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Trajectories of Professional Authority: A Comparative Study of Medical Associations and Professional Authority Claims

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Abstract Medical associations not only organize their members' interests but also exercise professional authority within the field of health policy. An important aspect of professional authority is the medical profession's ability to position itself in relation to national health policy and whether its command of professional knowledge enables the profession to claim exclusive authority to reflect on health policy. This article analyzes and compares how medical associations claim authority over health policy and how they reposition their claims in light of perceived contestations to medical authority in public debates or from the political system. The study is based on a qualitative, descriptive analysis of 975 editorials in the medical associations' lead journals in the United States, the United Kingdom, and Denmark over a period of 60 years. The analysis explores the trajectories of authority claims in the three countries and how professional authority claims may be reconfigured to reflect external changes in health policy institutions. Whereas all the medical associations were highly critical of state-organized health systems in the 1950s and early 1960s, the British and Danish associations seem to shift positions entirely after national health systems are gradually implemented and the associations begin to present themselves as these public institutions' strongest supporters.

Keywords medical associations, professions, authority, qualitative, comparative.

The status of knowledge authorities in contemporary society is contested. While it is premature to simply write off professional authority as a victim of a "post-truth" era, medical associations continuously face the challenge of how to legitimize their role as the "preeminent" expert authority on health policy (Freidson 1970: 5). The literature is full of historical accounts from periods when medical authority did not seem to need any legitimation (Haber 1991; McKinley and Marceau 2002; Starr 2017). Narratives of a previous golden age of medical authority are not very useful, however, if we want to understand the character of medical authority claims in various contexts. This article offers a descriptive account of how medical associations claim professional authority in three different countries and over long stretches of time. Do they try to maintain traditional claims saying that only members of the medical profession can legitimately evaluate health care institutions, or do they reconfigure medical authority claims to situations where such monopolies can no longer be defended?

There are three main reasons why we should pay interest to medical associations' authority claims in a comparative perspective. The first has to do with the current discussions in health policy scholarship about whether the status and power of the medical profession is in decline or has simply changed. It is well known how the American Medical Association (AMA) played a major role in blocking proposals for national health insurance during the mid- to late twentieth century (Blumenthal and Morone 2010; Steinmo and Watts 1995). Some argue that recent health reforms like the ACA have shifted medical associations to become defenders of public health care (Jacobs and Skocpol 2015), while others argue that medical associations are as powerful as before but have merely shifted strategies from overt policy influence to subtle, backroom decision making (Laugesen 2016; Martin et al. 2015). These potential shifts of position call into question whether and how medical associations also position themselves differently and claim authority over health policy decisions and institutions. This is analyzed here through the lens of professional authority claims, as elaborated further below.

The second motivation to study authority claims from medical associations is to demonstrate the potential contributions of the sociology of professions to this field. Health policy scholarship mostly treats medical associations as interest groups seeking influence (Immergut 1990) but may overlook the subtleties of how professions develop and convey arguments to legitimize their positions in society and in relation to health policy. Whether professionalism should be understood as a value in itself or mainly as an ideological cover for professional interests (Evetts 2013), it is important to document in some detail how medical associations position and reposition themselves as expert authorities on health policy. Trajectories of authority claims are useful in this respect, because they connect the qualitative detail of specific context-dependent authority claims with the larger strategies or "professional projects" (Larson 2013) seen across time.

Finally, a third reason to compare medical associations is the current lack of comparative research. Most analyses of medical authority (Schlesinger 2002; Starr 2017) and of the medical profession's political power focus more or less exclusively on the American case. As identified in the sociology of professions, there are important national differences between whether professions rely on highly autonomous positions in the marketplace or develop more symbiotic relationships with the state (Svensson and Evetts 2010). These comparative differences are dynamic and not stable ideal types, however, because medical associations may reconfigure their authority claims over time to position themselves within the changing health care institutions and with the challenges posed to their authority. The comparison serves a descriptive purpose and is not intended to establish a causal link between health systems and professional authority. Authority claims may look like reactions to or even direct effects of external events such as policy reforms, but since the causal links are vague at best, they are interpreted here simply as self-descriptions of how medical associations legitimize their positions. The article compares the trajectories of authority claims in three countries with very different health systems and during a long period with major changes in all health systems. The research question here is what characterizes medical associations' authority claims during long trajectories in which professions try to reconfigure their position as expert authority on health policy decisions.

Professional Projects and Authority Claims

To place the argument within a theoretical literature, this section first introduces existing work on the role of professional associations in the public arena to identify how medical associations might reconfigure professional authority when faced with challenges. The second part of the section goes on to define the core concept of professional authority, including the key distinction between social and cultural authority claims.

