

Lars Thorup Larsen

No Third Parties. The Medical Profession Reclaims Authority in Doctor-Patient Relationships

Abstract: A key aspect of the classic doctor-patient relationship is the idea that doctors exert a professional authority through medical expertise while also taking care of the patient. Some professional organizations have held that “no third parties” should come between doctor and patient, be it governments or corporations. The sanctity of medical authority has also met resistance, and doctors are often said to face more demanding patients today with their own information about diagnoses. This article concerns how the medical profession reacts faced with challenged authority. Do they seek to reestablish a classic authority position or develop an alternative relationship with citizens? The analysis compares approximately 1.000 editorials in American, British and Danish medical journals from 1950 to the present. The analysis shows that all medical professions see their authority challenged by third parties, but some react defensively while others try to rethink the authority relation between professionals and citizens.

Keywords: Authority, doctor-patient relationship, document analysis, health care system, critique of medicine, social authority, cultural authority, self-diagnosis

A common assumption in studies of cultural history holds that we live in a society where authorities have fallen off the pedestal (Jensen, 2006). Similar assumptions are also found in the sociological literature on reflexive modernization, for instance in Giddens’ claim that a “non-traditional culture dispenses with final authorities” (1994, p. 87). In understandings such as these, what undermines authority are not particular actors nor their overt resistance to power. The previous obedience to religion, science, political institutions and father figures simply erodes through modernization (Inglehart, 1997). Narratives of a broadside erosion of authority are problematic for a number of reasons. They may easily lead us to the mistaken assumption that authority was somehow uncontested before modernity, and they may also lead contemporary sociologists to treat the problem of authority as more or less overcome in the present (Furedi, 2013, p. 3). Both of these sets of assumptions are problematic. Even if some authorities do of course change, it is important to maintain the analytical starting point that authority relations were never uncontested nor are contestations in the present necessarily signs of a general loss of authority.

If we consider doctors’ professional authority towards patients specifically, there are also dominant narratives about why doctor authority is not what it used to be. One narrative typical claims that medical authority has been overrun from above so to speak, that is undermined by managerialism and political controls (Freidson,

Lars Thorup
Larsen,
Department of
Political Science,
Aarhus University,
Denmark

Contact:
Lars Thorup
Larsen,
Department of
Political Science,
Aarhus University,
Denmark
lars@ps.au.dk

Received:
26 Feb 2016

Accepted:
9 Sept 2016

2001; Dent & Whitehead, 2002; Pedersen, 2011; Togeby, Andersen, Christiansen, Jørgensen, & Vallgård, 2003, p. 145). Another common story is that medical authority has been undercut by patients who google their own diagnoses or in other ways refuse to respect the doctor's superior medical expertise (Furedi, 2006; Hughes, McElnay, & Fleming, 2001; Scott, Deary, & Pelosi, 1995; Stevenson, Kerr, Murray, & Nazareth, 2007). All of these narratives may have some merit, but there may also be developments in another direction. For example, reflexive modernization can undermine our belief in authority, but at the same time increase the number and complexity of situations in which individuals need to depend upon specialized expertise (Beck, Giddens, & Lash, 1994). Further, by focusing on the decline of authority, one can easily naturalize the "before" as being a classic, uncontested relationship between doctor and patient.

Bearing these problems in mind, this article seeks to analyze how the medical professions in three different countries try to reclaim professional authority faced with various threats or challenges. Whether or not professional authority has indeed eroded, it is possible to compare how the profession perceives changes to doctor-patient relations and which solutions are proposed. The analysis here focuses specifically on how the medical profession characterizes the doctor-patient relationship and possible challenges to this relationship posed by external actors or by new developments in either science or society. The analysis also compares which courses of action the profession proposes as means to overcome the perceived challenges and reinstall authority. Who should do or understand what differently according to the profession? For example, does the challenge force the profession to act or should the problem be resolved by others? Or, as another alternative, does the profession present the case as if no changes are needed to restore authority?

Finally, it is important to underline the article's comparative ambition and explain the underlying case selection. Aside from comparison over time, the analysis also compares the medical profession in three countries, the United Kingdom, the United States and Denmark. These countries vary significantly with respect to the proximity of the medical profession to the state including variation in the health policy contexts in which doctor-patient relations are inscribed. The United States represents a market-based health care system with partial public funding (Medicare and Medicaid) and most doctors employed privately. The United Kingdom and Denmark both represent state-centered single-payer health care systems with a large proportion of doctors in public employment. In contrast to Denmark, however, the British medical profession has perhaps a stronger historical tradition of independence from the state, for instance through its autonomous scientific societies. These differences are not used for a parsimonious test of the general effect of health care systems on professional authority nor is the expectation that authority claims diverge completely between the cases. Nonetheless, the three different combinations of health care contexts and professions offer a variety of possible authority positions and threats from "third parties."

