‘The Good Citizen’
Balancing Moral Possibilities in Everyday Life between Sensation, Symptom and Healthcare Seeking

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ABSTRACT: This article explores how healthcare-seeking practices and the transformation of bodily sensations into symptoms are embedded in what we term a ‘moral sensescape’ of everyday life. Based on fieldwork in a suburban middle-class neighbourhood in Denmark, we discuss how a moral relation between the Danish welfare state and the middle-class population is embodied in a responsibility for individual health. Overall, we identify a striving to be a ‘good citizen’; this entails conflicting moral possibilities in relation to experiencing, interpreting and acting on bodily sensations. We examine how people meet the conflicting moral possibilities of complying with current public health rhetoric on proper healthcare seeking, including timely presentation of symptoms, and simultaneously try to avoid misusing the healthcare system and be characterised as overly worried or even as a hypochondriac; this challenge constitutes complex navigational routes through the moral sensescape of the Danish middle class.

KEYWORDS: Denmark, healthcare seeking, middle class, morality, sensations, sensescape, symptoms, welfare

The question of whether or not to seek healthcare with bodily changes that may or not be a symptom of illness is a question that takes place in the everyday life and bodies of people among a range of everyday life concerns. By exploring how moral possibilities for acting as ‘a good citizen’ are reflected in the bodily practices of the Danish middle class, this article particularly pays attention to the ways in which notions of morality are embedded in perceptions of bodily sensations and thereby create possibilities for interpretations and actions regarding the body, health and illness. Most prominently, these possibilities include concerns about the common good of the Danish welfare state, which may legitimate decisions in either direction in the question of whether or not to seek healthcare. The moral possibilities available to ‘the good citizen’ thus open different possible routes of navigation in what we conceptualise as ‘the moral sensescape’ of the Danish middle class.

As an analytical background, we draw on David Howes’ concept ‘sensescape’ (Howes 2005), through which he directs attention to how the experience of an environment is ‘produced by the particular mode of distinguishing, valuing, and combining the senses in the culture under study’ (Howes 2005: 143). By looking at everyday life in the Danish middle class as a distinct sensescape, we aim to explore the social and cultural embeddedness of bodily sensations and their potential transformation into symptoms.

Denmark is a small country known for its egalitarian Scandinavian welfare model. As the Danish public system is financed by income tax, one of the highest...
in the world (OECD 2015), the Danes ideally have free and equal access to healthcare and education. Denmark is often characterised by a strong civil society, social cohesion and high levels of social trust (Wiking 2014). The development of the welfare state along with social cohesion and trust in the population compose a relevant background for our analysis of the moral sensescapes of the Danish middle class. Many of the informants’ life stories are characterised by social progression from working class, lower-middle class or farming families into owning their own home in a suburban middle-class neighbourhood. Their stories are thus intertwined with the formation of the Danish welfare state in the second half of the twentieth century, and the development of a large middle class that has benefitted greatly from the welfare state (Jøhncke 2011; see also Olsen et al. 2012). With the aim of understanding the making and management of symptoms in this context, the article addresses the relation between the middle-class body above the age of 60 and the Danish welfare society, which is also described as ‘held together not just by mutual trust and common interests turn into welfare management of symptoms in this context, the article addresses the relation between the middle-class body above the age of 60 and the Danish welfare society, which is also described as ‘held together not just by the mutual identification and trust of the inhabitants of the country, but also by culturally defined mutual interests in certain economic and practical arrangements’ (Jøhncke 2011: 35). We propose that this mutual trust and common interests turn into welfare practices that ‘become embodiments of particular forms of ethical orientations and normative expectations’ (Langer and Højlund 2011: 1), which, in this article, we find in the notion of ‘the good citizen’. This social trust and sense of community thus provide the foundation for the moral sensescapes that people bodily navigate when experiencing bodily sensations.

