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Marginalized Citizens Experiences of Middle Class Moral Judgements in Communication with their GPs

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The purpose of this article is to explore how two different versions of participatory theatre give marginalized citizens living in disadvantaged areas an opposite basis for sharing experiences of being judged in communication with their GPs. The data were produced as part of a dialogic evaluation of two health communication interventions initiated by Region Zealand, Denmark. The purpose of both interventions was to invite citizens to participate in a dialogue on their experiences with their GPs, initiated through two versions of participatory theatre. The interventions were held in a range of disadvantaged areas. We used a variety of qualitative approaches such as participant observations, focus interviews and individual interviews in order to shed light on a) how the two versions of participatory theatre were developed and b) how the invitation to have a dialogue was experienced by the citizens.

The analysis was conducted abductively, moving between the data production, existing research on inequality in access to health care services and theories on social inequality and its moral implications.

Theoretically, we employ Bernstein's concept of framing, Skeggs' points about class as a relation between moral judges and judged, and perspectives on healthism, risk and responsabilization.

The analysis finds that *the first version* of participatory theatre frames the judge-judged relation as the problem, enabling the participating citizens to share experiences of being judged as morally inferior. The framing of *the second version* of participatory theatre however implies the judge-judged relation, whereby the participants feel that they are being judged. As a consequence, the participants dis-identify with the role of the patient in the second version and express resentment towards health institutions.

We conclude by suggesting that framing is a central perspective when researchers and health professionals wish to initiate dialogue with marginalized citizens and that the class perspective presented here is fruitful in exploring experiences of social inequality in access to health care.

Introduction: Unequal access to cancer care

Despite the fact that universal health coverage is fundamental to the Nordic welfare model, the Nordic countries struggle with profound social inequity in health (Diderichsen *et al.*, 2011). Universal health coverage is necessary for equity in health; however, it is not sufficient, as noted by Fried *et al.* (2013).

In recent years, Denmark has seen increasing interest in inequality in access to health care (Rigsrevisionen, 2019). Of particular political and scientific interest is inequality in cancer treatment – how it takes place and is reproduced in detection, treatment, palliation and rehabilitation (Pedersen, Ingholt and Tjørnhøj-Thomsen, 2015; Elstad, 2018; Dalton *et al.*, 2019).

Region Zealand is a pioneer in this respect, having launched a number of initiatives under the title of “Early Detection of Cancer”, targeting different areas and practices. This paper explores the initiative targeting marginalized citizens living in deprived areas with the aim of improving their communication with their GPs.

GPs in the Nordic countries are gatekeepers to specialist services (Vikum, Johnsen and Krokstad, 2013) and therefore exert a powerful influence on who gains access to cancer packages. According to Vikum *et al.* (2013), the decision of GPs to refer patients to specialist services is likely to be a central node in the mechanisms leading to inequity in specialist utilization and thereby cancer diagnosis and treatment.

In societies with greater inequality than Denmark, it is well argued that communication between patients and their GPs is strongly influenced by social class (Boulton, Tuckett and Olson, 1986; Verlinde *et al.*, 2012; Bell, 2014; Mackenzie *et al.*, 2019). In contrast, Denmark is often regarded as a classless society and the concept of class is considered a rare and old-fashioned topic (Prieur and Faber, 2013).

In this paper, we draw on a range of class theories, claiming an institutionalization of middle-class values and norms, meaning that central institutions of society are steeped in the perspectives of the privileged groups (see for instance Lawton (2000) in relation to death and palliative care, and Nyholm *et al.* (2018) in relation to breast cancer treatment). Here, we explore the implications of this in relation to communication between marginalized citizens and their GPs. In this respect, it is important to point out that the article does not analyse communication between patients and their GPs; rather, it analyses marginalized citizens' *experiences* of this communication as it was expressed at a range of evening events consisting of two different versions of participatory theatre.

After this introduction to the field of inequality in cancer care, we will introduce the part of the Early Detection of Cancer Initiative that focuses on citi-

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zens. Here we also address the reason why the project group chose participatory theatre: the risk of stigma. This is followed by two theoretical sections, in which we introduce a range of perspectives on class, moral judgments, healthism, risks and responsabilization. We then introduce our study and the data production, after which the analysis will unfold in four sections. Finally we discuss the findings and draw conclusions.

Health and stigmatization – participatory theatre as a solution?

In order to avoid the stigmatization embedded in health promotion focusing on individual lifestyles, Smith and Anderson suggest that alternative approaches to engaging communities in discussions on health inequalities are required, e.g. experimenting with participatory practices (Smith and Anderson, 2018).

In line with this, the Early Detection of Cancer project group, in the initiative targeting marginalized citizens, developed a health communication intervention with a culturally sensitive approach (Dutta, 2007). The purpose was to invite citizens to participate in a dialogue initiated through participatory theatre.