The article is structured into four parts. The first section develops a historical and theoretical background for the study of doctor-patient authority. This involves a clarification of the key concepts such as professional authority, but also a discussion about why the relationship between professionals and citizens, here patients, cannot be entirely separated from the policy context in which the professional work is embedded, here the organization of medicine and health care. The second section presents the empirical basis for the analysis and explains the essential methodological choices. Third is the analysis, which is structured by country, that is a country-by-country analysis of the dominant challenges to medical authority and the solutions or actions prescribed by the profession. Finally, the fourth section offers a comparative discussion about differences and similarities across the three countries. First, however, it is necessary to place the analysis within a broader theoretical literature on medical, and more generally, professional authority.

Scholarship on doctor-patient authority

The relationship between professionals and clients is not an entirely new field of study. In some situations, however, the connection to clients is mostly used to simply classify and separate professional knowledge from other types of abstract knowledge without discretionary or practical application (Brante, 2011; Freidson, 2001, p. 34), and thus not given detailed consideration in its own right. Other scholars explore the client relation more in detail, but typically limited to a single profession. One example here is Bourdieu's discussion of the ideal-typical relationship between lawyers and legal clients, although this is illustrated through a relational field perspective rather than a profession-centered perspective as such (Bourdieu, 1987). Besides classical works on the role of doctors and patients (Merton, 1957; Parsons, 1951), there is limited literature on the current status of doctor authority toward patients. One study investigates General Practitioners' perceptions of changing patient relations (Brown, Elston, & Gabe, 2015) while another study examines the reverse relationship, that is patients' ability to control doctors' orders (Menchik & Jin, 2013). Before analyzing whether the profession perceives its authority as being intact, it is useful to specify a yardstick of what medical authority could look like, even if it is merely the profession's wishful thinking.

The main title "no third parties" designates a key aspect of this yardstick, which is the idea of an unmediated relationship between doctor and patient. The expression itself comes from a famous declaration made by the American Medical Association in 1934. As the second out of ten "commandments" on health insurance, the declaration simply stated that "[n]o third parties must be permitted to come between the patient and his physician in any medical relation" (American Medical Association, 1934, p. 2200). The professional organization definitely had the federal government in mind when they drafted this New Deal era document, but it is important to remember that the medical profession also opposed the entry of corporations and private insurance companies into the organization of medicine during this period (Starr, 1982). The declaration also specifies that doctor-patient relations should be permanent and confidential, but although the patient should be free to choose his or her doctor, the relationship between doctor and patient is by no means equal in this understanding. This archetypical understanding of a "pure" doctor-patient relationship without the interference from third parties is still based on the doctor's superior authority position. No matter how benevolent a doctor is, the patient is subject to and dependent upon the doctor's superior medical competence, a significant dependence given the simultaneous exclusion of third parties.

The principle of no third parties is a good starting point for an ideal type of pure professional authority as seen from the point of view of the profession itself. It is, however, not an empirical characterization of how medical authority actually worked in the 1930s nor is it in any way a "natural" or normatively superior state of affairs. Most importantly, what presents itself as a doctor-patient relationship entirely free from political interference has immense implications for the organization and financing of health care. For instance, a later passage in the same document states that "[t]here should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession" (American Medical Association, 1934, p. 2201). The principle clearly limits the scope of health policy decision-making, which means that a ban on third parties between doctor and patient implies a sort of "shadow" political conflict about health economy and resources. Few scholars of professional studies would be surprised to find that professional organizations argue in their members' interests. Nevertheless, it is a healthy reminder that an uncontested authority position with no intervening third party is not the same as an interest-free or equal relationship. By excluding third parties, doctors also monopolize access to the patient with significant policy implications even when it is presented as being entirely apolitical.

If we turn to the generic theoretical notion of authority, it is built on a Weberian

tradition. Weber famously defined authority as “the probability that certain specific commands ... will be obeyed by a given group of persons” (1978, p. 212). By implication, professional authority is not intrinsic to a profession nor to its members and therefore cannot be studied solely through them. Ultimately, it is a question of whether or not professionals are able to command authority in the eyes of outsiders, here mainly patients, but also their command on having exclusive control with patient interaction. Weber’s focus on obeying commands and his three “pure types of authority” (1978, p. 215) do, however, seem too rigid to analyze what it means to accept a professional’s authority today. Instead, this article draws on Starr’s modernized Weberian definition of professional authority as a relation of “dependence on the professional’s superior competence” (1982, p. 15). Do citizens feel compelled to depend on the professional’s competence, and which factors explain their willingness to do so are thus the essential questions for a Weberian study of professional authority. As the methods section below clarifies, this article does not have any direct evidence of citizens’ acceptance of authority, since the data analyzed here only shows how the professional organization perceives and discusses possible threats and solutions to doctor-patient authority.

To adapt the general notion of authority more clearly to professions, the article uses Starr’s distinction between social and cultural authority as two conditions of a strong professional authority. Social authority concerns people’s willingness to follow the professional’s prescribed course of action. Cultural authority concerns whether people see the professional’s specialized knowledge as being necessary to interpret a given problem. In both cases, “people” should be understood simply as outsiders, which can include political authorities or, as here, individual citizens in their capacity as patients seeking medical advice. A profession’s lack of social authority would thus make citizens contest their recommended actions, and a lack of cultural authority would make them doubt the need for professional expertise. Previous studies have exemplified that while social and cultural authority can in some cases be separated historically because a profession may develop them in stages (Haber, 1991; Starr, 1982), the two categories are difficult to separate empirically in a present setting (Harrits & Larsen, 2016). It is rarely possible to code empirical sources as being solely about either social or cultural authority, but this is not necessary for the concepts to be analytically relevant.