Methodology

The analysis presented in this article draws on long-term ethnographic fieldwork carried out by Offersen from December 2012 to February 2015. The study is part of a large research programme aimed at improving organisational and clinical aspects of cancer diagnostics in Denmark. The fieldwork took place in a suburban middle-class neighbourhood in Denmark, where 14 households (18 key informants) were followed through twelve to eighteen months. The majority of informants were aged 60 or above, which had distinct significance for the analysis and the notion of ‘the good citizen’ as we argue that this notion stems from the contemporary social progression of the informants with the development of the Danish welfare state.

Overall, the fieldwork consisted of approximately six planned visits, three of which included a semi-structured interview, with each household. Furthermore, Offersen participated regularly in different community activities (local choir, sports and gymnastics). On some occasions, she followed informants to consultations with their general practitioner (GP), at the hospital and to the pharmacy. Interviews were recorded and transcribed verbatim, and fieldnotes were written immediately after each home visit or activity. For a period of six months informants regularly noted down bodily sensations and healthcare contacts which were elaborated upon in interviews.

The Good Citizen

The retired couple Jens and Sonja is serving coffee and freshly baked bread in the living room. The house is neat and clean. They spend a lot of time in and around the house, taking care of the carefully orchestrated garden, repairing the car in the garage, watching television, solving Sudoku puzzles or baking bread. These everyday life doings provide a striking contrast to the stories they tell of their upbringing. Jens grew up in the city in a small apartment with his parents and 6–8 siblings. He is not sure how many siblings he had. He recalls how one little sister died from pneumonia: ‘She died from cold. Yes, that is what I believe. It was so miserable … In winter it was difficult to get out of bed because the duvets had frozen on to the wall. I remember this happened many many times.’ Sonja, on the other hand, tells of a happy childhood. Her parents owned a smallholding in the country and to describe how every penny was turned she opens an old book with her father’s budgeting where every tiny expenditure and income is carefully noted.

As mentioned the informants’ life stories are characterised by social progress; they have been able to provide their own children with an upbringing under more socially and economically stable circumstances than they had experienced themselves. Indeed, they are stories of a different time but the contrast between then and now also illustrates the increase of the middle class alongside the development of the Danish welfare state in the last part of the twentieth century. Looking at these stories of social mobility, welfare state development and the sense of social cohesion and community, the relation between individual and society becomes a mutual moral relation with inherent rights and responsibilities as for example expressed in relation to healthcare by another informant:
The concern of this informant, who is a recently retired and physically active woman, is encapsulated in what we think of as the notion of ‘the good citizen’. Jane is aware that social welfare benefits, like free healthcare, come at a cost; not at the level of the individual, but at the level of society as a whole. Thus, she articulates the mutual interests in economic and practical arrangements as mentioned earlier. Along with most of the other informants, she voices an individual responsibility for taking good care of her body in consideration of a sense of community and cohesion of the Danish society, which is built on the mutual trust that everyone contributes with what they can and requests only what they need to ensure the common good of the welfare state. This moral relation between the body and the Danish welfare state is also described by Oxlund as a relation of debt which is imprinted at the biological level; ‘If you fail your own body, you are failing the entire body of the nation, seems to be the dictum here’ (Oxlund 2012: 44). In her disapproval of the overweight and smoking people in the supermarket, Jane clearly demarcates proper citizen behaviour from improper behaviour. It becomes a matter of balancing the rights and responsibilities that are inherent in the Danish welfare state and in the normative expectations of its citizens. A sense of national social cohesion seems to be at stake here, and improper behaviour puts this cohesion at risk. Social cohesion defined as ‘the belief held by citizens of a given nation state that they share a moral community’, where ‘citizens believe they share the norm of not cheating each other’ (Larsen 2013: 11), is characteristic of the Danish society according to Larsen. The belief in a shared moral community can be seen as the background of everyday actions towards what is perceived as ‘the good life’. Yet, individual perceptions of the good life vary and so do the ways in which people enact ‘the good citizen’. While ‘the good citizen’ exists as a shared normative expectation in Danish citizenship, people or different social groups may relate to it in different ways. For example, a recent Danish study suggests that expectations to comply with public health rhetoric translate into everyday forms of resistance (Merrild et al. 2016). Forms of resistance to acting ‘properly’ as a good citizen are also present among our informants in the middle class, but the key point is that people are morally related to the welfare society and do address the idea of the good citizen whether they resist or comply with it. Let us turn to show how normative expectations expressed in the notion of ‘the good citizen’ translate into experiences of embodied sensations.

