Parallel lives
Anthropological perspectives on social differences in bodily experiences of sensations and health care seeking practices

PhD dissertation

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### RESISTING REASON. A COMPARATIVE ANTHROPOLOGICAL STUDY OF SOCIAL DIFFERENCES AND RESISTANCE TOWARDS HEALTH PROMOTION AND ILLNESS PREVENTION IN DENMARK
This PhD thesis is in many ways written ‘at the margin’ as Kleinman described it (Kleinman 1997). Enrolled at the Faculty of Health, situated at the Centre for Cancer Diagnosis in General Practice at the Research Centre for General Practice, I was never really studying cancer; nor did I know anything about medicine or general practice. Moreover, at times I felt very far away from the familiar halls of anthropology. However, my intention has been to provide an anthropological perspective on social differences in health care seeking practices, with the aim of improving knowledge of how to reduce social differences in cancer survival. Doing so, my intention springs from an ambition to engage with the health promotion discourses’ approach to ‘decision making’ and ‘health behaviour’, where the moral imperative of improving knowledge and providing public health information to those whose beliefs and misunderstandings serve them poorly looms large (Good 1994). In what follows I explore the interfaces between disease and the social sphere in these parallel lives; lives that are lived within the same discursive context of health promotion and illness prevention, but which never intersect as they continue on different paths. And in classic anthropological style, I bring forth the significance of social processes and local meanings which inform and shape perceptions of bodily sensations and practices of health care seeking.

Entering into the biomedical field of early care seeking has been difficult, perhaps due to the ‘naturalness’ of the medical sciences, which dominate our systems of knowledge, making it difficult to challenge or question the rationality behind experiences of ‘alarm symptoms’ and health care seeking. Explanations of fear, ignorance or misconceptions are immensely persistent, always with the implicit aspiration not to waste any time. Likewise, taking the epidemiologically defined problem of social inequality in cancer survival as my point of departure for an anthropological study was truly challenging. I have tried to approach inequality in an as empirically and socially engaged way as possible, and to
retain the curiosity I felt in the early days of describing the project where it was difficult to imagine what having a certain socio-economic position might tell us about how health care seeking is practiced.

Some of these concerns have led me to use the terminology ‘differences’ or ‘disparities’ in health/illness throughout the thesis when addressing the issue which is usually termed ‘social inequality’ in health and illness. However, the overall meaning is the same, namely the epidemiologically described differences in health and illness status between socio-economic groups. I have chosen this wording in order to avoid any form of devaluation or degrading of the health and illness practices that I encountered; connotations which are inherent in the very word inequality.

My institutional grounding at the Faculty of Health has set out the frames of my research from the very beginning, and it has continuously reminded me how biomedicine informs medical anthropology at all levels of inquiry; from defining the object of study and the arguments of relevance, to selection of samples, settings and even research ethics (Ecks 2009: 82-83). Nevertheless, I have tried to remain true to my anthropological background, and I hope that this thesis will be read as a critical engagement with the early care seeking discourses with which I share the overall aim of reducing social disparities in cancer survival.

OUTLINE OF THE THESIS

I will begin by positioning of the thesis within the field of social differences and health care seeking. Next, I will present the overall theoretical frame of the thesis and give a short introduction to the specific analytical perspectives used in the three articles. In chapter three, I will go on to describe the methodology and the material, after which I will discuss some of the central implications and challenges of the choice of methods and research topic. Chapter four consists of the three articles forming the core of this thesis, which are intended to be read as different perspectives on the processes leading to health care seeking in different social classes. In chapter five, I will conclude by discussing the findings and put them into perspectives by identifying potential implications for the public health approach to improving social disparities in cancer survival.
CHAPTER 1:  
INTRODUCTION

Tim is a 67-year-old retired psychologist, who lives with his wife in a beautiful villa in an attractive suburban area. Tim has two sons and four grandchildren, whom he and his wife look after once in a while, “too much actually”, he sometimes adds. He has worked his way up from a working class childhood where none of his parents had an education. Originally, trained as a teacher, he educated himself further to become a psychologist, and he trained to become a zone therapist alongside his fulltime employment as a psychologist. Tim has always been and remains an active sportsman. His daily life is filled with activities, mostly sports such as tennis and cycling, but he is also very interested in politics and social issues, and in renovating their house which takes up much of his time. When I visit Tim, we usually sit in the living room, which is filled by bright light from the large windows overlooking the well-groomed and pretty back garden. We sit in a modern, elegant sofa arrangement, surrounded by designer lamps and paintings, and Tim always makes sure that we have tea and biscuits, which he arranges on the table in front of us.

During the first months I visited Tim he had a cough. He would excuse himself, saying that it was a cold, and we would drink tea and talk about the beneficial effects of honey. As time passed and the cough persisted, I commented upon it and he repeated that it was a cold, which
he could just not get rid of. He had tried to contact his general practitioner by telephone. However, he was put on hold and eventually he gave up and “didn’t really get back to it”. When he has a cold like that, he doesn’t smoke. He can stop and start as he pleases, it is no problem. He only smokes between zero and five cigarettes a day anyway; and never in front of his wife, who doesn’t approve, nor when he is among people who do not smoke. But at home in his own house, usually in the stairways in the basement, he allows himself the pleasure of a cigarette. Because as he says, “health also has something to do with happiness”. He knows that his cough could potentially be a sign of cancer, but he never really thought seriously about it. He knows his body so well he tells me, and that cough was just due to a sore throat and a persistent cold.

Like Tim, George also smokes. He rolls his own cigarettes; and when I visit him, he usually burns 4-5 “sticks” if we just sit and talk in his small, slightly messy, smoke-filled apartment. George has worked as an unskilled labourer all of his life, always as a warehouse man, but at different places and doing different tasks. During his work life, he put in a lot of hours, was always the last person to leave, and always the one to take on extra work when needed. George has been suffering from recurring, severe depressions from the age of 23, and lately it has been difficult for him to retain his jobs due to increasingly deep depressions. He is currently being allocated a reduced-hours job by the social services, and most of his day is spent helping out voluntarily at the community house in the neighbourhood where he lives. Currently, George’s oldest daughter, who is pregnant, is sleeping on the couch in the living room. The father of her unborn child is unknown, and George is taking on an active and supportive role in the pregnancy. However, she also suffers from recurrent depressions, and the social services has brought her under increased supervision and questioned her ability to take care of the baby to come.

George also has a cough. And from the very first time I met him, the cough continued until we parted at the end of the fieldwork. At one point, it got so bad that one of his friends told him that he needed to get it checked out with his GP. So he went and was diagnosed with pneumonia.
But as his cough continued, the GP referred him to have an x-ray of his lungs. It showed a 30% reduction in his lung capacity; he had chronic obstructive pulmonary disease. Returning from the GP’s office, I asked George if he had worried about getting the results from the x-ray, to which he responded that he had thought about cancer, but, “I am too busy for that now that I am going to be a grandfather and all”. However, the cough continues, and George continues to smoke, although he really wants to quit – especially now that he is going to be a granddad. So he has agreed with his daughter that when the baby is born they will smoke only outside on the balcony, which will, naturally, reduce the numbers of cigarettes they smoke, he reasons.

This thesis is about how people from different social classes manage signs and episodes of illness. It is written and conceptualised within the context of an escalating “cancer epidemic”, where the ability to diagnose and treat cancer is evolving, timely diagnosis is essential and ‘cancer is reframed as an acute condition’ (Tørring 2014). In Denmark, cancer survival is low compared with other countries (Coleman et al. 2011), and social disparities in cancer survival are high (Dalton et al. 2008, 2011). Epidemiological studies suggest that factors explaining these social disparities in cancer survival may be rooted in the processes leading to health care seeking (Auvinen & Karjalainen, 1997, Woods, Rachet, & Coleman, 2006). “The earlier the better” states a recent slogan from the Ministry of Health, and ways to improve early health care seeking, for instance through information campaigns on so-called ‘alarm symptoms of cancer’, are increasingly in focus in public health and health promotion policy and practice. However, as indicated in the cases presented above, bodily sensations are not always interpreted and managed from a biomedically informed perspective. Tim and George have very dissimilar social and cultural backgrounds, and their lives are very different. They both experience what could potentially be a symptom of lung cancer. But the management of their bodies, their perceptions and experiences of bodily sensations and their health care seeking practices are contextually grounded. This attests to how, as also argued by others, health care seeking is not a straightforward process practiced according to objective (biomedical) criteria (Andersen and Risør 2014; Garro
1998; Good 1977; 1994), or, indeed, necessarily triggered by symptom experiences (Hay 2008; Karasz & Dempsey 2008; Risør 2011).

Numerous studies within what has been termed the behavioural sciences of medicine (Good 1994) have attempted to map the causal pathways between social disparities and health care seeking practices in diverse social groups (e.g. Adamson et al. 2003; Richards, 2000, Whitaker et. al. 2015). The intent of this thesis is different. It seeks to provide an anthropological perspective on health care seeking that will help us ‘get at’ the diverse points of departure from where people from different social classes navigate in the increasingly complex realities of radical improvements in techno-medicine and proactive discourses of health care seeking as advocated for instance by early cancer diagnosis campaigns (Andersen et al. 2014). This raises increasing demands for patient proactivity and bodily sensitivity, and makes it more difficult than ever to seek care ‘appropriately’ (ibid). The present thesis therefore feeds into an essentially biomedically defined problem; namely the question of how health care seeking practices lead to social disparities in cancer survival. It springs from a concern to engage with the discussion on early care seeking, where increasing knowledge and understanding of ‘alarm symptoms of cancer’ is sometimes presented as the magic bullet by what I, using the terminology of Byron Good, broadly refer to as the ‘behavioural sciences of medicine’ (Good 1994: 6), without taking into account how social processes and local meanings inform and shape perceptions of bodily sensations and practices of health care seeking.

**AIM**

“*Cancer in itself is not incurable. It becomes incurable from the simple fact that its unfortunate victims harbour and nurse their cancers till it is too late*” (Childe 1906: 143-144).

So spoke surgeon Charles P. Childe more than a century ago, introducing the intricate relation between time and cancer, and spelling out the ‘early disease detection’ rationale as a means to change prognostic horizons; ‘If you present your symptoms due time, you may be saved’. This thesis springs from this rationale; and based on ethnographic fieldwork, it aims to contribute to our
understanding of health care seeking practices as they unfold in two different social classes. This, I hope, will bring us somewhat closer to an understanding of why some people come to ‘harbour or nurse their cancers until it is too late’. The empirical focus is two different social classes, which fare very differently according to cancer survival statistics (Dalton et al. 2008). As suggested by Nguyen and Peschard, I approach social differences “from the ground up” (2003:453) by focusing on everyday life as the context in which health care seeking and symptom appraisal is grounded. This is done in order to avoid simplified assumptions of causality (Andersen & Risør 2014) and in order to seek out other possible explanations of social diversities in cancer survival than lack of knowledge and awareness as presented by parts of the behavioural sciences of medicine. My interest in social differences and health care seeking thereby informed the fieldwork upon which this thesis is based, and I set out to explore the following research questions:

- How do different social contexts influence the ways in which embodied experiences of bodily signs and sensations are ascribed meaning as potential symptoms?
- How do existing health promotion and illness prevention discourses influence the practice of health, illness and the body in different social classes?
- How is health care seeking practiced in different social classes?

The papers in this thesis offer different perspectives on how social contexts inform experiences of bodily sensations, symptoms, illness and health seeking. Inspired by recent anthropological studies on health care seeking as being embedded in the everyday life of different social groups (e.g. Garro 1998, 2011; Hay 2008; Karasz and Dempsey 2008), I set out to explore how sensations are transformed into symptoms that must be acted upon. This was done in order to come closer towards an understanding of practices of health care seeking, and thereby contribute with new knowledge of the social processes relevant to cancer survival.

Thus, what follows is an attempt to engage in the discussions and analysis of social disparities and health care seeking from an anthropological perspective grounded in the everyday lives of people from two different social classes. The
central argument is that health care seeking is grounded in particular social lives, in bodies that differ and is perceived and practiced differently, conditioned by diverse social settings.

EARLY CARE SEEKING

The process of cancer diagnosis is usually described in terms of intervals, and the period leading to the first interaction with the health care system is mainly referred to as the patient interval (Weller et al. 2012). More specifically, this interval refers to the time from the first instance of noticing and interpreting a bodily sensation as a symptom until health care seeking is sought. Within the behavioural sciences of medicine (Good 1994) on early cancer diagnostics and health care seeking, raising public awareness of the so-called ‘alarm symptoms of cancer’ is often suggested as a means to reducing social disparities in the patient interval (e.g. Hvidberg et al., 2015; Ibfelt et al. 2012; Lyratzopoulos et al. 2013; Macleod et al., 2009; Simon et al. 2010; Walter et al. 2014; Whitaker et al., 2015). This unveils the assumption lying at the root of early disease detection (and the public health paradigm); namely that knowledge and awareness is the magic bullet leading to a shorter patient interval. Hence, ‘timely’ and ‘correct’ symptom recognition are conceived as triggers of early health care seeking, and the public is encouraged to seek health care as early as possible and to be attentive towards and to respond to a variety of sensorial markers which in the cancer epidemiological literature has been designated ‘alarm symptoms of cancer’ (Hamilton et al., 2009). This approach has been criticised for being based on a simplistic assumption of a causal pathway between symptom recognition and health care seeking (Andersen & Risør 2014). Two critical points in particular have been raised. The first point tackles the problem of contextualisation present in parts of the behavioural science of medicine and in early anthropological health care seeking studies. Andersen and Risør argue for the need to engage more critically in the investigation of causality and contextualisation in studies of health care seeking practices (ibid). Such criticalness, the authors argue, is lacking in a broad range of qualitative studies including medical anthropology. Indeed, within early anthropological literature on care seeking, decision making studies loom large, and they often assume individual rationality and offer decontextualized explanations of health care
seeking practices. For instance, Garro showed how decision models do not take into account the cultural, personal, social and cognitive constructive processes that give meaning to illness (Garro 1998). In addition, the health care seeking literature has focused on retrospective narratives on symptom experiences, interpretations most often neglecting that symptoms never start as symptoms, but must be interpreted as such (Hay 2008).

Anthropologists have for long been interested in the ways societies recognise and categorise symptoms, but this interest has only recently been translated into what some have termed sensorial anthropology. Sensorial anthropology focuses on how the different cultural settings in which bodies are situated predispose or construct perceptions of sensations associated with wellbeing or disease (Nichter 2008). At a conceptual level, this encourages a critical engagement with previous explorations of symptom experiences within medical anthropology by drawing attention to the very notion of sensations. This requires theoretical clarifications of how symptom experiences evolve in cycles of interpretation. Consequently, rather than simply asking how meaning and significance is attributed to symptom experiences, this thesis asks how embodied sensations are embedded in the social context and become endowed with significance as symptoms in the first place.

In returning to the case of cancer, discussions on how symptoms are evoked are relevant because they allow us to engage more critically with the inbuilt uncertainties in cancer diagnostics. Within clinical cancer research and epidemiology, the classification of certain bodily changes and experiences as alarm symptoms of cancer was developed to quantify the probability of having a particular cancer disease given the experience of ‘a specific bodily change’. Yet, identifying cancer alarm symptoms, or let alone deciding when to seek health care ‘in due time’, is not as straightforward as indicated in parts of the behavioural sciences of medicine (Andersen, Tørring, and Vedsted 2014). Quite contrary, what is commonly referred to as cancer alarm symptoms are often seen in the general population, and one study showed that 15% of a study population of nearly 1400 Danish people had experienced at least one alarm symptom within the past 12 months (Svendsen et al. 2010). Moreover, the positive predictive value (PPV) of alarm symptoms of cancer is very low, which means that the alarm symptoms are commonly experienced by patients in general practice, without them having cancer. One review for instance found that only 8 potential
symptoms of cancer has a PPV above 5% in primary care (Shapley et al. 2010), and others have showed PPVs ranging around 1-5% (Astin et al. 2011; Hamilton et al. 2009). In addition, a recent study has demonstrated that the GP’s gut feeling is a strong predictor of diagnosing cancer when non-specific symptoms were reported (Ingeman et al. 2015). These findings demonstrate the difficulties of diagnosing cancer in general practice (Hamilton 2010), where, quite contrary to the specific technological advancements such as biopsies and screening, diagnosis and referral is based on cancer symptomatology which is a difficult and complex predictor of cancer. Nevertheless, recommendations of early care seeking are based on just that symptomatology. This inherent conflict between medical technological advancements and improving precision of e.g. biopsies, blood tests and scans, and the vague and non-consistent symptomatology, increasingly add to the complexity (or uncertainty) of deciding “with what” to seek medical advice. This has led Andersen, Torring and Vedsted to argue that “symptoms of cancer are equally invisible and potentially omnipresent, reflecting a generally high level of statistical uncertainty in regard to defining characteristics of bodily signs of disease which constitute a need of medical assistance” (ibid:3-4). What is more, it places a large set of responsibilities on individual patient rationalities in determining when and how to seek care. Focusing merely on knowledge and awareness, decision making processes are implicitly singled out as explanations of divergences in care seeking practices between different social groupings without much attention being paid to the diverse contexts framing these decisions (see Andersen and Risør 2014 for further discussions on this), nor to the particular bodies in which care seeking is grounded.

SOCIAL DISPARITIES IN HEALTH

Having stated the problem and established the field in which this thesis is situated, I will now turn to the area of social differences in health in general and subsequently in cancer in particular in order to illustrate the significance of exploring social differences in healthcare seeking practices. Lastly, I will conclude this chapter by introducing the Danish social setting.
Social disparity in health and illness outcomes is a well-documented area of research within the health and social sciences (e.g. Dressler, 2010, Feinstein, 1993, Marmot & Feeney, 1997, Nguyen & Peschard, 2003, Popay, Williams, Thomas, & Gatrell, 1998). A vast number of Danish and international studies show that the prevalence of chronic and psychiatric diseases as well as cancer is much higher in lower social classes than among the higher social classes and that people from lower social classes suffer from multiple diseases, just as self-evaluated health is found to be significantly worse than in higher social classes (Diderichsen, Andersen, Manuel 2011; Larsen et al. 2014; Dressler and Bindon 1997; Dressler, Balieiro, and dos Santos 1998; Marmot et al. 1991; Undurraga et al. 2010). Within epidemiology, the interest in the mechanisms of social diversities in health came under growing scrutiny following the findings of the so-called Whitehall studies which demonstrated how social disparities in health were not a problem merely in economically disadvantaged and less developed countries. Focusing on British civil servants, the Whitehall studies illustrated that disparities in health were, indeed, very persistent in more developed countries, and that disparity played out as a gradient rather than as polar expressions of diversity in the population (Marmot et al., 1991; Marmot, Rose, Shipley, & Hamilton, 1978)\(^1\). These early studies led to the publication of the Black Report in the UK in 1980 (Townsend et al. 1992) which placed social inequality in health on the political agenda in a western context. Explanations for these diversities vary and range from the primary associations with education (ibid.), income (Pickett & Wilkinson 2014) and wealth (Nowatzki 2012) to more sociologically inspired associations with ability to understand, act on and assess medical information, which has recently been referred to as ‘health literacy’ (Madsen et al. 2009; Nutbeam 2000) and the influences of space and place on disease distribution (Cummins, Curtis, Diez-Roux, & Macintyre, 2007, Undurraga et al. 2010).

Mapping out the contours of health disparities is a significant contribution to the discussion of access to, and delivery of, health care services. Even so, social epidemiologists have been criticised for trying to explain disparities in

\(^{1}\) “The socioeconomic gradient in health refers to the worse health of those who are at a lower level of socioeconomic position – whether measured by income, occupational grade or educational attainment – even those who are already in relatively high socioeconomic groups” (Kawachi, Subramanian, & Almeida-Filho, 2002:649)
health through psycho-social theories and for measuring and using concepts such as social capital and social cohesion, presented as stemming from neutral and naturally occurring phenomena and clearly observable relations (Forbes & Wainwright 2001). From the social sciences, a long-voiced call has been made to seek explanations of health disparities in forms of embodiment of social hierarchy rather than as matters of causality and assumed universalism (Nguyen & Peschard, 2003). The argument is that the study of social differences in health must be grounded in the real lives of people, and it must be clarified what is meant by ‘social inequality’.

Within the social sciences, anthropology has always assumed the responsibility of grounding research in the lives of people; and within the immense focus on social disparities in health, a number of different analytical approaches have been taken, some of which I will elaborate on here. Focus has been on the way in which the ability to approximate expectations of local cultural models positively affects peoples’ health status (Dressler, Balieiro, and dos Santos 1998; Dressler and Bindon 1997; 2000), but also the subtler workings of power present in what have been termed identity politics (Whyte 2009) or ‘healthism’ (Lupton 1995) have been explored. Looking at how social inequalities in health are enhanced by the formation of social identities and subjectivities, it has been argued, among others, by Deborah Lupton that public health public discourses have had a large impact on the socio-moral landscape where avoidance or excessive health and illness behaviour for some became central in negotiating social identities (Lupton 1995). Approaching social inequality in health from this perspective highlights processes of social differentiation and draws attention to the social consequences of power relations and discourses in shaping peoples’ identities, health behaviours and embodied experiences. Power and social differentiation is also the focal point in studies exploring social differences in a global health perspective (Farmer 1999; Fassin 2003; Schepet-Hughes 1993). While these studies also attend to issues of cultural mechanisms and the formation of social identities, they are more concerned with the visible as well as the ubiquitous social structures that shape and potentially constrain peoples’ health-related practices. Paul Farmer’s influential work on AIDS and infectious disease has demonstrated how the social, economic, political and cultural forces and processes rendering certain groups of people at risk of disease or death are
foundational in shaping their embodied experiences and thus their health behaviours (Farmer 1999). However, only little anthropological research has so far explored social differences in health in a western or welfare-state context characterised by ideals of ‘imagined sameness’ (Gullestad 2001, further elaborated below).

SOCIAL DISPARITIES IN CANCER

It has been widely recognised that in Denmark, like in most of the other countries with which we compare ourselves, cancer is marked by social disparities in both incidence and survival (Dalton et al., 2008, Ellis, Coleman, & Rachet, 2011; Rachet et al., 2010, Woods et al., 2006). During recent years, our statistical knowledge has been refined, and we have comprehensive epidemiological explanations of the ways in which social differences in cancer survival manifest themselves. The associations between socioeconomic variables such as age, educational background, income, employment and marital/habiting status have been pointed out (Dalton et al. 2008; 2011; Frederiksen, Osler, Harling, & Jørgensen, 2008; Ibfelt et al., 2012; 2013; Neal & Allgar, 2005). Among others, it has been demonstrated, although with some ambiguity regarding cancer types, that people with lower socioeconomic positions (SEP) suffer from a more advanced stage of cancer at diagnosis (Dalton et al., 2011; Frederiksen et al., 2008, Hansen et al. 2008; Lyritzopoulos et al., 2013; Neal & Allgar, 2005). The stage of cancer at the time of diagnosis is widely recognised as an important factor for the prognosis (Jensen, Mainz, & Overgaard, 2002; Jensen, Nellemann, & Overgaard, 2007, Tørring 2011), and a number of studies hypothesise that these differences may partly be influenced by differences in health care seeking (Auvinen & Karjalainen, 1997, Woods, Rachet, & Coleman, 2006). Moreover, within the epidemiological literature, it has been suggested that people with lower SEP may be more likely to postpone seeking medical advice when experiencing potential signs of cancer (e.g. Lyritzopoulos et al., 2013; Macleod, et al. 2009).
SOCIAL DIFFERENCES IN DENMARK

The Danish society (along with the other Scandinavian countries) is often characterised as egalitarian, as a welfare state where the social security system protects citizens from severe deprivation. Since the 1933 Social Reform Act, various forms of welfare schemes covering the entire population, financed through taxation have been implemented (Jöhncke 2011). These schemes cover a number of areas such as free education, sickness benefits, pensions, child care facilities and health care as some of the most celebrated examples. This means that all primary and secondary health care services are provided free of charge, with general practice serving as the gatekeeper for the secondary, specialised hospital system. The basic principle guiding the entire healthcare system is equity, which implies that all citizens should have the opportunity to reach their full health potential (Krasnik, 1996: 3). In practice, this means that all Danish citizens are allocated a general practitioner, and, in principle, are able to make appointments for health, illness or symptom concerns free of charge. This is a generic opportunity, which means that the consultations available in general practice are offered in standardised slots of 10–30 minutes, depending on the nature of the defined problem. Recently, however, a number of private health insurance schemes are beginning to surface, bypassing the official referral system and allowing the insured individual fast and direct access to treatment.