It is a theoretical distinction between two necessary conditions for a strong professional authority. In empirical settings, however, a given profession at a given time and place may be more challenged on one of these dimensions, and therefore the professional organization’s authority claims will most likely reflect the status of their authority. In the case of a doctor-patient authority, some patients may accept or contest it out of habit, whereas others may do so because of how they understand the need for medical expertise. Similarly, the medical profession may see their authority as being challenged on some dimensions or in some types of situations interacting with the patient, or the profession may identify given social or political developments as the causes of the loss of authority. There are several conceivable outcomes of a broken or compromised authority relation, for instance, patients trying to control the outcome of professional decisions (Menchik & Jin, 2013).

Irrespective of what actually happens in doctor-patient encounters, this article focuses on the medical profession’s perception and the claims it puts forward to reestablished a compromised authority position. Does the professional organization go on the defensive and simply refuse to recognize third parties that pose a threat or challenge to their authority? Or do they choose to comply with the external demands, either willingly if the challenge is understood as being reasonable, or unwillingly if the challenge is somehow overwhelming or unavoidable? Key here is that there is a wide scope of possible strategies and responses, which calls for a qualitative exploration of the specific argumentation used by each professional organization.

Based on this overview of scholarship on professional authority, the following

three-legged research question can be formulated for this study: 1) What, if anything, does the medical profession (in Denmark, the United States, and the United Kingdom) identify as intervening “third parties” in their authority relation towards patients; 2) Which aspects of authority do they see as being contested, and 3) Which courses of action do they propose as solutions to reclaim authority?

Methods, data, and coding

The first methodological problem in the study of professional authority is to find credible sources to indicate whether or not—and perhaps also why—a profession commands authority over citizens in a given relation or capacity. The choice of research strategy easily becomes a dilemma between on the one hand a type of experimental setup designed to measure citizens’ willingness to comply with hypothetical authority “tests,” and on the other hand studies of real-life situations where the citizen’s compliance with authority is more difficult to measure and isolate. This study does not presume to be able to measure citizens’ willingness to comply with professional authority because there is no available empirical material from which to evaluate this willingness, and certainly not back in time. The material here can only show the professional organizations’ perception of professional authority, and it can only describe and explore these perceptions of authority, but not explain authority or its effect in practice.

The analysis uses editorials from professional journals as a proxy “voice” of the medical profession, although of course not all doctors are members of the underlying professional organizations. This material has the advantage of being published text, which can reasonably be said to represent the opinion of the professional organization. Even if editorials have different authors, they are subject to some sort of scrutiny by an editor appointed by the professional organization, and the texts can thus be said to speak for the profession. The journals selected for the analysis are the professional organization’s main general medical journal in each country, specifically the British Medical Journal (BMJ, 1840-present), the Journal of the American Medical Association (JAMA, 1883-present) and *Ugeskrift for Læger* (UfL, the Journal of the Danish Medical Association, 1839-present). Because these journals are aimed at a broader audience than just members of the profession, their editorials give a sort of window into how the profession portrays itself to the outer world. They are of course also aimed at doctors and can thus be read as instructions to doctors on how to act or react when faced with challenges from patients or from society. As mentioned before, the material is clearly limited in depth and does not claim to uncover an underlying “real” mechanism of authority. It is, however, quite well-suited to the specific task here, that is to describe how professions perceive threats to their authority and which authority claims and actions they prescribe as solutions.

The material further has the advantage that it facilitates comparison because editorials have similar length and scope across time and space. The data set here comprises a sample of 25 randomly selected editorials from every fifth volume since 1950 giving 13 volumes in each country and a total of 975 editorials. The analysis starts in 1950 because professional power and authority is often assumed to be at a high point during this period of professional “sovereignty” (Starr, 1982). There is, of course, a risk that the sampling will overlook relevant discussions in between the sampling points. If a perceived threat to professional authority carries great weight, it would most likely be discussed several times and thus still appear in the broad patterns of authority claims described here.

The data set allows for comparison across time and country, but the temporal dimension is mainly included to provide a variety of possible challenges to professional authority over the analyzed period. The following analysis is structured by countries because professional organizations, as well as the social organization of

professions typically, follow national boundaries. As mentioned before, the three countries represent three different medical professions in three different health policy contexts, since for example Danish doctors have probably never been able to keep third parties out of patient relations to the same extent as American doctors. The British medical profession has a longer history of independence (Saks, 2003, p. 37), but nevertheless, work within a health care system much like the Danish.