The Embodiment of the Good Citizen

During fieldwork, statements like ‘I am the kind of person who doesn’t go to the doctor’ and ‘I am never ill’ or ‘I have a strong health’ were often heard. Nevertheless, over time, illness episodes and healthcare seeking showed that this is not necessarily in accordance with what actually happens. Most of the informants do see their doctor once in a while, and they do have at least minor episodes of illness or symptoms. What is then at stake in these statements? As Gullestad describes: ‘Statements like “I am such and such kind of a person” imply ways of categorizing persons and certain standards for the evaluation of their behaviour’ (Gullestad 2001: 35, emphasis added). In light of the moral relation between the middle-class body and the Danish welfare state, the ‘strong health statements’ should, therefore, be seen as more of an evaluative than a descriptive character and can be understood as a cultivation of the moral relation to the ‘common good’ of the welfare society. An example of an attempt to live up to the ideals of being a good citizen when experiencing bodily sensations is demonstrated by Sonja when she tells about a time when she had some heavy bleeding and low levels of haemoglobin: ‘I went to work the day after. I was on weekend duty that Saturday. It was not really comfortable, I was super super tired, but I did my job’. She also expresses the difficulty she has in deciding whether some present bodily sensations could be symptoms of disease or not:

Sometimes I feel some stomach pain and then suddenly it disappears again. And you think: How long time should pass before it is over? Well, I better wait a little longer. But then again, I could also … It is because we have these old friends, and some years ago she had colon cancer. She is well over it now, but … This can make me think because when I hear about her symptoms... But then I also thought that this does not mean that I will get it as well. But on the
other hand, no one says that I wouldn’t get it. At the same time, I also thought when I stopped working that I would not be one of those … who would just be a hypochondriac; then you would go to the doctor with this, then with that. I don’t want to be that kind of person. But I also think: Is there something or not? I hope there isn’t anything if I go, you know? But on the other hand, you should not wait until there is something. We know that.

The complexity of healthcare-seeking processes is evident in Sonja’s stories. There is no right path to follow when juggling so many concerns of which remarkably few are about the actual sensations. By highlighting her ability and wish to keep working, even when she was ill and even though an absence from work was in fact legitimised by her GP, she draws on a culturally valued sense of agency – of being productive, working and busy and being heroically able to overcome illness. This is very similar to what Cameron Hay has termed the ‘John Wayne Model’ in the U.S. (Hay 2010), and this ideal is also inherent in our idea of the good middle-class citizen who contributes to ‘the common good’.

The multiple concerns in healthcare-seeking practices and sensation-to-symptom transformations can be seen as multiple possibilities for acting in a morally ‘correct’ way. This multiplicity of moral possibilities often entails an uncertainty which is sensorial and moral at the same time; when a bodily sensation is a symptom ‘worthy of healthcare seeking’, it is a moral assessment as much as a sensorial assessment. This uncertainty is often voiced in the informants’ efforts to legitimise healthcare seeking decisions. For example, during most field visits, Sonja’s husband, Jens, a retired general labourer, emphasises that he is the type of person who would not go to the doctor until ‘the very last minute’. When it turns out during an interview that he recently got his lungs checked, he is asked if he did that because of worrying about the consequences of his smoking habit, and he explains:

No, it was because I thought that when you had used the body for so many years then it would be a good thing just to be checked. To see whether it was still functioning the way it was supposed to. That was actually the reason. Then, of course, I was also nervous that something would be discovered. In case anything … I can’t deny that. Of course you are.