Professional associations are typically understood as interest groups protecting their monopolized market against outsiders, although in contemporary contexts a core function is the more "outward" role of legitimizing the profession's exclusive control of work tasks (Freidson 1970: 33; 1986: 186; 2001: 12). Because established professional monopolies are rarely exposed to serious challenges, the sociology of professions increasingly focuses on the ongoing work that professions undertake to cultivate and strengthen their position as knowledge authorities. One example is Larson's (2013: xx, 52) analysis of professional "projects" that seek to justify claims of "disinterestedness and public service" and the ability to speak "about and for their field." Abbott (1988) similarly argues that effective professional jurisdictions are usually sustained by claims made in the public arena and public opinion, cultivated over a decade or more. The professional projects can in principle involve many types of claims, some being merely image work and some focused more directly on positioning the profession as a strong authority on public policy.

It is perhaps analytically useful, however, to be more specific about the types of claims that professional associations might use to reconfigure their authority, if this is no longer taken for granted but rather something medical associations feel the need to defend in public. The ambition here is therefore to be more specific about precisely the types of situations where medical associations address potential challenges and make new claims about how the profession's authority should be understood in either a new way or essentially as it was before. Evetts (2013: 786) suggests that strong professions such as medicine are traditionally professionalized from "within," that is, they cultivate their own market, while weaker professions such as social work are rather professionalized by the state "from above." This assumption is too general to capture the dynamic changes within medicine, but it is perhaps useful to consider whether challenges to professional authority come from medicine itself, from external political or policy developments, or—as a third option—from cultural developments in society such as patient roles, media attention, and the like.

To specify possible challenges and pathways to reconfigured authority, it is necessary first to clarify the underlying theoretical understanding of authority and the distinction between social and cultural authority.

The generic concept of authority builds on a tradition from Max Weber (1978: 212), who defined it as “the probability that certain specific commands . . . will be obeyed by a given group of persons.” Obeying commands may sound like military discipline (Milgram 1974), but Weber’s definition applies to a variety of social situations where actors may follow a prescribed course of actions if they perceive the commands as legitimate. Here, I draw on Starr’s (2017: 15) modernized Weberian definition of professional authority as a relation of “dependence on the professional’s superior competence,” which is constituted by two dimensions, social authority and cultural authority.

Starr (2017: 13) argues that authority goes beyond the command of action because it “extends to the meaning of things.” Aside from Weber’s generic understanding of social authority, Starr employs the term *cultural authority* to analyze this aspect of professional work: “Social authority involves the control of action through the giving of commands, while cultural authority entails the construction of reality through definitions of fact and value” (13).

Cultural authority measures the degree to which citizens believe a profession’s exclusive expertise is necessary to perform a given work task, in this case to evaluate policies related to the professional area of expertise. It is thus a measure not of the profession’s knowledge in itself but of the perceived need for this specialized knowledge. An important threshold in the development of a profession’s cultural authority is when the public begins to ascribe “legitimate complexity” to the tasks performed by the profession (Starr 2017: 59), for instance whether citizens understand doctors or medicine as necessary to achieve health. This was not a given in the 19th century before the

breakthrough of scientific medicine (Haber 1991; Starr 2017), and it was also contested during the 1970s' "therapeutic nihilism" (Starr 1976).

Social authority measures whether a profession can "command" certain decisions or outcomes without outsiders necessarily questioning the legitimacy of these commands. For example, if a medical association can block certain policy proposals or interventions from being enacted even though they have no formal legal veto power to do so, this may indicate a high degree of social authority. This type of authority is often sanctioned in legal monopolies guaranteed by the state (e.g., Saks 2010), but it can also rely on status positions or trust established in interactions between professionals and citizens. Social and cultural authority are conceptually separate but hard to separate empirically because strong professional associations of course aspire to have both as mutually reinforcing sources of legitimacy.

Professional authority claims do not automatically equal influence, of course, so this analysis only shows medical associations' attempts to position themselves relative to health policy decisions or challenges in society. A classic and very emphatic example is the AMA's position against health insurance, which stated that "the medical profession alone can determine the adequacy and character of such institutions" (*JAMA* 1934). Even if the AMA was a major roadblock against national health insurance, their influence was never this absolute, which would also undercut most attempts at democratic decision making in health policy. The AMA's statement sounds definitive, but it is ultimately nothing more than a claim whose effectiveness rests on how outsiders perceive it as authoritative.

The theoretical argument here is mainly a conceptual framework designed to zoom in on and distill authority claims from their specific empirical context. While the theory does not predict a specific result, it is nevertheless expected that all medical associations experience some challenges to their authority during this period, for instance by having their professional authority called into

question by political authorities, by media coverage, or by patients. Besides using the claims as a barometer of these challenges, it is also important to identify potential changes in the types of claims themselves. Do they simply reject the challenges as being misconstrued by outsiders without the proper expertise, or do the challenges lead the associations to legitimize their positions in new ways?