Finally, a few words on the coding and interpretation of the sources. It is unlikely that profession will explicitly label its authority claims as such because having or exerting authority sounds less legitimate than promoting health based on scientific knowledge. As a consequence, the analysis must be able to interpret how an editorial—besides perhaps conveying a more specific piece of news or opinion—also entails an authority claim about doctor-patient relations. Since the editorials typically focus on problem areas or challenges, the claims typically identify how someone—could be patients, the state or other social organizations—should act differently in order to respect medical expertise. As an initial coding, the sources were first separated depending on whether their embedded authority claims—provided there were any—could be said to involve the doctor-patient relationship, or whether they mainly concerned conflicts with the state or simply contained news about recent developments in medical research. Only editorials on or with implications for doctor-patient relations were included in the analysis. The remaining sources (216) were finally subjected to a second coding process in order to identify for each editorial 1) what constituted a challenge or threat to doctor-patient authority, for instance, a perceived third party, and 2) who should do what differently according to the editorial. Although the tables do not specify the underlying source text for each individual source, which would expand the text significantly, the analysis exemplifies the dominant themes with key examples¹.

Another issue in coding the material concerns the built-in ambivalences of medical discourse, which the analysis automatically inherits. For example, the editorials often refer to “doctors” without specifying whether the text mainly concerns general practitioners, specialists or rather the whole profession. Many sources appear to talk about issues in general practice, but the authority question is no less relevant for specialists or hospital doctors who more often interact with patients whom they do not know in advance. This is precisely why a generic understanding of doctor authority is relevant, even if it is imprecise, as it concerns the authority ascribed to a doctor simply because he or she belongs to the profession.

Danish doctors’ authority toward patients

The first thing to notice in the Danish case is what is not there, and what is, in fact, missing in all three countries. One topic that many would perhaps intuitively associate with the change in doctor-patient relations over time is the effect of individualization, for instance, if patients in large numbers begin to google their diagnoses or preferred treatments instead of relying on the doctor’s advice. Whether or not this phenomenon is real in practice, it does not register in the material analyzed here. The individualization of patients may be an undercurrent in some of the typical authority claims that do appear here, but it is always mediated through other perceived challenges to medical authority, for instance, the increase in media attention and legal regulation in the area of doctor-patient relations.

¹ To facilitate transparency, the coding list can be obtained by contacting the author. References to the sources are not entirely uniform, because the three journals subdivide volumes in different ways. The Danish references indicate issue number within one singular volume per year whereas the US and UK references tend to have more volumes per year, but with continuous pagination.

One theme that receives considerable attention already in the 1960s and onwards is the question of medical malpractice or side effects emerging from treatment prescribed by doctors. This challenges the cultural authority of medicine because it may hurt the belief in medicine as a necessary means to achieve health. The editorials do not explicitly reference the ongoing international debates about anti-medicine, such as Illich's "Medical Nemesis" (1975), but they appear to refer implicitly to these broader debates. For instance, a 1965 editorial discusses the issue of iatrogenetic effects, that is medical problems caused by treatment, rather than the underlying disease, while another discusses the issue of side effects in broad terms (UfL, 1965, 05). In both cases, the editorials ward off the critique by saying that members of the public tend to misunderstand these problems as doctors' mistakes, but that they are really just indications of how complex diseases are. In consequence, the editorials see no need for doctors to act differently to overcome this challenge to cultural authority, except perhaps try to educate the public on the complexity of medical situations. Later editorials under the same theme, for example, a 1990 editorial on whether doctors' mistakes are really mistakes, tend to focus less on denying the existence of medical malpractice as the earlier texts did. Instead, focus is on the formal system of medical supervision, which should be controlled by doctors and not the state (UfL, 1990, 33).

A large number of the authority claims are the profession's reactions to contemporary discussions and proposals that seek to formalize or otherwise advance patient rights. In these situations, the formalization of patient rights works as a third party that comes between doctor and patient and threatens the social authority of the former. The editorials clearly warn against this development. The standard response to these types of proposals—for instance proposals about a patient ombudsman (UfL, 1995, 13), formalized medical ethics, patient complaints system, etc.—is that the previous unmediated relationship between doctor and patient were preferable. Not just preferable for doctors, but rather that the immediate needs of the patients were better served without formal regulation entering the social authority relation. Some patient rights such as the "waiting time guarantee" (Larsen & Stone, 2015) are not actually designed to empower patients in relations with individual doctors, but toward the public health insurance and public hospitals. Again, the reaction of the medical profession is to defend the status quo, a less regulated social authority relation toward patients (UfL, 2000, 35; 2005, 25-31). The threatening third party in these discussions is a new policy proposal that formalizes doctor-patient relations, which the profession clearly warns against. The profession presents itself as a sort of guardian of the patient's interests, for example, in protecting patients against marketization in the health care sector (UfL, 1995, 51), employers seeking access to health information on individual patients (UfL, 1995, 15), or the state seeking a doctor's evaluation of individual patients' fitness to be a parent (UfL, 2010, 45).

The editorials are particularly defensive against new transparency policies. For example, regulations that give patients and the public access to transparent records are fiercely opposed, for instance, transparency regarding possible competing interests (e.g. pharmaceutical sponsorship of doctors or research) or regarding complaints records on individual doctors. Almost all of these transparency regulations are criticized as being an unnecessary "public pillory" (Danish: *gabestok*) for doctors (UfL, 2005, 23, 35). These later period editorials do not go as far as to deny the existence of malpractice, competing interests or other compromising actions performed by doctors. They characterize the allegations against doctors as being overblown, but mainly they systematically favor solutions that intervene as little as possible into medical practice, for instance promoting an "open culture" where mistakes can be admitted without the need for whistleblower protection systems and similar formalized legal arrangements (UfL 2000, 19). The best remedy to doctors being in the pocket of the pharmaceutical industry is allegedly to promote an ideal of "openness,"

which on one hand does recognize competing interests as an actual problem for doctors' authority, but nonetheless, opposes all intervening third parties into the relation.

