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Speaking up, stepping back: Expertise, authority and the social negotiation of overdiagnosis

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ABSTRACT

The National Health Service Breast Screening Programme (NHSBSP) is a widely promoted public health intervention yet debates around overdiagnosis continue to shape discussions of its value. While prior research has examined health professional perspectives on breast screening, less is known about how those with healthcare related occupations mobilise and adjust their knowledge of overdiagnosis in different interactional contexts. This article draws on semi-structured interviews with twenty women who declined breast screening and/or breast cancer treatment following invitation to the NHSBSP. Most participants had health-related occupations, including general practitioners, medical writers, and patient advocates. Participants often drew on scientific literature to inform their decisions, with understandings of overdiagnosis and overtreatment playing a central role. This article examines how participants mobilised their expertise across different interactional contexts. Participants possessed significant expertise, but varied how much authority they claimed across interactions, so that knowledge and status were mobilised differently depending on context. In policy contexts, they challenged dominant narratives by raising concerns with those responsible for programme delivery and sharing alternative evidence. When interacting with clinicians, they adopted an authoritative stance, using their knowledge to contest prevailing assumptions about screening. In contrast, when engaging with lay audiences, they constrained their authority, signposting others to evidence rather than seeking to direct their decisions. These findings highlight that expertise and authority, are relational, shaped by audience reception, institutional recognition, and speakers' strategic restraint in how overdiagnosis is negotiated across policy, professional, and everyday settings.

1. Introduction

Population-based screening programmes are widely promoted as key public health interventions, designed to detect disease early among individuals who may not yet have symptoms or perceive themselves to be at risk (Public Health England, 2019; UK National Screening Committee, 2022a; 2022b). In the United Kingdom, screening is routinely offered for conditions, including cancers, fetal abnormalities, and diabetic retinopathy (World Health Organization, 2019), and is underpinned by principles intended to ensure that at both population level and individual level, the balance between benefits and harms is optimised. It has been recognised that agreed criteria should be met before a screening

programme is implemented (Kelly, 2018). Commonly used criteria that provide assurance that there is sufficient evidence supporting a screening programme being implemented are specific principles such as disease significance, test suitability, treatment availability, and cost-effectiveness (Wilson and Jungner, 1968).

However, advances in diagnostic technologies (UK National Screening Committee, 2023) and better treatment outcomes (Litton et al., 2018; NHS England, 2021) have raised concerns about the unintended consequences of screening, particularly the identification of abnormalities or conditions that may never cause harm. Central to these concerns is overdiagnosis, which refers to the detection of abnormalities that would not have become clinically significant within a person's

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lifetime (Welch et al., 2011). Recognition of overdiagnosis has prompted growing debate about the balance of benefits and harms in screening and has contributed to increased emphasis on informed choice, where both participation and non-participation are recognised as valid responses to screening invitations (UK National Screening Committee, 2024).

Breast screening, delivered through the National Health Service Breast Screening Programme (NHSBSP), provides a key site in which these debates play out. The NHSBSP is a population-based initiative that began operation in the UK in 1988 (NHS Cancer Screening Programmes, 2008). Over the years, improvements to the diagnostic equipment used within the programme (UK National Screening Committee, 2022b; Wald et al., 1995) alongside advancements in breast cancer treatment have resulted in reduced mortality (Litton et al., 2018; NHS England, 2021). The NHSBSP continues to offer breast screening to women aged 50 to 71 years every three years, aiming to further reduce mortality by detecting cancer early (Office for Health Improvement and Disparities, 2021). Women are invited by receiving a postal invitation, which includes either a pre-booked appointment or instructions on how to book an appointment (NHS Digital, 2022), along with an information leaflet outlining benefits, risks, and the importance of informed choice (NHS England & NHS Improvement, 2019).

While the programme is associated with reductions in breast cancer mortality (Litton et al., 2018; NHS England, 2021), it also raises ongoing concerns about overdiagnosis and its downstream consequences, including overtreatment. These issues are particularly visible in ductal carcinoma in situ (DCIS), which is a non-invasive breast cancer detected through mammograms (Cancer Research UK, 2017). While DCIS can be a precursor to invasive cancer, not all cases progress, contributing to concerns about overtreatment (Han and Khan, 2018), which may lead to unnecessary medical procedures (National Cancer Institute, 2011), and reduced quality of life (Pickles et al., 2022).

Although informed choice has long been an explicit principle of UK screening policy (UK National Screening Committee, 2024), debates about overdiagnosis have intensified scrutiny of whether breast screening materials communicate both benefits and harms in a balanced and comprehensible way (Johansson and Brodersen, 2015; Newport and Donnelly, 2023). Existing research examining cross-national differences in the way that informed choice is addressed across breast cancer and fetal trisomy anomaly screening found that attempts to achieve informed choice through the use of decision aids generated tensions between improving informed choice, increasing uptake and comprehensibility of the information presented (Tyldesley-Marshall et al., 2022). Similar tensions were also identified from research from Australia and Spain examining how breast screening experts communicate breast screening to patients, with findings revealing that the majority of breast screening experts stated that information about overdiagnosis should be limited to reduce patient confusion (Parker et al., 2015; Toledo-Chávarri et al., 2017). Research has also examined how members of the public interpret screening information (Woof et al., 2020) mainly focusing on the impact of receiving breast cancer risk screening results (McWilliams et al., 2023). Less attention has been paid to individuals who choose to decline breast screening and/or breast cancer treatment on the basis of concerns about overdiagnosis, particularly those with scientific, biomedical, or clinical knowledge. This group is analytically interesting, as they may be both targets of public health interventions and holders of knowledge typically associated with professional authority. Their decisions to decline breast screening and/or breast cancer treatment on the basis of concerns about overdiagnosis therefore raise important questions about how expertise and authority are mobilised in relation to dominant screening narratives.