Without entering into an analysis of the social class structures of the Danish society in which this study was carried out, a few descriptive words may be appropriate. Despite the overriding Danish egalitarian ideology, the statistics clearly demonstrate social differences within society; nearly 25% of the adult Danish population between 18 and 59 years of age belong to the middle class, the higher classes account for 10% of the population and the lower classes for 66% (Olsen et al. 2012). Olsen et al. define the middle class as independent businessmen, senior executives or people with short or middle-range educations who earn less than twice the average income in Denmark, which was 403,500 Danish Kroner in 2012 (Sabiers and Larsen 2014). The lower social classes are defined as skilled and unskilled workers and people who are out of the workforce for 4/5 of the year; and the higher social classes are defined as independent businessmen, senior executives and people with high education earning more
than twice the average Danish income and all university graduates independently of their income (Olsen et. al. 2012:37). In many ways, these social differences are uncomfortable reminders of social structures in the Danish society which are sometimes neglected and most often ignored. However, as Gullestad argues, certain public debates serve to illuminate social differences and in effect render them problematic (2001: 63-63), and the debate on social differences in health is a case in point. Something happens when the discussion of inequality is moved into the area of health and illness outcomes within a national social and cultural context of imagined sameness. The social boundaries that are invisible most of the time are brought to light by findings such as absolute differences in life expectancy of almost 10 years between the two quartiles of men aged 30 years with the highest and lowest income, and 6 years for women (Baadsgaard and Brønnum-Hansen 2012). In a sense, health and illness can be considered a symbolic arena where the differences displayed in the statistics spell out the invisible diversities and social stratification in society at large, what Bourdieu has termed “the symbolic construction of class making” (Bourdieu 1987:8). It challenges the ideal of equality, solidarity and welfare for all in the Danish ‘egalitarian’ welfare state, which has recently been described as an invisible class society (Olsen et al. 2012) – and which has a health system that is based on equity, free and equal access for all.
CHAPTER 2:  
THEORETICAL FRAME

In this chapter, I introduce anthropological perspectives and discussions that are central to the present thesis. I begin by elaborating on the way in which I have applied the concept of social class in my study of what is most often referred to as ‘social inequality’. Subsequently, I introduce what is referred to as ‘the health promotion paradigm’ as a specific approach to managing health, illness and the body as argued by bio-power studies (Lupton 1995; Rose 2007; Rose, Nichlas and Novas 2005), and I suggest that the principles of health promotion and illness prevention inform the early care seeking discourse at all levels. It is pointed out how anthropological studies on resistance (Abu-lughod 1990; Ortner 2006; Scott 1985) illuminate how people from different social classes engage differently with health promotion and illness prevention. This leads me to situate health care seeking within medical anthropology, and relate care seeking practices with the wider social concerns and grounded in people’s everyday lives (Garro 2011; 1998). Finally, I present different theoretical approaches to further our understanding of the concept of symptoms and introduce what has become known as sensorial anthropology (Hinton & Hinton 2002; Hinton et al. 2008; Nichter 2008a). Departing in sensorial anthropology I focus specifically on the body as an individual physiological entity closely linked with embodied experiences of sensations.
SOCIAL CLASS

The Norwegian anthropologist Marianne Gullestad uses the concept of “imagined sameness” to illustrate how the ideal of solidarity and equality requires that social boundaries and differences remain invisible in the Nordic welfare states (Gullestad, 2001: 63-64). Although relative poverty is low and income disparities small in Denmark compared with the rest of the world, social differences do exist, and this issue is increasingly being addressed, albeit often from the perspective that it is something new, something which is growing and most probably brought about by the global economic crisis. The ‘social inequalities’ are increasingly taking centre stage in public or academic debates. Class differences are, however, rarely discussed explicitly, and class remains a concept most often used in large-scale macroeconomic, sociological studies. Nevertheless, as illustrated by the social differences in income and life expectancy outlined in the introduction, and inspired by Gullestad’s (1992; 2001) writing on equality in modern-day Norway and Sherry Ortner’s work on class and culture in America (Ortner 1998; 2003), I have chosen to approach social diversities through the concept of class to highlight the historical, social, cultural and economic connotations of inequality in Denmark and to draw attention to the social processes influencing people’s lives. As argued by Diane Rey, “class is part of the micro politics of people’s lives. It is lived in and through people’s bodies and permeates their thinking” (Reay 1998: 265). The conceptualisation of social classes is by no means intended to imply any form of conformity of the informants’ lives or health and illness-related practices. Accordingly, I use class as a research approach and apply it in a descriptive sense as a rough categorisation, not as a particular theory of class (Goldthorpe & Marshall 1992: 382). This opens up the investigation of the interconnectedness between macrosocial structures and the everyday experiences of the individual.

I aim at the obvious social differences, and I do not attend to individually based socioeconomic position (SEP), as often used in studies of social disparities². Social life, of course, does not always fit neatly into the categorisations of social class that I here use to describe and operationalise social differences. I am merely describing emerging tendencies and patterns in order to

² Socioeconomic position refers to the status of the individual in a system of ranked positions, based on criteria that include occupation, income and education (Dressler 2000)
be able to engage in a comparative discussion and analysis (the challenges of which I will discuss in the chapter on methodology). The class approach to health should therefore not be seen as units of analysis but rather as descriptions grounded in class-based parameters, such as association with the workforce and ownership of property. Perhaps the concept of class will provoke some, catch the attention of others, but most importantly it will encourage us to think about the nature of the Danish society and the lives lived behind the statistics.

THE PARADIGM OF HEALTH PROMOTION AND ILLNESS PREVENTION

Since the 1970s, the new public health discourse (Lupton 1995) has been intrinsically linked with the approach to illness prevention and health promotion. A strong focus has been placed on the significance of lifestyle factors, such as smoking, alcohol and dietary intake, thereby increasingly allocating an individual responsibility for active preservation of good health and prevention of illness (Briggs 2003; Lupton 1995). In the Danish context, the messages of new public health are expressed through various behavioural health promotion and illness prevention campaigns, and the early health care seeking discourse is but one of these. Whereas lifestyle recommendations (e.g. on smoking, alcohol and diet) have focused on individual behaviours, the emphasis on early care seeking aims at altering relations between the public and the health care system in terms of when and how to contact and access the health services. The power and domination of the new public health discourse has had significant implications for the organisation of health care both inside and outside of the clinic, and for policy development in Denmark as well as in the rest of the world (Baum & Fisher 2014; Mattingly et al. 2011). It has been argued that the principles behind the organisation of the Danish welfare system are supported by culturally defined mutual interests in economic and practical arrangements, and is based on shared values of solidarity, universalism and social homogeneity (Jöhncke 2011). One example is the tax system which ensures a minimum level of welfare for all citizens and at the same time obliges all citizens to participate and contribute to the common good. The public health paradigm may be seen as feeding into this socio-political reality by emphasising the moral values of and obligations to maintain good health (Oxlund 2012: 43-44). By engaging in health improving practices, you become ‘a good welfare-state citizen’, the logic goes.
Within the social science literature, attention is increasingly placed on the role of biomedicine in the shaping of expectations to contemporary forms of bodily practices, assumptions and attentiveness as advocated by health promotion and illness prevention (Lupton 1995; Rose 2007; Rose and Novas 2005; Shilling 2002). According to sociologist Nikolas Rose, technological advancements in biomedicine and novel conceptions of biological citizenship have resulted in a re-coding of duties and the growth of a somatic ethics where people increasingly experience, articulate, judge and act upon themselves (and others) in the language of biomedicine to maintain the body’s wellbeing and functioning (Rose 2007: 25-26; see also Rose and Novas 2005 for an elaboration of the notion of biological citizenship). These developments, argues Rose, are reinforced by the normative power of official health promotion discourses where the body and its well-being have become the centre of ‘moral judgments’; of good and bad; encouraging people to become active and responsible consumers of medical products and services (ibid, see also Lupton (1997) for a more critical discussion of health consumerism).

Despite the overall focus on the influence that biomedical technologies and discourses have on the lives of populations and individuals, bio-power studies have pointed out social differences in the acting out of (or rejecting) these obligations (Lupton 1995; Rose 2007). More recent studies focusing on social groups and the management of health and illness in less affluent settings have demonstrated considerable social differences in modes of appropriation (Biehl, Good, and Kleinman 2007; Seligman et al. 2015; Whyte 2002), by emphasizing, in the words of Whyte, “how situated concerns move social actors differently” (Whyte 2009:6). Similarly, in the first article of this thesis, Resisting reason. A comparative anthropological study of social differences and resistance towards health promotion and illness prevention in Denmark, we analyse how health promotion and illness prevention are integrated into people’s everyday lives. By attending to the micro politics of people’s lives, we focus on what James Scott (1985) has termed ‘everyday forms of resistance’ and analyse how health promotion discourses are appropriated, and at the same time embraced and resisted, by people from different social classes. We argue that rather than passively receiving and accepting (or ignoring) these dominant messages, people from different social classes actively engage with health promotion and illness prevention in their own and distinct ways. Engaging in such discussions and
analysis, this thesis argues, is central as it highlights the omnipresence of the health promotion discourse while at the same time underlining that it is practiced differently in people’s lives. Focusing on different forms of resistance towards the health promotion paradigm brings out the ways in which the messages of illness prevention or health promotion are adjusted to particular social lives, but it simultaneously illuminates the standardisation of the official health promotion discourse where the ‘right way’ of improving health and preventing illness dominates. One central point raised is similar to an argument made by Marc Nichter in his work on global health and international development as he argues; “placing emphasis on what a population does not know deflects attention away from the important issues of what people do know and how they learn” (Nichter 2008b: 7). And what is more, it exemplifies how certain values and lifestyles are overridden and devalued and brings forth issues of power, right or wrong health status, moral responsibility and self-determination. Such issues are central when exploring healthcare seeking practices and trying to understand how people respond to potential signs of illness as will be discussed in the following section.

HEALTH CARE SEEKING CONTEXTUALISED

The changing approach to cancer as an acute condition (Tørring 2014), has brought with it a strong focus on early diagnostics; a focus which illustrates the current developments in the general thinking and manifestation of health promotion and illness prevention discourses. Research on healthcare seeking for cancer symptoms in what I tentatively dubbed the behavioural sciences of medicine in the introduction (Good 1994) has primarily sought to identify barriers to early care seeking by focusing, for instance, on lack of knowledge and awareness of cancer symptoms (e.g. Macleod et al. 2009), being ashamed or embarrassed about the symptoms and attributing them to common ailments (e.g. de Nooijer et al. 2001) or not wanting to waste the doctor’s time (e.g. Whitaker et al. 2015). While these studies have brought valuable insights into individual cancer patients’ reflections on symptom experiences and healthcare seeking decisions, they have, however, been dominated essentially by bio-medically informed and individualised behavioural approaches to health and illness behaviour (see Cohn 2014; Risør 2006 for critiques of behavioural approaches to health and illness). Overall, the behavioural sciences of medicine have favoured
seeing care seeking as rationally informed decision-making processes, considered relatively independently from the social situations and contexts in which they are grounded, overlooking the fact that retrospective accounts of symptom experiences and healthcare seeking are ‘narrative truths’ rather than ‘realist accounts’ of what actually happened (for further discussion, see Andersen and Risør 2014). Perhaps the focus on acuteness and timeliness in early cancer diagnosis discourses reinforces assumptions of care seeking practiced according to the rationally informed behavioural approaches, where ‘correct’ knowledge and awareness leads to the proper, potentially lifesaving health care seeking. While as argued by Byron Good; “disease is paradigmatically biological” and owing to the undeniable contributions of medicine to the achievement of longer and healthier lives, “we face a moral imperative to share that knowledge, to provide public health information to those whose beliefs serve them poorly as a basis for health behaviour” (Good 1994: 2). This thesis is an attempt to explore how this unfolds in ‘real life settings’; how people engage with information and how signs of disease are identified and managed in different social contexts.

More than 30 years ago, medical anthropological research demonstrated how interpretations of bodily sensations and health care seeking are embedded in specific social and cultural contexts (Alonzo 1979; 1984; Kleinman 1980). Since then, our understanding of decision-making in the context of health care seeking has been further developed. Care seeking has for instance been linked with cultural, personal, social and cognitive processes conferring meaning to illness (Garro 1998); and understandings about health and wellbeing have intrinsically been tied to the concerns and demands of the enactment of everyday life (Garro 2011). Essentially, the argument is that in order to understand what prompts health care seeking, it is necessary to look into the ways in which care seeking practices are embedded into everyday life, and how the moral obligations to maintain health and prevent illness as described above are met. This brings out the fundamental difference between, on the one hand, the approach behavioural sciences of medicine take to health care seeking and symptom appraisal (the knowledge and awareness approach) where responsibility rests with the individual to engage in rationally informed decision-making; and, on the other hand, an anthropological perspective which emphasises the sociocultural process of interpreting sensations and managing the body. However, parts of the
anthropological global health literature on health care seeking has criticised stands of anthropology for focusing solely on ‘the cultural’ (e.g. Fassin 2001). For instance, explanations of health ‘behaviours’ in terms of cultural barriers, such as cultural beliefs, ignorance or misconceptions, are found to filter out contexts, reasons taken for (not) seeking health care, structural constraints and for ignoring life contingencies; and in the very process blaming the victims (Kamat 2008; Nichter 2008b; Ribera & Hausmann-Muela 2011). Anthropological global health studies have also showed that, within the context of poverty and social inequality, the accumulation of problems in households influences how health care seeking is practiced, which requires a broader perspective rather than focusing on the particular events occurring around the single episode of illness, pointing towards structures of vulnerability as explanatory factors (Ribera and Hausmann-Muela 2011). While drawing inspiration from this line of thinking, the intention of this thesis is not to downplay the importance of collecting information on knowledge and beliefs in relation to seeking health care. Rather, it is to argue for the importance of understanding what goes on at ground level, where notions of pragmatism and struggles of daily life play a determining role when deciding what to seek care. What is more, it opens up for explorations of health care seeking not as single episodes of illness, but rather as embedded into and intrinsically linked with the practice of everyday lives that are shape by socioeconomic contexts.

One of the few studies which to my knowledge has compared health care seeking practices across social barriers in a western context was performed by two psychologists, Karasz and Dempsey (2008), who analysed health care seeking among women in two different sociocultural groups and illustrated how differences in ‘cultural anatomies’ conceived as the physical strains and demands of the body influenced how health care seeking was practiced. They argue that the body as an individual project and marker of identity prevails among what they refer to as the upper middle class, and structural inequalities may influence the health problems of the women of lower socioeconomic status (ibid: 432-33). Similarly, in the second article of this thesis, *Health care seeking contextualized: social class, social suffering and health consumerism*, we illustrate how different social classes’ material and social worlds profoundly influence their health care seeking practices. We explored the conditions for and emphasised the dynamic
and intersubjective processes that shape these practices and describe how the notion of proactivity is reinforced by the normative power of the early care seeking discourse, which brings the body and its well-being to the centre of what Rose refers to as ‘moral judgments’ of good and bad (Rose 2007: 25-26). We view this focus on proactivity and bodily attentiveness as being conditioned by notions of consumerism, encouraging people to become active and responsible consumers of medical products and services in their effort to remain healthy and reassure themselves that they are not sick. The consumerist tendencies may have been encouraged by recent trends and developments within the health care system in the direction of service provision, but are also driven by the health promotion message that health is not just something which can be taken for granted, but which must be actively worked at (Shilling 2002: 627). However, the proactivity implicitly required by health promotion discourses does not resonate in all social contexts. In fact, experiences of social suffering, where the suffering is both socially and physically informed, “resulting from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems” (Kleinmann, Das & Lock 1997: ix) many times characterise health care seeking practices. Health care seeking shaped by social suffering rather than what from a biomedical point of view is considered important symptoms may seem counterintuitive as it challenges the biomedical natural order (Good 1994). It draws attention to the social constraints which may influence suffering in the physical, psychological and social sense. Let me elaborate by presenting the case of Brian, a key informant from the LWC, who is also introduced in our second article;

Brian is 49 years old. He weighs about 150 kg and is living on early disability pension due to his anxiety and borderline disease. He attributes his psychological problems to his early childhood experiences of abandonment as he spent the first months of his life at an orphanage, after which he was adopted to a home where his adoptive mother beat him on a daily basis until the day he turned 18. He has diabetes, high blood pressure, asthma and has been treated for prostate cancer. However, what worries him the most when I meet him is his teeth. Or rather lack of, as he doesn’t have a single tooth in his mount. He tells me that it is the medicine he has been taking which has ruined
his teeth. For ten years he had constant pain in his mouth, at one point he was taking 128 painkillers a week. But then he had all his teeth cleared out and had a set of false teeth put in. However, they don’t fit him anymore, as his jaw withdrew and now they are just lying in his drawer. A new set would cost 5500 DKK; “and I just don’t have that kind of money”, he tells me. “And the reason I don’t lose weight is that I can only eat soft food now, I can’t eat carrots or apples, I just can’t. And if I talk to a doctor about this, they don’t see me as a whole person. I can’t eat, I have diabetes, high blood pressure and it also has something to do with the pain I feel in my knees and my hips. I can hardly walk because I have been too fat for too many years. And that is why I don’t go to the doctor. She doesn’t hear what I say. There are so many small things that all link up with my disease. But the doctor only wants to talk about one thing. She doesn’t see me as a whole person. I am just told to eat healthy. But I can’t because I have no teeth”.

When I meet Brian, it is his teeth which worry him the most, and he does not really relate this to his other diseases. But as the winter passes, he gets more and more ill, both due to his diabetes, but his anxiety also gets out of control. One afternoon I meet him after he has been to see his GP. He had managed to get a so-called ‘acute appointment’, because he had a total breakdown. He is clearly quite frustrated and complains that the GP did not have time to read his journal. She doesn’t do anything, she doesn’t listen, he says. “She just asked me if I have been stressed out lately, and then I told her (ironically), well, no except from the fact that my mom is dying of cancer, my daughter is having her child removed by the social services, I have prostate cancer, high blood pressure, asthma and diabetes, no then I don’t think much is going on right now”.

The social suffering is evident and proactivity is clearly not part of Brain’s everyday experience of his body and of health care seeking. However, my reason for elaborating on this case springs not only from a wish to bring attention to how the social context frames health care seeking practices. It is also to bring into the analysis the lived experiences and the significance of the physical bodies that people live in and through in the diverse social contexts, to which I will turn my attention in the final part of this chapter.

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A number of scholars writing within what has been termed ‘sensorial anthropology’ have raised the point that experiences of bodily sensations and their transformation into symptoms must be analysed to properly grasp the associations between illness experience and health care seeking (Hay 2008; Hinton and Hinton 2002; Hinton, Howes, and Kirmayer 2008; Nichter 2008a). The point of departure is the understanding that bodily sensations never start as symptoms – they only become symptoms through a social, interpretive process (Hay 2008). Thus, the concept of the symptom has been scrutinised (Eriksen & Risør 2014; Martinez-Hernaez 2000), and it has been argued that the very word ‘symptom’ implies recognition of an objective, clinical reality, which instantly raises questions of competency (Hay 2008). This has made some scholars emphasise that in order to understand how health care seeking is triggered, it is vital to focus on the process of symptomisation and the ways in which sensations or distress become symptoms negotiated through social spaces (Risør 2011).

The study of illness experience with a focus on bodily sensations has shown how attending to the process of interpreting and transforming sensations into meaningful symptoms are of particular relevance to the anthropology of medicine (Hinton, Howes, and Kirmayer 2008). Cameron Hay was one of the first anthropologists to prospectively study how sensations are transformed into symptoms that must be acted upon (Hay 2008). Based on detailed ethnographic material from rural Indonesia, Hay developed a framework – a sensation-to-symptom model – furthering our understanding of how people move from ‘being fine to being sick’, which takes into account the socio-cultural context and the cultural knowledge used to interpret bodily sensations. She argues that, “attending to the process through which sensation are read, pathologized and sensationalized offers insights into how specific frames of cultural knowledge and social interaction – rather than embodied experience per se – determine who becomes a patient and who does not” (ibid: 224). Highlighting embodied experiences of sensations directs our attention towards the ways in which embodied experiences of physical sensations are informed by the physical body itself as well as by knowledge, language and social context (Lock and Nguyen 2010: 90). In their early work, Nancy Scheper-Hughes and Margaret Lock introduced “the three bodies”; ‘the individual body’, ‘the social body’ and ‘the
body politic’ (Schepere-Hughes and Lock 1987). These novel perspectives on the body were intended to broaden anthropological analysis of the previously somewhat black-boxed and biologically monopolised body. The different perspectives on the body were conceived as the individually experienced body, the symbolic meanings of the body as well as the politically surveillance and controlled body. These insights have grown out of a mounting focus on the body within anthropology (e.g. Douglas 1966; 1970; Martin 1987), and they have contributed with more refined understandings of experiences of health and illness (Schepere-Hughes & Lock 1991), and developed our knowledge of what it means to be sick, well or to move in-between.

Building on these different notions of the body, Margaret Lock to the analysis further and developed understanding of how individual bodily sensations can be understood as local entanglements of historical, cultural and techno-scientific conditions as well as individual physiology in her ground-breaking study on women’s experiences of menopause in Japan and the United States (Lock 1993). The analysis in article three of the thesis, Noisy lives, noisy bodies: Exploring the sensorial embodiment of class, is inspired by Lock’s work and applies the concept which she defined as ‘local biology’ to understand how perceptions of embodied experiences of physical sensations are grounded in the subjectively experienced, socialised and physiological body (Lock 1993; 2001; Lock, and Nguyen 2010). Lock introduced the concept of local biology to focus attention on “the way in which biological and social processes are inseparably entangled over time, resulting in biological difference” (Lock and Nguyen 2010: 90). In our article, we build on the idea of different bodies, and by analysing the interplay between physiology, social contexts and embodied experiences of how the body feels, we suggest that what we describe as ‘bodily noises’ influence individual experiences of the body as well as cultural interpretations of that experience (Nichter 2008a). Our main argument is that the local biology informs both the experience, interpretation and management of embodied sensations, which potentially influence the ways in which health care seeking is practiced. In many ways, the variations of noises in different social bodies reflect what has been called “the embodiment of inequality” (Fassin 2003), and, we argue, challenges the rationally informed, individualised behavioural approach to early care seeking which rests on assumptions of a universal body.
SUMMING UP

Attempting to understand health care seeking grounded in bodies and lives that differ, the analysis in this thesis tries to move away from causal explanatory models of knowledge and behaviour. The theoretical framework presented here is intended to position the thesis within the field of medical anthropology and to illustrate some of the most important theoretical perspectives used to illuminate the social processes surrounding health care seeking. I have focused on various aspects of these processes, based on the assumption that health care seeking cannot be analysed as a single episode, but must be viewed as being embedded into everyday life and the overall practice of health, illness and the body. The intention is to broaden our understanding of how biomedical domination and subordination of imaginings of health and illness at times serve as vehicles of differentiation, and may, in fact, perpetuate the very social diversities they seek to alleviate.
CHAPTER 3: METHODOLOGY

In this chapter, I introduce the design and the methods used in the study. I first describe the conceptual design of the fieldwork, the recruitment, the informants and the scope of the material. Subsequently, I elaborate on the implications of the chosen methodology and discuss some of the challenges of the design of the fieldwork with a particular focus on access, anthropology at home and the comparative perspective. Finally, I discuss a number of strengths and limitations of the study, and raise some of the most important ethical issues.

ESTABLISHING A FIELD

When trying to understand how people move from feeling fine to feeling sick, it is necessary to thoroughly understand their everyday lives. This view rests on the assumption that in order to understand illness, it is necessary also to understand health (Hay 2008: 206), all of which is embedded in everyday life. In fact, it has been argued that ‘health-related behaviour’ is a routinized feature of everyday life (Williams 1995). Thus, I set out to engage with the life worlds of people in two different socioeconomic contexts to better understand just how social context, experiences and interpretations of sensations and health care seeking interact. I did this through actual physical presence in my informants’ worlds
and through the practice of ethnographic fieldwork (Hastrup 2012; Hastrup and Hervik 1994) carrying out participant observation and repeated interviews.

Fieldwork is often described as fundamental to anthropology; particularly the practice of participant observation - being there and establishing relations with the people under study, and empirically approaching the questions asked (Hastrup 2004b; Gupta and Ferguson 1997) - has been referred to as a ‘rite de passage’, that which distinguishes anthropology from other related disciplines (Clifford 1997). One of the methodological premises in ethnography has historically been to categorise people or units when defining our field, village, tribe or population under study; and fieldwork has therefore been accused of not only reproducing categorisation of populations, but also of reproducing distinction and othering through its own valuation and hierarchisation of the design and the practice of fieldwork (Gupta and Ferguson 1997). Moreover, perhaps grounded in ethnography’s inbuilt valuation of the Malinowskian tradition of the field, the vocabulary used to describe fieldwork activities, like “going to the field”, “coming back”, “revisiting”, etc., implicitly constructs the image of bounded, separate and far-away “fields”, where we can work with definable others in neat, manageable categories (Clifford 1997, Gupta and Ferguson 1997).