Finally, another perceived threat to medical authority comes from the media whose attention to problems in doctor-patient relations is also presented in the editorials as an unnecessary third party. Similar to the reactions against politically induced transparency measures, the editorials here are equally furious against media "scares" and "witch hunts" against doctors and medicine. This discussion concerns cultural authority because the public reputation of medicine is on the line, but indirectly also social authority if patients act on information from the media rather than relying on the doctor's traditional knowledge monopoly.

Table 1 summarizes the dominant themes in the Danish editorials. At least three characteristics stand out. First, the Danish editorials do not present an explicit ideal of how doctor-patient should work, but indirectly they oppose all potential changes to the existing, unmediated authority relation. This fits with the thematic discussion of "no third parties" in the introduction, but only rarely do the discussions concern actual interactions with patients. The perceived threats to both cultural and social authority are not seen as coming from patients themselves, but from other intervening third parties who claim, wrongfully in the eyes of the medical profession, to take care of the patient. Second, the Danish editorials are not particularly clear on solutions, that is who should do what differently than now. A large number of editorials simply identify a problem without any clear indication of who should do what differently. Third and finally, when there are suggested courses of action, they usually defend the status quo. To the extent that a need for change is even recognized, the Danish editorials mostly suggest that outsiders should understand them better or that problems can be solved within the status quo. In other words, the Danish medical profession reclaims authority in a quite defensive manner and without any real attempts to find a new foundation for the profession's social or cultural authority.

Table 1

Danish doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Malpractice/side effects/iatrogenetic effects	Educate the public on complexity of medical situations
Regulation of medical ethics	Remain unregulated patient interaction
Patient rights (legal, ombudsman and choice)	Avoid regulation, but protect patients against marketization
Media scares	Resist witch hunts
Transparency policies (competing for interests/complaints)	Resist public "pillory"

American Doctors' Authority Toward Patients

The American editorials are surprisingly similar to the Danish in terms of their defensive tone and their clear preference for status quo solutions with as little formalization of doctor-patient relations as possible. The similarity is surprising, given how different political and social circumstances American doctors' work under compared to the Danish, although parts of the material reflect the diverging health care systems.

The first area where the US editorials resemble the Danish is in their reactions to

broader social critiques of medicine such as anti-medicine. These critiques are especially relevant for the profession's cultural authority because the public's willingness to accept professional decisions and various privileges may depend on whether or not they believe medicine to be a necessary means to achieve health. While the editorials do not say explicitly that patients increasingly challenge their authority, there is nevertheless a clear recognition in JAMA that the public image of doctors influences patient relations. One editorial from 1965 references the "Dr. Jekyll image" of doctors, but finds comfort in a report showing that doctors still rank highly on occupational prestige (JAMA, 1965, 194(11), p. 22). Similarly, other editorials address various media critiques or panics, typically by stating that the public should stop blaming doctors, but without any suggestions that either doctors or patients should act any differently than they did before. In other words, the editorials try to defend doctors' honor and demand respect from the public, but without any suggestions for actions to improve the cultural authority of doctors.

The American editorials also resemble the Danish when it comes to the later discussions about transparency policies, typically fueled by proposals about the disclosure of competing (financial) interests, industry funding and complaints records. The similarity is perhaps surprising, considering that a larger proportion of American doctors compared to Danish work in privately owned, profit-seeking or even outright capitalist organizations. The proposed alternatives offered in the US editorials are similarly devoid of real changes in authority relations, and they generally just propose that conflicts of interest should be addressed through informal appeals to 'balance and openness.

The social authority of American doctors is clearly more challenged by the introduction of "managed care," DRG systems and other economizing instruments in the health care sector. These developments are generally viewed as disruptive, because incentives work "differently" in medicine, as one editorial says (JAMA, 2005, 294(14), p. 1821). JAMA stays very close to the original no third party argument here, which is to oppose any development that interferes with an imagined, "pure" fee-for-service interaction with the patient. When I say imagined, it is not to suggest that there is no real threat to the social authority of doctors in policy tools like managed care and health economy. Imagined, however, is the absence of economic incentives in unregulated fee-for-service medicine, both in these editorials and in the original 1934 AMA declaration. The editorials do not say that authority is threatened, but instead, it is argued that patients' access to medical services will be limited by these policy reforms. Again, the profession's preferred solution is to maintain the status quo. Ironically, the JAMA editorials also criticize the opposite development, such as reforms seeking to expand access to health care, either through a new single-payer health care system (JAMA, 1975, 234(9), p. 25) or through expansions of Medicaid coverage for uninsured children (JAMA, 1995, 274(18), p. 33). The editorials clearly oppose such expansions of access to health care, for instance, arguing that any single-payer health care system would interfere as a third party between doctor and patient (JAMA, 1975, 234(9), p. 25).