Within health research, an important distinction is increasingly drawn between expertise as knowledge-related and authority as status-related (Pilnick, 2022). Work on patient involvement in decision-making has been central to articulating this distinction, demonstrating that patients may hold substantial forms of expertise

rooted in lived experience, embodied knowledge, or analytical engagement with evidence, even when they lack the institutional status for that knowledge to be recognised or acted upon (Entwistle et al., 2008; Entwistle and Watt, 2006). In healthcare encounters, individuals may adjust how confidently or cautiously they present their knowledge in response to audience, setting, and anticipated consequences (Pilnick and Dingwall, 2011). These dynamics are particularly evident in screening, where population-level evidence, uncertainty, and moral responsibility intersect, and where differing interpretations of evidence is visible for example, as Timmermans and Angell (2001) demonstrates, clinicians do not apply evidence-based medicine in a uniform way but instead interpret it in relation to their local work practices, highlighting how uncertainty is not eliminated but continuously managed. These insights may also explain how knowledge about potential harms of screenings i. e., overdiagnosis, is unlikely to be applied in a uniform or purely technical way but is instead interpreted and enacted through context-specific forms of judgement.

From an interactional perspective, Goffman's (1959) idea of social performance provides a nuanced framework for understanding how the presentation of knowledge is shaped by audience and context. Rather than treating knowledge as something that is simply transmitted, Goffman conceptualises interaction as a form of performance in which individuals actively manage the impressions they give to others in order to sustain credibility and fulfil expected roles. Central to this is the notion of impression management, whereby speakers calibrate how confidently or cautiously they present themselves in light of anticipated reactions. His concept of footing further illuminates how individuals shift their stance within interaction, aligning themselves differently depending on the social and moral demands of the situation (Goffman, 1959). Applied to healthcare, this perspective draws attention not only to how people present themselves as knowledgeable, but also to how audiences recognise, resist, or dismiss those claims. This is particularly important in contested areas such as overdiagnosis, where the credibility of speakers may depend as much on audience reception and institutional context as on the knowledge being communicated.

At a broader level, Gieryn's (1983) concept of boundary-work extends this interactional focus by highlighting how the legitimacy of knowledge is shaped through ongoing processes of negotiating the boundaries of what counts as valid evidence. Boundary-work draws attention to how actors actively define what counts as credible evidence and who is authorised to contribute to knowledge production (Gieryn, 1983), particularly in contexts where scientific claims are contested or politically sensitive (Epstein, 1995; Goldenberg, 2016). In healthcare policy, these processes are especially visible in areas such as screening, where institutional actors must balance evidential uncertainty with the need to maintain public trust and programme stability. Efforts to foreground risk uncertainties involved in participating in screening can therefore be understood as attempts to expand the boundaries of legitimate screening knowledge by bringing attention to harms that are perceived to be under-acknowledged. However, such attempts are not neutral; they may be resisted when they challenge established evidential framings or disrupt dominant narratives about the benefits of screening.

Building on these insights, Evans and Collins' (2010) notion of interactional expertise offers a way of theorising how individuals can participate meaningfully in technical debates without necessarily holding formal authority within a field. Interactional expertise refers to the ability to understand, interpret, and communicate specialist knowledge with fluency, even in the absence of contributory expertise or institutional status. This is particularly relevant in healthcare contexts, where individuals may develop substantial familiarity with clinical and epidemiological evidence through professional, experiential, or self-directed engagement (Pols, 2014; Prior, 2003). However, Collins and Evans (2019) also highlight that possessing such expertise does not in itself guarantee recognition as an authoritative speaker.

Taken together, these perspectives provide a framework for examining how understandings of overdiagnosis are mobilised, constrained,

or resisted across different interactional contexts. However, these concepts are not used here as parallel explanations, but as complementary tools for analysing different dimensions of how expertise is socially negotiated. [Pilnick's \(2022\)](#) distinction between expertise and authority provides the central analytic frame, allowing us to examine how participants could possess substantial knowledge about overdiagnosis while not always being recognised as authoritative speakers. [Evans and Collins' \(2010\)](#) concept of interactional expertise explains how participants developed fluency in epidemiological and clinical evidence while occupying ambiguous positions between lay and professional domains. Whereas [Gieryn's \(1983\)](#) concept of boundary-work, draws attention to the institutional processes through which some forms of screening knowledge are recognised as legitimate while others are marginalised. However, these perspectives alone do not fully explain how authority is negotiated in interaction. [Goffman's \(1959\)](#) concept of footing is important because it highlights how speakers adjust their stance in response to particular audiences and anticipated reactions. Together, these concepts allow us to examine not only how participants attempted to claim authority, but also how authority was granted, withheld, resisted, or strategically avoided across different settings.

