more involved in medical decision-making than they were traditionally – even with information they find on the internet – if only they act as if they respect professional authority. These shifts between tactics, roles and faces may look differently in other empirical contexts, but there is a key point here in also extracting them from being just about medicine and diagnostic outcomes. More generally, this shows how citizens can interact with professional knowledge authorities in relationships where both the knowledge and the possible actions available to each side is more complex than very traditional hierarchical relationships. The relational nature of professional and medical authority is an important conclusion here, which is given a stronger emphasis here by placing doctors’ and patients’ connective tactics directly side by side.

It is worth discussing critically, however, how specific the picture painted in this analysis actually is, or whether it may reflect the applied concepts, methods and empirical settings. In terms of theory, it is important to stress that while the relational approach was a methodological choice from the beginning, the analytical findings are not just products of a preconceived theory. As explained, we used an iterative abductive process in which the theoretical focus on connective tactics gradually developed during the analytical process. The original focus and interview guide focused on challenges to medical authority broadly. The analysis added the concept of connective professionalism to understand the observed dynamic between doctors and patients, and finally we integrated insights from symbolic interactionism to grasp the tactical and tactful aspects of this interaction.

The methods and data of course also affect the results. One consideration here is that while interviewing parties separately serves to disclose important ambiguities that would otherwise be held secret, it may also emphasize the tactical aspects more. The methods may thus paint a very cynical portrait of medical encounters, because such a characterization lets informants appear to be smart and in control. Some of this is counterbalanced by placing doctors and patients and their various tactics side by side, which leads us to the conclusion that is not
merely cynical or tactical, but also connective and courteous. Going forward, however, a next step for future research would be to combine these data with observational studies or other types of data. This approach would allow for the examination of how doctors and patients react and respond to each other and thereby provide insights into how authority relations are negotiated, established and reconfigured in specific interactions.

Further, it is interesting to consider whether the empirical context of the Danish health care system constitutes a very unusual or rather normal case of professional authority. Acceptance of professional authority has been shown to follow more generic factors rather than cultural specificities, although with some differences such as less reliance on seeking second opinions in the Danish context (Harrits and Larsen, 2021). When second opinions are less commonly used than in the United States, for instance, the importance of keeping a good relationship with your physician may be higher. There may also be a stronger emphasis on informality and egalitarian ‘levelling’ in a Danish cultural setting, which is also manifested in medical practices typically decorated without medical diplomas on the wall, doctors wearing everyday clothes, etc. The informal surroundings notwithstanding, however, our analysis shows that both sides prioritize tact in their mutual encounters, and the doctors clearly tend to shift in and out of formal authority roles. So, while each empirical context exemplifies different parameters – for example in privately financed health systems or in different clinical settings – we believe that connective tactics would still be important even in different cultural manifestations, although further studies would be needed to examine this in future research.

Finally, we might consider whether the pre-pandemic data still holds in a post-pandemic society where knowledge authorities have experienced new and stronger challenges. Medical and knowledge authority surrounding vaccines and epidemiological information given to the public may potentially look different today. The roles and functions of general practitioners do not seem to have changed as much as may be the case with how citizens generally position themselves towards institutional medical authorities such as national health boards, vaccination programs, etc. In other words, we think the connective and tactfully relationship between doctors and patients will clearly persist even if the pandemic has created new dependencies and forms of resistance, and perhaps also with the increased use of online consultations where connective tactics may play out differently. As with the Danish cultural context, this also demonstrates how different types of clinical settings could be shown in future studies to create other connective tactics.

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**Data availability**

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**Appendix A. Supplementary data**

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**References**


8