The intervention took the form of two evening events entitled “Go and see your GP on time” and “Make the most of your GP consultation” held in a range of disadvantaged areas during 2017, 2018 and 2019. Both events consisted of participatory theatre and a presentation by a health professional on symptoms and “dilemma reflections”. We concentrate on the two versions of participatory theatre as they unfolded in the two rounds of events.

Participatory theatre positions the audience as active participants and political subjects, because they are invited to interact with the actors by suggesting solutions to the dilemmas presented in the plays. Participatory theatre holds a potential for empowerment and social transformation, which lies in its origins in the Theatre of the Oppressed (Boal, 1978; Singhal, 2004). However, the question is whether the method itself is sufficient, or whether it is necessary to consider more deeply how the content of the plays is framed. In this regard, it is important to dwell on the issue of stigma: what is the link between “stigmatization” and health communication? Where does the stigma spring from, what is at stake and how does it operate? These questions are important in attempts to avoid stigma and to empower marginalized citizens by enhancing their communicative skills. We suggest a theoretical explanation that relates closely to the work of Beverley Skeggs and her point about how class is lived as a relation between moral judges and those who are being judged.

Class as moral judgments: individualization and responsabilization

In Denmark the concept of individual lifestyle choices (the so-called KRAM, a

Danish acronym for diet, smoking, alcohol and exercise) dominates health promotion and prevention interventions, despite the fact that structural conditions that are not freely chosen largely shape the health of individuals (Elstad, 2013; Larsen, 2016).

This preoccupation with individual health is at the core of neoliberal Western society, also Denmark (Bakah & Raphael 2017), as individual responsibility for health “proved to be particularly effective in establishing the ‘common sense’ of neoliberalism’s essential tenets. In contrasting a vision of autonomous, prudent and self-responsible individuals to images of the careless and the fool-hardy, a link was easily made to the burden of social spending” (Crawford, 2006, p. 410).

In this light, “healthism” becomes central to how the neoliberal subject is governed through a strong moralization, embedded in responsabilization (Brown, 2005, p. 44) and health is to be regarded as ‘a kind of moral performance infused with ideological meanings’ (Montelius and Nygren, 2014, p. 435).

Many scholars have pointed out that the core of contemporary class relations is struggles around moral authorization (Skeggs, 2004; Lawler, 2005a; Sayer, 2005; Aamann, 2017). Therefore, in a neoliberal era, referred to as the ‘field of judgments’ (Rich and Evans, 2009, p. 163), class is constructed as relations and tensions between the judges and the judged, ‘between those who can authorize their judgements and those who cannot’ (Skeggs, 2011). Lawler points out how class manifests itself “as circulating through symbolic and cultural forms – through, for example, the means by which people become judged as morally worthwhile, or as having the right kind of knowledge or ‘taste’” (Lawler, 2005b, p. 797).

Class judgments are therefore a central part of the ruling relations, which Smith defines as “that extraordinary yet ordinary complex of relations...that connect us across space and time and organize our everyday life...” (Smith, 2005, p. 10).

In this sense, neoliberalism’s ruling relations strongly emphasize questions of health, personal worth and class-based moral value: a healthy lifestyle is a key marker of moral worth and thus also of middle-classness (Aamann and Dybbroe, 2018). Seen in this light, neoliberal conduct works through a type of stigma (Tyler, 2013) that relies on moral judgments rooted in class: by scapegoating the ‘irresponsible’ lower- class subjects, processes of othering establish a position for the responsible, respectable and morally worthwhile middle-class subjects.

Data and methods

The empirical data analysed emanate from a dialogic evaluation (Fetterman, 2018; Olesen, Phillips and Johansen, 2018) of the part of the Early Detection of

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Cancer Initiative targeting marginalized citizens.

As already elaborated, the project group chose to hold a range of evening events in deprived areas with two different versions of participatory theatre. The first version consisted of 12 events during 2017 and 2018, with the participation of 337 citizens. The second version consisted of four events in 2019; here, 108 citizens took part.

The project group consisted of a medical programme manager, a project manager, a health promotion consultant and three actors, one of whom had the role of facilitator in the plays. They obtained the dialogic evaluation from Roskilde University when the first version of the evening events was nearing completion. The main purpose of the evaluation was to explore how the citizens experienced the participatory theatre.

Data were produced using various qualitative methods: participant observations of the last one of the “Go and see your GP on time” events and four “Make the most of your GP consultation” events. Besides the events, we also participated in a communal meal, and had everyday conversations with the citizens. We conducted two focus group interviews with 13 participants, one individual telephone interview and interviews with the members of the project group, as well as with the social workers in three of the disadvantaged areas. In line with the dialogic evaluation approach, we also had meetings with the project group during the period in order to reflect on and further develop the second version of the participatory theatre.