To do this, we examine how participants mobilised their expertise around overdiagnosis across policy, professional, and everyday interactional contexts. We show that participants did not deploy their scientific or biomedical knowledge of the potential harms of the NHSBSP in a uniform way. Instead, they calibrated how much authority they claimed, and how they presented their knowledge, depending on whether they were engaging with policymakers, clinicians, or lay others. The study therefore asks not only whether participants possessed expertise, but when that expertise became recognisable as authority, when it was resisted, and why participants sometimes chose to limit their own influence.

2. Materials & methods

2.1. Sampling and recruitment

Twenty participants voluntarily took part in this study. Women were eligible if they had declined one or more of the following after receiving an invitation to the NHSBSP: (1) screening investigation (e.g., mammogram); (2) further diagnostic tests (e.g., biopsy, ultrasound); (3) treatment (e.g., mastectomy, chemotherapy, radiotherapy); and/or (4) any other related medical intervention (e.g., ongoing medication). Exclusion criteria included: (1) inability to speak or understand English without an interpreter, and (2) those who were terminally ill, as it was felt ethically inappropriate to involve this population in a study of healthcare decision-making.

Recruiting individuals who had declined breast screening and/or breast cancer treatment posed challenges identifying potential participants. Initial recruitment involved contacting third-sector organisations and online communities related to breast cancer and menopause, as the age group invited to the NHSBSP coincided with menopause for many women. Study information was also shared on online forums such as Menopause Matters, Mumsnet, and Netmums, but recruitment remained difficult. To enhance recruitment, the study was promoted in an online discussion group for healthcare professionals interested in overdiagnosis and overtreatment, wider social media platforms (Facebook and X, formerly Twitter) and participant word of mouth. Interested individuals received detailed study information, and all eligible participants provided informed consent before data collection.

Given the recruitment challenges and the relative homogeneity of participants, data saturation was not determined in the traditional sense, which assumes a fixed point at which no new information emerges ([Glaser and Strauss, 1967](#)). Instead, data collection ceased when incoming participants continued to share similar experiences, indicating that further recruitment was unlikely to yield additional diversity (see Supplementary material 1 – Table of characteristics of participants).

Because detailed data on the extent and type of participants' health or medical backgrounds were not systematically collected, the analysis does not compare occupational subgroups. Accounts from participants without known health-related occupations were interpreted cautiously and were not used to make claims about systematic differences in capacity or willingness to speak out.

2.2. Data collection

Semi-structured interviews were conducted between May 2021 and April 2022, either online via Microsoft Teams ($n = 7$) or by phone ($n = 13$), based on participant preference (see Supplementary material 1 – Table of characteristics of participants). A topic guide covered participants' experiences of declining breast screening and/or breast cancer treatment, as well as their decision-making processes (Supplementary material 2 provides full details of the topic guide). The guide was piloted by an individual with lived experience of declining breast screening and breast cancer treatment due to concerns about overdiagnosis and overtreatment, and their feedback contributed to refining the guide to ensure clarity, relevance, and sensitivity in exploring participants' experiences.

All interviews were audio-recorded using an encrypted digital device or online software. Recordings were transcribed verbatim, with all identifiable information removed, and pseudonyms were assigned to maintain confidentiality.

2.3. Data analysis

Reflexive thematic analysis was chosen to explore participants' lived experiences and perspectives ([Atkinson and Heritage, 1984](#); [Braun and Clarke, 2014](#)). The full dataset was coded inductively using NVivo V.12, with themes generated from topics raised by participants then refined and examined across the dataset to assess consistency, identify deviant cases, and ensure a comprehensive understanding of perspectives on declining breast screening and/or breast cancer treatment. Findings were interpreted in relation to existing literature on health screening and medical decision-making in social science and public health research, (details of which can be found in ([Jeffers, 2024](#)), alongside a sociological framework conceptualising expertise as knowledge-based and authority as status-based. This theoretical lens shaped the analysis by focusing attention on how participants mobilised their knowledge of overdiagnosis, as well as how their claims to authority were enabled or limited by professional hierarchies, institutional norms, and interactional expectations. Differences in how participants presented information to policymakers, clinicians, and lay audiences were not assumed in advance, but became apparent during the interview process as participants reflected on the audiences they addressed, the responses received, and responsibilities felt when sharing their views.

3. Findings

Previous papers using this dataset explored how participants made their decision to decline, which showed that participants perceived NHSBSP information as biased towards uptake and that they actively weighed the benefits and potential harms of the NHSBSP when they were invited to participate and/or were presented with breast cancer treatment options. Their understanding of overdiagnosis shaped their dissatisfaction with information and confidence in making the decision to decline ([Jeffers et al., 2024](#)). A separate paper drawing on this dataset explored participant's experiences of disclosing the decision to decline with family, friends and healthcare professionals (from a patient perspective), showing that although some received supportive responses, others encountered scepticism or disapproval, particularly from clinicians. These responses made disclosure challenging and led some participants to become more cautious about how and where they shared their decision. Overall, the findings highlighted the burden of having to justify declining screening, as the participants managed the anticipation

and experience of their decision being perceived as unacceptable (Jeffers et al., 2025).