The aim to study different social classes using ethnographic fieldwork from the very beginning presented immense methodological challenges, first and foremost in relation to identification and recruitment of the respective classes, but also in relation to location and placement in ‘a field’. The absence of a ‘bounded village’ or ‘population’ was obvious, as the empirical object was two groups of people externally defined and categorised as distinct social classes, which was, indeed, conceptual constructions (Marcus 1995, 2009) rather than actual, coherent populations. Conscious of this, I initially described and conceptualised the present study as a traditional neighbourhood study where informants were identified by spatial boundaries, drawn up by traditional socioeconomic characteristics, which provided a place (a neighbourhood) where recruitment and participant observations could be initiated. As pointed out by Joanne Passaro, we still perform ethnographic studies in “epistemological villages” among others because we need to define projects that we can actually carry out using traditional anthropological methods (Passaro 1997:161). These early conceptual
considerations testified to how the sample and setting were defined by a biomedical epistemology, but also, at a more general level, how biomedicine and epidemiology were central to the development of the overarching research aim (Ecks 2008); namely that of exploring some of the mechanisms of social disparities in cancer survival.

During recent years, the Danish housing market has undergone substantial social segregation with higher social classes increasingly seeking towards certain attractive enclaves, and lower social classes gathering in public housing associations (Olsen et al. 2012). This provided the opportunity for geographically localizing the social classes of interest; and the two different provincial neighbourhoods from where the informants were recruited were identified based on a combination of population composition and context analysis (Larsen 2010). The informants were defined primarily on the basis of their form of residency, (whether they were owning or renting their home), and the areas of residency were identified on the basis of traditional socioeconomic parameters described in detail in the section below. The neighbourhood approach to identifying certain populations is by no means new within sociology and epidemiology. In particular, the neighbourhood approach to health has been much used; and correlations between morbidity, mortality, health-related behaviour and social class have been identified (e.g. Cummins et al. 2007; Diez Roux and Mair 2010; Macintyre, Ellaway, and Cummins 2002). It is important to stress, however, that I do not take the concept of neighbourhood to imply any sense of shared community; the concept is merely used as a descriptive measure of location and to provide the grounds for the conceptual construction of social class. Thus, it was used as a methodological grip to enter into the field in both an analytical and a methodological sense; as a way of getting to the informants.

What started out as a neighbourhood approach to identifying different social contexts and recruiting people of different social positions, resting on a conceptual construction of the field, quickly became a fieldwork strategy of trying to piece together a field of different social situations by following connections, associations and relationships - what Marcus refers to as following the people (Marcus 1995:106, 2009). Thus, my initial field sites, defined as two
Methodology

geographically distinct neighbourhoods, from where I departed on recruitment, were gradually replaced by the interpersonal relations with my informants. The participation in the different life worlds took the form of repeated visits and personal engagement rather than ‘pitching up my tent’ and moving in. This approach underlines how; “ethnography of course means many things. Minimally, however, it has always meant the attempt to understand another life using the self – as much as possible – as the instrument of knowing” (Ortner 2006:42). In practice, my fieldwork was “situated less by a discrete place... than by interpersonal relationships”, and the field was where the key informants were (Clifford 1997: 189).

IDENTIFYING KEY INFORMANTS

The growing segregation of the Danish housing market, where inhabitants of public housing for the most part consist of what socioeconomic studies refer to as people with lower socioeconomic positions and, conversely, where people from higher social classes primarily reside in attractive residential areas (Diderichsen, Andersen, Manuel 2011; Olsen et al. 2012), provided a way of initially identifying the informants’ social position on the basis of residential status. In addition, I recruited informants above 40 years of age because people in this age group has an increased risk of getting cancer (Engholm et al. 2012), which makes them particularly interesting from an early care seeking perspective. Thus, the area from where the lower working class informants were recruited was a public housing association where the unemployment rate and social deprivation was high and the overall income was low. All informants in this social class were living in rented apartments. Conversely, all the informants from the higher middle class owned their own house, which was situated in an attractive and high-status residential area where the property value was generally set above four million Danish Kroner. This was assumed to require an above average income or wealth status, while depending on geographical location, an average one-family house costs around two million Danish Kroner.

Twelve key informants were selected through purposeful sampling (Bernard 1994); six came from what in a descriptive sense is termed the lower working
class (hereafter referred to as the LWC) and six from the higher middle class (hereafter referred to as the HMC). I contacted gatekeepers in the housing association in the LWC neighbourhood and a local golf club in the HMC neighbourhood; and I was invited to present the research project during a number of general meetings held at these two locations. As I had the opportunity to present the project to a large number of people in different social settings, I was given access to a large number of individuals who fitted the identification criteria (ownership of house or renting of apartment and 40+ years of age). Everybody who expressed an interest in the project was given a leaflet introducing the overall aim and requirements of participating informants. Subsequently, after 2-3 days, I rang up those whom I found best matched the defined categories in order to answer any questions they might have regarding the project or their participation. After our telephonic conversations, they all agreed to participate, and we made an appointment for the first interview during the next 2 weeks. After the first attempt of recruitment, I was left with 12 informants, one of whom contacted me at his own initiative after a personal encounter at a tennis club where I had also advertised the project via flyers. All informants were followed throughout the fieldwork period, except for one of the LWC informants with whom I lost touch after 10 months due to his severe depression.

The key informants, representative of two different social classes, were characterised as follows:

Lower working class (LWC) informants:

• Holding no formal education or short vocational training
• Renting their apartment in a low-income and socially deprived area
• Had been living on federal transfer payments for over one year at the time of the study.

Higher middle class (HMC) informants:

• Holding a higher education and/or a financial position above average
• Owning their own property in a high-status residential area where the property value was generally set above four million Danish Kroner
Epidemiological research identifies socioeconomic position based on measures such as educational background, marital and financial status; and these indicators were used as descriptive measures to delineate the contours of the disparities between the two groups. However, rather than being about statistics, this thesis is intended to take note of subjectivities because these subjectivities give life and complexity to the contours of the disparities we know so well. Therefore, it was by following the informants in their everyday lives that their social class positions were contextualised, elaborated and challenged. At the risk of simplification and generalisation, I will now attempt to give an overview of the informants and try to introduce some form of texture to the life worlds that I encountered.

INTRODUCING KEY INFORMANTS

The informants in the two social classes reflected the prevalent statistical descriptions of the social diversities in health and illness in different social groups in Denmark (Diderichsen, Andersen & Manuel, 2011; Larsen et al., 2014), but also recent writings on the Danish class society which describe the social classes based on education, occupational position and income and point out the social problems associated with social position (Olsen et al. 2012). For instance, all informants from the LWC suffered from one or more chronic illnesses or so-called ‘lifestyle’ diseases. Most of them were overweight and smoked, and all were outside the labour force, living of various forms of social welfare benefits, which meant that they had very few means of existence. Conversely, the informants from the HMC were financially well off and had chosen to withdraw from working life to live off their pensions and assets. Most had a higher education, and none of them suffered from any of the ‘lifestyle’ disease, none were overweight and only one smoked and suffered from two chronic illnesses, despite their average age being somewhat higher than that of the LWC informants.
### Overview of the LWC informants:

<table>
<thead>
<tr>
<th>Informant</th>
<th>Age</th>
<th>Educational background</th>
<th>Marital status</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kirk</td>
<td>58</td>
<td>Metal worker</td>
<td>Divorced</td>
<td>3</td>
</tr>
<tr>
<td>George</td>
<td>55</td>
<td>Unskilled worker</td>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Ingrid</td>
<td>71</td>
<td>Office Clerk</td>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Fanny</td>
<td>41</td>
<td>Unskilled worker</td>
<td>Cohabiting</td>
<td>3</td>
</tr>
<tr>
<td>Brian</td>
<td>49</td>
<td>Unskilled worker</td>
<td>Cohabiting</td>
<td>3</td>
</tr>
<tr>
<td>Nichole</td>
<td>53</td>
<td>Building technician</td>
<td>Widowed</td>
<td>1</td>
</tr>
</tbody>
</table>

### Overview of the HMC informants:

<table>
<thead>
<tr>
<th>Informant</th>
<th>Age</th>
<th>Educational background</th>
<th>Marital status</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harriet</td>
<td>71</td>
<td>Banking/financial services</td>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Tim</td>
<td>66</td>
<td>Psychologist</td>
<td>married</td>
<td>2</td>
</tr>
<tr>
<td>Esther</td>
<td>65</td>
<td>Sociologist</td>
<td>married</td>
<td>2</td>
</tr>
<tr>
<td>Ben</td>
<td>72</td>
<td>Project manager/director</td>
<td>married</td>
<td>2</td>
</tr>
<tr>
<td>Jane</td>
<td>66</td>
<td>Office clerk/housewife</td>
<td>Widowed</td>
<td>2</td>
</tr>
<tr>
<td>Charlotte</td>
<td>62</td>
<td>Bioanalyst/Managing director</td>
<td>Cohabiting</td>
<td>3</td>
</tr>
</tbody>
</table>

### DESCRIBING THE MATERIAL

The data produced through the fieldwork consists of field notes, recordings of conversations, interviews transcriptions and symptom diaries. After each field visit, extensive field notes were written. I chose not to write any field notes during participant observation, primarily due to the nature of the relationships
that developed with my informants. Although it was always clear that I was there carrying out a study and that they were the object of that study, our relationship became very friendly, resembling companionship, and I found note-taking intrusive to this relationship (Emerson et al. 2010). Thus, after each field visit I raced home and wrote up field notes.

All 12 key informants were interviewed three times during the 12 months of fieldwork, and the interviews were audio-recorded and transcribed verbatim. During the formal interviews, I did take notes, mostly regarding the social situation, the non-verbal communication and the context of the interview; and in many ways the interviews also formed part of the participant observation (Rubow 2004). The interviews were semi-structured in the sense that they rested on an interview guide (see appendix 4-6), and they lasted between 1 and 3 hours. Although areas of particular interest were also explored, and most often the interviews took the form of conversations regarding a pre-decided topic (Kvale 1996, Rubow 2003).

As many of the field visits took the form of social activities, relationships developed with family and friends belonging to the same social classes as the key informants, which widened the group of informants to more than the 12 key informants. As described above, the number of times I visited and carried out participant observation varied between the two social classes (I will return to this issue below in the section on access). However, the absolute minimum of participant observation was six visits during the fieldwork period, which left me with several hundred pages of written notes and more than a thousand transcribed pages. Both interview transcripts and field notes were subsequently analysed thematically (Emerson, Fretz, & Shaw, 2010, Hammersley & Atkinson, 1995). All key informants filled out symptom diaries over a period of 3 months in which they recorded any experiences of symptoms or discomforts and their management of these experiences and symptoms. The symptom diaries were used as points of departure providing specific cases to explore when discussing experiences of sensations and the management of these sensations in one of the interviews.
When working ‘at home’, fieldwork is, as vividly described by Allaine Cerwonka, interwoven with mundane details of normal life, disrupting the traditional ideal of fieldwork as a ‘rite de passage’, but at the same time exemplifying how the traditional anthropological ideal of immersion in the field has evolved in the era of globalisation (Cerwonka 2007). The issue of distance is always pertinent, both in the analytical but also in the methodological sense. Although it has long been established that objectivity is not a function of distance, but rather a theoretical stance (Passaro 1997: 52-53), an all-pervading aspect of working ‘at home’ was the limited separation between the field and the home (Gupta and Ferguson 1997).

This implied, first and foremost, the challenge of distancing the familiar (Gullestad 1992: 28-33). The HMC proved particularly demanding to study, because in many ways their social and cultural background much resembled my own. I therefore continuously struggled to distance myself through analytical reflection of what was going on, which was aided by my comparative perspective. In the LWC, I found the ‘exotic’ which in many ways helped me question how the HMC were acting and what they were saying. However, the constant reflection whether I was asking the right questions and whether I took things for granted was probably grounded in the ‘obviousness’ of what my informants were saying and doing (Gullestad 1984). Their practices and explanations often seemed so self-evident to me that sometimes I did not question them until returning from the field and writing up the field notes; and at other times, it almost seemed stupid to ask. These are classic examples of the challenge of creating distance to the anthropologist’s own culture. As Passaro notes, whereas the issue of whether there is enough distance in the ethnographic knowledge production when conducting fieldwork at home is often raised, the question of sufficient closeness is rarely an issue the other way around (Passaro 1997). Those benefits of familiarity with context, history and society when studying at home were, however, pertinent, and they allowed me to ask in-depth questions that may not have been accessible if the cultural context had been unfamiliar.
As Rabinow has pointed out, fieldwork is always contingent on the informants available (Rabinow 2007), and the question of access to the right informants is a crucial issue when designing and carrying out ethnographic fieldwork (e.g. Hammersley and Atkinson 1995: 54-79). Although epistemologically different, this aspect shares traits similar to those which in epidemiology and health sciences are referred to as various forms of biases. Without entering into an epistemological discussion of the notion of evidence, I simply wish to make a few comments on the implications of the recruitment process. In both social classes, the socially active individuals were the ones who were there, who participated in social events and were therefore accessible, and perhaps more importantly, who I expected would be able to and interested in sticking with the project for the entire period of 12 months.

This may seem a rather pragmatic solution; but as argued by Stefan Ecks, all use of evidence is strategic and selective no matter how the objective, sample or setting is selected, or how the relevance, ethics, argument or style of presentation is prepared (Ecks 2007:82). Thus, rather than focusing on representativeness, this thesis seeks to explain, elaborate and offer perspectives on ways of being by pointing out patterns, connections, processes and meanings. In anthropology, understanding is always linked to participation and evidence to experience (Hastrup 2004a), and understanding evolves through the continuous interaction of empirical data and analytical reflection.

Another aspect related to access has to do with my admission into and participation in the informants’ lives, which turned out to be methodologically as well as analytically interesting. As my area of interest was experiences and interpretations of bodily sensations and health care seeking in everyday life,
participant observation took the form of following my key informants regularly in whatever they would define as everyday life. Hence, I participated in a wide range of everyday activities such as grocery shopping, playing golf, leisure activities, and various kinds of social events in the housing association, doctor’s appointments and job activation. However, everyday life takes place primarily in the home with all its privacy, intimacy, closeness and familiarity, which makes it enormously difficult to participate in, and to legitimately “hang out” there (Gullestad 1984; 1992). There was a vast difference in the ways in which I was allowed into the homes; a difference which was probably related to the different roles I was given, and took upon me, in the field (Rabinow 2007; Hammersley & Atkinson 1995; Wadel 1991). Whereas I seemed to have an almost natural form of legitimacy among the LWC informants, meaning that I could more or less visit them how often and whenever I liked, the relations with the HMC informants had a distinctively different character. When making appointments with them, I had to have an explanation for what we were going to do; an objective or a specific activity in which we were going to engage. For instance, once I suggested to Tim that we could take a walk around his neighbourhood and chat about the area in which he lived, he bluntly stated that he did not find that beneficial to the project. So, instead, we sat at his coffee table and talked, and through our conversations he allowed me into his everyday life (see Rubow 2003) for an elaboration on the conversation and interview as participant observation). Although this was an exception to the rule, and the rest of the HMC did not question what did or did not make sense for me to participate in, fieldwork among the HMC very often took the form of conversations over coffee in the living room. The informants accepted that I tagged along to leisure activities such as golfing, gymnastics or the yachting marina, but my interests and perhaps also my person seemed to somewhat puzzle them; while at the same time evoke their curiousness. My affiliation with the university surely gave me a form of legitimacy, which was at the same time countered probably by my age, perhaps also my gender, but definitely by the naïve and at times seemingly stupid questions I continuously asked about their everyday life and their experiences and perceptions of health, illness and bodily sensations.

This obligation of purposeful visits and difficulties in just “hanging out” was also reflected in the fact that I spent less time with the HMC than with the LWC
informants. Initially, my hanging out with the LWC was probably facilitated and enabled by the space provided by community house, where I met with some of the LWC informants weekly to play cards, and which gave me a central place to hang out. I quickly became part of the group and was taken in as one of them; expected to show up on a weekly basis. From the very beginning, I was allowed into the social setting and soon also into their homes. And, eventually, it was possible to drop by without a purpose, play computer, make puzzles or just hang out.

This process of getting accepted may also have been linked with the facilitator-like role I was given in the LWC. In the beginning of the fieldwork period, my professional position was very much in focus. “Here comes our professor”, Kirk, a metal worker who was spending most of his time at the community house rather than at his job activation, would greet me when I arrived at the community house, and we would laugh. Brian would engage in discussions about anthropology, and Ingrid, an elderly, former office clerk who was constantly preoccupied with concerns about her health, would try to get me to elaborate on whether specific medical advice she had been given were correct. However, eventually as it became clear to them that rather than being some sort of professional, I had a genuine interest in their lives, I became almost a form of resource person. As when Nichole was struggling to find out about how to become an educated cantor and wanted me to go with her, because “You are much better at talking than me. I don’t talk much”. Or when after a visit to the GP, Fanny was joking that I should always go with her to consultations because; "then I would get a much better treatment and be allowed to ask all my questions”. Or when Brian suggested that I went with him to a meeting at his daughter’s school, where they were going to discuss her weight and her asthma, perhaps in order to have a person of authority on his side.

As argued by George Marcus, the practice of fieldwork must be subjected to continuous reflection – both in relation to representations and relations build with informants (Marcus 1997). The inequality in power relations between me and my informants was clear from the very identification of informants throughout the fieldwork period. The limits of ethnographic engagement were primarily defined by the HMC informants, whereas the working with the LWC took the form of the more traditional ethnographic study of the subaltern (ibid: 99
These striking differences in relationships with the two informant groups in many ways attest to the challenges of “studying up”, as many other scholars have noted before me (Knudsen 1995; Marcus and Hall 1992; Nader 1972). However, without returning to the representation debate of the 1980s, I merely want to point out how the differences in access and fieldworker roles had a number of implications for the material, to which I will return in the concluding discussion. Due to the relational nature of ethnographic fieldwork, relations with informants are the prerequisite of all forms of anthropological knowledge. This presents at one and the same time the strengths and weaknesses of fieldwork. For me, it may present itself in a somewhat lopsided material in the sense that the fieldwork among the LWC informants produced more condensed and richer materials than it did among the HMC. Although bringing with it uncomfortable reminiscent of anthropology’s implicit power to define its object, the salience of this may have been enforced by the comparative perspective, to which I will now turn.

THE COMPARATIVE PERSPECTIVE

The comparative perspective has historically been a corner stone in ethnography, and it brought to this project much of its sense of novelty and uniqueness. It underlined the ways in which different conditions of existence produce and structure different ways of being in, acting on and perceiving the social world (Bourdieu 1984). Continuously stepping in and out of the different social and cultural worlds empirically demonstrated how economic, social and cultural differences were produced and reproduced by the very contrast between of daily lives of distinct social classes (Bourdieu 1984; 1987; Gullestad 1992: 5-6). These differences almost inscribed themselves into the fieldworker’s body; and the continuous shifts between the different contexts were at times difficult to deal with. One day I was listening to impending threats of forced removal of children from home due to the social services’ perception of the inability of young mothers to take care of their babies, sexual and physical abuse, unemployment and the struggles of ‘being heard’ by the social services. The following day, I found myself looking at pictures of houses in Spain, discussing which restaurant to take the grandchildren and which movie to watch afterwards, and trying to figure out whether I should come golfing, go sailing or spend a morning
exercising by walking along the beach. The contrasts were striking at emotional, sensational and visual levels alike; I could almost taste it, definitely feel it, and, of course, I could see it everywhere I turned my attention. It was the comparative perspective which allowed me an insight into the parallel lives which were lived alongside within the same (Danish) cultural and (public health) discursive contexts, but which were nevertheless so different that that they felt like different worlds.

Although methodologically trying, the comparative perspective was analytically rewarding and provided me with clarity and insight. But it continued to hunt me whenever I tried to transform these insights into analysis. I had severe descriptive challenges. The conceptual categorisation and analytical construction of social class proved immensely difficult when describing the two social classes in a comparative perspective. The dangers of oversimplification were omnipresent, and in my attempt to offer anthropological insights into social differences and health care seeking, it was difficult to retain the nuances of the differences within⁵. Therefore, I hope that the reader will bear in mind throughout the reading of the articles that the descriptions are intended not as district descriptions of class-based life worlds, but rather as comparative analytical perspectives grounded in two very different social contexts, which encourage, enable and bring out certain patterns of perceptions and interpretations of bodily sensations and health care seeking. While as in the words of Susan Whyte; “by analyzing the political and economic bases of health, and by embedding health conditions in the other concerns of daily life, comparative ethnography ensures differentiation and nuance. It helps us to grasp the uneven effects of social conditions on the possibilities for the formation of health identities and subjectivities” (Whyte 2009:6).

STRENGTHS AND LIMITATIONS OF THE STUDY

In closing this chapter on methodology, I will conclude by reflecting on some of the most impending limitations of this thesis. Firstly, the very focus; namely the

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⁵ These challenges have been amply described by Henriette More as the differences between and differences within categories (eg. More 1993)
social processes surrounding care seeking and the perception of illness and bodily sensations, were not issues which could be easily accessed verbally or extracted simply by asking about concrete experiences of bodily sensations and reflections made about these. The bodily experiences was hard to described in words, and I was often left with feelings of frustration after completing the interviews, questioning my own skills as an interviewer; why had I not asked more insightfully or in more detail? However, I was asking about something which had neither a concrete language nor sufficient words – namely the verbalisation of bodily experiences and sensations – and I was asking for interpretations that my informants had not always made (Scarry 1985). As time passed, it became clear to me how the very grounding of health care seeking and the management of bodily sensations were only accessible through the fieldwork – through being there and experiencing, seeing, feeling and taking part in daily life. I have no doubt that the key to understanding these issues had to be found in my own prolonged embodied experience of fieldwork and in my stacks of field notes (Hastrup & Hervik 1994; Hastrup 2003).

That being said, some of the challenges of the very practice of fieldwork in everyday life, which I have discussed above, deserve a few critical remarks. Apart from all the issues relating to entering the privacy and intimacy of the informants’ homes and participating in their everyday lives, which naturally presented a number of challenges, there was a specific point to be made regarding the way in which the field visits were arranged. Every time, a specific date was agreed on and a time was set, and my informants arranged our meetings when they “had time”. They looked for openings when they had nothing planed, because this is the way in which many Danes living in urban areas manage and structure time, plan their daily life, and arrange for visitors to come by. Even though few of my informants had ordinary jobs to attend to, they still structured their time according to calendars and “fitted me in”. When I explicitly asked them not to change any current plans as I just wanted to tag along, it was difficult for them to abide with this; they cleared their schedule, finished their chores before I came and at times they would even arrange specific events for me to participate in, such as leisure activities which we had talked about and they had described for me in conversations. Again, however, the advantages of time must be emphasised, and if I had relied solely on interviews and perhaps single visits to the home, the sense of everyday lives would have been very difficult to
achieve. Still, my participation in and understanding of my informants everyday life was, of course, partial (Clifford 1986), achieved through the form of the visit, which perhaps merely allowed me onto the front stage of their lives (Goffman 1959). Thus, the paradox of entering the home and seeking to participate in everyday life brings about a number of interesting issues and complexities, particularly when doing ‘fieldwork at home’, which could form the basis of an independent article on its own.

Finally, I want to return to the significance of the illness status and age in the two social classes, which have played important roles in the analyses presented. As I have argued in the articles, the presence and status of good health in the HMC starkly contrasted with the presence and, at times, status of illness in the LWC, which had great implications for the ways in which the body was attended to and managed. However, these very diverse physical conditions are reflected in Danish population-based studies, which have found large social differences in multi-morbidity, chronic illness, self-evaluated health and psychiatric diseases (Larsen et al. 2014; Diderichsen, Andersen, and Manuel 2011). As such, the informant groups, although small in numbers, reflect the overall pattern of disease distribution in the Danish society. In addition, the HMC informants were slightly older than the LWC informants, which may have had an effect on the importance attributed to maintaining good health. However, as the age groups represented by the informants of this study are similar to the age groups which are at increased risk of getting cancer, this implication does not necessarily influence the significance of the findings.

