



Rhetorical work and medical authority: Constructing convincing cases in insurance medicine

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ABSTRACT

This article explores general practitioners' (GPs) persuasive efforts in cases where biomedical evidence is absent but expected. Health insurance in Western countries is based on the biomedical ideal that legitimate complaints should have objective causes detectable by medical examination. For GPs responsible for assessing sickness and incapacity for work, the demand for objective evidence can be problematic: what if they as experts deem that a patient is in fact sick and eligible for benefits, but are unable to provide objective evidence to that fact? How can they convince bureaucrats in the insurance system to accept their judgment? Taking 'medically unexplained symptoms' as my case, I draw on focus group and follow-up interviews with GPs in Norway to explore how GPs attempt to persuade bureaucrats to accept their professional judgment. Proposing the concept of 'rhetorical work', I reconstruct a typology of such work that doctors engage in to influence bureaucratic decision-making and provide long-term health benefits for patients. I then discuss the potential societal implications of GPs' rhetorical practices and the applications of the concept of rhetorical work in future research.

1. Introduction

Throughout Western countries, policy-makers have taken measures to control and reduce expenditure on health-related benefits (OECD, 2010). Increasingly restrictive eligibility criteria form the core of such measures, based on the principle that 'legitimate access should be limited (...) to cases in which incapacity judgments are rooted in medical evidence (...)' (Meershoek, 2012: 545). Critics have noted that these policy changes are based on medical ideals rather than clinical realities (cf. Krohne and Brage, 2008; Meershoek et al., 2007; Meershoek, 2012). In many cases, patients suffer from conditions for which doctors fail to provide evidence – at least of the type that is expected. Owing to the lack of objective 'signs of disease' (e.g. x-ray images or laboratory tests), such conditions are often characterized as subjective and they constitute the largest group of complaints in primary care (Brown, 2007: 773). For general practitioners (GPs) responsible for legitimating sickness, such subjective complaints can be problematic: what if they, as experts, deem that a patient suffering from 'subjective complaints' is in fact sick and eligible for health benefits? How can such conditions be certified convincingly by GPs?

This paper explores how, when biomedical evidence is absent but expected, doctors can convey the warrants for their judgment that a

patient is incapacitated. The data are based on focus group and follow-up interviews with GPs in Norway about their work with the large, heterogeneous group of patients suffering from *medically unexplained symptoms* (MUS). MUS are thought to differ from other subjective complaints (e.g. 'headache' or 'loss of appetite') in being persistent, debilitating and often widely contested conditions for which medical science has no explanation (Barker, 2010; Brown, 2007). (In some studies, however, MUS is not differentiated but equated to subjective complaints, cf. Reid et al., 2003; see Rasmussen, 2020 for details). Taking MUS as its case, this paper explores situations where doctors lack authoritative means of persuasion, in the form of biomedical signs of disease, and thus face a problem of persuasion.

Drawing on an interactionist view of work (Strauss et al., 1985), I propose *rhetorical work* as a concept to analyse how doctors (and other professionals) attempt to overcome such problems of persuasion. The analysis reconstructs a typology of rhetorical work that doctors may do to influence bureaucratic decision-making to provide long-term health benefits for patients. I refer to this work as 'rhetorical' because its purpose is to persuade bureaucrats to influence the outcome of health insurance claims. As I will discuss below, rhetorical work in the context of health insurance can be interpreted as a problematic contravention of policy implementation in democratic societies, but it can also be

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interpreted as an attempt to protect the civil rights of people suffering from conditions that are treated unfairly by insurance schemes under the sway of biomedical dogma. In the latter interpretation, GPs are patient advocates – not in the narrow sense of doing whatever the patient wants, but in the legal sense where fending for the rights of the client is a prerequisite for justice.

2. Objective evidence and medical authority

Since the mid-19th century, medical discourse has distinguished between two forms of information relevant to medical assessments: *symptoms* and *signs* (Foucault, 1994; Aronowitz, 2001: 803); the former are what patients experience, the latter are indications of the underlying pathology. Thus, symptoms and signs mirror the distinction between illness and disease (Eisenberg, 1977) which is why subjective complaints are called ‘illness without disease’ (cf. Aarseth et al., 2016: 1391), i.e. symptoms without signs. As evidence of sickness, symptoms and signs have different standings, manifest in the use of ‘subjective’ and ‘objective’ as qualifiers: in medicine, as in science and Western culture more generally, objective denotes that something is ‘real’ or ‘factual’, untainted by biased subjectivity (Daston, 1992; Shapin, 2012). In the context of health insurance, objective signs of disease are thus considered authoritative and unequivocal evidence that the patient is sick – as if the body vouches for the patient.

As well as being authoritative, objective evidence is also *expected*, based on the idea that symptoms are the result of ‘distinct, objective entities’ (diseases) that cause ‘objective changes in the body’ (Chiong, 2004: 130). In other words, symptoms should have a cause, and that cause should be detectable by medical examination. This is the core of ‘the biomedical model’ which, despite challenges to its validity, remains the most influential model of health and disease, indicated by reference to it simply as ‘the medical model’ (Harrison, 2009). The influence of the biomedical model is visible in policy documents and procedural guidelines (cf. Meershoek et al., 2007; Harrison, 2009), as well as medical and lay culture (Album et al., 2017). The problem with ‘symptoms without signs’ is therefore normative: objective signs should accompany subjective symptoms. Without such evidence, the patient’s claim to ill health might thus be cast into doubt as the threat of shirking looms.