Methods and Data

No single data source captures professional authority in its entirety. Whether a profession really has authority in the eyes of others requires in-depth data of citizens' perceptions of professions. This study is about how professions *claim* authority, which can be documented through various sources including public relations campaigns, op-eds, appearances at parliamentary hearings, and so on (Larsen 2020; Larsen et al. 2012). The criterion here is to select representations of the medical associations' "voice" that enable comparison across countries and long stretches of time (Abbott 1988: 61). I therefore use a sample of editorials from professional journals across three countries and six decades. The relevance of this data is that an editorial in *JAMA* or *BMJ* usually serves no other purpose than to position the profession or the association on a given topic. The editorials are not scientific publications in themselves, but they often reflect on the implications of certain developments within or outside of medicine. Just as the associations do more broadly, the editorials have an inward and an outward role (Freidson 1986). Inward, they are obviously addressed at association members; but they also point outward because most editorials use nontechnical language and often literally address external actors, for example, by saying what policy makers should do. This outward role is perhaps clearest in the associations' generic flagship journals where the editorials are often written as, and perceived by outsiders as, statements from the medical authorities.

I include the lead journal of the largest medical association in the United States, the United Kingdom, and Denmark. The membership of the AMA has declined significantly for decades in favor of specialty or state-based associations, but it is still the largest umbrella organization similar to the British and Danish associations. The three countries share some basic characteristics as wealthy societies where the medical profession achieved strong social closure (Saks 2010) long before this period. The countries clearly differ on health care systems. Denmark and the UK both have single-payer systems with universal health insurance increasingly supplemented by private insurance and provision (Blank et al. 2018; Larsen 2020; Larsen and Stone 2015). The fragmented US health system has undergone several reforms, and reform attempts, during the period but continues to be dominated by private insurance, financing, and provision in combination with public programs.

The medical profession also varies between countries. American doctors are a very strong profession mainly based in private markets, whereas Danish doctors are positioned much closer to the state (Svensson and Evetts 2010), even if most physicians and some specialists are self-employed under government contracts. British doctors similarly combine public and private employment, but the profession has a longer history of autonomy from the state with strong scientific societies like the Royal College of Physicians. These differences do not imply a specific expected outcome, because the main analytical ambition is to explore and describe how each association reconfigures its positions over long trajectories.

The editorials come from the *Journal of the American Medical Association* (*JAMA*, published since 1883), the *British Medical Journal* (*BMJ*, since 1840), and the Danish *Ugeskrift for Læger* (*Journal of the Danish Medical Association*) (*UfL*, since 1839).[1] With the increased specialization of medicine and medical journals, the role of generic flagship journals may change, but as long as they maintain a position as signposts of the medical profession internally and

externally, they continue to be useful expressions of the style of authority claims. The journals have some degree of editorial independence from their parent associations, but since they rarely print the author's name, they can be said to represent the associations' public voice.

Twenty-five editorials were selected from thirteen volumes in five-year intervals going back to 1950, an era sometimes characterized as the highpoint of medical authority (Starr 2017), to 2010. The editorials were not selected on the content; simply the twenty-five last published in each volume were selected, giving a total data set of 975 editorials (325 in each country), each with 1–3 pages of text. They were organized and coded in NVivo. The overall inclusion criterion was quite broad in the sense that no editorials were discarded as entirely irrelevant. The first coding cycle did, however, separate one group of editorials that did not clearly contain any discernible claims about medical authority, because they merely discussed new scientific results reported elsewhere in the issue. As an example, a *BMJ* editorial "Measuring Improvement in Rheumatoid Arthritis" (*BMJ* 1950c) discusses this subject without any discernible claims about what medicine thinks should be done or how the medical profession should be seen by others. The existence and proportion of this scientific content may still be important for the journal to be able to convey the profession's cultural authority. The analysis therefore considers the overall proportion of these editorials without describing the content.

All the remaining editorials were coded as having one authority claim each and differentiated as being mainly a claim about either social or cultural authority. Reducing each editorial into one authority claim obviously comes at the expense of the sentence-by-sentence detail in other approaches (e.g., Wodak and Meyer 2009). The editorials are very short texts with one topic and a similar narrative structure where the discussion of the topic concludes with what should be done differently (i.e., social authority) or who should understand the topic in a certain way (i.e.,

cultural authority). Thus, the ideal is to reduce the data without a quantification that loses access to the actual language and arguments in the editorials (Schwartz-Shea 2013).

Following the theoretical definition, a social authority claim uses medical expertise and the position of the medical profession as a basis for prescribing action; that is, it states what someone—individuals or institutions—should do differently. It may also involve a claim about what nondoctors cannot legitimately do or decide without the profession's backing. A typical example in this category is a Danish editorial that discusses waiting time in the health care sector and argues that—according to medical expertise—the problem should be solved through increased public funding rather than marketization or private sector alternatives (*UfL* 1990c).

Cultural-authority claims do not directly prescribe action but argue why the medical profession should be seen or respected in a certain way, typically with reference to their expertise or professional values. For example, a *JAMA* editorial titled "The ADR Numbers Game Revisited" lashes out at public misconceptions of adverse drug reactions as an avoidable problem, which is "nonsense . . . as every physician knows" (*JAMA* 1975a: 1257). Cultural authority claims are sometimes hard to distinguish clearly from social authority, which calls for cautious interpretations of the overall classification and more attention devoted to content description.