Field notes were written down immediately after the observations and interviews were transcribed. The two evaluators met regularly to discuss the analyses. Two reports finally presented the evaluation to practitioners and politicians (Olesen and Aamann, 2019a, 2019b).

Here, we wish to explore in depth a range of empirical expressions, which, although in subtle ways, relate to questions of moral worth and to experiences of being judged. In order to elaborate a theoretical understanding of these parts of the data, we employ an abductive approach, using Bernstein’s concept of framing, developed to study interactions in institutional settings (Bernstein, 1977). Bernstein’s research into educational settings revealed that social class relations are applied at a broader societal level, at an institutional level, and at an inter-individual level, utilizing the same logic in regulating the unequal distribution of various discursive, material and social resources. Bernstein points out how class is constituted by cultural and moral control and he understands people as actively employing frames in any practice involving power and class. Bernstein draws attention to the stability of these frames for interaction and how they are maintained or attempted to be destabilized. Our analysis is based on a socio-linguistic exploration of framing in the events observed. Here, Bernstein’s con-

cept of ‘codes of control’ in framing interactions (Bernstein, 1977) is used to identify who rules, controls, stabilizes and destabilizes the interactions between the project group and the participants.

Results

The project group “We try to avoid stigmatizing people”.

The project group was intuitively well aware of how stigma works through the moral judgments of healthism, and they worked strategically to avoid such judgments, as the heading of this section indicates. In our interview with the three actors, one of them said: “...we talked about how we can create something for people where we don’t come along and moralize or appear superior to them...”. The ruling relations are what the group was keen to avoid. Instead they wanted to create events “at eye level” with the marginalized citizens.

For the first version, the group worked to frame the play in a way that would position the doctor as using a difficult language and not caring whether the patient understood or not: “But we also work on the language. For example in the doctor scene, the doctor uses lots of terminology kind of over his head, and he doesn’t understand a word of it”.

As noted by Jønsson, people with multimorbidity often feel that health professionals look down on them (Jønsson, 2018). The purpose of the framing was therefore to develop a version of a participatory theatre play that was recognizable to the participants and would encourage them to reflect on what to do in uncomfortable situations.

First version: “You don’t want a sermon thrown at you when you’re feeling awful”

The careful framing meant that the first version focused on how to deal with a busy, lifestyle-oriented doctor in order to be heard, in terms of the conditions under which the communication takes place.

From the field notes:

The GP uses a lot of specialist terminology and uses the KRAM factors in a sophisticated way. She says for example: “You have certainly lost a lot of weight, well done” even though the weight loss is one of the symptoms of cancer and the reason why the patient has come. Also, she suggests “a prophylactic stop smoking course”.

After the play, the facilitator starts the discussion:

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Participants say: “It’s a big step that he’s come to see the doctor”

Facilitator then asks: “Why hasn’t he visited the GP sooner?”

Participant: “You just can’t cope with having a sermon thrown at you when you’re feeling awful.”

The use of the word “sermon” indicates that the participant experienced the doctor as a “holy priest”, preaching at the patient. The use of the expression “can’t cope” also indicates that it felt like a moral devaluation: one needed to have extra energy to put up with the lifestyle focus, because it implied a moral judgment. As Aamann and Liveng have shown, these moral judgments are closely connected with stereotypes of white working-classness and are common features of health policies targeting mothers of obese children (Aamann and Liveng, 2016).

The ruling relations were central to the framing, but in such a way that they were visible and open to criticism. It was the ruling relations that were framed as the problem. Here, the participatory theatre succeeded in contesting the ruling relations of marginalization as the product of individual deficiencies, redefining it as the product of structural inequality. The plays challenged the oppressiveness of particular social norms and allowed participants to validate their experiences of bad communication; they created a space in which participants were able to “widen their repertoire for social change” (Erel, Reynolds and Kaptani, 2017, p. 305). The first round of events succeeded in framing the plays in a way that met the participants’ experiences of being judged as morally inferior. The citizens were able to share their experiences of being rejected by doctors and they received communicative tools to work on.

This is only possible if the participants are able and willing to identify with the characters in the play. As we will show in the following section, this was not the case in the second round of events.

Second version: “But I’m nothing like him”

The second round of events had new participatory plays. Here the framing was radically different. After having observed during the first event, the researchers met with the project group. It was revealed that the group had received a request from a medical centre. The centre had problems with what were considered to be “demanding patients” and with patients who were a “strain on the budget” of the services, the project group explained us. The group then decided to develop a participatory theatre play and without further deliberation, they decided to use these plays for the next round of events.