ETHICAL CONSIDERATIONS

When agreeing to participate in the study, all informants signed a letter of informed consent, thereby accepting that the information they provided could be used in the study. However, although informed consent was obtained from key informants, the very nature of fieldwork means that the research is constantly developing and moving in new directions. Thus, the project was always evolving, and participation was constantly negotiated. In addition, many people in the social settings who also contributed with information signed no declarations, although they indirectly contributed to the research project. Nevertheless, as
ethnographic knowledge is always relational and develops through shared experience, people who were present and participated in the social situations obviously contributed. Of course, any explicit statement or request that certain information should be withheld was followed. All informants have been anonymised and given fictive names, and any information which could potentially reveal the identity of the participating individuals has been omitted. However, due to the geographically confined recruitment, many of the informants in the two social classes of course knew each other; which made it difficult to keep the anonymity among the informants themselves. Nevertheless, this has been strived for, and episodes or stories deemed too sensitive have also been omitted.

When studying illness and perceptions and interpretations of symptoms, the issue of whether the fieldworker is morally obliged to intervene and comment on the nature of potentially dangerous disease is invariably present. Fortunately, no such instances occurred, perhaps due to my status as layman in regards to illness identification, which did not give me much advancement in identifying serious disease.

Another and important area of ethical consideration is the potential effect that the researcher might have on the informants` health and illness-related behaviour and attention. The issue of enforced symptom experience is naturally a prerequisite, which requires constant methodological and analytical reflection throughout the entire duration of the project. However, it is assumed that the anthropologist’s presence in the field is always determinant for the direction of attention, but at the same time it is a basic condition for the anthropological production of knowledge (Hastrup 2003, 2004b).

Overall, the fieldwork was designed and carried out in accordance with the internationally approved statement of ethics by the American Anthropological Association (American Anthropological Association 2012), and it was approved by the Data Protection Agency (Journal no. 2012-41-0866)
CHAPTER 4:

RESULTS
Parallel lives.

PAPER I

RESISTING REASON. A COMPARATIVE ANTHROPOLOGICAL STUDY OF SOCIAL DIFFERENCES AND RESISTANCE TOWARDS HEALTH PROMOTION AND ILLNESS PREVENTION IN DENMARK

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**Introduction**

In Denmark, as in most of the western world, the fundamental pillars of biomedicine and health promotion dominate the way in which health, illness and the body is thought about and practiced (Lupton 1995, Rose and Novas 2005). In the 1970s, the new public health discourse began to influence the way in which health promotion and illness prevention was approached, turning focus towards lifestyle choices, such as smoking, alcohol and dietary intake, and active preservation of good health and prevention of illness as an individual responsibility (Briggs 2003:288, Lupton 1995: 49-51). What has been referred to as the consumption of health (Lupton 1995, Shilling 2002, Rose 2007) started to dominate the ways that many people related with their health and bodies, which brought with it the active pursuit of good and healthy lives. The power and domination of the new public health discourse has had significant implications for the organization of healthcare and for policy development in Denmark as well as in the rest of the world (Baum and Fisher 2014, Mattingly, Grøn and Meinert 2011). In the Danish context, the messages of new public health are expressed through various forms of behavioral health promotion and illness prevention. For instance, the Danish Health and Medicines Authority administers a number of annual interventions and information campaigns focusing on “lifestyle changes” and targeting the most widespread risk factors, such as alcohol habits, diet, physical activity and smoking. During the past decade, campaigns have also begun more explicitly to address the interface between the general population and the healthcare system, for example by addressing issues of healthcare seeking and symptom awareness, e.g. in campaigns advocating increased awareness of “alarm symptoms of cancer” (Sundhedsstyrelsen 2013).

Besides attempts to improve the overall health status in the Danish population through health promotion and illness prevention, a major policy focus has been to reduce the rising social inequalities in health (Ministeriet for Sundhed og Forebyggelse 2013, 2014). Initially, attention was directed towards the social differences in the risk of getting a disease and in improving the prognosis, but recently, social differences in the practice of health and illness have become an area of policy intervention through awareness and education campaigns addressing different populations.

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6 We have written on the move towards health consumerism elsewhere (see Merrild et al. in press)
In the social sciences, a number of studies have explored the social or cultural “effects” of the new public health discourse through the lens of bio-power and with reference to health subjectivities (Briggs 2003, Lupton 1995, Rose and Novas 2005). These studies illustrate how the discourses of new public health and health promotion tend to impose notions of responsibility for maintaining good health requiring people to practice certain types of informed health behavior and utilize the health services “appropriately”, thus reinforcing the expansion of health consumerism. Although bio-power studies have pointed out social differences in the way that these obligations are met, more recent studies focusing on social groups and the management of healthcare in less affluent settings demonstrate considerable social differences in modes of appropriation (Biehl, Good, and Kleinman 2007, Seligman et. al. 2014, Whyte 2002).

Inspired by these findings, the aim of this article is to explore how the dominant health promotion discourse is appropriated by two different social classes in the Danish welfare state. We bring attention to the different ways in which health promotion and illness prevention, in a broad sense, is practiced, transformed or contested in everyday life through a comparative analysis of detailed ethnographic material. By placing health and illness concerns in the context of everyday life, we examine “how situated concerns move social actors differently” (Whyte 2009) and how agency is played out through forms of resistance (Abu-Lughod 1990, Ortner 2006, Scott 1985). This leads us to suggest that, in order to understand the dynamics of social inequality in health, it is vital to recognize how people from different social classes actively engage with health promotion and illness prevention in their own and distinct ways, rather than passively receive and accept the messages of health and illness education campaigns. Furthermore, the different forms of resistance also underline the significance of the overall sense of well-being as opposed to the presence of multiple illnesses when health promotion is appropriated to the actualities of people’s lives.

Overall, by looking into the patterns of everyday forms of resistance, we explore how subjective frames of reference and the overall normative power of the health promotion and illness prevention discourse are played out in everyday health and illness practices.
Approaching everyday forms of resistance as expressions of health subjectivities

The aim of Merrild’s fieldwork was to gain insight into the micro-politics that shape health and illness practices in the everyday lives of different social classes. Overall, the fieldwork illustrated the persistence of varying forms of “non-compliance” with dominant health-promotion recommendations, drawing our attention to what Scott (1985) has termed everyday forms of resistance. Scott exemplifies these forms of resistance as foot dragging, dissimulation, false compliance, pilfering, feigned ignorance, etc., i.e. forms of class struggles requiring little or no coordination or planning, but which rather take the form of individual self-help that avoids direct or symbolic confrontation with authority or elite norms (Scott 1985:29). In the analysis we present below, we explore health practices through the lens of resistance, which allows us to attend to the often neglected ambiguities and complexities that shape health subjectivities. Opening up the relationship between resistance and the power of the health promotion and illness prevention discourse creates a space where the subjectivity of experiences takes the center stage (Hoffmann 1999: 674), and we examine how the practice of everyday forms of resistance correlates with the formation of health subjectivities in different social classes (Whyte 2009).

In the following, we take resistance to be those everyday acts of modification or rejection of the health promotion paradigm that emanate from intentionality and the pursuit of projects (in the sense of subjective aspirations or goals) within the context of power and relations of social inequality, asymmetry and force (Ortner 2006: 144-46). The concept of resistance has been subjected to much scrutiny, and particularly the emerging interests in so-called everyday day forms of resistance has led to discussions of what actually constitutes acts of resistance (ibid: 44). The concept of resistance is still surrounded by ambiguity and debate particularly regarding its intent and recognition. It has been argued that when resistance is depicted even in small scale acts of opposition, it loses some of its meaning and it becomes difficult to recognize what these acts aim to achieve (Keesing 1992). For instance when refusal and denial to carry out requested tasks or to obey orders it termed resistance, the questions can be raised of for whom and with what aim. Nevertheless, there is common agreement that acts of resistance are closely linked with power and domination from where they enumerate (e.g.Foucault 1983). However, rather than focusing on the
significance of the small-scale subversive acts of rebellion in themselves, we wish to develop Abu-Lughod and Ortner’s conceptual understanding of resistance as a diagnostic of power, which can lead us to interesting insights about the forms of power at which they are directed (Abu-Lughod 1990, Ortner 2006). Thus with reference to the work of Foucault (1983), Abu-Lughod and Ortner illustrate how studying resistance can bring out structures of domination, differentiation and subordination, structures which are otherwise left unnoticed. Thus, studying everyday modifications, rejections or neglect of the normative messages of the health promotion discourse (such as assuming responsibility of our own health and illness by eating healthy food, exercising, not smoking and seeking timely and appropriate healthcare), and how these acts are played out in particular situations in the micro-politics of people’s lives, allows us to take a novel look at how contemporary health subjectivities are determined by both structural influences such as economic and social policies, as well as by specific everyday morals, practicalities and interaction that frame health practices in different social classes. While, as Whyte reminds us, “by describing patterns of social interaction, morality, and meaning, they suggest the processes through which assumptions and consciousness about health assume significance” (Whyte 2009: 13).

**Methods and material**

This study draws on material collected during 12 months of fieldwork in 2012-13 carried out by the first author (CHM) in the welfare state of Denmark. The fieldwork was conducted among two different social classes in two different suburban areas using participant observation to study the everyday lives of the informants. Overall, the fieldwork aimed to develop a comparative understanding of how the socio-economic system is produced and reproduced in everyday practices and to locate the different forms of life observed in relation to each other (Gullestad 1992: 6, 26, Reay 1998: 268).

Twelve key informants were selected through purposeful sampling (Bernard 2002); six came from what, in a descriptive sense, is termed the lower working class (LWC) and six from the higher middle class (HMC). The social classes were initially identified solely on the basis of ownership of property. Hence, HMC informants all owned a house situated in an attractive and high-
status residential area, where the property value was generally set above 600,000 USD, while the LWC informants all rented their apartments in a socially deprived housing association located in an area with high unemployment rates. The key informants, representative of two different social classes, were characterized as follows:

Lower working-class (LWC) informants:
- Holding no formal education or only short vocational training
- Renting their apartment in a low-income and socially deprived area
- Living on federal transfer payments for over the past year at the time of the study.

Higher middle-class (HMC) informants:
- Holding higher education and/or a financial position above average
- Owning their own property in an area where the housing prices are above 600,000 USD

A number of traditional socioeconomic measures (such as educational background, marital and financial status) were subsequently applied as descriptive measures. The informants were both men and women; some were single, some cohabiting, and some married. All informants have been anonymized and given fictive names, and any information which could potentially reveal the identity of the participating individuals has been omitted. Interviews are written as direct quotes and appear in italics. Field note extracts are also reproduced in italics, but with no direct quotes.

All key informants were followed regularly in their everyday lives during a period of 12 months. CHM participated in a wide range of everyday activities, such as hanging out at home, grocery shopping, playing golf, leisure activities, social events in the housing association, doctor’s appointments and job activation. As many of the field visits took the form of social activities,

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7 An average one-family house (depending on geographical location) costs around 300,000 USD.
relationships developed with family and friends belonging to the same social classes as the key informants, thereby extending the group of informants beyond the 12 key informants. After each field visit, extensive field notes were written. All 12 key informants were interviewed three times during the 12 months of fieldwork, and all interviews were recorded and transcribed verbatim. Both interview transcripts and field notes were subsequently coded and analyzed thematically (Emerson, Fretz and Shaw 1995, Hammersley and Atkinson 1995).

A note on inequality in the Danish welfare society – different social worlds

The Danish society is often described as an egalitarian system characterized by an ideal of “imagined sameness”, as introduced by the Norwegian anthropologist Marianne Gullestad (2001). However, social as well as public health research continually illustrates that society at large is marked by increasing inequalities (Baadsgaard and Brønnum-Hansen 2012, Diderichsen et al. 2011: 12-18, Olsen et. al. 2012). Nearly 25% of the adult Danish population between 18 and 59 years of age belong to the middle class, whereas the higher classes account for 10% of the population and the lower classes for 66% (Olsen et. al. 2012)\(^8\). These figures demonstrate the presence of inequality in the Danish society at large. However, economic difference is merely one aspect of social inequality which manifests itself in many different ways. It also translates directly into inequality in health (Marmot et. al. 1978, 1999, Townsend, Davidson and Whitehead 1988). Not only do we see substantial class differences in the risk of getting a disease, but considerable differences are also found in the prognosis. For instance, in 2009, the absolute difference in life expectancy between the two quartiles of Danish males aged 30 years with the highest and lowest income was almost ten years, while the corresponding number for women was six years (Baadsgaard and Brønnum-Hansen 2012).

Other differences in social class are evident in social and cultural terms, in life modes and lifestyle, and these are produced and reproduced by the very contrast of the daily lives of distinct social classes (Gullestad 1992: 5-6, Bourdieu 1984, 1987, Williams 1995). In line with this, we will show that class was an integral part of the informants’ subjectivities and of the micro-politics of

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\(^8\) The lower classes include the underclass and the working class. The higher classes consist of the upper class and the higher middle class; see Olsen et al. 2012: 37.
their lives, lived in and through the body (Reay 1998). Class is expressed in forms of social, cultural and economic capital, through sociality and modes of interaction and communication – the very practices, tastes and preferences that are eloquently described by Bourdieu as the symbolic construction of class-making (1987:8).

The social inequalities between the informants from the two different social classes initially came across in their economic situation and in the uneven distribution of different diseases. In the housing association where the LWC key informants resided, eight in ten were outside the workforce and living on different forms of social welfare benefits (federal transfer payments). The overall health status was poor, crime rates were high, and several local interventions had been initiated in order to counter these trends, such as a satellite police unit, a social service office, and a designated health visitor supporting the many young mothers in the area. But, as will become evident below social inequalities also manifest as social practices, such as communication (verbal as well as body language), interaction, and body maintenance and appearance – in sum, the social and cultural forms of capital (Bourdieu 1984, 1987). In order to look closer at this, let us turn to the case of Brian.

Resisting health promotion in everyday life

“We are so happy to have stopped smoking”

The worn-out buildings and the different shades of gray surrounding the parking lots in the LWC neighborhood gives the impression of monotony. Inside the buildings, the staircases are made of raw concrete, and the doors to each apartment are anonymous, merely displaying a name sign and a button at the center of the door, supposedly a doorbell. Brian, a LWC key informant, lives in a relatively large, tidy and bright apartment behind one of those doors together with his girlfriend Fanny and their 8-year-old daughter. He has no formal education, has had a number of different low skilled jobs, mostly in the manual sector, and he has also been temporarily self-employed. Most of his employments have been short-term, and many have ended abruptly for different, often dramatic, reasons. Brian is 49 years old and, like many of the other LWC informants, he does not have a single tooth in his mouth. He has been living on
early retirement allowance for the last ten years. Like most of the LWC key informants, Brian is overweight and he is diagnosed with borderline, anxiety, diabetes and asthma and has also been treated for prostate cancer a few years ago. Although the first encounter with Brian and the other LWC key informants gave the impression that their health problems were of a physical character, it soon became clear that many of them also had a number of different psychiatric diagnoses, which they often presented as their main health concern.

As the following discussion, which took place one afternoon when Brian and Fanny were playing cards at the community house with CHM and three of their friends, Carl, Janet and John, will demonstrate, health promotion and illness prevention messages were much debated issues in social situations.

*There is a ‘cancer doctor’ who says that the number of lung cancers could be reduced by as much as 70% if everybody switched from normal cigarettes to e-cigarettes, Brian tells me triumphantly. Yes, and also the other illness….. what is it called…. COPD, adds Carl. Janet pulls out her iPhone, and turns on a newsflash from one of the national broadcasting channels. A consultant doctor appears on the small screen and claims that if all smokers switched to e-cigarettes we would witness a significant drop in both lung cancer and COPD. Then a woman from the Danish Health and Medicines Authority takes over the screen and emphasizes that the Danish Health and Medicines Authority definitely does not endorse the use of e-cigarettes. Janet looks at me triumphantly, and John and Brian ensure me how happy they are to have stopped smoking. They have both regained the senses of taste and smell, and the four of them begin to discuss how amazing it is that so many in the neighborhood have switched to e-cigarettes in just six months. And nobody is exposed to passive smoking anymore, concludes Brian. Carl remarks that it seems as if Brian has spread a health-enhancing standard in the area. Everybody nods in appreciation….. (Field note extract).*

The example illustrates how people practice their own form of health promotion and tap into the health promotion discourse in their own terms. As argued by
Sherry Ortner (1989:12) in her elaboration of practice theory, such practices reflect and elucidate the structures in which they are embedded, in this case, the structure of the health promotion discourse of anti-smoking. By engaging with and accepting the premises of the health promotion discourse, we see how the practices of Brian and the other LWC smokers emerge from the health promotion discourse. They have adopted the message that smoking is bad for them and that it causes damage to their health, and they use the rhetoric of public health, such as quoting statistical illness incidence, drawing on expert opinions of doctors and using words such as ‘health enhancement’. Switching to e-cigarettes (electronic cigarettes) is considered equivalent to smoking cessation, even though the nicotine intake remains the same, which is something that they are perfectly aware of and eagerly discuss.

At first sight, smoking e-cigarettes is not an overt form of resistance to the health promotion discourse. Quite contrary, as demonstrated above, the LWC informants draw on public health reasoning, to evidence and support their actions and to substantiate the choices they make. Smoking e-cigarettes thus becomes a form of selective compliance with health promotion messages of anti-smoking. However, when this selective health promotion practice is brought into contact with the established healthcare system, it transforms into an act of resistance. Suddenly the practice, which was previously considered a health enhancing activity, ”retains oppositional authenticity and agency by drawing on aspects of the dominating culture” (Ortner 2006:62) – here the health promotion discourse of anti-smoking. This was demonstrated a few months later when Brian participated in a patient education program and pulled out his e-cigarette during class. When he told me about the incidence, he was shocked and surprised by the virulent reaction by the nurse who was teaching.

She yelled at me, he explains, and told me that I’d better put that thing away immediately. She didn’t even want to hear what I had to say about it - how it [smoking e-cigarettes] had helped me, how I have quit smoking more than 40 cigarettes a day. It made me really angry the way that she made a fool of me in front of the whole class. And all over her slides was written STOP SMOKING.... (Field note extract).
Brian and the other LWC smokers stop smoking because they believe that smoking is bad for them, but they quit smoking in a different sense than advocated by the health promotion and illness prevention discourse. When grounding their reasons for not smoking they tap into the health promotion discourse, leaving their practices as expressions of what Scott refers to as “hidden transcripts”, namely those “practices which confirm, contradict or inflect what appears in the public transcript” (1990:4-5), in this instance the health promotion discourse.

Overall conformity in health practices does not exist, and in the following we turn to explore health practices as they manifest in the HMC context, and see how it is not only LWC informants who resist the enactment of health and illness as defined by biomedicine and the health promotion and illness prevention discourse.

“We don’t have breast cancer in my family”

The neighborhood of the key HMC informants is an expensive upper-class suburban area. All of the informants live within walking distance to the sea, and all houses are large and spacious, each with a well-kept green garden. The physical surroundings and the ambiance is one of lightness, abundance and individuality, which is also found in the house of Jane, a 67-year-old key informant. She is a small and friendly-looking woman with short hair and a tanned face. She has previously worked in the credit union sector, but after her husband’s death 15 years ago she decided to end her working life, albeit she is still a member of several boards of directors. Since her husband’s death, Jane has lived alone in her large house, but she has an extensive social network, and several times a year she travels to exotic destinations such as Borneo and Peru. As all the other HMC informants, Jane leads an active life and plays golf and tennis several times a week, which is an important and socially informed part of her life. Her late husband was a GP, and many of her friends and neighbors work as medical specialists as do both of her children. She often consults with her children, especially her daughter, before making decisions regarding her health, but she does not univocally accept and embrace health promotion messages, a
point made evident in the following interview extract, where Jane and CHM are discussing the potential risk of getting cancer;

\[ J: \text{Since we have spoken last time, I have actually called and cancelled my breast screening appointment.} \]

\[ C: \text{Did you.......... why?} \]

\[ J: \text{Because I decided that I would not get breast cancer.} \]

\[ C: \text{Yes?} \]

\[ J: \text{Plus that if I did get it, then I would not have anything done about it.} \]

\[ C: \text{Ok. You have to explain that to me.} \]

\[ J: \text{Yes.......... Yes...... do you mean why I don’t think that I will get it or why?} \]

\[ C: \text{Yes both. And why you don’t want to have anything done about.} \]

\[ J: \text{Well, we don’t have any kind of breast cancer in my family, right. And we have.... Well, I have breastfed my children a lot – both of them, right. And there is some old well-known study which shows that it works if you breastfeed your children. At least not that many of those who have breastfed a lot get breast cancer} \quad \text{(Interview quote).} \]

Although ascribing to and enacting the healthy lifestyle as directed by the health promotion and illness prevention discourse, Jane resists dominant views on what counts as ‘appropriate and informed utilization of the health services’. She refers to her age of 67 years when explaining her decision and to her previous experience with her husband’s deterrent death from cancer as a reason for not wanting to go through any form of diagnostics or treatment therapy herself. "I don’t want to get sick and spend all that time sitting up there [at the hospital...] I have been through that once already" (interview quote). And, if she does get cancer, her children will surely look after her, she reasons.
Although the informants in both classes actively engage in the health promotion and illness prevention discourse and legitimate their everyday health practices with references to dominant discourses, some of these lives allow their prescriptions more than others. By juxtaposing the cases of everyday forms of resistance with the established regimes of proper health practices, we get a glimpse of the complexity and subjective ambivalence of resistance (Ortner 2006). Simultaneously, these forms of resistance illustrate the diversity inherent in the category that we know as “the active and informed subject”. Moreover, analyzing resistance demonstrates how power relations take many forms, have many aspects and interweave (Abu-Lughod 1990: 48). The health promotion and illness prevention discourse is powerfully present in the lives of all informants – irrespective of social class. By looking into the way that everyday health practices take the form of resistance towards the health promotion and illness prevention messages, the normative power of the discourse is brought out. This elucidates how the dominating definition of what it means to stop smoking takes on a narrow and normative form and refuses alternative smoking cessation methods, perhaps even methods with harm reductive potential. Likewise, when breast cancer screening is rejected on the basis of subjective experience and personal relations, the standardization of health promotion and illness prevention is questioned and the subjectivity of health practices is exemplified. Thus approaching resistance as diagnostic of power illustrates how people experience and ‘live’ this power in different ways.

In the remaining part of the article, we focus on just those competing concerns and the differences in maintaining health and dealing with illness, respectively, which is further elucidated through the everyday acts of resistance.

Maintaining health or dealing with illness – exploring situated concerns

Herbal solutions - “But of course they don’t like that”

The LWC informants in this study defy the passive role which the rhetoric of public health often assigned to people from lower social classes by the health promotion discourse, where knowledge and education is often promoted as the solution to health disparities (Baum and Fisher 2014:214-16). Everyday forms of resistance, such as switching to e-cigarettes as a way to stop smoking, or using herbal drinks as a form of medicine, as we shall see in the following case, are
practices deeply intertwined with and expressive of health subjectivities and situated concerns of individuals (Whyte 2002).

The significance of dealing with illness as an intrinsic part of life is exemplified in the case of Ingrid, a 70-year-old LWC informant. She has lived alone in her small apartment in the housing association since she divorced her husband almost 30 years ago. She has worked as an office clerk her whole life, but has been living of retirement benefits for the last five years. She rarely sees her two adult children; a situation which is causing her a lot of concern. Ingrid has a large social network and is very outgoing. She often goes to the community house to participate in different social activities such as meetings, communal eating and general socializing. The community house has several functions. First and foremost it provides a place to hang out, but the facilities also accommodate different social events, and the place is always full of people engaged in discussion, arguments, fun and laughter. Particularities of illness issues, especially the deteriorating health of people living in the neighborhood, are vigorously discussed, and advice and suggestions are offered in abundance. Often people would compare blood sugar levels, discuss their medical consultations and share information and personal experiences with both new diagnoses and the progress and status of “old” problems. Dealing with illness and different forms of suffering is considered part of everyday life, and health-related issues are discussed in social situations in a matter-of-fact way using concrete examples.

During the fieldwork period, Ingrid commutes back and forth between her GP, the hospital and an eye specialist for a number of different conditions, and she worries a lot about her deteriorating health. Most health services in Denmark are available free of charge as they are financed through taxation, with equity serving as the overarching principle (Krasnik 1996). Accordingly, most of the Danish population has free and, in principle, equal access to primary healthcare clinics, who serve as the gatekeepers to more specialized treatment in hospitals or specialist clinics. Thus, Ingrid schedules appointments with her GP as she finds necessary while she needs not worry about the financial burden. One of the reasons for her regular visits to her GP is monitoring of her low hemoglobin levels in preparation for an operation. She is a proactive patient, and, like most of the other key informants, she seeks information about her many symptoms and illnesses on the internet and discusses her health with a number of people in her social network. During one of her health-related discussions with a friend, an
herbal mixture was suggested, which she now drinks to improve her low hemoglobin level. She has already witnessed a rise, and she has told the doctors at the hospital that she will continue with her herbs until her hemoglobin reaches the desired level. “*But of course they don’t like that*”, she explains while laughing. She does not know why, but they gave her a prescription for something and told her to take that drug instead. During one of her regular monitoring visits to her GP, the low hemoglobin level and the herbal mixture were discussed.