Jens insists that this happened as a part of a 60-year health check even though his wife corrects him on the matter, suggesting that he went to the GP out of worry for his lungs. A general observation was that informants legitimise healthcare seeking in relation to health checks, which are commonly referred to as ‘60,000 miles’ check’, indicating an occasion for checking the status of the body. By using the metaphor of keeping a car running, informants highlight the morally unquestionable necessity of this particular visit to their GP. In this way, they are provided with a comforting certainty about their health status without the need to consider the moral legitimacy of potential worries; they behave like good citizens by taking care of their health and yet not overusing the common good of the healthcare system. In a similar fashion, many informants also stated in relation to actual symptoms that they would have their doctor look at it ‘the next time I’m going there anyway’. This may imply that the moral legitimacy of the symptom is uncertain and, to stay within the confines of the good citizen, they better not express their sensorial concerns until a legitimate occasion occurs, as for instance a control consultation for blood pressure.

Navigating the Moral Sensescape

What is at stake then when people experience sensations and ‘bodily navigate’ the environment that we suggest may be a moral sensescape of the middle class? Mattingly argues that ‘moral pluralism characterizes ordinary life’ (Mattingly 2014: 9). In this sensescape, where ‘the good citizen’ is a key shared value, moral pluralism can be considered as the different and sometimes conflicting moral possibilities that are available to the middle-class body to sustain a place in the category of good citizens. Seen from an analytical perspective, this entails that navigating the sensescape with regard to health does not only concern what actually happens in a particular event but also involves consideration of the whole range of possibilities; what might happen as well as what might have happened (Mattingly 2014; see also Zigon 2009). People thus navigate in a sensescape of different possible moral routes.

This is particularly evident in the light of contemporary public health rhetoric, which emphasises individual responsibility and ‘symptom awareness’ as central strategies to disease control (Petersen and Lupton 1996), thus socialising people into a body political taking the shape of healthy citizens who are capable of conducting proper healthcare seeking. Being a good citizen thus implies that you are responsible for taking good care of your body, you are expected to comply with authoritative messages of proper healthcare seeking (which also assumes proper and timely interpretation of bodily sensations as symp-
bodily sensations to healthcare seeking can take many directions.

This is demonstrated in the case of Jette, a retired woman in her early 60s, who talks about the kinds of symptoms that would make her visit her GP:

J: ... if you have a lump in the breast, and you feel that there’s something unusual there, then it would be quite fair to ask your doctor if he could take a look at it or run a test. I wouldn’t have a problem with that.

S: OK. Would you make an appointment to have it checked? We have talked about this before ...

J: Yes, we have talked about it before. It is that thing with my moles. I haven’t done anything about that yet, but I will. I will, but it is not something I am afraid of. I just don’t think I will get cancer ...

S: But you have the thought of having it checked?

J: I have the thought. I need to have it checked at some point. The next time I’m going there [to the GP].

S: But you said earlier that if you found a lump ... and that you know this is [something you should react on] ...

J: Yes, I would feel that. But as you get older, you get all sorts of spots on the skin here and there. That doesn’t have to be anything ... I also have something here. You just get that. It is this thing about wasting the doctor’s time. I really respect this. You should be careful not to come when it is not necessary. It is quite alright to come if you are afraid. You shouldn’t go around being afraid. But I am not afraid, so I ... You just don’t go to the doctor every time you feel something. I don’t.