A second-cycle coding differentiates between whom the authority claims are addressed toward, either the state and policy makers, on the one hand, or citizens and the broader public, on the other. For example, a cultural authority claim targeting citizens/society discusses the negative images ascribed to doctors in the media in light of a new occupational prestige ranking where doctors perform well (*JAMA* 1965). As an example of a state-directed social authority claim, an editorial urges British policy makers to take steps to reduce global health inequities (*BMJ* 2005a). Overall, the second-cycle coding should give a sense of where the three medical associations feel the most challenged or, at least, where they direct their claims the most. The distinction was

difficult to operationalize in a few cases, but again, the classification is less sensitive, because it mainly serves as a structure for presenting the content and not as documentation of a causal claim.

The data are presented in a way that facilitates a descriptive overview. The text characterizes the typical formulations and arguments in authority claims in each category, which are supplemented by frequency tables showing the number of editorials coded in each category. While this section seeks to strengthen transparency about selection and coding procedures (Schwartz-Shea 2013), the analysis does not allow readers to "see" the data for themselves. This would not be possible with the amount of documents across three countries and six decades; but since the analysis references published texts, they are of course retraceable this way. The analysis prioritizes giving a sense of the content and arguments in typical authority claims, although structured along the different categories of claims.

US: Authority Claims in *JAMA* Editorials, 1950–2010

JAMA editorials rarely contain emphatic claims of unlimited authority similar to the cited AMA declaration on health insurance from 1934, although the period does cover several major policy reforms and proposals in the same field. The *JAMA* editorials are generally more subtle and context-specific. About 42% of the editorials mainly report or discuss new medical findings without identifiable authority claims.

A smaller group (22%) is classified as social-authority claims directed at citizens or society broadly. A core theme here is the sanctity of the doctor-patient relationship and where the physician is framed as obliged to act as a sort of protective guardian of the patient. This broader theme is covered in editorials on topics such as tuberculosis (*JAMA* 1950c), childhood accident prevention (*JAMA* 1950a), encouraging childbirths in hospitals rather than at home (*JAMA* 1955c), monitoring families' use of pharmaceuticals (*JAMA* 1960), and in recent decades also lifestyle behavior such as

smoking and obesity. Common here is a situation or context where the physician can and should act as a social authority and thereby relieve patients at risk.

Over the last 30 years, editorials in this group tend to portray the doctor-patient relationship as more contentious or even challenged. Examples here include the role of doctors in do-not-resuscitate orders (*JAMA* 1985a), end-of-life decisions (*JAMA* 1995a), and organ donation (*JAMA* 2005), but also critical pieces on conflicts of interest, typically related to financial disclosure policies for competing interests (e.g., *JAMA* 2000a, 2010).

Another group of editorials (22%) contain cultural authority claims directed toward citizens and society. Most of these fall during the first few decades and focus on key developments or persons in the history of medicine, typically framed as honorable representatives of the profession's ethics and scientific progress (e.g., *JAMA* 1950b, 1955a). Some also reflect on the contested public image of medicine, typically arguing that the honor and occupational prestige of doctors is actually better than usually portrayed, for instance by citing an author who described doctors as the "flower . . . of our civilization" (*JAMA* 1965: 182).

The cultural authority claims also display more defensive positioning after the mid-1960s, which may reflect a need to legitimize and defend medical authority more against a contentious public image. For example, *JAMA* accuses the mass media and the public of "gossipmongering" and misrepresentations of doctors (e.g., *JAMA* 1970, 1980). They also call on doctors to be more cautious with the press and protect their public image (*JAMA* 1985c, 2000b).

Compared with the Danish and British editorials, *JAMA* directs few authority claims at the state and policy makers. Only a few cultural authority claims are directed at the state, such as a broad call for respect from Congress (*JAMA* 1955b). More common are social authority claims directed at the state or Congress (12%) in which the association addresses various policy proposals.

Some of these, especially in the 1950s, emphatically oppose the inclusion of doctors or health care institutions in social security and related programs, specifically in arguments against government regulation of retirement age and insurance for dependents (*JAMA* 1955d, 1955e). Another notable editorial greets the World Medical Association for its role in "preventing socialism . . . from creeping in a back door," here identified with social security, as "unnecessary interference by a government in medical care plans . . . and attempts to . . . arbitrarily interject themselves between the doctor and his patient" (*JAMA* 1955f: 1020).

The ideological terminology is toned down later, but a few editorials basically repeat similar arguments. For example, fierce resistance to national health insurance proposals, either because they lack "new dollars" or because any such system interferes with the "right" of physicians to treat patients solely based on their mutual decisions without interference (*JAMA* 1975b: 960). Some editorials argue that problems in the existing private system, for instance children without health insurance, should be solved through tax breaks rather than Medicaid expansion (*JAMA* 1995b). Major health reforms such as Medicare or Medicaid do not attract much attention, which may result from the five-year intervals.