*Ingrid tells the GP that she has been drinking the mixture and, while laughing and glancing over at CHM sitting in the corner of the office, adds that she has drunk it even though she knows that it is not popular. The GP seems evasive, but finally looks firmly at Ingrid and tells her that if the mixture was to have any effect she would have to drink an enormous amount. They didn’t like it at the hospital either, Ingrid smiles, which makes the GP promptly ask if they gave her something else instead. They gave her a prescription. And how many milligrams are you taking, the GP wants to know. Ingrid does not know, she has to take the prescription morning and evening....*

*The GP tests Ingrid’s blood, and it appears that her hemoglobin level has risen again. Well that is good, says the GP, and Ingrid bursts out, Ohh, then it [the herbal mixture] must have worked. The GP ignores her comment and suggests that they make a plan for increasing her low hemoglobin to the desired level, and they agree that Ingrid should return in two weeks to have another test. And when you have made my hemoglobin level rise, I will return to the hospital for the surgery, Ingrid concludes. The GP nods and adds reassuringly that Ingrid should not worry, ‘we will get it up before that time, no problem’ (Field note extract).*

When CHM and Ingrid leave the GP, Ingrid continues to talk about the herbs and how the health sciences do not acknowledge its effect, and how she tried to get the GP to explain why the herb has had the effect on her hemoglobin level that her blood count just showed. Whether or not the herbal mixture had any effect is not the issue. Rather, is the way in which Ingrid’s knowledge and experience
with the herbs are disregarded and considered inferior to the biomedical perspective, which insists on a prescription drug. Initially, Ingrid resists and insists on the effects of her herbal intake, but eventually she responds “appropriately” to the situation and takes on the role of the compliant patient, who lets the GP raise her low hemoglobin. Nevertheless, after the consultation, she expresses her frustrations, and in the months after she continues to take her herbs alongside her prescribed drugs as a way of retaining some form of agency in the battle for her weakening health.

The case of Ingrid demonstrates how the acting subject at the same time resists and supports the existing system of power (Abu-Lughod 1990: 47) through contesting, but at the same time subsuming to the dominant health promotion discourse. Her practices clearly emerge from the structural context of the dominance of bio-power, as it is played out in the clinical setting, but at the same time demonstrate the potential resistance of health practices. Although Ingrid complies with her doctors’ advice of taking the prescription drug, she maintains the significance of her own remedy and insists on her right to agency by continuing with the use, pursuing her project of dealing with her illness within the relations of asymmetry and force (Ortner 2006). Drinking a herbal mixture may seem a minor and insignificant act of agency, but it illustrates how people practice their own form of health promotion and modify the dominance of bio-power which insists on following medical regimes and being compliant. Ingrid’s health and illness practices demonstrate the diversities and differences in modes of appropriation of health promotion and illness prevention, and how these different appropriations are shaped by the values and convictions – the subjectivities – of different social lives. The various forms of resistance are shaped by different social contexts and follow different logics as will be illustrated in the following case.

**Dietary changes**

Esther is a sociologist by training and has a long and wide-ranging career behind her. She is a square-built woman in her sixties, who lives in a large house together with her retired husband. As their financial situation allowed it, she chose to terminate her working life a few years ago and retire with her husband. Esther takes an interest in organic food, she is outspoken and very engaged in her
young grandchild and involves herself actively in the local community where she is a well-known figure. Like the other HMC informants, she exercises, eats healthy, keeps fit and tries to avoid getting overweight. Maintaining a slim figure in the HMC is partly described as a health concern but just as importantly as a matter of appearance. Expression such as “not letting oneself go” or “letting it get too far” are often used and demonstrate how the HMC informants are “involved in observing, imposing, and enforcing the regulations of public health, particularly through the techniques of self-surveillance and bodily control encouraged by the imperatives of health promotion” (Lupton 1995: 76). The enactment of the health promotion messages, such as exercising and eating healthy, are unquestionable and a way of life for Janet and the other HMC informants. None of the HMC informants were overweight, and none of them had any lifestyle or psychiatric diseases. The importance of being able to lead an active and healthy life was exemplified in various instances, where the HMC informants made claims on their bodies and functionalities. As one of the other key informants said,

"we reach a certain age and if we exercise, well, we are not supposed to have pains in the knee, then we can get a new knee, right? And a new hip and so on…... We don’t just put up with it as they did in the old days". (Interview quote)

Only one of the HMC informants smoked, which largely reflects the socioeconomic distribution of smoking among this group in Denmark. He explains,

“I smoke between zero and five cigarettes a day, and I will control it myself, and decide myself whether I will smoke or not. But I don’t smoke in front of my wife as she finds it stupid that I smoke, and she can’t help comment ing on it” (interview quote).

So he smokes on the stairways in the basement, and he does not smoke when he is with people who do not smoke so that he does not have to justify his seemingly
inappropriate practice; a practice that falls outside the contemporary notion of the civilized body, which is subject to conscious and rational control (Lupton 1995:70). However, at home in his own house, he allows himself the pleasure of smoking a cigarette because, as he says, “health also has something to do with happiness” (interview quote). Like the LWC smokers, he is perfectly aware of the health hazards of smoking. But he has been living with myxoedema for many years, and he relies on studies which have shown that smoking has a beneficial effect on his chronic illness. So he has found a balance and concludes that smoking is good for one thing and bad for another, a reasoning which ultimately is made to enhance his health.

Returning to Esther, who during some months has been concerned with irregularities in her cholesterol level and some unexplained elevated liver counts. Earlier in the morning on the day of the visit referred here, she has been called in for an ultrasound of her liver. She is usually fairly calm and formal, but today she is rather shaken up by the urgency of the situation, which CHM discusses with her in detail,

She has always been concerned about that liver, but does not know why – ever since she had the scan that she paid for herself at the private clinic. They told her that it was a fat liver, nothing else. Now she worries that it is the cholesterol medicine that she has been taking, which she has suspected all along. But she has all kinds of things going around in her head. Could it be the medicine or all those dietary changes that she has been making? ..... She has been checking a lot on the internet, she says, and continues to reason and search for possible explanations and scenarios that could explain her high liver counts....... And if it turns out to be the medicine, which she has never liked anyway...... But you are not taking the medicine, CHM ask her. No, and I haven’t done so for a long time, she answers. Does the doctor know, CHM continues. No, she has not told him Because if I can achieve the results through changing my diet myself, I would much rather do that, she says firmly. (Field note extract)
Esther, like Jane and the other HMC informants, does all “the right things”: she eats healthy, she exercises, and she acts on bodily sensations to the extent that she has her liver examined at her own cost. She deals with and puts a lot of effort into her health, and nobody in the family understands that she is suddenly at risk of being seriously ill. Nevertheless, she does not take the prescribed drugs which she firmly believes does her more harm than good. She reasons according to the health promotion discourse. Yet, at the same time, she acts on subjective sensations and trusts her own judgment above that of the GP. By achieving the results through changing her diet, she draws on advice from specialized dieticians, while also enacting her health subjectivity and selectively choosing from health promotion and biomedically informed knowledge.

Once again, it is exemplified how the health promotion discourses frame health practices, but standardization is resisted and the health subjectivities are played out in the pursuit of the project; hereof maintaining good health. The contrasting concerns of dealing with illness are brought home by the following statement from Brian, who often unloaded his distress of encounters with the health care system when socializing with his friends.

> It is not allowed to be fat anymore, Brian almost shouts, but it is allowed, he continues, they cannot decide that. It was the same when he went to see his own GP, he explains; she said it as well. She said that he had to lose weight. If he did not, there would be all the secondary complications to his illness. But he told her that he could not lose weight because eating was the only joy in his life. And then she just said, “then it is your own fault”. …. Everybody has such a bleak perspective on things, he moans, also the GPs, they are so pessimistic. If I die tomorrow or if I turn 55, either way I won’t feel the difference …. (Field note extract)

Brian’s statements may be seen as expressions of anger, frustration, and direct opposition towards the health promotion discourse. But they also exemplify how certain values and lifestyles are overridden and devalued and bring forth issues of power, domination, right or wrong health status, moral responsibility, and self-determination. The structural impediments of Brian’s life, in the form of economic constraints, exclusion from the workforce and marginalization due to
his psychiatric illnesses, positions him at the margin of society, and his health and illness practices further underline this exclusion. Brian is dealing with illness in his everyday life and he is clearly assuming the sick role as a mode of resistance, as also suggested by Scheper-Hughes and Lock (1991:423). He resists the moral obligations of staying health, while at the same time, expresses an alternative health subjectivity which diverges from the one prescribed by the health promotion and illness prevention discourse. But in doing so he feels disarmed by the hegemonic power of new public health, where each individual is responsible for his own health, subject to moral judgments, and where compliance with medical advice is positively valued (Lupton 1995:71).

Conclusion

We have explored social inequality in health through the lens of resistance, and demonstrated how health promotion messages are appropriated by the two studied social classes. At the same time as resisting the health promotion discourse both social classes also embrace, accept, and actively employ the messages and principles of health promotion and illness prevention in both complex and ambiguous ways. The presence and status of good health in the HMC starkly contrasted the LWC. Although all informants were interested in improving their well-being, a central concern in the HMC, was maintaining their good health, as illustrated by the cases of the key informants Ingrid and Jane. In the LWC, exemplified in the case of Brian and Esther, dealing with general hardship and the presence of multiple illness and social concerns shaped their mode of and approach to health promotion. These findings, dealing with illness or maintaining good health correspond with many other studies which have illustrated how the significance, meaning and status of health, illness, and the body are different in diverse social groups (e.g. Blaxter and Patterson 1982, Lock 1993, Williams 1995). They also contest to how the overall structural determinants and political economy influence and constrain how people from lower social classes live their lives.

Moreover, comparatively contrasting health practices that challenge the imageries drawn up by the health promotion discourse and approaching resistance as a diagnostic of power, as suggested by Abu-Lughod (1990) and Ortner (2006), has brought out the moral imperatives of maintaining good health
which requires people to practice certain types of informed health behavior and use the health services “appropriately”. We demonstrated how people from different social classes use biomedical language and symbolism when substantiating their health practices, which highlights the omnipresence of the biomedically founded health promotion discourse. However, in the process of practicing health promotion in everyday life, the messages are appropriated subjectively, and the boundaries of the discourse are challenged accordingly. This supports Ortner’s views on how people pursue their own intentions and projects, albeit closely related with ideas of power and structures of dominance (here of the health promotion and illness prevention discourse) and inequality (Ortner 2006: 145). The cases presented above, all exemplify ways in which people from different social classes resist the standardization of health promotion and illness prevention. But what is more, they illuminate structures of domination, differentiation and subordination and reflect how some patterns of resistance are more subjected to exclusion and marginalization than others.

Along with other writers on resistance (Abu-Lughod 1990, Keesing 1992, Ortner 2006, Scott 1985, 1990), we point out how the different forms of resistance are closely intertwined with and, in fact, emanate from the power at which they are directed; in this case, the health care system and the health promotion discourse. We argue with Ortner that representations, discourses, and language all serve as elements of the hegemonic processes that sustain systematic inequalities (Ortner 2006: 19). The ubiquitous position and authority of health promotion and illness prevention discourse may fail to acknowledge how people from different social classes actively engage in health enhancement and illness prevention in their own and distinct ways, by applying, transforming, and trying to convert the messages to the conditions under which they live. These transformative practices are at risk of being stigmatized and deemed ‘wrong’ which illuminates how the health promotion and illness prevention discourse contributes towards establishing normalities, and in the process creates categories of deviants – of those who do not conform to the standards of ‘normality’ and assume responsibility of maintaining health and preventing illness. If the ways in which the different contexts constraints or enables health and illness practices are not acknowledged as expressions of health subjectivities, the public health awareness and education campaigns may bear the risk of even perpetuating the very inequalities they try to
diminish, as the wealth of meanings, experiences, and embedded nature of bodily practices are ignored (Andersen and Risør 2014:4). As argued by Baum and Fisher, the institutionalization of individualism, biomedicine, and behavioral views of health and illness helps “to maintain a form of social silence around the alternative views of health that challenge the normality of everyday social, economic and cultural inequalities” (2014:218). What is more, it overrides how the lives of disadvantaged populations are structured and conditioned by the wider social and political organization of society, and their marginalization is perpetuated by the social support of the dominant ways of practicing (in this case) health and illness (Bourdieu 1997).

On a practical level, our analysis has pointed out how everyday concerns and subjectivities matter so much that they produce resistance, although with different life goals and intentions. Failing to recognize and acknowledge the health practices that are actively carried out in different social classes, may lead to misinterpretations of these practices as lack of understanding rather than subjective attempts to improve health and deal with illness.
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HEALTH CARE SEEKING CONTEXTUALIZED: SOCIAL CLASS, SOCIAL SUFFERING AND HEALTH CONSUMERISM.

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Introduction and background

Based on long-term, comparative ethnographic fieldwork among two different social classes, this article illustrates how health care seeking practices are embedded in everyday life and shaped in the tension between notions of health consumerism and degrees of social suffering. The study is situated in Denmark, a Nordic welfare state of 5.6 million people, built around notions of universality and homogeneity. Since the 1933 Social Reform Act, welfare schemes covering the entire population and financed through taxation have been implemented (Jöhncke 2011). These schemes cover many areas, e.g. free education, sickness benefits, pensions, child care facilities, and health care as the most celebrated example. Thus, all primary and secondary health care services are provided free of charge, with general practice serving as the gatekeeper for specialized treatments. Despite the nature of the extensive Danish welfare system, Denmark is witnessing growing social differences, and a recent study mapping the social cohesion of the Danish society has referred to Denmark as an invisible class society (Olsen et al. 2012). Building on statistical analyses of educational and economic position Olsen and colloques show how nearly 25% of the adult Danish population between 18 and 59 years of age belong to the middle class, whereas the higher social classes account for 10% of the population and the lower social classes for 66% (Olsen et al. 2012). Olsen and colleagues define the middle class as independent businessmen, senior executives or people with short or middle-range educations who earn less than twice the average income in Denmark, which was approximately 60 000 USD in 2012 (Sabiers and Larsen 2014). The lower social classes are defined as skilled and unskilled workers and people who are out of the workforce for 4/5 of the year; and the higher social classes are defined as independent businessmen, senior executives and people with high education earning more than twice the average Danish income and all university graduates independently of their income (Olsen et. al. 2012:37). In this study we follow this class based approach to understanding social stratification, although we use the concept of class merely as a rough description of social differences. Social differences have been shown to translate directly into health and people from the lower social classes carry a higher burden of both morbidity and mortality (Pickett and Wilkinson 2015). In 2009, the absolute difference in life expectancy between the two quartiles of 30-year-old Danish males with the
highest and the lowest income was almost ten years, while the corresponding number for women was six years (Baadsgaard and Brønnum-Hansen 2012).

Accounting for 31% of all deaths in Denmark in 2012 (Statens Serum Institut 2012), cancer illustrates the growing social inequalities and class differences in health in Denmark (Olsen et al. 2012); and numerous studies have shown that people from lower social classes get cancer more often and are more likely to die from it (Coleman et al. 2011, Dalton et al. 2008, Rachet et al. 2010, Woods, Rachet and Coleman 2006). The processes leading to social inequality in cancer survival are, however, difficult to map out. Differences in stage of cancer at the time of diagnosis or treatment have been suggested as major factors explaining inequalities in survival (Dalton et al. 2011, Frederiksen et al. 2011, Ibfelt et al. 2012, Woods, Rachet and Coleman 2006). A number of epidemiological and public health-based studies hypothesize that the differences in cancer stage may partly be influenced by differences in health care seeking practices; and it has been suggested that people from lower social classes may be more likely to postpone seeking medical advice when experiencing potential signs of cancer (e.g. Lyratzopoulos and Abel 2013, Macleod et al. 2009). In the literature on early cancer diagnostics and health care seeking, raising public awareness of the so-called ‘alarm symptoms of cancer’ is often suggested as a means to reducing social disparities in cancer survival (e.g. Ibfelt et al. 2012, Lyratzopoulos and Abel 2013, Macleod et al. 2009, Whitaker et al. 2015). Hence, ‘timely’ and ‘correct’ symptom recognition is conceived as triggers of early health care seeking, and the public is encouraged to seek health care as early as possible, and to be attentive towards and to respond to a variety of sensorial markers designated ‘alarm symptoms of cancer’ (e.g. Hamilton et al. 2009). This ‘awareness’ perspective may be challenged in a number of ways; some of which will be discussed in this article. As has been argued elsewhere, identifying cancer alarm symptoms, or let alone deciding when to seek health care ‘in due time’, is not as straightforward as indicated in parts of what we could broadly refer to as the public health literature (Andersen, Tørring and Vedsted 2014). The classification of certain bodily changes and experiences as alarm symptoms of cancer was developed to quantify the probability of having a particular cancer disease given the experience of ‘a specific bodily change’. However, epidemiological research on cancer symptomatology illustrates that ‘alarm symptoms’ are common in the public (Svendsen et al. 2010) and when presented
to a general practitioner have low positive predictive values for cancer (Hamilton et al. 2009). This has led Andersen, Tørring and Vedsted to argue that “symptoms of cancer are equally invisible and potentially omnipresent, reflecting a generally high level of statistical uncertainty in regard to defining characteristics of bodily signs of disease which constitute a need of medical assistance” (Andersen, Tørring and Vedsted 2014:3-4).

The case of cancer is illustrative of existing social inequalities in health in Denmark, and it also allows us to engage with current developments in the general thinking and manifestation of health promotion discourses focusing on early disease detection. To understand the triggers of health care seeking, it is however necessary to look into the way in which health care seeking is embedded into everyday life – and practiced by people who do not have cancer but are expected to proactively respond to more or less common symptoms. In this way we hope to contribute to the understanding of the social differences in the timing of cancer diagnosis, by seeking out an understanding of the ways in which health care seeking is practiced in different social classes. This leads us to challenge the awareness perspective discussed above, where the primary barriers to early health care seeking are assumed to be grounded in symptom appraisal and lack of knowledge and awareness. We will argue that information campaigns referring to knowledge of cancer alarm symptoms as a magic bullet to ‘ensuring timely health care seeking’ do not take into account the social and cultural embeddedness of bodily experiences and health care seeking practices. Rather, we suggest that bodily experiences and decisions to seek medical advice are tied to forms of social suffering, intrinsically linked with the politics and economies of life, generated by social conditions and constituted as an embodied social process in persons (Ceres 2011, Kleinman, Das and Lock 1997).

**The patient as a consumer?**

The social science literature has emphasized the role of biomedicine in the shaping of contemporary forms of subjectification, bodily practices, assumptions, and attentiveness (Lupton 1995, Rose 2007, Shilling 2002). According to sociologist Nikolas Rose, a leading figure in this literature, technological advancements in biomedicine and novel conceptions of biological citizenship
have resulted in a re-coding of duties and the growth of a somatic ethics, where people increasingly experience, articulate, judge, and act upon themselves (and others) in the language of biomedicine to maintain the body’s wellbeing and functioning (Rose 2007: 25-26). These developments, argues Rose, are reinforced by the normative power of official health promotion discourses where the body and its well-being has become the center of ‘moral judgments’; of good and bad; encouraging people to become active and responsible consumers of medical products and services (ibid). Inspired by this thinking and immersed in the significance of developments in biomedicine, other researchers, who are more focused on health care seeking practices, suggest that lay people are moving towards a more ‘consumerist’ approach when seeking health care (Shilling 2002, Lupton 1997). Being a ‘consumerist patient’, in Shilling’s terminology, implies an increased attention to the body, but it also refers to more subtle notions of the body as a vehicle for gratification, for pleasure, and for self-cultivation (Shilling 2002: 628). Overall, this literature refers to the body’s changing status and its wellbeing as something that is no longer just ‘taken for granted’, but lies at the center of our attention and commands our resources, and which is now, so to speak, open ‘to investments’ (ibid: 627). In terms of health care seeking, a consumer is thus a subject concerned with health and engaged in and able to seek information about the body’s maintenance and optimization, and therefore ‘consumes’ health care as a service that may maximize well-being and protect the subject from the adversities of poor health (Lupton 1997, Shilling 2002). As such, health consumerism refers to individual practices of the body, which are reinforced and supported by the organization of the healthcare system. Moreover, a wide range of ‘patient centered’ approaches are increasingly being introduced into the healthcare system, and with varying degree of intensity these initiatives address and activate patients as users of healthcare services. Being allocated a ‘user identity’ has thus become central in current organizational healthcare to promote e.g. empowerment strategies and involvement in care and diagnostic process, and such initiatives in many ways feed into health consumerism.

Whereas there is considerable agreement in the literature that biomedicine is an important factor in shaping bodily perceptions or practices, only little attention has been devoted to the conditions under which the patient as a consumer materializes in specific socio-political contexts. However, Lupton points out how a focus on consumerism may ignore a number of complex aspects of health care
seeking, such as the embodied and affective dimensions of illness and the unequal power relation intrinsic to the clinical encounter (Lupton 1997: 379-80). Research focusing on the clinical encounter has pointed out how differences in communication between GPs and people from lower social classes have an impact on for instance the information exchanged in the clinical encounter (Willems et al. 2004). Willems and colleagues showed that the somewhat passive communicative style presented by people from lower social classes in the clinical encounter, resulted in misunderstandings of the intents and desires which resulted in less information being shared (ibid).

Other studies focusing on social groups and the management of health care in less affluent settings demonstrate considerable social differences in modes of appropriation, discussing for instance the moral discourses underlying health practices and beliefs in different social and cultural classes (Karesz and Dempsey 2008). They also illustrate the intrinsic tie between health and wellbeing and the concerns and demands of the enactment of everyday life (Garro 2011). The materialization of bio-power or the construction of the ‘health consumer’ is thus, in the words of Whyte, not given (2009:10), but rather an empirical question that calls for comparative ethnography.

Against the back-drop of the current health promotion discourses as they materialize in the case of cancer, we explore the conditions for, and emphasize the dynamic and intersubjective processes that shape, health care seeking practices departing in the writings on social suffering (Kleinman, Das and Lock 1997) and health consumerism (Shilling 2002). We explore health care seeking practices as they unfold in two different social classes in Denmark, and we argue that they materialize in the tension between notions of health consumerism and degrees of social suffering. We point out how the adverse influence of social, political, and economic hardship produce embodied forms of suffering which do not match the proactive approaches to health care seeking practiced by the health consumer or portrayed by the image of the patient as a service user. We take experiences of social suffering among the lower working class informants, to be both socially and physically informed by the larger socio-political structures, and partly grounded in unemployment, deteriorating family relations, stressful and sometimes violent lives as well as bad health. Therefore, attending to the different forms of social suffering draws attention to forms of suffering that result
“from what political, economic, and institutional power does to people, and, reciprocally, from how these forms of power themselves influence responses to social problems” (Kleinman, Das and Lock 1997: ix). The present article takes us closer towards an understanding of the different conditions framing health care seeking practices and the socially diverse manifestations of health promotion discourses.

Methodology
This study draws on material collected during 12 months of fieldwork carried out by the first author in 2012-13. The fieldwork was conducted among two different social classes situated in two different neighborhoods. In order to access different social classes the neighborhoods were selected based on a combination of population composition and context analysis (Larsen 2010). Hence, informants who we in a descriptive sense have termed higher middle class (HMC) informants all owned a house situated in an attractive, high-status residential area, where the property value was generally set above 600 000 USD (an average one-family house costs about 300 000 USD, depending on geographical location) and were either university graduates and/or had a financial position above that of the average Danish income earner (which is approximately 60 000 USD). Informants who we in a descriptive sense have termed lower working class (LWC) informants all rented their apartments in a socially deprived housing association located in an area with high unemployment rates. They either had no formal education or short vocational training; and at the time they were invited into the study, they had been living on welfare benefits for at least the past year.