End-of-life decisions constitute another threat to the unmediated social authority of doctors. From 1990 and onwards, there are several discussions about do-not-resuscitate-orders and other related proposals for formalization (JAMA, 1990, p. 264(10), p. 33). These are situations where the patient is—either temporarily or permanently—unable to consent to the doctor's proposed treatment. The profession again prefers the unregulated status quo where a doctor exerts social authority and decides on a case-by-case basis. This means opposition not only towards policies that would regulate end-of-life decisions, but also legal action or general juridical models that would also act as a sort of a third party between doctor and patient. The editorials do not really seem to consider that some of these court decisions or proposals may come from patients' wishes, or at least the profession prefers to remain

the sole interpreter of patients' wishes and thus to preserve an authority relation toward patients.

Unlike the Danish editorials, an increasing number of the American documents in the past few decades do actually point to doctors as the agents responsible for taking action in the given situation. For instance, there are discussions about how doctors should work to avoid social exclusion among the elderly (JAMA, 2010, 304(17), p. 1955), how they should handle informed consent in interactions with patients from multicultural backgrounds (JAMA, 1995, 274(10), p. 39), or doctors' role in the prevention of opium addiction (JAMA, 2010, 304(14), p. 1612). These editorials do not refer to a clear and identifiable challenge to professional authority, and no unifying third parties are involved. It is, however, an increase in the number of situations where JAMA calls on doctors to act instead of only pointing fingers at others, even if it is not a fundamental change from how they worked before. There are also a few editorials in the most recent volume that call on doctors to cooperate when faced with crisis over surgical mortality or questions about financial impartiality (JAMA, 2010, 304(15), p. 1721; 303(1), p. 75). These types of situations would previously have been brushed off as witch hunts against doctors. So, while the American medical profession's standard response to perceived challenges is to avoid general regulation models and maintain a largely unregulated social authority relation towards patients, there may be small steps towards cooperating with these systems that regulate the doctor's professional work.

Table 2

US doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Doctors' image as Dr. Jekyll, critique of medicalization	Demand respect for patient guardianship, defend honor in public
Transparency policies (competing for interests/industry funding/complaints)	Resist regulation, call for "balanced" policy or culture of openness
Managed care/health economy/incentives in doc-patient relations	Resist incentives and bureaucratic third parties, maintain fee-for-service remain.
Uninsured patients/children	Avoid Medicaid solution, avoid third parties
End-of-life decisions, "do not resuscitate"—orders, etc.	Avoid general or legally formalized model, preserve discretionary judgment

British Doctors' Authority Toward Patients

The British editorials reflect some of the same themes as in the US and Denmark, such as challenges to their work situation brought on by managerialism as a third party coming between doctor and patient. For example, there are complaints about "hamster health care" with doctors running like hamsters in a wheel while seeing patients less (BMJ, 2000, 321, pp. 1541-2). Another editorial criticizes the adoption of "personal medical systems" for each individual patient because the system is managerially and not professionally driven (BMJ, 2000, 321, p. 1359-60). We see other topics that could just as easily have been written in JAMA or UfL, for instance, about

the need for doctors to maintain the social authority position as gatekeeper to specialist referrals (BMJ, 1995, 311, p. 1447), or the public being “totally misguided” in its perception of facial transplants (BMJ, 2005, 331, p. 1349).

There are also situations, however, where the perceived challenges to medical authority prompt new types of responses and solutions compared with the other countries. One editorial, for example, reminds doctors that problems in the NHS are no excuse for “cavalier” treatment of patients and their relatives (BMJ, 1990, 301, p. 1407-8). This editorial exemplifies a common characteristic in many if not most British editorials, which also set them apart from the Danish and the American: The agents responsible for acting differently are doctors themselves, either with the aim to make the threatening third party go away or to reconstitute doctor-patient authority in light of the given challenge. The authority claims made by Danish and American doctors were almost exclusively met with calls for someone else—patients, the public, the state, the media, or other perceived third parties—to act differently. The British editorials are different here. The implications for action they derive from challenges to existing authority positions typically say what doctors can or should do differently. Also, while a few editorials in BMJ also ward off critique, they do not automatically defend the status quo as fiercely as the other journals do.

When the BMJ calls for doctors to act differently in light of a given situation or challenge, it does not mean that the profession does not assert its social or cultural authority toward third parties. It is perhaps more accurate to say that the authority relation towards patients is reconfigured according to the given challenge. A large proportion of the British editorials describes a specific type of delicate situation—supposedly one that many doctors face in encounters with patients—that requires the doctor to handle the interaction differently than hitherto and to do this with some professional diligence. For example, there are editorials about how doctors should handle patients seeing prostitutes (BMJ, 1960, 2, p. 1974), how to handle addicts who try to trick the GP for prescriptions (BMJ, 1975, p. 541), when to go against patients’ wishes with electroshock treatment (BMJ, 1980, 281, p. 1588), how doctors can be sensitive while still treating male rape victims (BMJ, 1990, 301, p. 1345), how to act on seizure patients’ access to driving again (BMJ, 2010, 341, p. 1260), or how to prevent heart disease with binge drinkers (BMJ, 2010, 341, p. 1146).