Jette’s story illustrates how the experience of a bodily sensation – the mole – opens possible moral routes for its transformation into a symptom of illness or an absorption back into an ordinary embodied being-in-the-everyday-life-world. The moral possibilities at play here are complex interactions between the various perspectives on everyday life morality, such as taking good care of your body and the common good of the healthcare system simultaneously. It can be seen as a moral compass of the body used to navigate its everyday life context. Jette describes the moral possibility of what might happen if she discovered a lump in her breast, a well-recognised symptom of breast cancer. In this case, the socially legitimate moral route would take her straight to the doctor; it would be ‘quite fair’ to do so, that is she would embrace the moral relation to the welfare state by seeking care appropriately and thereby also fulfil the normative expectations of being a good citizen. However, in the case of a mole that has changed appearance, which Jette does not consider as alarming although she is aware that this may also be a symptom of cancer, a whole range of other moral possibilities become visible. When trying to explain the contradiction between what she has just said about the hypothetical breast lump and the actual changing mole, Jette applies different moral possibilities. First, she refers to a moral possibility of bodily ordinariness, ‘as you get older you get all sorts of spots on the skin’. Second, she states, ‘I need to have it checked at some point’, and, although this does not take her straight to her GP; this moral possibility is related to the public health rhetoric of seeking care ‘in time’. Yet, inherent in this sentence, we also find the uncertainty of the moral legitimacy of the symptom, as discussed earlier, which transforms ‘in time’ into ‘at some point’. Third, she again applies the moral possibility of being a good citizen; this time by the responsible choice not to ‘waste the doctor’s time’, which can be seen as a commodified ‘common good’ of the welfare state.

Bodily navigation in this moral sensescape thus requires balancing of the moral possibilities at play. This balancing is a continuous process; Jette has not presented the mole to her doctor, but she has not ruled out the possibility to go there in the near future either. Thus, an ongoing moral and sensorial balancing effort is taking place in her everyday life.

Concluding Discussion

We presented the contextual background for ‘the making and management of symptoms’ as a moral sensescape of the middle class, which encompasses a moral relation to the Danish welfare state that extends to individual bodies in a responsibility for individual health. We showed that this is expressed as a striving for acting like a ‘good citizen’, who ideally cares for and aims at protecting the ‘common good’ of society. In this case, this is done through appropriate use of the healthcare system, which also entails the way bodily sensations are endowed with significance as symptoms of possible illness.

With the overall aim of exploring the making of symptoms and thus attempting to ‘open up the phenomena we name symptoms’ (Eriksen and Risør
2014: 90), we suggest that morality embraces the processes of distinguishing ‘normal’ from ‘worrying’ sensations and that healthcare seeking is an essentially moral process, which is navigated along culturally shared moral possibilities.

On the basis of our findings, we see two main implications. First, as a practical implication for understanding the healthcare seeking practices that many public health interventions seek to influence, we showed how moral possibilities for perceiving, interpreting and acting on bodily sensations create different, sometimes even opposing, navigational routes throughout the moral sensescapes of everyday life when it comes to ‘the making and management of symptoms’. People can seem less concerned with the actual bodily sensations than with their moral possibilities for agency around it. However, the rhetoric of proper healthcare seeking is profound, and it feeds into the continuous construction of the moral possibilities that are available to ‘the good citizen’ when distinguishing between ‘fine’ and ‘sick’ (Hay 2008). The cases primarily focused on how the embodiment of ‘the good citizen’ implies that healthcare-seeking practices are based on considerations about both the ‘common good’ of society and about timely healthcare seeking with ‘legitimate’ symptoms.

Second, in terms of theoretical discussions, our study feeds into recent efforts of a medical anthropology of sensations to challenge the taken-for-grantedness of symptom categories (e.g. Nichter 2008; Risør 2011). Symptoms should not be confined to be ‘natural signs’ indicating a real relation to disease (Staiano-Ross 2011). Rather, symptoms are complex, interactive and point both forwards and backwards in time as well as inwards and outwards of the human body. Looking in all directions is a way to avoid uncritically adopting the prevailing biomedical conceptualisation of the phenomenon, and this forces us to rethink ‘what is called symptom’ (Eriksen and Risør 2014: 89).

Placed in the context of the Danish middle class, this study highlights relations between a welfare state and its citizens in a particular local moral world characterised by social trust and the belief that inhabitants in this relatively small and homogenous nation share a moral community. The perspectives of moral sensescapes and possibilities are likely to take very diverse forms in less homogenous settings, larger communities or different age groups. Therefore, further studies on morality and sensations exploring for example moral sensescapes across generations, class, gender or different healthcare and welfare systems could be of interest to both medical anthropology and public health research informing our understanding of symptoms, healthcare seeking and public-health interventions.

**References**


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