In total, we invited 12 key informants from the identified neighborhoods selected through purposeful sampling (Bernard 2002: 192-93); six came from the LWC and six from the HMC. The 12 informants were approached during social arrangements in the two selected settings, and invited to participate by the first author. They were giving written information regarding the project, and subsequently contacted by telephone to verify whether they were still interested in participating and answer any potential questions they might have. The informants were both men and women; some were single, some cohabiting, and some married. Using participant observation, the first author followed all key informants regularly in their everyday lives during a 12-month period,
participating in a wide range of everyday activities such as hanging out at home, grocery shopping, playing golf, leisure activities, social events in the housing association, visiting the general practitioner (GP), and job activation. After each field visit, extensive field notes were written. As many of the field visits took the form of social activities, relationships developed with family and friends belonging to the same social classes as the key informants, thereby extending the group of informants beyond the 12 key informants. Accordingly, the ethnography was “situated less by a discrete place…than by interpersonal relationships”, and the field was where the key informants were (Clifford 1997: 189).

All 12 key informants were interviewed trice during the 12 months of fieldwork, and the interviews were recorded and transcribed verbatim. Furthermore, all key informants filled out symptom diaries over a period of three months, recording any experiences of symptoms or discomforts and how they had managed any such experiences. The symptom diaries were used as points of departure in one of the interviews where specific cases of symptom experiences were explored. Both interview transcripts and field notes were subsequently coded using NVivo 10. The text was analyzed through focused coding and thematic patterns were identified and analyzed in a dialectic process moving between empirical data and analytical reflection (Emerson, Fretz and Shaw 1995).

The project was conducted in accordance with the Code of Ethics of the American Anthropological Association (http://ethics.aaanet.org/category/statement) and was approved by the Danish Data Protection Agency (j.no. 2012-41-0866). All informants and neighborhoods have been anonymized and given fictive names, and any information which could potentially reveal the identity of the participating individuals has been left out.

**Studying social class**

It has been argued that class is a culturally and discursively constructed category (Ortner 2003); yet, at the same time the figures outlined in the introduction suggest that there are unequally distributed material resources, based primarily on educational and financial position, to be taken into account in the Danish society. However, economic difference is merely one aspect of social inequality; social inequality also manifests itself in health status, management of the body,
life modes, and lifestyle; all of which are produced and reproduced by the very contrast of the daily lives of distinct social classes (Bourdieu 1984, 1987, Ortner 2003).

The comparative character of the present fieldwork illustrated and emphasized just those different physical and social dimensions of class. Continuously shifting between discussions and concerns revolving around forced removal of children from home, assaults, prolonged unemployment, recurring depression, and the strains of physical challenges such as overweight, galloping sugar levels, and irregular heartbeats in the LWC stood in stark contrast to the concerns of the HMC which included, among others, the management of holiday houses abroad, exotic travels, and stimulating activities with friends and family, along with descriptions of how the body was kept in shape through various forms of leisure activities and dietary measures. All of the informants were outside the formal labor market. But whereas all but one of the informants in the LWC were clients with the social services and all were living off different forms of social welfare, the HMC informants were retired and living off their assets or private pensions. Thus, there were great differences between the two classes in terms of how they were influenced by the institutional political, economic, and social powers and how these differences shaped the practice of their everyday lives. It was striking both at the emotional and at the physical level, but also in relation to the autonomies of the different social lives. The ways in which different conditions of existence produce and structure different ways of being in, acting on, and perceiving the social world (Bourdieu 1984) empirically demonstrated how economic, social, and cultural differences were produced and reproduced in the daily lives of the informants.

In the following we provide ethnographic illustrations of the two different settings, exploring how health care seeking is practiced in the two different social classes. The cases presented here do not represent ‘perceived cancer symptoms’, but are meant to illustrate how common health care seeking practices and symptom experiences are embedded in everyday life worlds; their politics and their hardships. They are selected due to their representativeness and reflect the patterns of health care seeking found throughout the two social groups, illustrating both differences between the two social classes, and also difficulties in determining or defining ‘with what’ to ‘legitimately’ seek medical advice.
Practicing health care seeking

Consuming health

From the very beginning of fieldwork, it became clear that mobility and physical activity as such was highly valued by the HMC informants. Although retired and living of their assets, they kept busy schedules, packed with different kinds of leisure activities such as golfing, gymnastics, attending courses and lectures, taking care of grandchildren, spending time with friends etc. In their everyday life they were very conscious about maintaining their health so that they could keep up this lifestyle. As such they were attentive towards their bodies, and in the pursuit of good health they continuously kept track of it by using various assistive devices such as bathroom scales, sphygmomanometers etc. Although rarely suffering from specific health problems they frequently made use of health services such as their GP, dieticians, or physiotherapists. Often, when irregularities were found, the GP was consulted to make sure that everything was ok, and specific checkups were frequently requested (e.g. examinations for prostate cancer, blood tests, and general health checks). When discussing health care seeking, this constant monitoring of the body was often reflected. As Esther, a retired but well-to-do woman in her sixties explains;

“We feel that when we reach 50 – 55 years of age or something like that, then we book an appointment with the GP in order to have what we call a 50,000 kilometer service. Then we need to have our blood pressure and that kind of thing checked. . .(…) And, well,.... that is something we have decided. Tom (her husband) has actually always done it. He has always been very conscious about wanting to, well, to have different things checked out. Blood tests and so on....And then I also asked to have a total examination. And I got it.”

Like many of the other HMC informants, Esther’s health care seeking practices in many ways resemble what we could call a ‘consumerist’ approach to health care (Shilling 2002). Such health care seeking practices point out how some people have taken responsibility for proactively maintaining good health and preventing illness; and they also show how attentiveness towards potential bodily irregularities becomes an imperative of personal values and ambitions seeking out the good life. And furthermore, they illustrate how health care, in this setting,
is approached in the same way as other products and services (Conrad 2007:138) utilized to enhance or ensure a productive and pleasurable life. As exemplified in Esther’s description above; she wants to know if she has any physical problems that she should be aware of so that she can act proactively upon it; and she expects a clear and precise response or result; expectations that are enabled by the increasingly technical, specialized, and proactive diagnostic practices of medicine.

In this spirit, Esther regularly visits her GP and has blood tests taken to keep track of her cholesterol, and sometimes these tests show irregularities. And, so, the latest blood test indicated a problem with her liver; and when the first author comes to visit her shortly after, she looks solemnly as she sits down to talk, explaining in a quiet voice.

_E: _I have some news today. You know I have my cholesterol checked with my GP. And last time, they found that the numbers indicating my muscle enzymes were too high. I asked what it meant, and if it was dangerous, but they told me it wasn’t because it was not that high. Then I had the blood test taken again, but for two weeks I did not hear from them. So I called down there to ask a few days ago, and he (the GP) told me that I had increased liver values. And, of course, it is all connected. So I was referred to an ultrasound at the hospital, and they called me yesterday. I have to come down there today at 1pm.

_CHM:_ Ok. (We sit together in silence for a little while). And what do you think about that?

_E:_ Well, of course, I am worried, and imagine the worst, cancer as the ultimate worst, and all kinds of other things.....

_CHM:_ But is it because it happens so fast?

_E:_ Yes it is. And that they call me. I have not even gotten an invitation, or signed anything saying that I wanted to be called in if they had a cancellation. But what upsets me most is that I would not have found out about it if I had not called them myself and pressed for the results from those tests. And now, I worry that it is the medicine I have been taking, which has been bad for me. I have suspected it all along. And it is all connected, because it all started way back when I had my liver scanned, at my own expense, at that private clinic. I have always worried about that liver; and back then, I was told it was a fat liver, nothing else.
As this example makes clear, Esther does everything she can to ensure her good health so that she can remain fit and active and continue with her lifestyle of golfing and playing tennis several times a week, working in her garden, taking care of her home, her grandchild, etc. She has continuously been attentive towards her liver and has proactively reacted on vague and ambiguous, but potentially serious, sensations. Unfortunately, though, in this case, her proactivity eventually causes her much concern and suffering, as she suddenly finds herself at risk of serious illness and “cancer as the ultimate worst”. And it adds to her distress that the health care system has seemingly delayed her test results and thus failed to meet her demands of proper service provision.

By pointing out the consumerist ethos, we wish not to suggest that proactivity and attentiveness is always accommodated when health care is sought by the higher social classes. This is evident in the case of Charlotte, another HMC informant in her early sixties, who is also retired and living off her assets. Like Esther and the other HMC informants, Charlotte wants to keep her body in check; and to do so, she wants to have an expert’s opinion regarding her specific problem. As she recounts on previous experiences with her GP:

“I think that I have had difficulties getting through……. I think that I might as well just write an email to my GP saying that I would like to have a scan for that osteoporosis, because I have had this recurring back pain. But it doesn’t work that way. No, I have to come down here first, because we have to have a chat about it. Then she gets paid for a consultation again, right? And that annoys me.... That you can’t..... Because I am so familiar with myself and my body and the (health care) system that I know that I have the right to get that scan, for example, for osteoporosis. But, no, I have to go down there (to the GP) first... Have a little chat and.... Well, last time I was there, I actually asked directly for a referral to a gynecologist. I didn’t get that.”

The experience of not being able to get through was often recounted by the HMC informants and was causing them a lot of suffering and distress. Yet, our interest here is not whether the service is provided according to the patient’s wishes or not, but rather the way in which health care seeking springs from a proactive and attentive orientation towards the body and is practiced in a direct and matter-of-
Health care seeking contextualized

fact way. Healthcare, whether in the form of an examination or treatment, a referral, or a prescription, was approached as a service by the HMC informants. These services could be the object of intentions, expectations, and even claims. This approach makes sense when viewed within the context of the social conditions shaping the lives of the HMC; their relative affluence, independence, and high social position shield them from social force, political and economic hardship, and social suffering. It could be argued that the imperative of the maximization of lifestyle, potential health, and quality of life, which Rose (2007:25) refers to as the somatic ethics, primarily become possible when political, economic, and social forces do not infringe on the practice of everyday life.

The cases of Esther and Charlotte illustrate that health care seeking practices as they materialize in the HMC can be seen as approximations of health consumerism resembling what has been called ‘proactive perceptions’ and practices of health and the body; as also previously found in higher social classes by others (Bourdieu 1987, Lupton 1995, 1997, Shilling 2002). Our empirical findings echo those of Katz (2000), who illustrates the imperative connections between activity and well-being in aging populations by the so-called disciplinary discourse on the management of everyday life. Like the participants in Katz study, the HMC informants were all pensioners and their somewhat advanced age perhaps increased their focus on maintaining their good health and preventing illness. However, other studies with younger participants have pointed out similar findings; for instance how the conceptual models of cause and cure are rooted in the body as an individual project in some populations (Karasz and Dempsey 2008). Thus, we side with Andersen and Whyte in arguing that for some populations, reducing potential health risks has become an imperative, where “numerical results of check-ups and home monitoring are appreciated and became central in individual processes of taking control over and responsibility for one’s health” (Andersen and Whyte 2014:266). We further suggest that such practices resonate with the proactive attentiveness towards sensations and symptoms potentially indicating (cancer) disease, encouraged by the early health care seeking discourse presented above. Although attentiveness and proactive presentation may be required to play into the health care seeking discourses on
early diagnosis, this does not always reverberate with the ways in which trouble and illness is addressed in the LWC.

**Dealing with multiplicities of trouble and disease**

One of the most striking experiences when getting to know the informants in the LWC was the immense influence which the social services had on their lives. They were, as implied by the class based description, all out of the workforce and living of social welfare benefits, and therefore dependent on the rules and regulations of the social services. The lives encountered were shaped by haphazardness, adversity and a sense of calamity, as illustrated by the case of Fanny. She had moved 26 times before she turned 18. Both her parents were alcoholics; and being the oldest of her siblings, she often had to assume responsibility by taking care of them. She left school after the ninth grade and has had a number of petty jobs ever since. Before she met her current partner, she lived in a violent relationship for a number of years, which eventually ended in great trauma and dramatic dispute over the children. All her four children have special needs, and the oldest has lived in an institution since he was six years old. For the last four years, Fanny has been a client with the social services, living off welfare benefits. She has been sent back and forth between different job trainings, but has been unable to fulfill the demands due to severe pain in her shoulder, her hand, and sometimes her arm. Fanny blames the pain on her many years of working as an erection technician, where she had to assemble minor parts with very small repetitive movements for long periods at a time. She is hoping to be allocated early retirement pension, but according to regulations the social services continuously try to find some form of job that she can manage. Every time the social services allocate her to new job trainings, the workload reinforces and brings out the pain which have now developed into paresthesia. The social services regularly encourage her to visit her GP to follow up on her diffuse and shifting pain. However, Fanny is reluctant to follow their advice; but as her pain gets worse, and realizing that increasing demands are impending, she eventually schedules an appointment with her GP. The first author accompanies Fanny to the appointment, and after waiting 30 minutes in the waiting room, Fanny is called into the consultation room.
When sitting down, the GP gives Fanny a quizzical glance and Fanny says that it is her arm which is causing her trouble again. She constantly feels a tingling sensation in it. The GP takes Fanny’s hand and puts pressure on her wrist; “can you feel this”, she asks, “is something happening now?” “It hurts and tingles”, Fanny replies, and her hand makes a few spasms. While the GP is examining her hand, Fanny says that the social services have asked if she could be referred to a neurologist. “A neurologist can’t help you with this”, says the GP, “there is a problem with the blood flow, and it may be due to overexertion, but overweight may also have something to do with it”. Fanny immediately begins to explain how they have made her wash the floor during job training sessions, but the GP cuts her off by saying that she wants to finish explaining, and she continues her elaboration about how the veins and wrist are connected, and how the blood flow can be cut off. “So it might help if you lose some weight”, the GP concludes. Fanny responds that she is already doing that, she has lost 20 kg since last year. “The rest is just a little baby fat”, she says while smiling. The GP laughs, but then suddenly stops as if realizing that Fanny was not making a joke. The GP suggests that surgery might help her, and that she can refer Fanny so that the surgeons can check the blood flow. “But it depends on how much time you have, because it could very well be that losing some weight might solve the problem”. Fanny explains that she has a meeting with the social services next week where they will consider sending her for another job training session, and she can’t stand having to go through that again. The GP concludes that she needs the referral so that the surgeon can decide on how bad it is, whether she just needs to lose some weight (Field note extract).

Fanny leaves the consultation with a referral to surgery. The GP addressed the health problem with which Fanny approached her, namely the pain in her arm, but as Fanny asks the first author later, “if this is solved then what about the rest?” Fanny’s suffering extends beyond the pain in her arm. As is the case of all the LWC informants, she has a number of other physical and social problems. For instance, she suffers from severe abdominal pain and repeated and unexplained incidences where she has stopped breathing, but these concerns never make it to the consultation room. While at this point in time, her most impending challenge is the social services’ increasing demands which overshadow most of her other problems. This very clearly reflects how social
suffering is intrinsically tied to the politics and economies of life generated by social conditions and constituted as an embodied social process in persons (Ceres 2011: 3, Kleinman, Das and Lock 1997). Living on welfare benefits in Denmark brings with it a number of demands, like attending job training. If these demands are not met, the social services may withdraw their financial support, leaving the welfare recipient with nothing. This means that the social services play a vital role in controlling and directing Fanny’s life in the sense that they have the power to demand that she tries out different jobs and performs certain activities.

If we, for the sake of the argument, consider that the pain in her arm is an embodiment of social class, it becomes clear how her employment history has instigated her injury and that unemployment and living on welfare benefits is subjecting her to the demands of the social services, demands which shape and reinforce her physical pain. Her very concrete pain is continuously inflicted by the work situations which she cannot manage, e.g. washing the floor, lifting heavy things, etc., and is a very concrete expression of her suffering. From the point of view of social suffering, her illness condition is partly influenced by the formal requirements of the welfare state. Her suffering is played out as diffuse pain, reinforced by the institutionalized requirements of welfare state policies; requirements that may indeed make more intractable the problems they seek to alleviate.

It might be argued that social suffering is a somewhat ‘dramatic’ concept to use in a Danish affluent welfare context. Nevertheless, examining health care seeking from the perspective of social suffering underscores the social adversity of the LWC informants’ situations, and highlights the very different positions from which people seek care. Simultaneously, it challenges reductionist perspectives on ‘what counts as a legitimate medical object’ in the clinical encounter, resembling what Mik-Meyer and Obling address as the classification of patients in legitimate sick roles (Mik-Meyer and Obling 2012:1026). This is clearly illustrated by Brian, who has been living on early retirement benefits for the past ten years and who has multiple somatic and psychiatric diagnoses:

“I really don’t think that if you go to see your GP, then you go there to tell her, well for instance, that you are just feeling bad. But why are you feeling bad? She has to try to understand what is going on with this person. Because it is the
person…. When you go to see your GP, then it is you as a person it is all about. (...) She asked me if I had been stressed out lately, and then I told her; no, except my mom is dying, my daughter is losing her unborn child to the social services, and I have had prostate cancer, I have high blood pressure, asthma and diabetes then no, I don’t think much is going on at the moment (field note extract).

People from the lower social classes often carry heavy and complex social histories in addition to multiple diseases, and the cases of Brian and Fanny illustrate the situations of the LWC informants in this study. As Brian explains;

“I can’t walk properly. I feel pain everywhere because I am too fat and… my knees hurt and… He (the GP) doesn’t see me as a whole person. It is just like, ok this is this and that is what he tells me. I have tried to ask him if all the different things may have something to do with each other…. If we can look at it as a whole, but no, I can have a general health check and some blood tests and then we can see… No, I don’t feel like talking to him, so I have stopped going”.

Brian and Fanny’s situations bring out the social suffering of the informants in the LWC, where the increasing demands to proactively attend to, and seek care for, potential alarm symptoms are challenged by competing concerns like unemployment, poverty, and deteriorating family relations. The ways in which they manage – or are able to manage – their health may hence be seen as expressions of social suffering. As exemplified in the example above, Fanny makes the appointment with her GP on the verge of her impending meeting with the social services where she expects further demands to be made on her working situation. Her pain is objectified as the basis of her suffering, while her other (and potentially more serious) health concerns are left unattended. And as we have just seen, Brian continuously stresses the need for the GP to approach him as “a whole person”, and tries to draw attention to his physical as well as social impediments, but when the GP tries to accommodate this by offering a general health check, Brian resigns and disassociates himself from medical care as such.
Concluding discussion

We have illustrated how health care seeking practices materialize in different social classes by drawing up exemplary cases. We found that notions of proactiveness and individual responsibility inherent in the move towards health consumerism are more successfully adopted by the HMC than by the LWC, supporting arguments raised in previous studies (Lupton 1995, Rose 2007, Shilling 2002). In linking differences in health care seeking practices to diverse social classes, we argue for differences of degrees not absoluteness of practices. Accordingly, the discursive and social conditions framing health care seeking practices are manifested in degrees of social suffering, which illustrates how bodily attentiveness and the ways in which trouble and illness are dealt with are embedded in social and cultural contexts, where social suffering and health consumerism are to some extent at odds with each other.

Cancer was introduced as an exemplifying case to challenge the assumption that raising public knowledge and awareness of potential alarm symptoms is the magic bullet that will improve early health care seeking practices and, in effect, reduce inequality in stage of cancer at the time of diagnosis (e.g. Ibfelt et al. 2012, Lyratzopoulos and Abel 2013, Quaife et al. 2014). Furthermore, the cancer case also emphasizes the complexities of current forms of medical care, where expectations of patient responsibility and bodily sensitivity are increasing, which further complicates the process of responding correctly to the expectations of the health care system. The focus on identification of alarm symptoms, as advocated by the currently dominating discourses on early health care seeking and cancer diagnosis, seems to rest on the assumption that ‘proper’ knowledge and awareness will lead to the prescribed forms of health care seeking practices. And, indeed, raising awareness may invite health care seeking practices as found in the HMC and exemplified by the cases of Esther and Charlotte. Yet, the social suffering of Brian and Fanny illustrates how solely approaching care seeking from the perspective of increasing knowledge and awareness may be tantamount to turning the blind eye to the fuzziness and ambiguity that often characterize health care seeking practices among people in disadvantaged situations – which may not have much to do with information level. By rhetorically asking how is Brian to deal with potential alarm symptoms when his whole life is falling apart or if Fanny’s indeed very specific, brief, and concrete presentation really
addresses her complicated illness situation, it becomes apparent how diffuse and ambiguous dealings with illness signs and worries do not fit with the proactivity and bodily attentiveness advocated by the early health care seeking discourse. Health care seeking is not just a matter of going to see the doctor (Andersen, Tørring and Vedsted 2014); it is both socially situated and sanctioned, embedded in the practice of everyday life, and it resonates differently with the current dominating cancer and early care seeking discourse.

The fallacy of assuming that knowledge and empowerment is the magic bullet that can improve early care seeking is also apparent in the literature on clinical anthropology. For instance, it is argued that health care seeking practices play into ‘a clinical logic’ where the established frames for legitimate health care seeking encourage specific, singular, and well-defined presentations of medical problems in the clinical encounter (Andersen, Tørring and Vedsted 2014). Likewise, Mik-Meyer and Obling (2012) draw attention to the ways in which medical truths lay out the rules for how health problems enter into the consultation. In line with these arguments, it seems plausible that behavioral requirements labelled as attentiveness, proactivity and individual responsibility, more recently camouflaged in parts of the public health literature as for instance patient empowerment and involvement (McDonald, Bryce and Graber 2014) and promoted by the increasing trends of service provision in the health care system, can be connected with the social (and class based) distinction of the ‘proper’ patient role. Aimed at enhancing patient responsibility for illness prevention and treatment (e.g. early care seeking, participation in screening, and various self-care regimes), these ‘service user’ initiatives, which have been rolled out in the health care system during the past years, promote patient centeredness; materializing as an institutionalized version of health consumerism. However, they run the risk of contrasting the social suffering of people living in social contexts and with illness trajectories similar to those of Brian and Fanny by solely focusing on the patient populations who are able and willing to be empowered, participate in decision-making, and play the leading part in managing their illness own. This leads us to venture the suggestion that health promotion discourses encouraging early health care seeking are based on assumptions that reverberate in empowerment and patient involvement strategies - assumptions which may, in fact, serve to perpetuate the very social inequalities in health which they seek to alleviate.
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PAPER III

DIFFERENT BODIES, DIFFERENT LIVES: EXPLORING THE SENSORIAL EMBODIMENT OF CLASS

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Situating the study

The understanding of symptoms as experienced and interpreted culturally and responded to socially is by no means new in medical anthropology (e.g. Good 1977; Lock 1993; Martinez-Hernaez 2000). This understanding has been developed and extended by what has been described as sensorial anthropology (Nichter 2008) or the medical anthropology of sensations (Hinton et al. 2008), which focuses explicitly on the experience and interpretation of sensations - the sensorial process. Departing from these conceptions of the sensorial process, the present paper explores how physical and social circumstances shape the meaning, interpretation and practice of the body and become fundamental for the attentiveness to and the transformation of bodily signs and sensations into symptoms. The paper is situated within the context of growing social differences in the Danish society (Olsen et al. 2012) as exemplified by social differences in cancer outcomes (Dalton et al. 2008; Ibfelt et al. 2012; Rachet et al. 2010; Lyratzopoulos et al. 2013). Hence, studies have shown a significant social gradient in stage and 1-year survival among deprived compared with affluent Danish populations (Dalton et al. 2008; Ibfelt et al. 2012), which indicates social differences in how cancer symptoms are identified and health care is sought. Knowledge of how people from different social classes engage with their bodies may accordingly further our understanding of how diverse interpretations of sensations affect how people engage with the health care system. The suggestion that economic inequality and socio-political structures produce not only health inequalities but also different bodies made by scholars writing on the anthropology of biomedicine (Fassin 2003; Lock and Nguyen 2010:109) appears more relevant than ever. Social differences in cancer stage at diagnosis, and thus in survival, are often ascribed to a lack of knowledge within the behavioural science of medicine (e.g. Ibfelt et al. 2012; Lyratzopoulos et al. 2013; Whitaker et al. 2015). In this paper, we situate our analysis of embodied experiences of sensations within the realm of the body and with reference to Lock’s concept of local biology (Lock 1993; Lock 2001; Lock and Nguyen 2010). Lock introduced the concept of local biology to illuminate the interplay between the sociocultural environments and biology, and she points out how embodied experiences of sensations are influenced by and grounded in both the biological and the social (Lock 1993, 2001: 484). Inspired by this line of thinking, we seek to add new dimensions to the dominant discourse on symptom awareness shaping public
health approaches to early cancer diagnostics by exploring how meanings and experiences of sensations are transformed into symptoms among people from what we in a descriptive sense have chosen to term the lower working class (hereafter referred to as LWC).