Accordingly, a seminal problem associated with subjective complaints within the context of health insurance is one of *persuasion* – getting others to believe that what you say is true. For patients, the problem is getting doctors to believe them, which can be a daunting task. Patients often feel distrusted (Åsbring and Närvänen, 2004, 2002; Nettleton, 2006; Nettleton et al., 2005) and full access to the ‘sick role’ can be withheld when the reality and severity of their suffering is called into question (Åsbring and Närvänen, 2003). Some people with MUS must thus work hard to be regarded as credibly sick by their doctor (Werner and Malterud, 2003; Werner et al., 2004) or change health-care provider, hoping to find one that will believe them (Åsbring and Närvänen, 2004: 233).

If doctors come to believe that – despite the lack of objective evidence – the patient is too sick to work, they face a similar predicament in persuading welfare bureaucrats to trust their professional judgment. It is known that doctors struggle to mediate the nature and complexity of subjective complaints ‘to an imagined reader, who is often sceptical regarding the legitimacy of such illnesses, both because of their low prestige and because they do not fit very well into the biomedically oriented ideology of [the welfare bureaucracy]’ (Aarseth et al., 2016: 1391; see also Kiessling and Arrelöv, 2012: 5). Moreover, survey studies suggest that GPs frequently write medical certificates *strategically* to improve patients’ chances in the system (Bringedal et al., 2017; Gulbrandsen et al., 2004). However, even though there is cause to believe that this does indeed occur, little is known about *how* doctors work to construct convincing cases for disability benefits in such situations. What persuasive efforts can they resort to? This is the question addressed by this article.

3. Rhetorical work and insurance trajectories

To explore how doctors work to construct convincing cases when biomedical evidence is absent, I take a rhetorical approach. Previous work in medical sociology have shown how professional groups such as cardiologists (Griffiths and Hughes, 1994; Hughes and Griffiths, 1997), haematologists (Atkinson, 1995), health care managers (Hughes, 1996) and paediatricians (White, 2002) employ ‘rhetorical skills’ (Hughes, 1996) to coordinate meaning and action in health care. Following these works, I define rhetoric not in the narrow sense as mere ornate and superficial speech (Garsten, 2009: 3), but as a means of coordination, by *persuasion*. To be persuasive, the ‘orator’ must attend to the (assumed) temperament, values and beliefs of their audience as much as to their own goals (Hughes, 1996: 298). Rhetoric is therefore ‘other-oriented’ and thus a fundamentally *social* activity; not a distraction to understanding what is really going on, but itself part of how social reality is constituted in action.

Drawing on Strauss and colleagues’ extensive concept of work (1985: 290), I propose the concept of *rhetorical work* to discuss the sorts of activities doctors engage in to persuade welfare bureaucrats. Although the words ‘rhetorical’ and ‘work’ have been fused before (cf. Proppen and Lay Schuster, 2010; White, 2002), I have not found any attempts to elaborate on rhetorical work as an analytical concept in sociology. Rhetorical work stands out from previous conceptualisations of rhetoric in sociology in three ways.

First, whereas previous conceptualisations limit rhetoric to spoken and written language (cf. Hughes, 1996; Hughes and Griffiths, 1997; White, 2002), rhetorical work includes *all actions* that are taken with a view to persuade, to influence how people think and act in specific ways. Moreover, inasmuch as it is part of the attempt to persuade, rhetorical work includes actions that *precede* the ‘point of impact’ (where rhetoric meets audience), such as planning, collecting information and organising meetings.

Second, unlike studies that make rhetoric about the effects of language (cf. White, 2002; White and Stancombe, 2003: 21), rhetorical work centres instead on *actors’ aims to persuade* – even if they fail. Those aims are in turn directed at an assumed problem of persuasion; an anticipation that persuasive efforts are necessary to ensure or avoid various outcomes. Intent and problem-orientation are therefore pivotal. Note that since rhetorical work regards *all actions* taken with a view to persuade, it can entail actions that are also captured by other action-centred concepts. So, inasmuch as the aim of actions such as manipulating symbolic margins (*boundary work*, Gieryn, 1983) or performing a role (*impression management*, Goffman, 1990) is to persuade, they may be considered forms of rhetorical work. (Likewise, persuasive efforts may be considered forms of, say, boundary work, inasmuch as those efforts entail manipulation of symbolic margins).

Third, while there has been a tendency to delimit rhetoric to ‘non-technical’ matters such as the cultural or moral aspects of a case (cf. Griffiths and Hughes, 1994; Hughes and Griffiths, 1997: 598), rhetorical work *pertains to ‘technical’ as well as well as ‘non-technical’ matters*. Indeed, science studies have shown that disputes over ‘technical matters’ are a commonplace in the history of science (Barnes et al., 1996; Collins, 1975), and that experts engage in various attempts to make their case persuasive (cf. Shapin and Schaffer, 2011). Moreover, sometimes the notion of a clear-cut boundary between ‘the technical’ and ‘the non-technical’ is exactly what necessitates rhetorical work to begin with, such as when patients with MUS apply for benefits.