A significant group of state-oriented (social) authority claims in the US concern managed care and related cost and quality control measures (HMOs, DRG rates, prospective payment systems, etc.), particularly in the 1980s and 1990s. These editorials frame professional authority as threatened not by "socialized" medicine but rather by new payment systems designed to replace fee-for-service models and increase cost consciousness among physicians (*JAMA* 1985b). An example here is a 1990 editorial titled "Problems with Incentives" (*JAMA* 1990), which captures the profession's opposition to control instruments governing doctors through economic incentives. A series of related discussions during the 1980s and 1990s contain similar critiques of such instruments and mostly characterize them as "unnecessary."

Compared with the editorials on health insurance, *JAMA*'s positions against incentive-based control instruments seem a bit ambiguous. On the one hand, *JAMA* fiercely opposes the expansion of health access in contexts where it is implemented from above, such as with coverage for uninsured children or health-related aspects of social security; on the other hand, the editorials also systematically criticize policy instruments rationing, limiting, or economizing health access, such as replacing fee-for-service with managed care (*JAMA* 1995b). These are not necessarily mutually exclusive positions, because both types of situations involve outsiders seeking to define the criteria for health access.

Although the challenges thus change over time, *JAMA* seems to demonstrate a continuity in the style of social authority claims about controlling action legitimized through exclusive knowledge. *JAMA* does of course change some positions during this long period and address them at new issues and challenges, but this material does not show a substantial reconfiguration of its positioning, that is, how medical authority is legitimized. Positions on health access seem to be evaluated based not on the deservingness of those seeking access but on whether the profession continues to be gatekeeper and define access to health care. Later authority claims show less ideological tint and more subtle arguments against outsiders challenging medical authority, but the positioning is essentially similar. Table 1 offers an overview of authority claims in *JAMA* editorials.

[Table 1 here**]**

UK: Authority Claims in *BMJ* Editorials, 1950–2010

The British medical profession may never have had the same social and political power as American doctors had in the mid-20th century, but it nevertheless enjoys high autonomy. Exclusionary social closure was established already in an 1858 act (Saks 2003) and the Royal Colleges have a long tradition for giving policy advice and for being heard (Larsen et al. 2012). It is

thus interesting to see how the profession claims authority during a period where the National Health Service gives doctors a lot of stakes with the state and policy makers.

The proportion of *BMJ* editorials on new medical research is 31%, and despite fewer cases in recent decades, the journal continues to feature medical research and function as a resource for cultural authority. The *BMJ* authority claims are not generally skewed toward either the state or citizens/society but are more evenly balanced. Social authority claims toward citizens and society constitute the largest group (27%). They include many topics in medicine, but a dominant theme is how physicians should handle patients with a specific condition, for example cystic fibrosis (*BMJ* 1970a); how to act sensitively toward male rape victims (*BMJ* 1990b), manage patients with bipolar disorders (*BMJ* 2000d), treat noncompetent patients under a new act (*BMJ* 2005b), or treat users of smokeless tobacco (*BMJ* 2010a). These are only a few examples, but a common thread is that the patient's special situation calls on the physician to reconsider his or her authority position. In other words, these are not discussions about what medical treatment should be given, but about *how* it is given, and how doctors should position themselves in front of patients with a sensitive condition.

The cultural-authority claims directed at citizens and society are relatively similar to *JAMA*'s, that is, the early period has many editorials honoring important persons in the history of medicine. Examples here are editorials such as "Beneficent Influence" of the London School of Hygiene and Tropical Medicine (*BMJ* 1965) or a retrospective piece "Landmarks in Medicine" (*BMJ* 1985b). Not all are as blatant homages to medicine as these, but they show an association with an ongoing conversation about the position of medicine and its sub-specialties in society. The *BMJ* editorials generally seem much less defensive than *JAMA*'s, and they rarely just complain about being misunderstood in the media. In the relatively few *BMJ* editorials on scandals and conflicts of interests, the authority claims also point toward the profession itself. For instance, a

piece about research misconduct concerns how the profession should act differently to not lose the public's confidence (*BMJ* 2000b).

Authority claims directed at the state are fewer, especially on cultural authority (2%), whereas social-authority claims directed at the state comprise 22%. These social-authority claims mostly concern the profession's relationship with the NHS, and the coverage therefore follows the gradual development of the NHS. In the 1950s, the editorials are quite adversarial and focus on major problems in the newly minted NHS (established in 1948), but the claims are not nearly as opposed to national health systems as in *JAMA*. One editorial argues that the British Medical Association will continue to "selflessly support" the NHS despite "grave doubts . . . about the wholesale intrusion of the State into personal medical services for the sick" (*BMJ* 1950b: 1262). It goes on to criticize financial problems in the NHS as a sign that "the honeymoon period of the Welfare State is over. The uneasy marriage between the medical profession and the State is now undergoing the strains of an unbalanced domestic economy" (1263).