This paper builds on these analyses by examining how participants attempted to communicate their understandings of overdiagnosis across different interactional contexts, and how these efforts were shaped by the responses they received from others. There is a focus on how authority was recognised, resisted, or strategically avoided in policy, professional, and everyday settings. Across these contexts, participants drew on similar forms of expertise but encountered different opportunities to claim and receive recognition for authority. The analysis therefore focuses not only on what participants said, but also on how they believed that their claims were received, challenged, ignored, or validated by different audiences.

Participants were not only making the decision to decline breast cancer screening and/or breast cancer treatment, many were also keen to share their reasons more widely. None argued that breast screening was absolutely without value and should not be offered. Rather, they held the view that there was a risk of the NHSBSP causing harm due to concerns about overdiagnosis and this shaped nuances in how the participants shared information about the potential harms of the NHSBSP, and their reasons behind the ways they shared the information with different people were discussed. These differences in presentation were elucidated through the interviews, as participants described reflecting on who they were speaking to, how their views might be received, and what responsibilities followed from sharing evidence about screening harms. For example, some described using their knowledge of overdiagnosis to raise concerns with those responsible for programme delivery, clinicians and fellow healthcare professionals, while others focused on supporting informed choice by signposting friends and family to evidence that had informed their own decisions.

3.1. Challenging dominant narratives in policy spaces by raising concerns with those responsible for the overall delivery of the NHSBSP

When raising their concerns, these participants mobilised their expertise in relation to overdiagnosis to question dominant assumptions regarding screening participation and the communication of benefits and harms in policy spaces. For example, one of the participants discussed dissatisfaction about the way that her concerns were responded to by those responsible for the delivery of the NHSBSP when she explained how she tried to engage with the director of the NHSBSP (at that time) to express her dissatisfaction with the way that the information about the benefits and harms were presented:

‘I said I think women should be shown this [referring to the findings from the Cochrane review] because it would be a really useful decision-making aid and I didn’t get a reply. And then I wrote again, and I got a letter back says you know I’m unable to comment on the content of your letter, but I’ll pass this to my colleagues for them to send a response directly to you. But of course, nobody ever replied so they didn’t engage at all ... Basically, there was a lack of engagement with them, with an argument that the services were inappropriate and should be reviewed’. (Jodie (medical writer/editor) - declined all breast screening invitations)

Within Jodie’s interview, she disclosed how her job role involved working closely with breast screening and breast cancer experts, therefore these experiences alongside her professional knowledge as a medical writer/editor, may explain how Jodie mobilised her knowledge of the potential harms of the NHSBSP as well as her skills of critically appraising medical information and presenting it in a way that is easily understood to engage directly with those overseeing the NHSBSP. Jodie’s decision to write to the programme director illustrates an attempt to intervene in policy discourse by raising concerns about how evidence is selected and communicated. In particular, she recommended incorporating findings from the Cochrane Collaboration review by Gøtzsche and Nielsen (2006), which highlights issues such as

overdiagnosis. By proposing this alternative evidential source, Jodie sought to broaden and potentially rebalance the knowledge base underpinning screening invitations. Her perception that the response she received was inadequate suggests that her concerns were not fully acknowledged, demonstrating the challenges individuals face when attempting to contest dominant narratives and yet not seen to possess an authoritative status.

This account suggests that participants’ difficulties were not simply due to a consequence of failing to claim authority effectively. Rather, authority appeared to be dependent on whether institutional actors were willing to engage with alternative interpretations of screening evidence. Although participants often attempted to present themselves as credible contributors to policy discussions, their claims were ignored or dismissed, highlighting how authority is not only merely claimed by speakers but also how authority is dependent on whether it is granted by audiences and institutions. We now turn to considering how some of the participants adopted an authoritative stance in professional interactions, contesting prevailing screening narratives and raising concerns directly with clinicians and fellow healthcare professionals.

3.2. Adopting an authoritative stance by contesting dominant screening narratives and raising concerns with clinicians & fellow healthcare professionals

The majority of the participants had health-related occupations, and some described situations where breast screening was discussed with healthcare colleagues. In these contexts, the participants sought to draw on their professional expertise to assert authority and raise concerns about the potential harms of participating in the NHSBSP, often questioning the evidence underpinning dominant screening narratives. However, despite these efforts, many encountered difficulties when doing so, particularly when engaging with clinicians and healthcare professionals involved in promoting or delivering the NHSBSP. This reflects a tension between claiming authority and having that authority recognised, illustrating how professional hierarchies and institutional commitments shape whose knowledge is treated as legitimate, even among those with relevant expertise. For example, Donna said:

‘I mentioned, you know how you talk at work, and I was saying oh that I didn’t go for my mammogram. We were talking actually at work because you know, one of the things that we were asked to do is encourage people to uptake screening because I’m a GP and we had to increase our screening uptake. And I was talking about well, you know, I have some concerns about the way breast screening particularly is presented. Erm, and I didn’t go for mine and she was like you didn’t go! You know, sort of, how irresponsible’. (Donna (GP) - declined all screening invitations)

In discussing her decision to decline breast screening, Donna introduces an alternative interpretation of screening rather than simply accepting prevailing professional assumptions. While her role formally required her to encourage screening uptake, she nevertheless voiced concerns about how breast screening is framed and presented within the healthcare system.