Rhetorical work can thus be defined as *any purposeful action undertaken to overcome an anticipated problem of persuasion*. Within the context of sickness benefits and health insurance, the goal of rhetorical work is steering what I, in the vein of Strauss, have dubbed *insurance trajectories*. The term refers to the unfolding of insurance cases, from their initial suggestion as insurance cases to their conclusion (a return to work, a disability pension or social security). The need for rhetorical work arises from the absence of an authoritative means of persuasion in the form of

objective biomedical evidence, amounting to a loss of influence over the insurance trajectory. MUS and other subjective complaints thus reveal how medical authority resides not only in its practitioners but also in the institution of biomedicine and in the types of evidence constructed in its name. In health insurance systems governed by a biomedical ideology, a lack of objective evidence means a lack of authority. Thus, although not limited to ‘symptoms without signs’, the need for rhetorical work seems particularly pressing in these cases. To regain control, doctors must find a way to construct a credible case for patients to receive benefits.

4. Health insurance in Norway

The study’s empirical focus is Norway. With its single-payer universal system, Norway has one of the most generous insurance schemes and the most comprehensive activation policies in the OECD region and the highest rate of people on disability benefits in Europe (OECD, 2010; Ringard et al., 2013). National health insurance systems differ, and compared to countries such as Switzerland and the UK, GPs hold a more central position in the Norwegian system (OECD, 2010; Aarseth et al., 2016). Nonetheless, the Norwegian system exhibits the characteristic division of labour between medical and legal expertise and has undergone policy changes to limit and control expenditure by an emphasis on medical evidence and causal explanations (OECD, 2016). Thus, even in a single-payer universal system, GPs have to legitimate benefits that they want patients to receive (Ringard et al., 2013).

Three gates protect health benefits in Norway: the medical gate, guarded by the patient’s GP, followed by two bureaucratic gates within the Norwegian Labour and Welfare Administration (NAV), namely a local and a regional NAV office. GPs communicate with the local offices who in turn communicate with the regional ones. Legally, benefits are restricted to patients whose impairments are primarily due to disease or injury (and not, e.g., economic or social issues, see Ministry of Labour and Social Affairs, 2016). GPs must therefore attest to the probability that impairment is primarily due to disease. Since a National Insurance Court ruling in 1994, granting benefits without objective evidence of disease is permissible but has the status of an exemption (Ministry of Labour and Social Affairs, 2000: 89). Regional officers decide whether to approve or reject a claim, based on GPs’ medical certificates and fitness for work reports from local officers.

5. Methods and materials

The article is based on a small and explorative study of MUS, and analyses focus groups and interviews with GPs working in Norway. Two focus groups (FGs) were conducted in 2015, moderated by the author with the aid of an assistant. FG1 consisted of five experienced GPs in their 40s, four women and one man, where all but one worked in the capital, Oslo. FG2 consisted of nine GPs, four women and five men, of varying experience (two were relatively inexperienced) and age (one below 40, three in their 40s and five between 50 and 67), all but one working in rural areas.

I recruited established groups in the continuing medical education program, wherein regular group sessions are a mandatory activity. A potential drawback of this strategy is the risk that old conflicts or pecking orders will hamper the discussions. The advantages are easy recruitment; that participants have already made time in their busy schedules; and that having met before can make conversations flow easier (Morgan, 1996: 37–38).

FGs were held where the groups usually meet: FG1 in a private home in the evening; FG2 in a meeting room at a workplace during the day. FG1 was relaxed and good-humoured; FG2 was also good-humoured, but somewhat more formal. As moderator, I shifted between high and low involvement (Morgan, 1996), guiding discussions as the need arose. I used a semi-structured interview guide which included sections on MUS, diagnosis, sickness and work incapability assessments, and health benefits and NAV. The FGs lasted 90–95 min. I introduced myself as a

sociologist and PhD student, and presented the general aims of the study. The assistant introduced herself as a medical doctor and researcher, and as my assistant in the FG.

Four follow-up (FU) interviews were conducted in 2016 – two interviews from each FG (three singles and one group). FG participants who had agreed to be contacted for a FU interview were recruited. Five experienced GPs agreed to participate. The interviews lasted 30–75 min (~50 on average). Two were conducted in private homes, two at work. It was clear from the FGs that communicating with NAV about benefits for patients with MUS put GPs face to face with problems of trust and authority. The aim of the FU interviews was to probe deeper into these issues, to learn what GPs did about them, if anything. Additionally, the FGs indicated that local factors affected GPs’ power to ‘get things done’ in these cases. I therefore focused on details about local factors.