Other editorials in the same period complain about being under the "absolute power" of a cabinet minister, and about state organization of "registrars" (resident doctors in hospitals) (*BMJ* 1950a: 1158). The association's relative uneasiness about state medicine persists until the early 1960s in this material, for instance when an editorial greets the incoming Conservative Health Minister Enoch Powell for calling the NHS a "Lumbering Leviathan" (*BMJ* 1960).

The majority of social authority claims since the 1970s concern budgets, both their size and how they are regulated by economic and managerialist control mechanisms rather than by doctors. The editorials are not fond of managerialist systems—for instance, a critical editorial criticizes "Hamster health care" where doctors run the wheel (*BMJ* 2000a). But the *BMJ* editorials are generally much less critical of state regulation than *JAMA* and to some extent also the *UfL*. Most *BMJ* editorials since the 1970s do not challenge the state's role in regulating health care at all, but

mainly ask for more resources to reach certain policy goals (e.g. *BMJ* 1970b, 1975, 1985a, 1990a, 2000c).

Asking for more resources is an unsurprising finding in itself, of course. Indirectly, however, these editorials convey an image of the *BMJ* as generally accepting the overall national health policy goals and the state's legitimate authority to formulate these goals. The difference between the early contentious claims and the later more appreciative claims toward the state suggests a reconfiguration of the professional "project." Professional authority no longer appears to be framed in as much opposition to or competition with the state. In more recent discussions about marketization, the *BMJ* goes even further and directly warns against the partial marketization of the public system or similar more or less neoliberal policies that allegedly "diver[t] public resources to private interests" (*BMJ* 2010c: 1281; see also 2010b). It is interesting here how the association positions itself as a sort of guardian of the public system's core values. The professional project thus aligns strongly with the NHS even if they might in some situations disagree with the government's policy proposals. The *BMJ*'s strong opposition to marketization or "neoliberalization" in health care seems quite different from *JAMA*'s positions, but it is in fact similar to the Danish development analyzed below.

In sum, the *BMJ* editorials demonstrate an initial uneasiness about state medicine and the newly created NHS as a perceived threat to professional authority. Later editorials are not nearly as defensive against outsiders; that is, both citizens, the media, managers, and politicians are framed in less pejorative terms than in the other countries. The *BMJ* editorials do not to the same extent present professional authority as under siege, or at least it conveys a more consistent altruistic outlook. Table 2 offers an overview of authority claims in *BMJ* editorials.

[Table 2 here]

Denmark: Authority Claims in *UfL* Editorials, 1950–2010

The Danish journal *UfL* has the highest total proportion of sources reporting new medical research (47%), although all of these cases are from before 1990. The *UfL* thus has quite few pieces on health policy in the first few decades, but it almost exclusively writes about health policy in recent decades. This change may potentially affect the association's cultural authority, and the *UfL* risks being seen increasingly as a magazine for union members, while discussions of medical science probably move into specialized and non-Danish publications.

The remaining authority claims are mainly directed at the state, although I begin again with a short overview of the claims directed at citizens and society. There are quite few social authority claims in this category (8%), mainly concentrated in the last three decades. Similar to the *BMJ*, some editorials concern the physician's authority position in front of patients, for instance about preventing medicine abuse and whether the doctor should be a role model on smoking, alcohol, and so on. (*UfL* 1970a, 1980a, 1990b). A few editorials discuss how doctors should protect patients against the state's interest in individual medical knowledge.

Many social authority claims, particularly in recent decades, concern patient rights (*UfL* 1995d, 1995e, 2000d, 2005h) and doctors' legal protections against complaints and malpractice suits (*UfL* 2000a, 2000b, 2000e, 2000f). The conflict level is higher here, because although doctors are traditionally characterized as a sort of guardian of the patient, new patient rights and other legal protections against malpractice are characterized as threats to this authority relation. The editorials do not radically oppose patient rights as such, but they argue for moderation and for not exposing the medical profession to an open public scrutiny. Several editorials criticize both patients and the health care sector for being "fixated on guilt" in relation to malpractice (*UfL* 2000c) while the media are criticized for their "scare campaigns" on the topic of overmedication (*UfL* 2005h).

The topic of patient rights illustrates how professional authority is increasingly formulated as a cooperation with patients rather than being under the professional's exclusive command. Even in examples where doctor-patient confidentiality is described as being almost sacrosanct, the social authority toward patients is not taken for granted as clearly as before. Recent volumes even discuss how doctor-patient confidentiality should perhaps no longer be as protected (*UfL* 1995a, 1995b) but could be compromised to improve cooperation among doctors (*UfL* 2005g).

Cultural authority claims directed at citizens and society comprise 13% in total and, like the other countries, editorials since the mid-1960s often focus on public skepticism toward medicine. Some of the early editorials in this category tried to explain away the phenomenon of medical malpractice as being a complete misunderstanding, for example by saying that iatrogenesis (health effects caused by medical treatment itself) is really caused by "complex states of disease" rather than by a lack of professional expertise (*UfL* 1965b). A later editorial similarly discusses if doctors' mistakes are really mistakes and argues that only a medical board could evaluate this (*UfL* 1990a).