In light of the growing attention awarded to early disease detection as a form of disease control, as for instance exemplified in current approaches to early cancer diagnostics, it is vital to understand how people from diverse social contexts invest their bodies with meanings, and how these meanings are influenced by the “noise” that the body does or does not make. Drawing on comparative ethnographic fieldwork in different social settings, we illustrate how the physical and social strain affects the meanings and interpretations of bodies in the LWC. Hence, we understand local biologies not in an ‘evolutionary sense’, but as a way of approaching the interplay between physiological condition, social context and embodied experiences of how the body feels. We argue that the local biology is intrinsically linked with both the experience and the interpretation of embodied sensations.

Methodology – studying social class

The overall aim of the fieldwork was to develop a contextually and situated understanding of how sensations are experienced and acted upon, specifically how health care seeking was practiced in two different social classes. The paper sides with the argument made by Whyte; “by analyzing the political and economic bases of health, and by embedding health conditions in the other concerns of daily life, comparative ethnography ensures differentiation and nuance. It helps us to grasp the uneven effects of social conditions on the possibilities for the formation of health identities and subjectivities” (Whyte 2009:6).

One of the main understandings brought home by the fieldwork was the ways in which social differences manifest themselves in a variety of ways, ranging from life modes, economy, health status, management of the body and lifestyle. Twelve key informants were selected through purposeful sampling (Bernard 2011: 192-93); six came from the LWC and six from the higher middle class (HMC). The informants were a mix of men and women; some were single,
Different bodies, different lives

some cohabiting and some married; and all were above 40 years of age. The social classes were identified on the basis of property ownership. We follow recent writings on the Danish class society (Olsen et. al. 2012) in describing the two social classes identified based on education, occupational position and income, and we applied these measures in a descriptive sense to contextualise the informants’ social class positions. The informants resided in two different geographical areas, which were selected based on a combination of population composition and context analysis (Larsen 2010). The LWC informants, who we focus on in this paper, all rented their apartments which were situated in a socially deprived public housing association in an area with high unemployment rates. The buildings were monotonous, grey apartment blocks circling a parking lot in front and with green areas with playgrounds in the back. None of the informants had any formal education, some had short vocational training; and at the time of their inclusion into the study, they had all been living on welfare benefits for at least the past year. The HMC all owned a house situated in an attractive and high-status residential area where the property value was generally set above 400,000 GBP. The area was characterized by diversity; all the houses were architecturally different and had spacious gardens. They were situated somewhat secluded and fenced off from one another by either brick walls or high hedges, and the fronts of the houses were well maintained which made the area look aesthetic and pleasant. All informants were either university graduates and/or had a financial position above average.

The comparative perspective of the fieldwork brought out how different conditions of existence produce and structure different ways of being in, acting on and perceiving the social world (Bourdieu 1987). We have discussed practices of health care seeking, health promotion and illness prevention in the two social classes elsewhere (Merrild et al. in press). However, in this article, we solely elaborate on how sensations are managed and interpreted in the LWC social context. Still, it must be stressed that this understanding was brought about by continuously stepping in and out of the LWC and HMC informants’ different social and cultural worlds which empirically demonstrated how economic, social and cultural differences are produced and reproduced by the very contrast of daily lives of distinct social classes (Gullestad 1992: 5-6). Thus, the way in

Informants of this age groups were included because people aged 40 years or more have an increased risk of getting cancer and therefore also of experiencing potential cancer symptoms.
which the social inscribed itself into the body was brought home by moving back
and forth between the social classes, and it was through prolonged participant
observation – by being there, observing, feeling, sensing, learning, tasting,
listening and discussing – that the understanding of the diverse physiological and
social bodies presented here was essentially developed.

The first author of this article carried out 12 months of participant
observation. She followed all key informants regularly in their everyday lives,
participating in a wide range of everyday activities. The ethnography was
accordingly “situated less by a discrete place…than by interpersonal
relationships”, and the ‘field’ was where the key informants were (Clifford 1997:
189). Furthermore, during the fieldwork period, all 12 key informants were
interviewed three times by the first author. The first interview was a narrative life
story interview; the following two were more focused on symptom experiences
and the practice of health care seeking. In addition, the informants filled out
symptom diaries over a period of 3 months in which they recorded any
experiences of symptoms or discomforts and their management of these
experiences. The symptom diaries were used as points of departure in one of the
three interviews which explored specific symptom experiences.

The noisy body
The overall state of health of the LWC informants was poor, and they all suffered
from a number of psychiatric and somatic diseases, which confirmed the
increased incidence of disease among lower social classes in Denmark
(Diderichsen, Andersen, Manuel 2011). As a consequence, illness, pain,
discomfort and physical irregularities were part of their everyday life and were
brought into the social setting as graphic descriptions of illness experiences,
narratives of psychiatric disturbances, virulent illness episodes; and varying
forms of bodily distress due to chronic disease, among others, were often
thematised in everyday discussions and conversations. Challenges of failing
health and physical and social misfortune were displayed and dealt with socially
and as a natural part of life. For instance, one day when the first author of this
article was sitting in the community house together with a key informant,
Nichole, an elderly well-known figure in the community, Jackson, enters the
room and sits down at the table. His taint is pale, almost yellowish, and he only
has two teeth in his mouth. While he is talking, he is huffing and puffing as if he is having trouble catching his breath;

Jackson quickly takes over the conversation, and starts telling stories about his life, as he often does, and today he is talking about his previous work life as a truck driver. He used to drive in Sweden, Norway and Finland and he was on the road for more than 25 year. But he eventually had to stop because his back could not hold up anymore. He ruined his back when he was young. He was delivering grain and food stuff and later he drove for a coal company. So he was retrained as a bus driver instead, but his back couldn’t stand that either, so in the end he was just doing small trips for the grocery shops. But he doesn’t drive anymore, as his vision has become so bad. At his last trip, he had 0% vision on one eye and 16% on the other. And then his wife and kids told him to stop. We ask him how he manages now, and he tells us that he had an operation for cataract and now his vision is 70% on both eyes. Nichole and I, who are going to Nichole’s house, get up and signal that we are on our way, but Jackson continues to talk, and tell us stories from his trips to the far north. We put on our coats and Nichole says that she has to be careful not to catch a cold in this cold weather. “I am walking around with pneumonia”, Jackson says. He was helping his son in law remove some wood from their garden and he was only wearing a thin jacket and a t-shirt. “So that landed me pneumonia” (Fieldnote extract).

As reflected in this field note extract, in many ways deprivation marked the informants’ bodies; bodies which were characterised by overweight, stigmatised practices such as smoking, food preferences that did not follow the official dietary guidelines and a distinct lack of physical exercise, all of which was reinforcing their bad health. What is more, their bodies also told the stories of the strain of social class; of carrying out physically demanding jobs in the manual sector as is often the case among people from the lower social classes; and of the physical wear and tear of having lived a tough life. At the time of the study, however, they were all living off various forms of social welfare benefits. For many of them, the economic and social politics of the welfare state played a
prominent role in the organisation of their everyday lives. Many were living on the edge of mainstream society; and their social, domestic and financial situations were fraught with uncertainty and shaped by the social stress of deteriorating family relations, the challenges of being poor in an affluent society, marginalisation from the workforce, and social exclusion due to psychiatric and physical inabilities. Yet, this is not to suggest that the informants were excluded from or did not engage with the public health discourse. In fact, quite to the contrary, numerical measurements were continuously used as points of reference and brought up in social situations in order to keep track of their bodies, health and illnesses. This in many ways resembled the situation described in a recent study of elderly people in Denmark, which argues that numerical standards and measurements have become integral to the way in which people relate to their bodies (Oxlund 2012:53). In the present social setting, however, measurements were also used to emphasise the seriousness of conditions; and bodily deficits were many times used for rivalry and to impress – comparing deteriorating blood sugar levels, dwindling blood counts or other areas of bodily weakness. There was a sense of unaffectedness in how illness, bodily dysfunctions and uncomfortable sensations were treated as part of life among the informants. Their unfit bodies were sometimes ridiculed and at other times disgraced.

As argued by Lock, well-being, health and illness are in part informed by the material body, but at the same time it is socially conditioned (Lock 2001:483-84). A recent report on the overall health status in Denmark pointed out that people from lower social classes often suffer from multiple illnesses, low self-rated health and from physiological and social constraints (Larsen et al. 2014). Among the LWC, these tendencies were obvious; and what is more, ailment was many times intrinsically linked with their social situation. This potentially makes some bodies more “noisy” than others. Following Lock and Nguyen (2010), we suggest the social and physical conditions shaping the lives of the lower social classes produce ‘local biologies’. The social organisation of their daily lives in many ways resisted the conventional ideals of ‘the good life’, ideals and conventions which were incoherent with their lived experiences of everyday life. The noises were by no means restricted to their bodies; the social situations also roared – financially, personally, and professionally. In returning to the initial reflections on ‘symptom awareness’, we may thus suggest that bodily
‘awareness’ unfolds differently in different social classes – in different local biologies.

**Embodied sensations**

Increasing early cancer diagnosis is primarily approached by raising awareness and expediting recognition of potential cancer symptoms based on the assumption that this will prompt early care seeking as advocated by parts of the behavioural sciences of medicine (Lyratzopoulos et al. 2013; Walter et al. 2014; Whitaker et al. 2015). Notwithstanding the importance of knowledge of cancer symptoms, understanding interpretations and modes of managing the body is also pertinent if we are going to understand the premises of health care seeking. Thus, it has been argued that studies of when and how people seek care demands contextualisation (Andersen & Risør 2014), and that the increasing diagnostic technological advancement and specificity within the medical sciences, which allows us to look ‘inside the body’, places further demands on the sensitivity of bodies in the already complex task of seeking care with the “right tings” (Andersen et al. 2014). In many ways, the multiplicities of bodily ‘noises’ and the informants’ deteriorating physiologies seemed to defy the bodily sensitivity required in order to seek care early. The local biology of the LWC was tied to the lived experience of everyday life, and their bodily situatedness influenced their embodied experiences of physical sensations (Lock and Nguyen 2010: 90-91). In other words, the local biology shaped, enabled or constrained experiences and interpretations of bodily sensations. For instance, Nichole, who was diagnosed with breast cancer 10 years ago and who is now living on early retirement disability pension due to radiation damage, describes how she experiences and communicates bodily sensations in this way;

“Back when I was diagnosed with cancer, I also told my GP that I was SO tired. And she asked me if I got out every day, and I did, I had to. She thought that it seemed wrong if I was so dead tired, right. But I just have that drive in me, right. I just have to get out and do something, right. Even if I have to crawl on my damn knees, right. Then I just have to get out. She didn’t understand that at all, so she just thought that it was a winter depression. But it turned out to be cancer”.
Nichole had worked hard all her life until the day she was diagnosed with cancer. She started to work as a sandwich maid the day after she finished primary school; and having been raised by her single, unskilled mother in the 1960s, she was used to taking her turn in order to make ends meet. Trying to break free from her social heritage, she continuously strived to do better; and hard work and no fuss seemed to be the mantra she lived by. Even now, ten years after she stopped working and lost much of her social life with it, she still has to get out every single day. She fills her days with activities because she just cannot stay still, no matter how much her body aches.

By suggesting that sensing and reacting to bodily sensations is related with social position, we do not mean to exoticise the LWC ways of giving meaning to their bodies. Quite on the contrary, perhaps recognising these local biologies can serve to challenge the ways in which “culture” has been used to explain poor health and non-compliance with medical regimes (Lock and Nguyen 2010: 103). Among the informants, attention towards the body was primarily raised by that which seemed dramatic and intense and which did not seem to invite the bodily sensitivity encouraged by, e.g., early cancer diagnosis discourses. Perhaps the salience of the local biologies encountered in the LWC was underlined by its apparent opposition to the sensorial assumptions of early disease detection. Consider for instance the case of George, an unemployed manual worker who was recently diagnosed with COPD. He was coughing during the entire fieldwork period; and after an incidence of pneumonia, he had an x-ray of his chest, which only showed his COPD. However, his cough continues. After a few months he fills out the symptom diary, but although his cough is still there, he does not refer to it at all in his diary entries. Instead he writes about a stomach problem, muscular tensions and headaches, which are all bodily signs and sensations with which he is also familiar and from which he suffers regularly. In addition, he is diagnosed with a sleeping disorder during the period where he fills in the symptom diary to which he subsequently ascribes his constant tiredness, heart problems, depression and difficulties sleeping. The cough is filtered out, albeit not in a physical sense. It is crossed off as COPD, as George has so many other physical ailments (noises) potentially muddling his sensorial attention. This illustrates how the prerequisites for proactively attending to the body may be tied to local biologies, and it emphasises the significance of acknowledging the prerequisites for proactively preventing serious disease.
**Conclusion**

In this article, we use the concept of local biology to illustrate how staying healthy and becoming ill carry different meanings in socially deprived contexts that are at odds with those characterising the dominant health and illness discourses; meanings which are intrinsically linked with the social and physical bodies. Thus, we argue that as a means to improve early disease detection, symptom recognition and bodily awareness rest on the idea of a standardised body and does not take into account that the bodies of people from lower social classes are different in terms of physiology and social meaning. Living with numerous lifestyle and chronic diseases and mounting social strains may result in bodily ‘noise’ in the form of abundances of physical and socially informed sensations, which shape experiences and interpretations of the body, adding to the complexity of deciding with what to seek care (Andersen et al. 2014).

Truths about the body demand contextualisation, and as argued by Lock, ‘standardised’ medical interventions (in the widest sense) run the risk of overlooking the differences of local biologies (Lock 2001: 487-89, Lock and Nguyen 2010: 90-92). Attempts at influencing care seeking practices must take these differences into account and must recognise that, as we have shown, local biologies provide people from lower social classes with a point of departure for health care seeking different from that of more privileged classes. In many ways, our findings point towards what has been termed the embodiment of social inequality (Fassin 2003), which refers to the ways in which biological facts become social facts and vice versa, and how embodied experiences are situated in the social world. The tenet that what may appear as no or a ‘delayed’ reaction to bodily signs and sensations is due to lack of knowledge and awareness rests on clinically informed assumptions of symptom recognition (Hay 2008:198-200).

Our findings show that bodies are situated in their local entanglements of physiology and social context, and that the meanings of sensations are tied to the physical and social circumstances. Sensations, we argue, may thus be conditioned by the historical, material and social structures framing people’s lives; here exemplified by the lived experiences of being an unemployed manual labourer or an early disability retiree living off welfare benefits. These findings invite the conclusion that culturalism which within anthropology refers to culture, (lack of) knowledge or beliefs being used as explanations for non-compliance with medical advice (Fassin 2001; Good 1994; Lock and Nguyen
2010), directs attention away from what may be at stake when local biologies are played out in the realm of the sensorial. We suggest that in order to understand care seeking practices in lower social classes, it is necessary to recognise that bodies differ and that the embodied experiences of sensations perhaps sometimes drown in abundances of bodily ‘noise’.

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CHAPTER 5:
CONCLUDING DISCUSSION
In this final chapter, I will discuss the overall conclusions of the thesis; and in line with my intention of offering an anthropological perspective on social differences in care seeking, this final discussion will focus on the practical implications of the points raised in the articles. Therefore it is less a theoretical discussion than an attempt to raise a series of discussions on how we may understand and deal with the challenges of early care seeking and social differences in cancer survival.

The overall aim of this thesis is to contribute to our understanding of health care seeking practices as they unfold in two different social classes in Denmark and contribute to the discussion of social differences in cancer survival. I have approached this ambition by focusing on contexts and by grounding health care seeking in different social lives, in bodies that differ and in diverse social settings in the Danish welfare state. My focus on situatedness and context is twofold. First and foremost I centre on the different social conditions in which my informants live and illustrate the situatedness of their practices of health, illness and bodies. However, I also consider dominant approaches to health promotion and illness prevention as a discursive and socio-political context requiring people from different social classes to competently navigate in an increasingly complex reality of technological advancements characterised by improved precision and detailed knowledge of the body through blood tests, scans and biopsies (Keating and Cambrosio 2012). These medical improvements and their increasing abilities to look into the body and discover serious disease at still earlier stages, at the same time raise the public’s expectations to the health care system, as well as reinforce proactive early health care seeking discourses.

By situating the management of the body and health care seeking practices within these two different kinds of contexts, it is shown how people from different social classes attend to their bodies and engage with dominant health promotion and illness prevention discourses from different points of departure. Accordingly, the analytical inferences presented in this thesis complement existing knowledge of the very diverse groundings of care seeking practices, by adding to our understanding of how people relate to the health care system and manage health and illness in everyday life in diverse social settings.
I raise three key points, one emerging from each article, and discuss their contribution to how we may improve our understanding of early health care seeking and social differences in cancer survival.

- Health promotion, illness prevention and awareness campaigns are appropriated differently in the context of social classes, and the messages do not always resonate with the lived experiences/realities in lower social classes. Maintaining standardised forms of health promotion and illness prevention potentially reinforces the very social differences in health and illness which they seek to alleviate.

- Health care seeking practices are shaped by diverse social contexts. The diffuse and complex forms of social suffering of lower social classes are difficult to accommodate in the Danish health care system; current early care seeking, empowerment and patient involvement strategies are based on assumptions that do not always apply to the lived realities of lower social classes.

- People have different points of departure for attending to and acting on bodily signs and sensations, and bodies cannot be viewed solely from a universal, biomedically informed perspective. Rather bodies must be understood as embedded into the physical and social circumstances that surround them, which can make experiences of sensations fundamentally different.

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**DIFFERENCES OF APPROPRIATION**

The suggestion that public health behaviour change approaches are less effective in populations with unfavourable social and economic conditions has been made by others before (Baum & Fisher 2014; Blaxter et al. 1982; Briggs 2003). What I would like to add to this understanding is a perspective on why this may be so by identifying the diverse ways in which messages of health promotion and illness prevention are given meaning in different social classes in Denmark. Looking closely at these differences of appropriation highlights how standardised health promotion and illness prevention creates ‘normality’ and frames the ‘right’ health behaviour. Using the example of smoking, in Article 1 of this thesis, *Resisting reason. A comparative anthropological study of social differences and resistance towards health promotion and illness prevention in Denmark*, we illustrated how the seemingly simple message of ‘stop smoking’ was interpreted by Brian and
the other LWC smokers. During the period of fieldwork, almost all smokers in the LWC neighbourhood switched from ordinary cigarettes to electronic cigarettes. Among the LWC informants this behavioural change was socially perceived and communicated as having quit smoking, but when Brian presented his electronic cigarette during a course he attended at a local patient school, it was rejected and denounced by the health professional who was teaching lifestyle changes. Brian never attended the patient school again after that experience. Despite the fact that he and the others intended this ‘behaviour change’ as a way of improving health and preventing illness, in this case their practices were deemed ‘wrong’ from the perspective of the established health care system. Brian continued smoking his electronic cigarette as did the other smokers in the LWC neighbourhood; and recounting his experience to his fellow smokers somehow further distanced Brian from the established health care system. I use this example to illustrate how the health promotion messages and principles are appropriated differently in the different social settings. Although we found that people engaged in their own forms of health promotion and illness prevention, these practices at times came across as everyday forms of resistance (Scott 1985) when they did not fit into the established ‘truths’ of medical science.

Viewing different forms of health and illness-related practices as forms of resistance illustrate how they are closely intertwined with and, in fact, emanate from the power at which they are directed; in this case, the health care system and the health promotion and illness prevention discourse. The ubiquitous position of these discourses is traceable in how people from different social classes actively engage in health promotion and illness prevention in their own and distinct ways, which leaves little room for the divergent ways of applying the messages, transforming them, and trying to adapt them so that they make sense in their everyday lives. Recognising how these practices are actively carried out at ‘ground level’ may help us understand what initially appears as misconceptions may in fact be subjective attempts to improve health and deal with illness.

I want to discuss primarily two aspects of the implications this may have. Firstly, I suggest that notions of ‘harm reduction’ could be applied with advantage. Harm reduction has primarily been used in the area of drug use and HIV. It is considered an approach or strategy rather than a goal in itself, the overall aim of reducing the negative consequences of a given harmful practice (Hilton et al. 2001). In terms of health promotion and illness prevention, this means that focus
is directed towards the practicalities and conditions of people’s lives; and it is acknowledged that although not all people conform to the standardised messages of not smoking, seeking early and appropriate care, exercising and eating healthy, most people still want to stay healthy and prevent illness; and many times do what they can to achieve this. Perhaps it would prove beneficial to build on these intentions. Such an approach is similar with what in the global health and development literature is known as a bottom-up approach (Chambers 1983; 1997). Building on the notions of harm reduction may make it easier to appropriate the health promotion and illness preventive messages to the ‘real lives’ of people living in other socioeconomic worlds than that of opinion makers, health promoters and health professionals of the higher middleclass (Grøn 2004). As argued by Baum and Fisher, the institutionalisation of individualism, biomedicine and behavioural views of health and illness helps “to maintain a form of social silence around the alternative views of health that challenge the normality of everyday social, economic and cultural inequalities” (Baum and Fisher 2014:218). Too rigid standards of proper health behaviour result in the establishment of ‘delayers’ or non-compliers or other ‘patient problems’, who do not fit into the public health ‘normality’ which imposes the standards of ‘proper’ health and illness behaviour. Of course, this is not to suggest that aspirations towards achieving good and healthy lives should be less; rather, it is suggested that the inherent devaluation of those lives that do not conform to the health promotion ideal could be avoided. It is not enough to alter the form and differentiate information campaigns or knowledge interventions. What is needed is, in fact, to adjust the contents of the messages conveyed so that they speak into different realities.

Secondly, by looking at the forms of resistance towards health promotion, the imperative structures of right and wrong health behaviour become clear, bringing forth issues of othering and exclusion. This leads me to point out how, returning to the case of cancer, the increasing technological development within biomedicine means that early disease detection is shaped by specificity and rapidity, which cannot be directly transferred onto care seeking practices. As we have seen in the empirical examples presented in this thesis, people living disadvantaged and difficult lives, in particular, have trouble following these advancements, as they are too far removed from, and consequently have little resonance, in their everyday lives. It may be necessary to recognise and accept that some aspects of social differences, for instance those which influence the
distribution of health, income and social differentiation, are beyond the realm of health promotion and illness prevention as they relate with the very social and economic structure of society, even if they do find strong expressions in the area of health and illness. By no means do I suggest resorting to mere relativism. Rather, to be careful not to define those lives that cannot conform to the recommended health and illness practices as ‘wrong’, as we will thereby run the risk of further alienation and of perpetuating the social differences in health and illness that we seek to alleviate. If we focus on what people are actually doing to improve their own health and prevent illness, we may be able to relate with these locally informed practices, and in doing so find common grounds on which to stand in the pursuit of reducing social differences in health and illness.

ASSUMPTIONS OF LIVED REALITIES

In Article 2 of this thesis, *Health care seeking contextualized; Social class, social suffering and health consumerism*, we looked into how health care seeking is practiced in different social classes in a socio-political context which we described as being shaped by current trends of health consumerism and where health care systems increasingly offer health care according to service provider-oriented principles. We pointed out how notions of proactivity and individual responsibility for maintaining good health and preventing illness, implicit in the move towards health consumerism, were more successfully adopted by the HMC than by the LWC. This was reflected in the way the informants appropriated public health messages and in their health care seeking practices. The lives of the LWC were often shaped by social suffering, which was reflected in their health care seeking practices. We illustrated how proactivity and the pursuit of ‘good health’ may be subordinate to other and more pressing socially informed concerns intrinsically linked with the social situation. This is not to say that daily challenges and concerns are restricted to the lower social classes, but merely to suggest that the current organisation of the health care system in many ways feeds into the consumerist ethos by encouraging service user approaches. Examples of this may be measuring patient satisfaction, offering free hospital choices or ratings of services provided. Perhaps even more important in this context are recent empowerment and patient involvement strategies, which are currently being advocated as the magic bullet that will enhance patient
proactivity and solve many of what is sometimes referred to as ‘patient problems’. Patient empowerment and involvement centre on involving the patient, for instance by encouraging proactive approaches to existing illness in the sense of asking questions and actively participating in deciding how to manage one’s own condition; all with the intent of improving quality and safety of treatment and prevention (McDonald et al. 2013).