As a sociologist with pragmatist orientations, I approached MUS as a category that refers to patients, conditions and practices that are considered ambiguous and challenging, and with the ambition to understand what makes it so and what GPs can do about it. In the FGs and FU interviews, MUS was thus treated as a *placeholder* for conditions where a lack of biomarkers complicates clinical work, leaving it up to the participants to ‘fill in the blanks’. (I did, however, ask about fibromyalgia and myalgic encephalopathy, both controversial and common examples of MUS in the somatic medical literature).

The sessions were audio recorded. Analytical and contextual notes were written after each, no later than the next morning. Informed consent was obtained in writing. The Norwegian Social Science Data Services approved the study. The recordings were transcribed in NVivo 10, using Barbour’s (2013) annotation style. Underlining indicates emphasis. Anonymity was ensured by altering participants’ names and facts about persons and places that were discussed. The author translated all the excerpts.

A thematic analysis was conducted, broadly in line with Braun and Clarke (2006), combining descriptive and in vivo coding styles (Saldana, 2009: 369). I initially expected MUS to be conceptually challenging for GPs but found that practical challenges were more pressing. The analysis therefore focused on the challenges GPs faced in communicating and cooperating with NAV, as this featured often in the FGs. After rereading the data, the problem of persuasion emerged as a key concern for the GPs. They also had ways of dealing with it, which inspired me to do FU interviews centred specifically on what they did to persuade NAV in these cases. Those interviews also served as a check on my interpretation of the FGs – the notion of a problem of persuasion resonated well with the participants. Inspired by the tradition of elaborating the concept of work in sociology, rhetorical work emerged as a useful concept to capture the sum of GPs’ persuasive efforts.

The analysis resulted in three substantive categories that made sense of the various practices described by the GPs. These categories are presented below as a typology of rhetorical work, a reconstruction of the various things the GPs did to persuade NAV officers and guide insurance trajectories in lieu of objective evidence.

6. Results

In the following, I present a typology of rhetorical work related to GPs’ task of legitimating sickness for health insurance. The typology is based on discussions about patients with MUS, and specifically those whom GPs consider to be incapacitated and in need of temporary disability benefits – a ‘work assessment allowance’ – or a permanent disability pension (in some instances, despite the patient’s desire to continue working). As these benefits are normally only relevant after one year of sick leave, the cases in question had usually lasted long and the goal of the rhetorical work was typically to steer and shorten the trajectories. The GPs also discussed instances when they did *not* think their patients were incapacitated, in which case rhetorical work to obtain benefits was not an issue (see also Meershoek, 2012). Below, cases are thus depicted where GPs are *convinced that the patient’s claim is*

legitimate. Moreover, as the data are limited to GPs' perspectives, the analysis describes *attempts* to persuade.

The reconstructed typology consists of three types of rhetorical work, each a *tempered* form of manipulation, or of shaping information or affecting the recipients. The types are 1) composing 2) enhancing and 3) circumventing the medical certificate. The certificate is the nexus of this rhetorical work since it officially mediates medical certification between GPs and NAV. The three-page, standardized form is issued by NAV and 'largely reflects a classic, mono-causal and biomedical model of disease (...)' (Aarseth et al., 2016: 1383, 1391). We therefore begin by addressing rhetorical work related specifically to the mandatory task of composing this certificate.

1) Composing the certificate

To the GPs, composing a medical report was not simply a matter of stating medical facts; in cases where objective evidence was lacking, the task was described as being one of persuasion. As Robert, a GP, put it, they had to present the case 'in such a way that they [NAV] will believe it, and can see that it's real' (FG2). What did the GPs do to make the certificate convincing when evidence was missing?

First, the FG participants discussed de-emphasizing or excluding case information from the certificate. The 'what' that was de-emphasized or excluded was always an aspect of the patient's past or present circumstances. This is unsurprising: in Norway and many other countries, health insurance is reserved for *medical problems*, a legal category that explicitly precludes social and economic factors (NAV, 2008). Including such factors in the certificate could adversely affect the insurance trajectory, as Steve explained (FU):

Steve: (...) I've seen examples where that ruined the case, that I've included a sentence about additional problems the patient has, of a social kind, (...) that does increase the burden, and places higher demands on the functioning of the patient. (...) But what they [NAV] will do, in the rejection letter, is they'll have used that sentence as a warrant, saying 'this isn't a disease, it's a social burden, taking care of small children is not a disease'. I think that's horrible. That they'll grasp at one straw, one sentence ...

Interviewer: But do you include these things anyway? Or are you sometimes attentive to such things?

Steve: You know, I guess it has led me to being attentive to it. And make sure that I don't include it. And, of course, if it has no direct medical implication, and I'm not concealing anything – because that's something else, concealment, that doesn't fly. But in those cases, it's probably better not to include it. Because you see the people at the other end [NAV officials] misusing it. Misinterpreting it.

Although Steve prefers full disclosure, he has learned to expect NAV to misunderstand the role of social circumstances in the patient's predicament. He thus sometimes omits such information from the narrative to seem more persuasive and prevent what he considers illegitimate rejection of the case. It is noteworthy that the factors Steve excludes are ones he considers important for an accurate understanding of the case (they 'increase the burden'). To persuade NAV, the GPs would thus provide a piecemeal account of their own holistic understanding. They adapt the message to fit (what they anticipate to be) the interpretative style of the receiver to bring about specific outcomes.