In recent decades, medical malpractice is no longer presented as nonexistent. The proposed solutions, however, are still based on a classic claim of cultural authority; that is, only doctors are qualified to understand and evaluate possible cases of malpractice. Other claims advocate moderate or symbolic solutions as being preferable to formalized patient rights, for instance proposals for developing an "open culture" (*UfL* 2005d), a "shift of culture" (*UfL* 2010f), or simply doctors' self-regulation (*UfL* 2000g). Besides medical malpractice, similar concerns are voiced against making complaints records public (*UfL* 2005a, 2005b, 2005i) or against demanding financial independence from the pharmaceutical industry (*UfL* 2000h, 2005h, 2010a, 2010b, 2010f). All these forms of public transparency or media exposure are characterized as affronts to the cultural authority of medicine and ridiculed as being witch hunts, a public "pillory" or "public hangings based on village gossip" (*UfL* 2005a, 2010b). Besides showing cultural authority under pressure, these defensive

postures suggest that the medical association positions itself differently toward the state from case to case. While critical of state interference in the doctor-patient relationship, the profession itself calls on the state to protect it from public exposure and critical scrutiny (*UfL* 1990a, 2005a, 2005b).

Cultural authority claims voiced toward the state comprise 21% of editorials. Most of these were coded as cultural authority claims because they do not involve the profession directly, but are merely comments on current health policy issues framed in a “disinterested” style. These editorials often describe administrators and politicians as lacking the necessary medical expertise to understand an issue, for example, in discussions about hospital structures and medical specialties (*UfL* 2010d), about traffic planners’ lack of medical expertise (*UfL* 1970b), or the impossibility of nominating a nondoctor as director of the National Health Board (*UfL* 2010i).

There are fewer social authority claims on health policy decisions (11%), but these editorials show much more emphatic types of positioning. The *UfL* editorials on the state also diverge strongly between the early and later period and, even more dramatically than the *BMJ*, they appear to shift from being very critical of the state’s role in health care to portraying the profession as a guardian of the public system after 1965. Before this time, there were occasional echoes of American discourses about “socialized medicine.” For instance, one health insurance proposal is criticized for being “camouflaged socialization” and a “near dictatorship,” while another editorial talks in derogative terms about “welfare state mentality” (*UfL* 1960a, 1960b). Similarly, another editorial warns against the development whereby most doctors would become salaried public employees (*UfL* 1965a).

After these reforms passed in the mid-1960s to early 1970s (Larsen 2020), the editorials show entirely different positions with emphatic support of the public system. One editorial is puzzled by why visitors from the AMA saw Danish doctors as being “oddly faithful” to the public system (*UfL* 1980b). Also, the association later comes out as being “fundamentally against [patient]

co-payments" (*UfL* 1995c). The rise of the private health insurance market in the early 2000s is presented as a threat that may "erode this cornerstone of the welfare state" (i.e., the health care sector) (*UfL* 2000h, 2005f, 2010c). So, where the association previously argued that its social authority should be protected *against* the welfare state, the professional project now seems to focus intensely on protecting the welfare state against marketization. Finally, there are also a series of editorials similar to the *BMJ* with calls for additional funding (*UfL* 1995f, 2000c, 2005c, 2005e, 2005f, 2010e, 2010g, 2010h,).

In conclusion, the *UfL* editorials share characteristics with the content from both *JAMA* and the *BMJ*. With *JAMA*, they share the same defensive positioning against social developments such as patient rights and the public exposure of doctor-patient relationships. This is quite different from the *BMJ*'s position, which also considers what doctors could do differently. The Danish editorials suggest a trajectory similar to the British in the sense that both associations appear to reconfigure their professional project in a much more cooperative fashion. These data do not allow time-series analysis or precise time stamps on this apparent change, but the contrast is staggering between the 1950s and early 1960s, on the one hand, and particularly the period since the 1990s, on the other. Authority claims appear to be reconfigured in a way where doctors are portrayed as guardians not only of patients or their market position but also of the national health system in which most of them work. This is very different from the *JAMA* editorials which still seem to contest the state's authority as a legitimate decision maker on health care, although this adversarial relationship may have thawed after the ACA. Table 3 offers an overview of authority claims in *UfL* editorials.

[Table 3 here**]**

Discussion

The analysis of editorials illustrates both the value and the limitations of covering such a long stretch across three countries. It is much easier to see the difference between authority claims responding to similar challenges than it is to define in the abstract what a defensive social authority claim looks like. Comparisons over long trajectories show how professional associations' positioning in the public arena develops slowly, as Abbott (1988: 61) also argues. This is illustrated here by the British and Danish associations' slow, apparent shift in relation to the welfare state. The limitation of the wide period is that so many factors obviously influence and change during 60 years that causal effects cannot be demonstrated. The amount of material here makes it difficult to offer very transparent and detailed codings of each individual sentence, while it also does not offer quantifiable time-series analysis. The contribution is thus mainly explorative, that is, to show the analytical value of studying professional authority claims in a comparative setting and to suggest preliminary findings that could be studied in further detail.