The extract above demonstrates how authority can be relational and contested. Donna draws on her professional status and knowledge to raise concerns about how screening is presented, particularly implying criticism of how benefits and harms are communicated. However, the colleague’s response; “how irresponsible”, suggests that professional authority is not automatically accepted simply because of someone’s status. Instead, authority can be negotiated within institutional contexts shaped by expectations about appropriate professional behaviour. In this interaction, Donna attempts to exercise authority by legitimising concerns about screening, while her colleague resists this challenge by framing non-attendance as irresponsible. This illustrates how dominant screening narratives can shape which forms of expertise are recognised as legitimate within healthcare settings.

Another example demonstrating how some of the participants adopted an authoritative stance by contesting dominant screening narratives was given by Natasha, also a GP, who discussed her appraisal of evidence that she presented to radiologists:

'The most unsuccessful lecture I ever gave was to the breast specialist interest group of the Royal College of Radiologists, somewhere in the northwest some time ago. Went down like a lead balloon. Cause it was, you know, what would persuade me to have screening mammography, the title of my second slide was 'nothing'. They really didn't like it'. (Natasha (GP)-declined all screening invitations)

The extract above demonstrates how Natasha mobilises interactional expertise. By presenting a lecture to a specialist audience of breast radiologists at a Royal College of Radiologists event, she demonstrates fluency in the language, evidence, and assumptions underpinning breast screening. Speaking in this setting positions her as someone capable of engaging credibly with specialist knowledge despite not occupying the same professional role as her audience. The extract also demonstrates an attempt to claim authority through the active contestation of professional norms. However, the reaction that it "went down like a lead balloon" suggests that this claim to authority was not recognised by the audience. From an [Evans and Collins, 2010](#) perspective, Natasha clearly demonstrates interactional expertise, but the negative response highlights the distinction between possessing expertise and being granted authority by the relevant expert community.

Similarly, other participants also discussed raising their concerns about the NHSBSP with breast radiologists, although in individual and more informal conversations:

'So, I talked to her a few times and we had conversations about screening. I said ooh do you do screening and, do you know the data, and do you know the evidence and she just you know, reeled the line. And it was quite interesting actually because, you can't even persuade the people whose expertise it is to read the epidemiology'. (Sam (academic in women's health) - declined all screening invitations)

Through her use of the phrase "reeled the line", Sam suggests that the radiologist was adhering closely to the official NHSBSP messaging rather than engaging with alternative interpretations of the evidence. Drawing on her own expertise in relation to the epidemiology of screening, Sam approached the interaction with the expectation that a specialist would be willing to critically engage with the data. However, the radiologist's response indicates a divergence between expertise and authority: while both individuals may possess relevant knowledge, the radiologist's authority is aligned with institutional positions that shape how that knowledge is expressed. The apparent reluctance to engage therefore highlights how exercising authority within professional settings can depend on the apparent legitimacy of established narratives, even where alternative expert interpretations are available, demonstrating how challenges to dominant screening frameworks may be constrained by institutional commitments as much as by differences in knowledge.

In contrast, Sam also mentioned a conversation that she had with a different radiologist and discussed how that healthcare professional had the same concerns about the NHSBSP that she did:

'The person at the [Professional body of radiologists] at one point, I went to see her, and we shared that we think that there's a problem. And she said you know, funnily enough I had a mammogram, and I had a scare and it was appalling and I'm never going again. A radiologist. The person at the [Professional body of radiologists] said you're right, there's a lot of people that have got jobs in this and the evidence isn't very good'. (Sam (academic in women's health) - declined all screening invitations)

In the extract above, Sam demonstrates that there were participants involved in the delivery of the programme who have not only had negative personal experiences of the NHSBSP, but they also did not

believe that, for them personally, the benefits outweighed the harms of the programme overall. This introduces a counter-narrative that disrupts the programme's dominant framing. Sam's presentation in the interview uses this shared professional view to present her authority and shared positioning as legitimate grounds for critical reflection among clinicians and fellow healthcare professionals, particularly in relation to concerns about harms such as overdiagnosis.

This theme demonstrates that participants' authority was contested not because they lacked relevant expertise. Many held professional roles including general practitioners, academics, medical writers, and journalists. Instead, resistance appeared to arise when their interpretations challenged dominant assumptions regarding screening. Authority therefore seemed contingent not only on professional credentials but also on alignment with prevailing institutional narratives. We now turn to considering how the participants shifted their approach when engaging with lay audiences by constraining their authority.

3.3. Constraining authority when engaging with lay audiences

Some of the participants described engaging in conversations with friends and family about breast screening, and while they were willing to share their knowledge and experiences, they were clear that they did not wish to influence others' decisions about participating in the NHSBSP or accepting recommended breast cancer treatments. Instead, the participants who made the decision to decline described how they shared sources of information to enable other participants to make an informed choice. As Sam put it:

'Oh, sister I've got the letter and I know you don't approve of it, and I went no, you must make your own decision, I don't want to influence you. Erm, but you know, what I think you could do is look at the Nordic Cochrane leaflet, which I think is more informative. And you could look at the Harding centre risk fact box, 'cause I think that's more effective, and do read the leaflets. Please, cause if you get breast cancer having not had a screening, I'm gonna feel guilty, I don't wanna do that. Er, I want you to make the right decision for you'. (Sam (academic in women's health) -declined all screening invitations)

In the extract above, Sam refers to the Nordic Cochrane leaflet that was published in collaboration with the Harding Center for Risk Literacy ([Harding center for risk literacy, 2013](#)), demonstrating her familiarity with alternative evidence sources relating to overdiagnosis and screening harms. By directing her sister towards these materials, Sam draws on a form of expertise grounded in her analytical engagement with scientific evidence and risk communication rather than personal experience. However, rather than using this expertise to explicitly advise her sister to decline screening, Sam carefully moderates how authoritatively she presents her views. Her repeated emphasis that her sister "must make your own decision" suggests an active effort to avoid assuming decision-making authority over another person's healthcare choices.