Second, the GPs talked about the importance of constructing causal connections between events in the narrative of the certificate. According to the GPs, NAV officials (and doctors) appreciate explanations that are in terms of cause and effect. For instance, as part of a discussion about people's shared desire for simple and causal narratives (in FG2), Jonathan commented on the construction of causality in the certificates: 'You look for causal explanations and models, even though we don't actually

know (...) that there is a causal connection. But we describe it that way because we know that it might have an impact with NAV'. A little later, Mary picked up on this thread:

Mary: We want these explanatory models. I think it's deeply human [to want that]. It's not just us doctors who want things to make sense. But I have a couple of patients where it's hard to say anything other than that these are fragile people. (...) But how can I write that to NAV (laughs)? (...) If we search, we'll usually find that people have had ... experiences, hard times. And then we can use that as an explanation (...).

As was clear from the group's chortling response, they did not think NAV would accept the narrative of 'fragile people'. Connecting the patient's condition to a past event was considered more persuasive. Although it was not mentioned, one likely reason why causality was considered persuasive is that it makes the patient's predicament an *effect* that the patient is less responsible for (causes *happen* to patients). Causal connections are the norm in biomedicine but here GPs claimed to *construct* such connections to *persuade* NAV – even if they disbelieved the validity of those connections (i.e. constructing causality is not about accuracy, but persuasion).

Third, the GPs talked, more or less explicitly, about diagnostic categories as useful rhetorical devices to influence insurance trajectories. For instance, as part of a discussion about fibromyalgia and formalities in the Norwegian Insurance Act, Julia (FU) explained that

Julia: (...) the question is 'do you [the patient] need that diagnosis?' And if they can function in a job, they don't really need it. They just need to know that 'It's nothing dangerous, and the best thing you can do is to stay active as best you can'. But if they can't keep a job, they need it to advance in the NAV system.

The GPs would thus use diagnoses to convince NAV officials that the patients were legitimate claimants. In other words, for MUS and other subjective complaints, diagnostic categories were used not because they accurately corresponded to the complaint diagnosed but because they might influence the insurance trajectory – not unlike how attorneys used categories of crime strategically in *Sudnow's* (1965: 262) classic study. (This practice was part of a larger pragmatic diagnostic approach I have described in detail elsewhere, see *Rasmussen, 2017*). In a representative survey of Norwegian doctors, 37 per cent said they would use 'strategic diagnoses' to legitimize sick leave whereas 26 per cent were undecided (*Bringedal et al., 2017*). The present analysis suggests a willingness to be strategic for more long-term benefits as well (but the strategy is likely to be limited to diagnoses without biomarkers).

2) Enhancing the certificate

Whereas the first type of rhetorical work relates to the composition of the certificate, the second type relates to the strategic acquisition of statements from other experts to enhance the impact of the certificate. Statements made by experts are a routine part of insurance trajectories and are commissioned by the GP, NAV or both. NAV will typically only procure expert statements if the GP does not provide a statement, or if GPs' statements are found dubious. Two types of statements are of interest here: those relating to medical diagnoses (typically specialists that confirm or rule out conditions) and those relating to functional capacity. Such expert statements can significantly affect the credibility of a case. From the GP's points of view, it is therefore important to ensure that the statement is 'good', i.e. convincing in its own right and supportive of the GP's certificate.

First, regarding diagnosis, the GPs talked about where patients should be sent if a specialist is needed to diagnose or rule out a condition. For instance, FG1 discussed places that diagnosed myalgic encephalopathy (ME) – this is a diagnosis that GPs can make themselves but, according to them, it is more convincing if a specialist is involved.

As Peter put it:

Peter: (...) if a diagnosis is needed (mhm), in relation to NAV for instance (mhm), one need only send a referral to [name of a doctor] at [a place in the city where Peter works], and you're guaranteed to have that diagnosis [ME] after one visit (mhm, yes!). Guaranteed!

Beth: Yeah, that's right.

Sue: That's rather interesting, right (yes, yes), that's ...

Peter: So you can order the diagnosis (yes) in that way (mhm).

Beth: It was like that in [another city where Beth used to work] too. There was this rheumatologist who was very into that, and if you sent them [the patients] there, they'd get the diagnosis [fibromyalgia] (yes, yes). That was quite all right (interviewer: mhm) (mhm).

Anne: It's the same with [name of a doctor] at [a clinic in a town] (Beth: yes) (mhm).

Interviewer: But, but, but ... (Beth laughs)

Even though it is unclear from the conversation whether this was something they themselves did, it is clear that it was considered a possibility for rhetorical impact. As Steve said about using specialists to rule out other conditions for ME patients: 'it makes it more credible if they rule it out rather than us' (FG2).