However, the framing was radically different: For example, the patient in the play was very rude to the secretary and also behaved inappropriately towards the doctor. As one participant explained: “Last time it was the doctor who didn’t listen to the patient and it was the doctor’s fault, and this time it was the patient who was being unreasonable”.

The consequence was that the participants dis-identified (Skeggs, 1997) with the patient in the play: “The idea seems to be that you can see yourself in the patient’s role, that you could maybe be like that, but I’m nothing like him”.

According to Erel *et al.*, it is crucial that participatory theatre is embedded in “a critical and emancipatory discourse of social transformation that highlights a range of different power relations” (Erel, Reynolds and Kaptani, 2017, p. 308). Otherwise, participatory theatre risks becoming “too individualized, focused on individuals’ ability to deal better with oppressive situations” (Erel, Reynolds and Kaptani, 2017, p. 307) and thereby contributes to “neoliberal ‘victim-blaming’” (*ibid.*) by ascribing problems to people’s individual deficiencies rather than social inequalities.

Our analysis suggests that this is what happened in the second round of plays and their framing. The problems occurred because the new play was developed to address a problem defined and framed by an institution, without taking into account the perspectives of citizens. The ruling relations were still involved, but they now dominated and were reproduced by the framing: the moral judgment of the marginalized citizens as deviant was now inscribed in the framing.

However, the participants did not act as passive objects of the “victim blaming”. Instead, they tried to contest the framing. An example from the field notes is when the facilitator asked: “[When the doctor talks about weight loss and smoking] Do you get a guilty conscience then?” The participants strongly object: “No way!” and one says: “She [the GP] can probably make a lot of money out of him [the patient]!”

This is in line with Skeggs and Loveday, who find that “those positioned as already marginal to the dominant symbolic, presented as ‘useless’ subjects rather than ‘subjects of value’” (Skeggs and Loveday, 2012, p. 472), “refuse to authorize those they consider lacking in value but with authority and in a position to judge” (*ibid.*). Seen in this light, the participants’ objections were attempts to de-authorize those they consider to be “judges”, namely the facilitator and the whole event.

Our analysis suggests that the second round of plays failed to empower the participants. The framing did not make them feel comfortable enough to share experiences and their communication skills in their GP consultations did not improve further.

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Resentment towards health institutions

In general, there was significant resentment towards institutional representatives. For example, one participating woman in a wheelchair told Aamann:

“Then someone came up to me and presented herself like: ‘I’m from the regional authority.’ So then I said: ‘Well, that’s nothing to boast about here’”.

As Aamann has shown, “the position of the ‘lower classes’ seems infused with a sense of being morally devalued by representatives of institutions of the state” (Aamann, 2017, p. 61). This means that “institutional representatives” often meet resistance among marginalized citizens, which is a coping strategy to avoid the judgments implied.

The actors also explained about their experiences with both rounds of events: “Well, there are certainly lots of people angry with doctors. And angry about doctors’ arrogance... you bet there are!”

This significant resentment testifies to the frustration and indignation among marginalized citizens, caused by their experiences of being morally devalued and the consequences. As researchers at the events, we also heard many stories about GPs neglecting worrying symptoms, and about the consequences of the spread of cancer when not detected at an early stage. Skeggs and Loveday conclude that “class relations are lived through a struggle, not only against economic limitation but a struggle against unjustifiable judgment and authority and for dignified relationality”. In the case of early detection of cancer, we might, raise the question of whether class relations are also lived as a struggle to gain access to early diagnosis and treatment.

Discussion and concluding comments

The analysis of the two rounds of participatory theatre shows how the same method and aim of empowerment can result in very different outcomes for the participants:

In the first play, they were allowed to exchange experiences about how it felt to be morally devalued in relation to the lifestyle focus of healthism, when communicating with their GP. In the second play, the morally devaluing judgment itself was reproduced. This meant that the participants dis-identified with the patient in the play and resisted the framing.

In light of this, we suggest that framing is a central perspective when health professionals wish to initiate dialogue with marginalized citizens. Furthermore, we suggest viewing framing in terms of a concept of class that is sensitive to its moral judgmental character in relation to risks and responsabilization.

Smith and Anderson state that “researchers could both avoid contributing to stigmatizing ‘labelling’ processes and do more to critically engage with ‘those

doing the labelling” (Smith and Anderson, 2018, p. 168). Following on from this, we hope that this article will invite professionals to consider how they frame their interventions and to what extent class-based moral judgments are reproduced or problematized.

When considering the Early Detection of Cancer events in a broader context of unequal access to health care, there seems to be a need to investigate the GP’s position as stakeholder. On the one hand, it is obvious that GPs cannot refer everyone to specialist services. However, on the other hand, we need to pay attention to the ways in which doctors assess who is presenting worrying symptoms and who is not.

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