This demonstrates how Sam deliberately constrains the authority attached to her expertise. Although she positions herself as knowledgeable enough to identify what she considers to be more balanced or informative resources, she simultaneously distances herself from responsibility for the eventual decision. Her concern that she would "feel guilty" if her sister later developed breast cancer highlights an awareness that expertise about screening harms does not eliminate uncertainty or risk. This does not suggest that Sam lacked authority in this interaction instead, her sister's acknowledgement that she "doesn't approve of it" indicates that Sam's views were already recognised as influential. Rather than withdrawing from authority altogether, Sam appears to exercise it in a particular way, directing attention towards evidence while deliberately avoiding responsibility for making the decision on another person's behalf. In this sense, stepping back reflects not the absence of authority but a deliberate limitation of its use, consistent with

a commitment to informed choice.

Some of the other participants also discussed how they did not want to influence others to make the decision to decline. However, for some, the reason for not wanting to influence other participants was due to concern for how other people might view them as intentionally encouraging others to go against dominant screening narratives and how that might manifest, Wendy said:

'I'll tell people about what I know if they ask me, but also because I'm in that kind of position of being able to look at the evidence a bit more objectively, I kind of feel as though I should tell people. But also, I don't want to influence them because, maybe people see me as a bit of a maverick by not doing what most people think should be done'. (Wendy (GP) - declined all screening invitations before & after identified with BRCA gene)

Wendy's account also suggests that stepping back may have served multiple purposes simultaneously. Like Sam, she appeared committed to supporting informed decision-making rather than directing choices. However, her concern about being viewed as a "maverick" indicates an awareness that openly encouraging others to decline screening could attract criticism or undermine her credibility. By presenting information only when asked and avoiding explicit recommendations, Wendy was able to raise concerns about overdiagnosis while maintaining a position consistent with professional expectations surrounding informed choice. Stepping back therefore appears to reflect not only a commitment to autonomy, but also an attempt to manage responsibility, uncertainty, and the social consequences of challenging dominant screening narratives.

Participants' restraint when speaking with family members and friends may also be understood in relation to experiences of resistance encountered elsewhere. Previous analyses from this dataset demonstrated that some participants anticipated criticism, scepticism, or disapproval when discussing their decisions to decline screening (Jeffers et al., 2025). In this context, moderating how strongly they presented their views may have reflected not only a commitment to informed choice but also an awareness of the social consequences associated with challenging dominant screening narratives. What appears as 'stepping back' may therefore represent both an ethical stance and a response to anticipated resistance.

This theme demonstrates how participants often occupied a more influential position when engaging with friends and family than when interacting with policymakers or healthcare professionals. Their health-related backgrounds frequently afforded them credibility and the potential to influence decisions. However, rather than maximising this influence, participants often chose to limit it. They shared evidence about the benefits and harms of screening, recommended information sources, and framed overdiagnosis as an issue worthy of consideration, while stopping short of directing decisions. Stepping back therefore did not represent a withdrawal from authority, but a deliberate effort to use authority in a manner consistent with informed choice while avoiding responsibility for decisions made by others.

4. Discussion

This paper shows that participants' expertise about overdiagnosis was not expressed in a fixed or uniform way across different interactional contexts. Participants possessed and mobilised scientific, clinical, professional, and experiential knowledge, yet whether this knowledge became authoritative depended on how audiences received it and how the boundaries of legitimate screening knowledge were drawn. The comparison across policy, professional, and everyday contexts therefore demonstrates that expertise is not simply held or expressed, it is performed in interaction, validated or resisted by institutions and audiences, and morally managed.

It is important, however, to treat these interactional claims cautiously. The data analysed here do not provide direct access to the

conversations participants had with policy actors, clinicians, colleagues, friends, or family members. Rather, they are participants' retrospective accounts of those encounters, produced within the interview setting. This is particularly relevant to the use of Goffman's interactional framework (1959), because concepts such as impression management and footing apply not only to the encounters participants described, but also to the interview encounter itself. Participants may therefore have presented themselves to the researcher in particular ways, for example as informed, responsible, cautious, or ethically reflective speakers. The analysis therefore examines how participants narrated and made sense of their own and others' conduct across these reported interactions, rather than treating the original exchanges as directly observed interactional data. The recurrence of similar accounts across participants and across policy, professional, and everyday settings suggests that negotiations of expertise, authority, credibility, and responsibility permeated the interactions they described.