Second, regarding functional assessments, GPs who were proactively engaged in acquiring statements from assessors of their choosing did so either because they knew the assessors would produce the results desired (convincing assessments or specific outcomes) or because they expected NAV's chosen assessor to produce unwanted results. For instance, Julia described three places to which she routinely referred patients that wrote 'good' (i.e. convincing) functional capacity statements: 'That's how it works, and it helps a lot to know whom I should refer (the patient) to' (FU interview). As Jonathan put it (FU interview):

Jonathan: There are some who suffer the great misfortune of being referred to some of NAV's old, sly foxes (mhm). (...) These specialists, that NAV refer [patients] to – I'm not sure whether they have their integrity in place, whether they're acting as the patient's professional expert or if they're running errands for NAV. To get more assignments [NAV pays them a fixed hourly rate].

Interviewer: It seems that, with regards to the patient's, sort of, chances in the system, that it's important you end up in the right hands?

Jonathan: In hands that aren't directly funded by NAV.

In line with his view of NAV's 'foxes', Jonathan was proactive in acquiring statements that would enhance the certificate, precisely to improve patients' chances in the system. For instance, he spoke of a place, Clinic A, that did good functional capacity assessments based on neuropsychological tests. Howard, also a GP, said he could get similar assessments at another place, Clinic B, which is privately run. As Jonathan, who knew about Clinic B, commented (FU interview):

Jonathan: Yes, but the private ones aren't as good at getting through to NAV.

Howard: No.

Jonathan: And their recommendations are much more vague. No, I only use (...) [Clinic A].

Howard: Great! Clinic A [repeating it as if making a mental note].

Jonathan then described having patients assessed at Clinic A. Formally, he should send his patients to a local outpatient clinic (Clinic C) that decides on the case. Nonetheless, Jonathan sends them to clinic A

because, as he put it, 'each time they'll send the patient back to the outpatient clinic because that's where they [his patients] belong. And then Clinic C has to return them to Clinic A and say "We lack the competence to perform neuropsychological tests". So there's only a three-day delay'.

Acquiring expert statements for rhetorical purposes requires knowledge about the potential providers and whether to avoid or commission their services. In some cases little work is needed apart from monitoring, for instance when NAV's preferred assessors are also considered competent by the GP, which was Anne's situation (FG1). Other times, this type of rhetorical work is an extensive effort.

3) Circumventing the certificate

The third type of rhetorical work relates to GPs' attempts to avoid the constraints of the written form. Some of the GPs endeavoured to bring about situations where they could discuss cases with NAV officials, preferably face-to-face, to explain nuances and make clarifications that were hard to put in writing (by gestures and other forms of expression) and persuade by impression management. To some extent, meetings between GPs and officials take place regardless of whether GPs aim to use those meetings for rhetorical purposes. Importantly, however, some GPs explicitly strove to make such meetings happen to persuade or thought of them and used them as opportunities to persuade when they took place routinely.

Peter, the most avid advocate of this approach in the focus groups, routinely invited local officials to come to his surgery for a meeting (an achievement some GPs considered impossible). Here, he explains the rhetorical advantage of meeting NAV officials face-to-face (FU interview):

Peter: Take this person [a previously mentioned patient with MUS]. I have written page after page, dissertations, back and forth, and that wasn't even enough. And [I] used phrases like (...) 'Listen to what I'm saying, there is nothing more to be gained'. But that wasn't enough. Of course, I also try to write as clearly and persuasively as I can, but even that isn't always enough.

Interviewer: But when you get to meet or speak on the phone ...

Peter: The phone is less powerful. It should be face-to-face.

Interviewer: Sure. But is it something that is said there, or that is emphasized, that works better than other things, or is it just about meeting up?

Peter: I think that it's about meeting up. And it's my intonation, my precision, my conviction. It's about me assuring that person [the NAV official] that 'You can trust me. You don't have to be in doubt. I know this. That's how it is'. But that's not something you can just write, like 'You can trust me, I know what I'm talking about' [pretends to type, hammers his fingers on the tabletop]. It just looks silly.

Meeting in person allows for expressions unavailable in writing (e.g. intonation and posture). Moreover, some expressions may have the opposite effect in writing than in face-to-face interaction. As Peter hinted at, saying that 'you know what you are talking about' and that people can 'trust you' is quite persuasive in person but outright suspicious in writing. The GPs (even those who did not engage in this form of rhetorical work) agreed that it was much easier to persuade people in person. As Peter clarified, meeting face-to-face – or 'making it personal', as he called it – helped him guide many insurance trajectories.

A distinction can be drawn between whether the interaction takes place before or after writing the certificate. Meeting *before* writing allows the GP to prime the readers of the certificate at NAV, for example so problematic issues can be nuanced and negotiated and so the official can perhaps be encouraged to be sympathetic to the case at hand. As Jonathan put it, he tries to meet before writing, 'to prevent my

certificate from dropping like a bomb on the caseworker's head, who is perhaps still of a mind that we should try this or that' (FU interview). Peter had also begun meeting NAV officials before issuing certificates to 'potentiate' the trajectory, as he put it (FU interview). Speaking of a patient who was going to apply for a disability pension, he said, 'we'll do the meeting at once. Before he applies. And then we'll say it like it is, and then she [the NAV official] will know. And then I'll write the certificate so she can tie it, when she reads it, to what I told her' (FU interview). As Anne and Julia hinted at in FG1, meeting before writing also allows the local NAV office and the GP to negotiate and agree on what should be written in the certificate in the first place (a form of *rhetorical teamwork*). In comparison, meeting *after* writing was described as less potent because the NAV official may have already formed an opinion based on the certificate.