There are numerous situations like these in the material. What binds them together is that although some of them may be related to new diagnoses or treatments in medicine, the editorials’ key message is not about new scientific evidence. It is about how the doctor should take care for and handle a potentially difficult situation with a specific group of patients. In this sense, what challenges the normal doctor-patient relationship in these situations is usually not new medical knowledge, but rather the part of the doctor-patient relationship that is not simply an exchange of purely scientific expertise. It can be situations that may be potentially embarrassing for the patient, or where the doctor has regulatory functions, such as giving or taking away a driver’s license.

What makes this group of authority claims interesting here is on one hand that the British medical profession appears more willing to take responsibility for new developments in doctor-patient relations, and thereby to offer a more genuine form of patient guardianship. On the other hand, these types of authority claims are also particularly interesting because while doctors appear much more willing to change here, this is not an end to the authority between a doctor and a patient. The new type of doctor-patient relationship described in these editorials is still an authority relation. It is precisely the doctor’s responsibility—not the state’s nor the patient’s—to handle or take care of a potentially difficult situation for the patient, even when the delicate nature of the encounter is prompted by the patients’ actions, special problems or social circumstances. The social authority of the doctor is reconfigured as a type of guardianship here, which is not necessarily completely new because many doctor-patient encounters were of course also difficult before this period. Nevertheless, one

could potentially see this as a medical profession that has taken the critique of medicalization and medical domination seriously and pursued a reconfigured form of professionalism and authority. Conceptually, this change mainly refers to social authority because of its orientation towards action, but indirectly it may also seek to rehabilitate belief in the benefits of medicine more broadly, i.e. cultural authority.

Table 3

UK doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Complex medical/social situations with patients (mental health, prostitution, obesity, elderly, pregnancy, male rape)	Doctors should manage situation with care, take responsibility for handling patient relations diligently given difficult situation (topical or new knowledge)
NHS limitations hurt patients and doctors	Treat them well despite limitations
Patient demanding direct access to specialists	Maintain GP gatekeeper function (referrals)

Comparative Challenges to Medical Authority

If we look across the medical professions in the three countries, they often identify some of the same developments as possible third parties threatening their authority towards patients, such as managerialism, formalized patient rights or critical media attention. Nevertheless, there does not appear to be any direct relationship between what threatens professional authority and the responses it provokes. There seems to be a range of possible ways that doctors can react to having their authority—cultural as well as social—questioned in public. The profession may choose to push back hard as Danish, and American doctors do against all challenges and simply argue that the public scrutiny of medicine is unreasonable and that no formal, legal or policy changes are necessary. It can also be less defensive and come up with more constructive ways to rethink the authority of doctors in light of how external conditions change or given that the public's trust can no longer be taken for granted. The range of possible responses may reflect that we are talking about a profession with a well-established professional monopoly, a status quo to defend. In any case, it is remarkable that Danish and American doctors are more similar than their British counterparts in this analysis. This pattern suggests that authority relations between doctors and patients are not determined solely by the policy subsystem on a macro level, which means being in either a market- or state-centered health care system.

If we ask more generally what challenges professional authority, there is no real evidence in this material to support the initial idea that doctors see their authority as being undermined by individualization or the spread of medical information on the internet. The topic simply receives very little attention and more broadly one could argue that patients have relatively little impact on the content of these editorials. The exception here are the specific debates in the BMJ on how doctors should address a potentially difficult situation prompted by the patient's situation or by some other social development. Even in these cases, the argument rarely calls for doctors to enter into a dialogue with patients on equal footing. The doctor should, both as cultural and social authority, take responsibility as guardian for the patient in a given situation, but few situations call for doctors to involve the patients in medical decisions.

The limited attention devoted to patients indirectly says something about the state of medical authority. It appears that the medical profession in all three countries sees little need to legitimize their authority position towards patients, perhaps because they see this relationship as being primarily defined by the exclusion of third parties. They do see professional authority as being contested, however, but mainly from external third parties such as political institutions, managerialism, negative media attention or the opening up of medicine to systematic scrutiny, for instance on medical malpractice, competing interests or medical decision-making in broad terms. Here, we also see how both dimensions of doctors' professional authority—social and cultural—are in play at once. It is difficult to expose medical decision-making to public transparency without a perceived threat to the profession's general reputation, and the protection of doctors' reputation against skepticism in public is often presented as an argument against change. So, while all medical professions continually try to command authority, they may do so either through action and change or, on the contrary, through a defensive refusal to make any changes to the status quo.

As a final note, it is worth to underline how this article answers the research question as well as reflect upon the reliability of the answer. The article argues that the medical profession continuously identifies external parties as intervening third parties that disrupt the idealized, unmediated authority relation between doctor and patient. The third parties are not simply actors, however, but also developments such as increased media attention, patient rights or marketization. The analysis points to challenges against both the social and cultural authority of doctors, but the two have proven difficult to separate. This is no surprise given Starr's original use of the terms but nevertheless, points to a limitation in the analytical setup. It is also essential to consider the possibility that when the study finds no major erosion in doctor-patient relationships, it is simply because the selected material and selected type of material is unable to show such a development. This is possible, and as the methods section argues, the study only provides a broad overview of what the profession says about authority. It would require other sources and another depth of analysis to determine the status of authority in practice, and it would most definitely require a combination of different methods.