Used in this cautious sense, Goffman's interactional perspective (Goffman, 1959), Gieryn's concept of boundary-work (Gieryn, 1983), and Evans and Collins' account of expertise (Evans and Collins, 2010) help explain why participants described similar forms of knowledge that apparently had different consequences across the three contexts. Evans and Collins' concept of interactional expertise (Evans and Collins, 2010) offers insight into how participants portrayed themselves as able to engage with epidemiological evidence, screening statistics, clinical uncertainty, and alternative sources of risk communication. However, Gieryn's exposition of boundary-work (Gieryn, 1983) highlights that expertise only becomes authoritative when recognised as a legitimate contribution to a particular domain of knowledge. In participants' reported efforts to engage with the NHSBSP, their emphasis on overdiagnosis challenged institutional framings of screening as a public health good and therefore appears to have been received as testing the boundaries of what counted as appropriate or authoritative expertise. Goffman's concept of footing (Goffman, 1959) helps to explain how participants retrospectively presented themselves as adjusting their stance across reported encounters, positioning themselves as challengers, colleagues, advisers, or cautious sign-posters depending on audience and anticipated response.

In their reported communications with policy makers, participants described expressing their claims to expertise through suggestions for reshaping how screening evidence and harms were communicated to those invited to participate in the NHSBSP. The analysis concludes that correspondence with those responsible for the NHSBSP, for example, was not simply an individual complaint about information quality but an attempt to broaden what counts as acceptable or legitimate evidence of official screening communication. By directing programme actors towards alternative evidence on overdiagnosis, participants sought either to bring less visible sources to their attention or to encourage a reassessment of evidence that may already have been known but appeared insufficiently influential within policy discourse. This can be understood as boundary-work (Gieryn, 1983), an effort to broaden the boundaries of what evidence counted as relevant to responsible screening communication and who was entitled to raise such concerns. However, the limited engagement that was described in response suggests that this expertise did not translate into recognised influence within programme governance or official screening communication. The issue was therefore not only whether participants possessed relevant knowledge, but whether institutional actors chose to recognise their interpretations as legitimate contributions to programme governance.

Professional encounters were described as involving a different version of the same problem. Here, participants positioned themselves not simply as lay critics of screening but often as colleagues with health-related knowledge, professional experience, and familiarity with scientific evidence. Evans and Collins' concept of interactional expertise (Evans and Collins, 2010) helps explain how participants described their abilities to engage fluently with epidemiological arguments and clinical debates. However, their accounts also show that technical fluency did

not automatically secure recognition as authoritative. Authority depended on whether their interpretations were accepted by professional audiences and whether critical engagement with screening came to be heard as legitimate professional judgement rather than deviance from dominant screening narratives.

The reported accusation of participants being “irresponsible” (pages. 17–18) is particularly important because it shifts the dispute away from whether participants’ arguments were supported by evidence and towards whether it was morally and professionally legitimate to make such arguments. Here, the reported concern that participants wanted to convey was not that screening lacked any possible value, but that the programme’s benefits and harms were being presented in ways that they considered insufficiently balanced. Colleagues’ reported responses did not directly refute this evidential claim; rather, they positioned non-attendance and scepticism as incompatible with responsible professional conduct. Through Gieryn’s concept of boundary-work (Gieryn, 1983), this can be understood as an attempt to define the boundary between acceptable professional scepticism and forms of critique deemed professionally illegitimate. Through the lens of Goffman’s concept of impression management (Goffman, 1959) this also highlights the effort required in such encounters to maintain professional credibility. Participants described how they sought to present themselves as scientifically informed, professionally responsible, and oriented towards patient care, while also expressing a position that challenged dominant expectations around screening uptake. Evans and Collins’ distinction between expertise and authority (Evans and Collins, 2010) helps clarify what was at stake here: technical competence could be recognised, while the right to translate that competence into professionally legitimate claims remained contested.

Accounts of conversations with radiologists further show that professional authority was not distributed simply according to who possessed knowledge, but according to how closely interpretations aligned with institutional and occupational norms. Where radiologists were perceived to “reel the line”, their authority appeared tied to established programme narratives; where one radiologist reportedly shared concerns privately, alternative evidential interpretations became momentarily legitimate. These examples show that professional authority around screening is not fixed but negotiated through institutional alignment, whether conversations are ‘official’ or ‘unofficial’, audience reception, and the interactional management of disagreement.

Everyday interactions with friends and family reveal a contrasting dynamic. In these settings, participants’ expertise and authority was often more readily recognised because their health-related backgrounds made their views potentially influential. Yet participants did not usually report seeking to convert this credibility into directive advice. Instead, they shifted footing from expert or critic to evidence sign-poster, directing others towards alternative information sources while emphasising autonomy and personal choice. This was not a failure of authority, but a deliberate limitation of its use. For example, one of the participant’s reported reluctance to influence their sister, and another participant’s concern about being perceived as a “maverick”, show that participants recognised the moral weight of their influence and the social risks of appearing to advise against screening. In this sense, authority was exercised through restraint as well as assertion, as participants instead used their expertise to open space for informed choice while avoiding responsibility for determining another person’s decision.

The movement from policy and professional contexts to family and friends also shows why responsibility is central to the relationship between expertise and authority. In professional settings, responsibility was sometimes attributed by colleagues or other healthcare professionals, as when scepticism was framed as “irresponsible”. In lay settings, responsibility was internally managed, as participants reported seeking to limit their influence because they recognised that screening decisions carried uncertain and potentially consequential outcomes. These two forms of responsibility are analytically connected. Both show

that disputes about overdiagnosis are not only about evidence, but also about what responsible speakers should say, how forcefully they should say it, and who should bear the consequences of influence. Together, Goffman (Goffman (1959), Gieryn (1983), and Evans and Collins (2010) help to understand how the claimed interactional expertise made participants capable of speaking about overdiagnosis, boundary-work shaped whether that speech was treated as legitimate, and footing shaped how participants managed the moral and reputational consequences of speaking up or stepping back.