The potential problem with persuasion in person is that such efforts may be of little consequence when the local office sends its recommendations to the regional office. This was part of the reason why some GPs, like Steve and Howard, did not engage in such rhetorical work. Others were keenly aware of this problem but, as Peter put it, 'that's why it's so important that these local NAV officials are totally convinced so that they'll write that "everything that can be done has been done. Any further treatment" – in cases involving disability pensions – "is just maintenance. There is nothing more to gain"' (FU interview). The goal of persuading the local official is therefore to start a *rhetorical chain reaction*. In support of this notion, research has shown that local NAV officials are often in doubt in these sorts of cases (meaning there is rhetorical leeway), but also that when they do become convinced, they too engage in what I call rhetorical work to persuade regional officials (Gjersøe, 2016: 137, 139).

7. Discussion and concluding remarks

I have described a typology of rhetorical work that GPs may undertake to construct convincing cases for health benefits in lieu of biomedical evidence. The typology fits with previous findings showing that many GPs are willing to act strategically on their patients' behalf (e.g. Bringedal et al., 2017; Gulbrandsen et al., 2004). It also contributes by detailing *how* that willingness may translate into types of action. The typology moreover expands on the field of inquiry by emphasizing actions that take place *outside* of the actual text of the certificate that can have a real impact on insurance trajectories (e.g. the strategic acquisition of expert statements and face-to-face persuasion). Furthermore, focusing on persuasion highlights some common ground between patients, doctors and bureaucrats in that they all (sometimes) have to work to overcome an institutionalized distrust in complaints that biomedicine fails to objectify; they are all part of the same *rhetorical chain* along which insurance cases are propelled by the force and direction of their acts of persuasion. This in turn allows us to unite different bodies of literature on topics such as patients working to persuade GPs (e.g. Werner and Malterud, 2003), GPs working to persuade local officers (e.g. the present study) and local officers working to persuade their regional counterparts (e.g. Gjersøe, 2016). Each of these teaches us something about the role of rhetorical work in insurance medicine, though from different angles.

The analysed data were shaped by researchers as well as participants. To the participants, I was a novice, non-medical researcher trained in the sociologies of medicine and professions, with an informal mannerism and a somewhat scruffy appearance. Based on the unfolding of the FGs and FU interviews, I think I came across as knowledgeable enough to engage with and informal enough to avoid mere 'correct' discourse. My assistant took a largely passive role, yet, being a medical doctor, her presence might have legitimated my researcher role and helped encourage the participants to engage in discussion. The choice to frame MUS as ambiguous and challenging might have prompted accounts about how such cases are understandable and can be handled, and accounts that clarify the nature of the challenge from a clinical point of

view (see Rasmussen, 2017, Rasmussen and Rø, 2018). The participants seemingly found MUS an engaging topic to discuss. Given the emerging analytical focus on lengthy insurance trajectories, having seasoned practitioners in each FG was crucial, and a higher concentration of experienced GPs could have strengthened the study.

The analysis is explorative and innovative. It does not provide an exhaustive description of the full array of rhetorical work; instead, its aim is to outline the main types of actions GPs undertake to persuade bureaucrats. Nor does the analysis tell us how often the types of rhetorical work described are actually performed in primary care; instead, the proposed typology is intended to capture *what* they do *when* they do it. Finally, since the data are limited to the GPs, I cannot speak of their factual influence on bureaucratic decision-making. The analysis is therefore limited to the strategies GPs' (claim to) employ. More research is needed to determine the actual influence and distribution of these strategies, for instance by studying certificate texts, or by following insurance cases along the rhetorical chain into the welfare bureaucracy. Nevertheless, the reconstructed typology of rhetorical work indicates where future studies might direct their attention. To further aid future research, I close by discussing some potential outcomes and implications of rhetorical work.

7.1. Potential outcomes of GPs' rhetorical work

The rhetorical practices of the GPs interviewed seemed highly variable. Since services such as health care are constituted in the act of delivering them (Lipsky, 2010), the possible outcomes of variations in rhetorical practice should be addressed. Assuming that rhetorical work actually affects insurance trajectories, one possible outcome is service inequality. Imagine the following scenario: the GP at clinic A may strive to ensure incapacitated patients receive disability pensions, whereas the GP at clinic B may not. Accordingly, patients with equal complaints will receive unequal treatment at clinics A and B. Another possible outcome, however, is service equality. Imagine the following scenario: patients at clinic A have their disability claims processed by office A, which is *more* restrictive than average, whereas patients at clinic B have theirs processed by office B, which is *less* restrictive than average. In this scenario, the rhetorical work performed at clinic A may help *reduce* the effects of differences in treatment for equal cases at offices A and B. Variations in GPs' rhetorical practices may even be responses to varying levels of resistance within welfare bureaucracies. We must therefore not assume that variations in rhetorical practice necessarily produce unequal treatment. It depends on the *dyadic relationship* between GPs and their local welfare office.