References

- American Medical Association. (1934). Proceedings of the Cleveland session. *Journal of the American Medical Association*, 102(26), 2191-2207. <http://dx.doi.org/10.1001/jama.1934.02750260037016>
- Beck, U., Giddens, A., & Lash, S. (Eds). (1994). *Reflexive modernization*. Cambridge: Polity Press.
- Bourdieu, P. (1987). The force of law: Towards a sociology of the juridical field. *Hastings Law Journal*, 38, 814-853.
- Brante, T. (2011). Professions as science-based occupations. *Professions and Professionalism* 1(1), 4-20. <http://dx.doi.org/10.7577/pp.v1i1.147>
- Brown, P., Elston, M. A., & Gabe, J. (2015). From patient deference towards negotiated and precarious informality: An Eliasian analysis of English general practitioners' understandings of changing patient relations. *Social Science and Medicine*, 146, 164-172. <http://dx.doi.org/10.1016/j.socscimed.2015.10.047>
- Dent, M. & Whitehead, S. (Eds). (2002). *Managing professional identities. Knowledge, performativity and the "new" professional*. London: Routledge.
- Freidson, E. (2001). *Professionalism. The third logic*. Cambridge: Polity Press.
- Furedi, F. (2006). *Culture of fear revisited*. London: Bloomsbury
- Furedi, F. (2013). *Authority. A sociological history*. Cambridge: Cambridge University Press. <http://dx.doi.org/10.1017/CBO9781139026338>

- Giddens, A. (1994). Living in a post-traditional society. In U. Beck, A. Giddens & S. Lash (Eds), *Reflexive modernization. Politics, tradition and aesthetics in the modern social order* (pp. 56-109). Cambridge: Polity Press.
- Haber, S. (1991). *The quest for authority and honor in the American professions, 1750- 1900*. Chicago: Chicago University Press.
- Harrits, G. S. & Larsen, L. T. (2016). Professional claims to authority: a comparative study of Danish doctors and teachers (1950-2010). *Journal of Professions and Organization*, 3(2), 154-169. <http://dx.doi.org/10.1093/jpo/jov011>
- Hughes, C. M., McElnay, J. C., & Fleming, G. F. (2001). Benefits and risks of self medication. *Drug safety*, 24(14), 1027-1037. <http://dx.doi.org/10.2165/00002018-200124140-00002>
- Illich, I. (1975). *Limits to medicine*. London: Marion Boyars.
- Inglehart, R. (1997). *Modernization and postmodernization. Cultural, economic and political change in 43 societies*. Princeton: Princeton University Press.
- Jensen, H. (2006). *Det faderløse samfund* [The fatherless society]. Copenhagen: People's Press.
- Larsen, L. T. & Stone, D. (2015). Governing health care through free choice: Neoliberal reforms in Denmark and the United States. *Journal of Health Politics, Policy and Law* 40(5), 941-970. <http://dx.doi.org/10.1215/03616878-3161162>
- Menchik, D. & Jin, L. (2013). When do doctors follow patients' orders? Organizational mechanisms of physician influence. *Social Science Research* 48, 171-184. <http://dx.doi.org/10.1016/j.ssresearch.2014.05.012>
- Merton, R. K. (1957). The role-set: Problems in sociological theory. *British Journal of Sociology* 8, 106-120. <http://dx.doi.org/10.2307/587363>
- Parsons, T. (1951). *The social system*. Glencoe: The Free Press.
- Pedersen, O. K. (2011). *Konkurrencestaten* [The competition state]. Copenhagen: Hans Reitzels Forlag.
- Saks, M. (2003). *Orthodox and alternative medicine: Politics, professionalization, and health care*. London: Sage
- Scott, S., Deary, I., & Pelosi, A. J. (1995). General practitioners' attitudes to patients with a self diagnosis of myalgic encephalomyelitis. *British Medical Journal* 310 (6978), 508. <http://dx.doi.org/10.1136/bmj.310.6978.508>
- Starr, P. (1982). *The social transformation of American medicine. The rise of a sovereign profession and the making of a vast industry*. New York: Basic Books.
- Stevenson, F. A., Kerr, C., Murray E., & Nazareth, I. (2007). Information from the Internet and the doctor-patient relationship: the patient perspective—a qualitative study. *BMC Family Practice* 8(1), 1. <http://dx.doi.org/10.1186/1471-2296-8-47>
- Togeby, L., Andersen, J. G., Christiansen, P. M., Jørgensen, T. B., & Vallgård, S. (2003). *Magt og demokrati i Danmark: Hovedresultater fra Magtudredningen*. Aarhus [Power and democracy in Denmark: Main results from the power study]. Aarhus Universitetsforlag.
- Weber, M. (1978). *Economy and society. An outline of interpretive sociology*. Berkeley: University of California Press.