The analysis suggests at least two main themes that call for further scrutiny in relation to how medical associations make and reconfigure their claims to professional authority. The first is that all three medical associations reflect on perceived changes and challenges in the authority relationship between doctor and patient. Not necessarily in daily interactions, but certainly in the way authority toward patients is legitimized in the public arena. This relationship was initially described as an almost sacred authority relation but is later characterized as much more complicated in terms of both social and cultural authority. The *BMJ* seems to reconfigure the authority positions the most in reflecting on current debates about doctor-patient relationships. On the contrary, *JAMA* and *UfL* display more defensive positions against the perceived threats of growing publicity and critical media attention.

The other main theme illustrated in the analysis is whether and how medical associations appear to reconfigure their authority relations toward the state during this period. An initial motivation for the study was to identify how the social and cultural authority of medicine is legitimized in relation to health policy. Since the institutional surroundings of medical work and the medical profession's political role have changed significantly since 1950, it is of course unsurprising that medical authority is repositioned. The interesting aspect is mainly how the professional "projects" seem to change and change differently in relation to the state. All three medical associations reflect critically on the introduction of economic and managerialist control mechanisms in health care such as the use of external quality measures, audit, and so on. The main difference is that while *JAMA* generally identifies these control measures as state-driven threats to their professional authority, the British and Danish editorials suggest a different path. Both the *BMJ* and *UfL* initially position themselves as external adversaries of the expanding welfare state institutions in health care during the 1950s and 1960s. They later come to identify their professions strongly with the very same welfare state institutions and even claim to protect the public health care system against marketization reforms. In other words, the British and Danish medical associations do not seem to view the public system merely as an external condition that they have to live with; rather, they take on a role as guardians of this system against marketization in health care, even if some private market reforms could easily secure doctors' new streams of revenue.

This material only displays snapshots of this change, but it could suggest a type of policy feedback loop between welfare-state expansion and professions that work in and seem to embody these institutions. It would require other types of data to demonstrate a policy feedback effect and identify the exact mechanisms (Campbell 2012; Pierson 1993). An interest-driven study of professions (Freidson 1970; Larson 2013) would probably argue that the medical profession gradually takes over the public health care system and therefore uses its authority to defend

privileges. Another possibility could be a socialization effect where new generations of doctors brought up after the 1960s simply take state institutions for granted. However, this analysis tries to show the analytical value of not merely equating professions with interests or privileges, but rather to show the profession's role in health policy and how this may change. This is also an argument for connecting insights from the sociology of professions with the study of medicine in health policy research. This material can only show the differences between periods and countries, but not offer evidence for various conjectures of when, why, and how authority changes. The article nevertheless suggests that professional associations reconfigure their authority positions over long stretches of time, sometimes as a defensive stand against external threats, at other times in a more appreciative or cooperative role toward changes in the surrounding values and institutions.

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Table 1 United States: Editorials in *JAMA*, Frequencies Within; N = 325

Year	Social authority claims toward		Cultural authority claims toward		No authority claims
	State	Citizens/ society	State	Citizens/ society	Medical research
1950	1	6	1	5	12
1955	4	6	1	8	6
1960	0	3	0	3	19
1965	1	2	0	10	12
1970	2	2	0	16	5
1975	4	3	1	5	12
1980	0	2	2	6	15
1985	7	3	0	5	10
1990	8	8	0	2	7
1995	6	11	0	3	5
2000	4	5	0	5	11
2005	0	7	0	3	15
2010	1	15	1	1	7
Total	38	73	6	72	136

Table 2 United Kingdom: Editorials in *BMJ*, Frequencies Within; N = 325

Year	Social authority claims toward		Cultural authority claims toward		No authority claims
	State	Citizens/ society	State	Citizens/ society	Medical research
1950	7	1	1	4	12
1955	3	3	2	5	12

1960	2	7	1	2	13
1965	1	8	0	3	13
1970	4	6	0	1	14
1975	1	13	0	2	9
1980	1	8	3	8	5
1985	6	8	0	4	7
1990	11	5	0	1	8
1995	11	8	0	1	4
2000	10	6	0	6	3
2005	7	4	2	11	1
2010	8	12	0	8	0
Total	72	89	7	56	101

Table 3 Denmark: Editorials in *UfL*, Frequencies Within; N = 325

Year	Social authority claims toward		Cultural authority claims toward		No authority claims
	State	Citizens/ society	State	Citizens/ society	Medical research
1950	0	0	0	0	25
1955	0	0	0	0	25
1960	0	0	0	0	25
1965	1	1	3	6	14
1970	0	1	4	3	17
1975	1	1	4	6	13
1980	3	2	4	8	8
1985	1	4	7	1	7
1990	2	1	7	3	12
1995	7	5	11	2	0
2000	7	5	7	6	0
2005	6	3	10	6	0
2010	9	2	12	2	0
Total	37	25	67	43	153

[1] The Danish sources unfortunately lack pagination but are