I would add that differences between local offices are no mere thought experiment. In Norway, such variations are well documented, with the size of the office indicated as an important dimension. Compared to larger offices, small ones (<40 employees) tend to have a lower workload, provide better quality services and have more experienced, satisfied employees (Fosstestøl et al., 2014). Less is known about variations *apart from* and *regardless of size* but there are reasons to suppose that size is not everything and that its effects are not the same everywhere. A case in point is that Steve, who worked in a small rural municipality, struggled to contact his local officials, whereas Peter, who worked in the city, had regular face-to-face contact with complete strangers from his local office. Future research into dyadic relationships between GPs and welfare offices should thus also consider structural features apart from size and local variations regardless of size.

Even if GPs' rhetorical practices do overall reduce the unequal treatment of equal complaints – though this is far from certain – there is still the matter of the way in which rhetorical work relates to the role of biomedicine in health insurance. Rhetorical work in insurance medicine can have effects comparable to the class of action known as 'workarounds' (Gasser, 1986). A workaround is a method to avoid a problem and one of its defining features is that it leaves the problem, the cause of the workaround, intact; an obstacle is circumvented rather than

removed. The cause of GPs' rhetorical workarounds is the biomedical ideology of the insurance system: because objectively verifiable signs of disease are *expected* to accompany symptoms, their absence makes patients' claimed ill health problematic. The problem addressed by rhetorical work is thus *the failure of reality to live up to biomedical expectations*. An unintended, and perhaps ironic, consequence of rhetorical work is thus that it protects the biomedical ideology of the system from potential criticism and change, thereby preserving the problem to which it is a response.

7.2. Implications of GPs' rhetorical work

Although the absence of evidence determines the need for rhetorical work, it remains a *choice*, a wilful attempt to steer insurance trajectories. Such commitments raise ethical concerns about jurisdictional boundaries. As stated, there is a political drive across the OECD to restrict expenditure on health-related benefits. Since GPs' rhetorical work is an attempt to make the system *less* restrictive than it is or is anticipated to be, each instance of rhetorical work could be interpreted as an illegitimate attempt to undermine policy implementation in democratic societies.

However, as I have also stated, health insurance policies have been criticized for relying on problematic idealizations of medicine. Taking that into account, an alternative interpretation is that, to the extent that GPs engage in rhetorical work, they do so to adjust problematic policy ideals to clinical reality. One virtue of this interpretation is that it avoids the assumption that fending for patients necessarily involves undermining the insurance system, typically expressed by contrasting doctors' roles as gatekeepers with their roles as patient advocates (cf. [Bringedal et al., 2017](#)). Instead, it frames a concern for patients as a concern for the appropriate functioning of the system (and vice versa). This resembles the function of advocacy within criminal law (cf. [Noonan, 1966](#); [Propen and Schuster, 2010](#)) which is to maximize clients' chances of a fair trial within the constraints of an inherently imperfect legal system. Thus, far from undermining the system, partisan advocacy may be understood as a *prerequisite* for justice. A similar interpretation of patient advocacy within the context of insurance medicine can be given: arguably, the function of GPs' rhetorical work is to ensure fair treatment for patients whose conditions are poorly understood by a system governed by biomedical ideology.

7.3. Broader applications of the concept of rhetorical work

Although the typology outlined above is made to fit GPs' role in insurance medicine, the main concept of rhetorical work has broader applications. Apart from contributing to 'the sociology of persuasion' ([Smithey and Kurtz, 2003](#): 324) – a sub-field that has yet to bloom – I have indicated its use concerning patients working to persuade their GPs, and bureaucrats working to bring about decisions in offices higher up the command chain. More generally, however, the concept of rhetorical work may be usefully employed in any situation where the authority to command is absent or challenged or where there are pressures or incentives to traverse jurisdictional boundaries in order to coordinate meaning and action. The concept may be used in any situation where attempts are made to guide the trajectory of a case through acts of persuasion. In particular, it is well-suited to analyse communication and coordination between professionals working within functionally differentiated social systems (e.g. between specialists in hospital departments), or between them (e.g. between forensic medical examiners and legal representatives, cf. [Rees, 2010](#)).

In such contexts, the tension between formalism and pragmatism discussed above can be expected. In a formalistic view, incumbents of an office should be disinterested in the treatment of a case at the next office, in which case rhetorical work is problematic. From a pragmatist view, however, rhetorical work could be seen as indispensable in making complex and imperfect systems function. As such, the concept offers a

chance to rethink how 'disinterestedness' is enacted within functionally differentiated professional systems, as a situated practice that springs from the concern that other actors will misunderstand the case or that competing interests will get in the way of due process.

Credit author statement

As stated in the manuscript, I had an assistant in the focus groups, who also tipped me about the use of established medical groups as a means of recruitment and assisted in that regard. Apart from her invaluable assistance, all the work related to this study (idea, planning, recruitment, conducting focus groups and interviews, transcription, analysis, and writing up) was performed by the corresponding author.

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