This systematic comparison across contexts demonstrates what is theoretically distinctive about the paper’s empirical contribution. The three settings are not simply different places where participants talked about screening; instead, they show different conditions under which expertise is claimed, performed, accepted, resisted, or deliberately restrained. In policy spaces, participants reported mobilising their expertise to challenge the evidential boundaries of official screening communication, but this did not readily become policy authority. In professional interactions, participants described that their expertise was often received as technically robust but became vulnerable to boundary-work around legitimate professional disagreement and to face-threatening judgements about responsibility. In lay interactions, participants’ expertise was potentially influential but was moderated through ethical restraint.

The findings align with existing research showing that overdiagnosis remains a contested and politically sensitive issue within breast screening policy and communication. Previous studies have highlighted tensions between improving informed choice, maintaining uptake, and communicating harms in ways that are both comprehensible and balanced (Parker et al., 2015; Toledo-Chávarri et al., 2017; Tyldesley-Marshall et al., 2022). Pickles et al. (2022) similarly show that women who became aware of overdiagnosis often criticised screening and clinical systems for failing to disclose potential harms. This paper extends this literature by showing how such critiques are negotiated by people who possess professional expertise. Their accounts suggest that the challenge is located not only in how overdiagnosis is communicated to the public, but also in how scientific evidence is recognised, resisted, or morally reframed within institutional, professional, and everyday interactions.

The wider implication is that informed choice cannot be understood solely as a matter of improving information materials. It also depends on the social conditions under which alternative interpretations of evidence can be voiced, heard, and treated as legitimate. Screening programmes must guard against misinformation and poorly evidenced claims, yet overly narrow boundaries around acceptable screening knowledge may also marginalise credible critiques when those critiques disrupt dominant assumptions. Recognising this tension is especially important in areas where population-level benefit, individual harm, uncertainty, and moral responsibility intersect.

4.1. Strengths and limitations

A key strength of this study was the use of qualitative interviews, which allowed for an in-depth exploration of women’s experiences of declining breast cancer screening and/or breast cancer treatment. Those who actively choose to decline are often marginalised in discussions about screening participation. In addition, the study engaged a sub-population, with the majority having health-related occupations. While this was not an intentional recruitment outcome, it was likely influenced by the word-of-mouth approach and the sharing of study information within an online overdiagnosis discussion group, which may have attracted individuals with professional backgrounds in healthcare. This unplanned sample composition was also analytically valuable, because it enabled examination of a group who occupied an ambiguous position between lay and professional domains and who were therefore especially well placed to illuminate how expertise and authority are negotiated across interactional contexts.

However, there are limitations to consider. The participants were highly self-selected, and the perspectives captured may not fully reflect the broader experiences of women who decline screening and/or breast cancer treatment. Additionally, the diagnoses and treatments discussed were based on participants' own reports and perceptions rather than verified medical records. The study also did not collect sufficiently detailed information about the extent, type, or duration of participants' health-related training or occupational experience. As a result, we cannot determine whether occupational differences systematically shaped how expertise and authority were mobilised. Future research could examine these differences more directly by purposively recruiting participants with a wider range of occupational backgrounds.

The study was also conducted during a period in which online forums, professional discussion groups, and social media platforms played an important role in connecting individuals interested in overdiagnosis and overtreatment. Several participants were recruited through online communities and discussion networks, which may have influenced both the composition of the sample and the ways participants encountered alternative perspectives on screening. As online spaces become increasingly important sites for discussing critiques of mainstream medicine, future research could usefully examine how expertise, authority, and legitimacy are negotiated within digital environments. Such settings may create new opportunities for alternative perspectives to circulate, while also raising challenges regarding the distinction between evidence-based critique and misinformation.

5. Conclusion

By examining how knowledge of overdiagnosis is mobilised in practice, this study contributes to ongoing debates about informed choice in screening by moving beyond a focus on information provision alone. It demonstrates that engaging with overdiagnosis is not simply a matter of understanding evidence, but involves how individuals interpret, adapt, and strategically deploy their knowledge across different contexts. Central to this is the distinction between expertise as knowledge and authority as status, highlighting how participants' ability to influence discussions about screening was shaped not only by what they knew, but by whether their knowledge was recognised as legitimate within institutional and interactional settings. Understanding how alternative perspectives on screening are voiced, resisted, ignored, or strategically moderated is therefore crucial for understanding how contested forms of medical knowledge circulate within healthcare and public debate.

CRedit authorship contribution statement

Shavez Jeffers: Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Alison Pilnick:** Writing – review & editing, Validation, Supervision, Funding acquisition, Conceptualization. **Natalie Armstrong:** Writing – review & editing, Validation, Supervision, Funding acquisition, Conceptualization.

Patient consent statement

Informed consent was obtained from all participants.

Reporting guidelines

Standards for Reporting Qualitative Research (SRQR)

Ethics approval statement

This study was approved by the University Ethics Sub-Committee of Medicine and Biological Sciences (Project No. 23512). Participants gave written informed consent to participate in the study before taking part.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.socscimed.2026.119933>.

Data availability

No additional data available

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