Literal Tricks of the Trade

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

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Abstract

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

Introduction

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

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

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

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

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

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

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

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

Due to real and imagined scarcity of resources, through waves of governmental austerity measures, and because of ideological struggles, the last couple of decades have borne witness to fundamental reconfigurations of public administration in general, and social security systems and welfare delivery

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

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

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

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

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

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

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

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

But what does it mean to claim that the social insurance agency has become more powerful over time, *vis-à-vis* physicians? What kind of power is at stake here? It seems to be the power over decision-making, or what

Steven Lukes calls the first dimension of power (Lukes, 1974: 12-13). In social insurance matters, increased power means that the judgments of the social insurance agency simply weigh more, and the judgments of physicians weigh less. To some extent, the power over physicians can also be understood in terms of the so-called second dimension of power: Whereas the first dimension of power deals specifically with influence over decision-making, the second dimension deals with what Lukes calls 'nondecision-making,' that is, the capacity to withdraw a question from the negotiation table (Lukes, 1974: 18-19). The decision process regarding sickness benefits is made to appear like a non-decision for the physician. That is, the social insurance agency sets the agenda, which effectively excludes the possibility to issue sickness certificates for some patients. In terms of these two dimensions, the power of the social insurance agency over physicians and their autonomy is strictly negative and repressive: the power has pushed back on the sphere of medical judgment. These two dimensions do not focus on the degree to which the content of the medical sphere may have been altered by the recent discursive and administrative changes. What I mean by this is that power also potentially has a productive dimension, that entails an active cultivation of the 'thoughts and desires' and 'preferences' of dominated groups, aligning them to suit the interests of a dominating group (Lukes, 1974: 23). Translated to the clash between the regimes of economic rationality and medical judgments, it means that the changed discourse on sickness absence could very well have trickled down to the minds and judgments of doctors. The question that must be asked, then, is if doctors voluntarily adopt strict views on sickness benefit eligibility with conviction. Do they accept and adopt the logics of austerity as part and parcel of a purely medical practice?

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

pain, etc.) (Alexanderson et al., 2018). These statistics suggest an increased polarization between the social insurance agency and GPs, and consequently, that the power over them (in this particular regard) is more repressive than it is productive. That is, the power of the SSIA does not seem to include control over GPs' (professional) thoughts, desires and preferences.

Resistance in the new landscape of social insurance systems

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

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

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

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

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

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

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

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

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

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

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

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

Use of techniques for having sickness certificates accepted

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Intent, multiple motives and the ambiguous target of resistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

social insurance agency in any way encourage or benefit from the use of techniques?

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

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

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

resistance does more than elicit a feeling—it influences the course of events in a very real sense.

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

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

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

Conclusion

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

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

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

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