In line with others, this thesis suggest, however, that the increased focus on proactivity and individual responsibility reflected in current forms public health discourses unfolding in the context of the Danish welfare state (and other neoliberal societies) can be associated with the ‘proper’ patient role (Lupton 1995; Rose 2007; Shilling 2002), where the everyday concerns and social, economic and personal strains are filtered out. And this focus partly rests on assumptions of why and with what people seek care. ‘Bringing the patent in’ requires a proactive approach to health care seeking which appears disengaged from the everyday lives of the people from lower social classes like the informants participating in this study. What is more, the omnipresent imperative of timeliness shaping the early care seeking discourse not only targets the contents of health care seeking, but also its timing. As our empirical examples of for instance Fanny and Brian have demonstrated, health care seeking is sought when problems are impending and when functionality is impaired. However, one of my other LWC informants, Ingrid, who was as proactive as any, read books on the body, followed up-to-the-minute health promotion and illness prevention trends, albeit not necessarily the official ones, and knew about all kinds of beneficial practices that could be used to improve her health and wellbeing. Ingrid is a pensioner, and although struggling with failing health, strained family relations and perhaps a somewhat tight economy, she reacts to bodily sensations; and during the fieldwork, she visits her GP at least ten times. When I accompanied Ingrid to her GP, she brought her little yellow slip with her list of problems, because “this time she (the GP) is not going to get away with not dealing with all the things”, she would tell me. But during the consultation, Ingrid’s list is reduced to the issue at hand. Still, Ingrid is persistent, so she schedules a new appointment, and another and another, but her list continues to be full. I included this example in order to illustrate that traces of proactivity were present although most care seeking practices I encountered in the LWC did not invite proactivity and self-managed care, and were embedded in the
organisation of the Danish welfare system and the daily struggles of life at the lower end of society.

One of Ingrid’s visits to her GP was scheduled because she felt bloated and experienced recurrent heartburns. She first noticed these bodily sensations 2 years ago; and when I meet her, she decided that now it is time to have her stomach examined. But why now? It was not getting worse, nor was she feeling more bloated than usual. Ingrid was very happy with her GP, and she went back again and again, always with a new concern. Brian had stopped going, unless he did not have an alternative, and Fanny primarily went when the rules and regulations of the Danish welfare state forced her to go. But common for all of the LWC informants was that their care seeking was often shaped by fortuitousness, and they went because they had nowhere else to go. Often the LWC informants complained that the GP did not attend to the totality of their situation; however, these complaints were never voiced by the HMC. And although lists were indeed also made here, their concerns (or the ways in which they represented their concerns) were tailored to the health care system and thereby adjusted to the clinical reality as has been described by others (Andersen & Vedsted 2015). The consumerist approach to care seeking was directed at getting a concrete problem solved, and care seeking was accommodated by the service offered by the health care system, such as, for instance, the services provided by recently introduced initiatives of the so-called yes-no clinics.

Although the inferences made by Childe (1906) referred to in the introduction took place more than a century ago, the assumptions of people “harbouring” their cancer symptoms still reverberate in current approaches to early detection and explanations of social differences in stage of cancer at the time of diagnosis and survival. However, in lives that are faced with impending economic ruin, family relations on the brink of collapse and daily bodily pain or annoyances serving as reminders of failing physical conditions, proactivity most often does not reverberate with the way in which health care seeking is sought. This indicates that when experiences of social suffering lead to health care seeking, the system often falls short. The Danish health care system is not organised to accommodate care seeking shaped by social suffering, and this creates a misfit between the intentions and needs of people from lower social classes and that of the health care system encouraging early care seeking.
Parallel lives.

THE MEANINGS AND SIGNIFICANCES OF SYMPTOMS

The final point that I make relates to the ambiguous meanings of the realist scientific category ‘alarm symptoms of cancer’ (Andersen et al. 2009; 2014). As exemplified in the cases of Tim and George introduced at the beginning of this thesis, both were experiencing what could potentially be an ‘alarm symptom of cancer’ – but their symptoms could also be just symptoms of a common cold or their well-known COPD – which demonstrates the semantic instability of embodied sensations and the challenge of identifying when or if sensations may be signs of potentially serious illness. In Article 3 of this thesis, Different bodies different lives; Exploring the sensorial embodiment of class, we directed our attention solely towards the LWC as we narrowed in on the body. We described how living with numerous lifestyle and chronic diseases and with psychiatric and social challenges brings with it variety of bodily ‘noise’ in the form of an abundance of physical and socially informed sensations. Bodies differ in terms of disease burden and social strains, and if embodied experiences of sensations are influenced by and grounded in both the biological and the social, as argued by Margaret Lock (Lock 1993, 2001: 484), it is vital to recognise that the bodies of the lower social classes may make more noise than less socially and physically strained bodies. Taking the concept of local biology as our point of departure, we analysed the local meanings of the body, which led us to argue that increasing symptom recognition and bodily awareness as a means to improve early disease detection ignores that people from lower social classes may have different physiologically and socially informed bodies, which shapes their experiences and interpretations of bodily sensations. The deteriorating social and physical situations in which the LWC informants found themselves were complicated by the abundance of physical and social sensations with which they constantly had to deal that could absorb potentially dangerous bodily signs and sensations.

Again, we are reminded of the importance of acknowledging the different points of departure that people have for attending to and acting on bodily signs and sensations. Although health promotion and illness prevention campaigns are designed to promote the health and quality of life of both individuals and specific populations, they overlook the fact that bodies differ both in terms of social and biological status (Lock and Nguyen 2010: 89). Thus, we argue that perceptions and interpretations of bodily sensations depend on the local biology, which makes these interpretations fundamentally different. This, for one thing,
emphasises the importance of attending to issues of multi-morbidity and what this means in terms of early cancer diagnosis. In addition, the social and economic strains on working class bodies may also affect the ways in which the body feels; and highlighting these differences may also help nuance the ways of approaching and conceiving how symptoms are established. Embodied experiences are situated in diverse social worlds and thereby conditioned by the social, economic and political structures framing people's lives (Scheper-Hughes and Lock 1987). The increasing complexity of deciding with what to seek care, which is growing within the context of the technological advancement and increasing specificity of the medical field (Andersen et al. 2014), adds to the challenges of living with ‘noisy bodies’. Thus, people from lower social classes face an even more complicated task of sorting through bodily sensations and filtering out the ‘noise’, which makes bodily attentiveness and sensitivity difficult to accomplish.

SUMMING UP

Studies from the behavioural science of medicine have brought social differences in health to the fore by measuring and categorising social diversities using socioeconomic variables such as economy, education or employment status. In Denmark where ideologies of homogeneity and ‘imagined sameness’ prevail, such studies have brought out social differences which are difficult to recognise and acknowledge in other areas of social life, but they become clear when presented as diversities in morbidity or mortality. The findings presented here build on this knowledge, and it directs attention to the lived experiences of social differences, experiences which are grounded in the socio-political organisation of the Danish society. By illuminating various ways in which class is lived in the context of increasing demands of bodily awareness and proactivity in early cancer detection, I have explored how health care seeking is practiced and how embodied experiences of sensations are played out in everyday life. I hope that the findings will inspire practitioners and policymakers of health promotion to acknowledge the situatedness of health, illness and the body – also if this means bending its ‘truths’.
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Parallel lives.


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Parallel lives.


Social differences in health are well-documented in Denmark like in most of the western world. People with little or no education, low income or living alone are more likely to get a serious or chronic disease, and they are more likely to die from it. Most serious diseases have the best prognosis if they are discovered and managed at an early stage. Accordingly, we have seen a shift in orientation towards early disease detection within health promotion and disease prevention. This is also the case in cancer prevention, where early diagnosis as a means to improve prognosis and lessen treatment interventions is prioritized. Within epidemiological research, it has been suggested that social differences in cancer survival rates may be due to differences in the timing of diagnosis, as people from lower social classes are diagnosed with more progressed disease; indicating differences in symptom management and/or health care seeking practices. However, most studies have been conducted retrospectively with people who have already been diagnosed with cancer, and we only have sparse knowledge on how symptom management and health care seeking practices are locally grounded in the practice of everyday life of different social classes in a Danish context.

The overall aim of this thesis is to explore how health care seeking is practiced in the everyday lives of two different social classes in Denmark. The thesis focuses on different, but interconnected stages of the management of symptoms and health care seeking; from the influence of dominant health promotion discourses to the diversity of meanings of symptoms and health care seeking.

The thesis is based on 12 months of ethnographic fieldwork involving the methods of participant observation, semi-structured interviews and diaries. Twelve key informants from two different social classes were followed; social classes which in a descriptive sense are termed the higher middle class and the
lower working class. The aim of the fieldwork was to gain an understanding of the practice of health and illness as embedded in everyday life.

The results are presented in three articles forming the core of the thesis covering the following areas.

**Article 1. Resisting reason. A comparative anthropological study of social differences and resistance towards health promotion and illness prevention in Denmark.** Accepted for publication by Medical Anthropology Quarterly

This article suggests that the concepts of resistance and formation of health subjectivities may serve as helpful tools to develop our understanding of how dominant health discourses are appropriated by different social classes and transformed into different practices of promoting health and preventing illness. We bring forth how health and illness practices both overtly and subtly challenge the normative power of the health promotion discourse. These diverse and ambiguous forms of everyday resistance illustrate how and when situated concerns move social actors to subjectively appropriate or reject health promotion messages. Overall, these different forms of resistance elucidate how the standardized awareness and education campaigns do not always serve to alleviate the social inequalities they try to diminish.

**Article 2 Health care seeking contextualized: social class, social suffering and health consumerism.** Accepted for publication by Medical Anthropology

This article shows how the higher middle class practices health care seeking resembling notions of ‘health consumerism’ and, conversely, that health care seeking practices in the lower working class are shaped by the adverse social conditions and informed by experiences of social suffering. We illustrate how these different health care seeking practices correspond diversely with current forms of medical thinking, materialized in pro-active discourses of early diagnosis and in the organization of the Danish health care system. In conclusion, we argue that health promotion discourses encouraging early health care seeking are based on assumptions that reverberate in empowerment and patient
involvement strategies - assumptions which may, in fact, serve to perpetuate the social inequalities in health.

**Article 3. Noisy lives, noisy bodies: Exploring the sensorial embodiment of class.**
Under review by Anthropology in Action, special issue on sensations and symptoms (May 2015)

Departing in the concept of local biology, we point out how the embodied experience of sensations is influenced by and grounded in the interplay between the biological and the social. We illustrate how discomfort, distress and multiple social concerns are part of life in the lower working class, and that this influences the perception and experience of the body. Thus, by analysing the interplay between physiology, social context, and embodied experiences of how the body feels, we argue that the bodily ‘noise’, often experienced by people in the lower social classes, is intrinsically linked with both the experience and interpretation of embodied sensations, which potentially influence the ways in which health care seeking is practiced.
DANSK RESUME


Studiet er baseret på et 12 måneder langt feltarbejde, der blev udført blandt to forskellige sociale klasser, som vi i afhandlingen beskriver som lavere arbejderklasse og højere middelklasse. Feltarbejdet bestod af deltagerobservation og gentagne interviews med 12 nøgleinformeranter, der blev fulgt i deres hverdagsliv. Informanterne udfyldte også symptomdagbøger i en periode på 3 måneder, hvori de noterede eventuelle ubehagelige kropslige tegn og fornemmelser, og hvordan de havde håndteret disse.

Resultaterne er beskrevet i 3 artikler:
Article 1  
*Resisting reason. A comparative anthropological study of social differences and resistance towards health promotion and illness prevention in Denmark.* Medical Anthropology Quarterly (In press)

I denne artikel undersøger vi, hvordan forskellige sundhedsfremme- og forebyggelsespraksisser bringes i spil i forskellige sociale klasser. Ved at undersøge, hvordan disse forskellige praksisser yder ‘modstand’ mod den normative sundhedsfremme- og forebyggelsesdiskurs, viser vi, hvordan den standardiserede tilgang til informationskampagner negligerer alternative måder, hvorpå sundhedsfremme og forebyggelse integreres forskelligt i det levede liv.

Sundhedsfremme- og forebyggelesdiskurser resonerer forskelligt i forskellige sociale kontekster, og ved at fastholde den ensrettede måde at praktisere sundhedsfremme og forebyggelse på, risikerer man at forstærke de sociale forskelle i sundhed og sygdom, som man sigter mod at begrænse.

Article 2  
*Health care seeking contextualized: Social class, social suffering and health consumerism.* Medical Anthropology (In press)

Inden for samfundsvidenskaben har flere studier peget på, at sundhedsydelser i stigende grad opfattes som forbrugsgoder, hvilket har givet anledning til, hvad man i sociologien har beskrevet som sundhedsforbrugerisme. Dette reflekteres blandt andet i den måde, hvorpå sundhedsvæsnet beskriver og markedsfører sine tilbud og stiller krav til patienterne om at være proaktive og ansvarlige for at opdage egen potentil sygdom. I denne artikel viser, vi hvordan informanterne i den højere middelklasse praktiserer lægesøgning ud fra de principper, som kendes fra forbrugerisme, hvorimod lægesøgning blandt informanterne fra den lavere arbejderklasse er formet af sociale udfordringer som for eksempel fattigdom, flere samtidige sygdomme, stadig stigende krav fra velfærdsstaten og social og/eller familier misstrivsel. Vi illustrerer, hvordan den proaktive sundhedsdiskurs med fokus på tidlig diagnostik resonerer forskelligt i de to sociale kontekster, som vi har undersøgt, og vi argumenterer for, at det øgede fokus på tidlig lægesøgning, er baseret på antagelser om, hvordan og hvornår man søger læge, som ikke altid giver mening i den lavere arbejderklasse.

Article 3.  
*Noisy lives, noisy bodies: Exploring the sensorial embodiment of class.* Anthropology in Action, special issue on sensations and symptoms (i review)
APPENDIX I

WRITTEN INFORMATION LWC
Invitation til at deltage i forskningsprojektet
”Hvornår er man rask eller syg? Hvornår søger man behandling?”

Formålet med projektet


Hvorfor vil jeg gerne tale med dig?

Jeg er interesseret i at tale med alle mulige forskellige mennesker, både kvinder og mænd, hvad enten du er i arbejde eller ikke er i arbejde. Eneste krav er at du skal bo i lejerbolig og være over 40 år gammel.

 Hvad vil jeg gerne snakke med dig om?

Jeg vil gerne starte med at snakke med dig om, hvad du gør, når du oplever tegn på, at du måske er syg. Jeg vil gerne besøge dig ca. 6 gange fordelt over et år, og det er fuldstændigt op til dig at bestemme, hvor og hvornår vi mødes. Dog er det vigtigt for forskningsprojektet, at jeg får lov at følge med dig til læge eller andre former for behandling, hvis du skulle have brug for dette.

Hvad kan vi bruge resultaterne fra projektet til?

Projektet skal hjælpe os med at få bedre viden om, hvad folk forbinder med sygdom, og hvad de gør, hvis de oplever symptomer eller føler sig syge. Vi vil bruge denne viden i arbejdet med at tilrette sundhedsvæsnets indsatser, således at disse bliver målrettet almindelige menneskers behov og interesser.

Jeg vil ringe til dig i løbet af de næste par dage for at fortælle dig mere om projektet, før du beslutter dig for, om du vil deltage.

Med venlig hilsen

Camilla H. Merrild
Antropolog
Forskningsenheden for Almen Praksis, Aarhus Universitet
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APPENDIX II

WRITTEN INFORMATION HMC
Invitation til at deltage i forskningsprojektet
”Hvornår er man rask eller syg? Hvornår søger man behandling?”

Formålet med projektet


Hvorfor vil jeg gerne tale med dig?

Jeg er interesseret i at tale med både kvinder og mænd, hvad enten du er på og eller udenfor arbejdsmarkedet. Eneste krav er, at du skal bo i en ejerbolig og være over 40 år gammel.

 Hvad vil jeg gerne snakke med dig om?

Jeg vil gerne starte med at interviewe dig om, hvad du forbindes med forskellen på at være rask eller syg, og hvad du gør, når du oplever tegn på, at du måske er syg. Derudover er jeg interesseret i at følge dig i nogle af dine daglige gøremål. Du skal ikke sætte ekstra tid af til mig, jeg vil bare gerne deltage i nogle af de ting, du laver i din dagligdag.

Jeg vil gerne besøge dig ca. 6 gange fordelt over et år. Det er fuldstændig op til dig at bestemme, hvor og hvornår vi mødes, og hvad jeg må deltage i. Dog er det vigtigt for forskningsprojektet, at jeg får lov at følge med dig til læge eller andre former for behandling, hvis du skulle have brug for dette.

 Hvad kan vi bruge resultaterne fra projektet til?

Projektet skal hjælpe os med at tilrette sundhedsvæsnets indsatser, således at disse bliver målrettet mod så mange forskellige almindelige menneskers behov og interesser som muligt.

Jeg vil ringe til dig i løbet af de næste par dage for at fortælle dig mere om projektet, før du beslutter dig for, om du vil deltage.

Med venlig hilsen

Camilla H. Merrild
Antropolog
Forskningsenheden for Almen Praksis, Aarhus Universitet
Mobil tlf. 40877657
APPENDIX III

INFORMED CONSENT
Tilladelse til at bruge mine oplysninger i forskningsprojektet.

Jeg giver hermed tilladelse til, at den information som videregives i interviews, samtaler og dagbogsregistreringer må bruges i forbindelse med forskningsprojektet ”Hvornår er man rask eller syg? Hvornår søger man behandling?”.

Jeg er bekendt med at mine personlige oplysninger anonymiseres, og at mit navn, cpr. nr. og identifikationsoplysninger ikke videregives, men kun kendes af projektansvarlig Camilla Hoffmann Merrild.

Navn:

Underskrift:

Dato:
APPENDIX IV

INTERVIEW GUIDE 1
INTERVIEW 1

- Introducere projektet

Navn, location osv. hvad vil jeg spørge om, er de ok jeg optager?

- Start med at fortælle om dig selv - åbent, hvad der falder ind (personlig information)
  - Hvor er du født, alder, søskende
  - Uddannelse, job situation
  - Familie relationer, gift eller ikke, børn etc.
  - Socialt netværk og støtte
  - Boligforhold (hvor længe har du boet her, hvor boede du før, deltager du i aktiviteter i nærmiljøet….)
  - Fritidsinteresser

  o Sygdomshistorie – har du nogensinde været alvorligt syg?
  o Fortæl om dit helbred? Families helbred?
  o Er sundhed og sygdom noget du tænker over? Hvem taler du med det om?

- Hvor tit går du til læge sådan ca.?
- Har du den samme læge hver gang du kommer? Hvem er din praktiserende læge?

- Hvad laver du i løbet af en dag – må jeg gå med på den tur du går/løber normalt, gå med på næste tur i Golfklubben, når du skal ned at vaske næste gang etc…….

- Afrunding
  - tjek har jeg været omkring det hele, hvordan har interviewet være (som forventet eller?)
  - har du noget at tilføje…….
APPENDIX V

INTERVIEW GUIDE 2
INTERVIEW 2
Dette interview skal komme rundt om situationerne omkring lægesøgning eller symptomoplevelser, med udgangspunkt optegnelserne i dagbogen

Hvordan har det været at skrive i dagbogen?

Tema:
- Situationer omkring symptomer og lægesøgning (hvornår går man til læge og hvad er et symptom?)
- Kategorier (hvordan opstår et symptom? Hvad er behandling? Hvor finder man behandling)
- Praksis (hvordan træffes sygdomsrelaterede beslutninger? - hvad gør du rent konkret for at søge hjælp når du har det skidt? ((detaljerede beskrivelser))

Gennemgå symptomerne og reaktionerne på dem, som noteret i symptomdagbogen:

Hvor var du henne da du oplevede symptomerne, hvad var der sket inden -> optakten, situationen omkring det at du fik det dårligt……

Tag fat i; hvad troede du der kunne være galt……

Hvorfor valgte du / eller ikke læge-/søgte behandling, hvordan gjorde du, hvad var der sket før, Var der andre muligheder end at søge læge/behandling? -> optakten, situationen omkring det.…

Hvem talte du med? Hvad talte i om? Hvorfor talte du med vedkommende?

Hvad har du dit medicinskab?


Synes du at du bruger mange penge på medicin eller på at holde dig rask?
- Gør du noget for ikke at blive syg (HVAD, HVORFOR/IKKE)?
APPENDIX VI

INTERVIEW GUIDE 3
INTERVIEW 3

Tema: Sundhed og social ulighed (diskurs)

How do existing health and illness related discourses (e.g. lay narratives and biomedical risk information) influence and shape embodied experiences in different social groups?

(Videns/information)
- Kan du komme på eksempler på råd du kender om det at leve sundt fra?
(eks./cases fra informations kampagner e.g. 6 om dagen, motion 30 minutter etc.)
- Kan du komme på eksempler på hvordan du lever sundt? (EX fra din hverdag, ting du gør som er sunde----)
- Hvad er sundhed for dig (hvad betyder det: kost, motion, mental sundhed eller?)?
- Hvor får du din viden om sygdomme fra?
- Hvad gør du hvis du oplever tegn på sygdom?
- Hvem har du tillid til når det gælder information omkring sundhed og sygdom?
(cases fra for eks. sundhedsstyrelsens kræft kampagne - kender du den/har du set den før, hvad tænker du om den, er den relevant, hvorfor / ikke?)

(Referer tilbage til det første interview og snakken om helbred)

Cancer som case
- Hvad tænker du på når du hører om kræft (hvad er det for en sygdom)?
- Hvad tænker du om risikoen for at få kræft?
- Er det noget der kan behandles, hvordan, hvor etc.?
- Hvilke symptomer forbinder du med kræft?
- Hvor har du din viden om disse symptomer fra?
- Er det noget du tænker over når du bliver syg (kan det være kræft)?
o Hvis du fik nogle af de symptomer du nævner, hvad ville du så gøre? (nævn kræft symptomer hvis de ikke selv kan)

o Er kræft noget der fylder (privat, i debatten, i samfundet)?

o Kender du nogen der har fået kræft? Hvordan har du oplevet forløbet? (fortællinger om kræft, hvordan snakker man om det)?

(hvad tænker du om kræft, om tror du det kan behandles, hvad du ville gøre hvis…. hvad er tænker tegn på sygdom… hvor ville du hente information, hvem de ville tale med etc. - informationer om 'viden', 'literacy' etc.?)

• Social ulighed? Sociale forskelle – har du oplevet det? hvordan kommer det til udtryk?

Tag udgangspunkt i kræftområdet, og i statistikker omkring ulighed og dødelighed, ”i DK er det sådan at man er i større risiko for at få kræft og dø af den hvis man har en lavere uddannelse eller indtægt”.

(kom tæt på de narrativer som eksisterer omkring kræft)

Udklip fra medierne;

"Regeringen sætter ind mod alkohol og smøger. Regeringen sætter i sit sundhedsudspil ind mod danskernes ulighed på sundhedsområdet, hvor rige lever længst” (DR 02.05.13)

• Oplever du social ulighed i DK (både socialt og i sundhed)? I din hverdag? Hvordan?)

• Er du tilfreds med dit helbred? Eller er der noget du gerne vil ændre ift. den måde du lever dit liv på?

• Hvad er et godt liv for dig (det gode liv og helbred)? Lever du sådan (hvorfor/ikke)?
APPENDIX VII

SYMPTOM DAGBOG
Symptomdagbog for

Navn: .................................................................................

CPR. nr ..................................................................................

Forskningsprojektet

"Hvornår er man rask eller syg? Hvornår søger man behandling?"
Om symptomdagbogen:

- Formålet med dagbogen er at finde ud af hvilke symptomer du oplever i din dagligdag.

- Det er meningen at du skriver i dagbogen hver 14. dag i 3 måneder. Jeg sender en sms til dig for at minde dig om det.

- Jeg vil gerne have at du skriver **alle** de ting du mærker i din krop, som du ikke finder normale, samt hvad du tænker om dem, og hvad du har gjort ved det.

- Hvis du har oplevet flere symptomer, fornemmelser eller ubehageligheder, må du meget gerne skrive dem én ad gangen, dvs. én i hver kasse.

- Det er frivilligt om du vil skrive dit cpr. nr. på.

- Hvis du har nogle spørgsmål til dagbogen, eller til de ting jeg gerne vil have at du skriver i den, er du selvfølgelig meget velkommen til at ringe eller skrive til mig.

På forhånd tak for hjælpen

Camilla Hoffmann Merrild

Forskningsenheden for Almen Praksis, Aarhus Universitet
Tlf.; 40 877657
E-mail; Camilla.merrild@alm.au.dk
Dato.

Har du oplevet nogle symptomer eller ubehagelige fornemmelser i løbet af de sidste 14 dage?  
Ja / nej

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Hvad tænkte du, at det kunne være der var galt?

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Hvad gjorde du ved det?

- [ ] Ikke noget
- [ ] Ringede til min praktiserende læge
- [ ] Besøgte min praktiserende læge
- [ ] Bestilte tid hos min praktiserende læge
- [ ] Snakkede med min familie/mine venner om det

Hvem:                                                                                       

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- [ ] Søgte andre former for behandling (for eksempel fysioterapi, akupunktur, healing eller andet)

Hvilke:                                                                                       

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