‘MY BODY IS KOREAN, BUT NOT MY CHILD’S…’: A FOUCAULDIAN APPROACH TO KOREAN MIGRANT WOMEN’S HEALTH-SEEKING BEHAVIOURS IN THE UK

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For my parents,

with love and respect

Abstract

This thesis examines the health-seeking behaviours of Korean migrant women living in the UK. Theoretically, it argues for treating migration as a process of 'subjectivisation', in the specific sense in which this concept is employed in the work of Michel Foucault, and claims that migrants' health-seeking behaviours always presuppose and refer back to a fundamental process of assuming, appropriating and manifesting the dominant form(s) of subjectivity within the domain of medicine of the host country – in the case of the UK, the medical subjective form of the 'active patient' and/or 'healthy citizen'. In the present work I show that Korean migrant women tend to resist this process of becoming-subject to the ideal active patient model until they happen to undergo some profound and life-altering experience that forces them to come to terms with the British system and its ideal forms of knowledge and behaviour. For most (but not all) Korean migrant women, this life-altering experience is that of pregnancy, delivery and childrearing. Pregnancy and childbirth constitute the turning point in a process of subjectivisation that culminates in the institution of a dual medical citizenship. In other words, while they never totally reject their former autochthonous mode of medical subjectivity ('good patient'), they nevertheless come more and more to approximate the British model subjective form. On the other hand, when it comes to their children, who are ethnically Korean but born and raised in the UK, they tend almost fully to surrender to the British ideal, recognising that their children, while Korean,

nevertheless possess originally British bodies that demand British treatment. This causes them to become extra vigilant and resourceful regarding their health-seeking behaviours, bringing them more fully in line with the ideal form of medical subjectivity of the active patient/healthy citizen.

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Contents

Chapter 1: Introduction

> What has changed the most since we settled in Britain was that my husband said if we were to settle here permanently, I should be either really healthy or really sick. He told me not to be in the middle. I didn't know what he meant at first, but now I know exactly what he meant. If only I could choose to be either way…our utmost priority is health.

This is what BM, one of the Korean migrant women I interviewed, replied when I asked how she was coping with her health issues in the UK. At the earliest stage of gathering data, I thought I could begin the interviews with my participants by asking what I thought was a very general question: 'how do you feel about your health since you migrated to England?' Shortly after, I realised that my question was not proper in the sense that their responses usually began with complaining about the NHS and ended with telling stories of various 'battles' they had to undergo in order to maintain their health since their migration. Because the women that I interviewed did not have any chronic diseases or injuries, I did not expect them to be so vocal and expressive about their health concerns; I expected health to be a more embedded, unconscious and background issue: instead, health and maintaining health, for these Korean migrant women, were everyday issues and in fact required much more proactive attitudes – when describing how they maintained their health, terms such as 'battles', 'fights', 'strategies' were frequently used.

It is the main objective of this thesis to capture what Korean migrant women in the UK do in order to stay healthy by drawing on Foucault for its theoretical-conceptual resources; it is therefore important to indicate briefly and at the outset how I utilise, transform and criticise Foucault's work in order to render it amenable to my own particular concerns. In the first place, and in general, I adhere to Foucault's own self-styled 'tool-box' approach (Foucault 1994), selecting concepts in an entirely pragmatic fashion as suitable for the task at hand. At the same time there is a certain logic to this bricoleur-style pragmatism; concepts are not just chosen at random – i.e., by 'me', the researcher-author – but in a very real way are selected by the problems themselves. The problems, or questions, sketch out their own possible lines of interrogation. Novelty in any research comes about, not simply through juxtaposing things haphazardly, but through discovering previously hidden lines and openings, points of 'a possible crossing-over' as Foucault calls them in his essay '*What Is Enlightenment?*'. (Foucault 1998: 315) One perceives a gap and selects the tool that appears most appropriate to that particular gap. In this case a gap revealed itself in the fact that the usual approaches to analysing and explaining migrants' health-seeking behaviours, thematised almost exclusively in terms of a combination of rational choices, factors and influences, were largely unable to account for the phenomena; something essential was lacking in these explanations conducted with reference to socio-economic status, language ability, education level, etc. None of these in isolation or in combination seemed able to make sense of how migrants set about dealing with their health needs.

This is discussed in more detail in Chapter 2, Literature Review.

Reading Foucault provides insight to the experience of migrants with regard to their 'subjectivity', meaning very generically their perceptions and experiences of themselves in the context of their migration from one society to another and their consequent straddling of two distinct worlds, with their respective social codes and structures. Following the longitudinal experience from their initial contacts with the GP through pregnancy and childbirth until the present point, Foucault's theory enables me to grasp the deep transformation of subjectivity, a process of trans-subjectivisation that could be seen to override particular 'factors', or that at the very least constituted something like a horizon against which 'factors' had always to be measured. It is in this context that Foucault's later work on subjectivisation and the practices and technologies of the self seemed most relevant.

However, Foucault's own work has absolutely nothing to do with the phenomenon of migration. Could Foucault's theories of the subject be modified to apply to migration and migrants' self-experiences, in other words, to theorise a kind of 'migrant subjectivity'? This seemed to imply a double transformation: of Foucault's own concepts on the one hand, and of the nature of migration on the other. It could not simply be a matter of grafting something like 'subjectivisation' onto a pre-conceived notion of migration, e.g., in terms of acculturation, but rather had to involve a re-

interpretation of migration itself – namely, as a complex de-subjectivising and re-subjectivising ordeal. The sorts of subjective transformations that, for Foucault, occur through *time*, from one epoch to another, would now have to be understood to apply principally to changes in *space*, changes of location, of nation, culture, etc. Indeed this constitutes a major reconfiguration of Foucauldian theory, since nowhere in his published work does Foucault undertake anything like a cross-cultural (e.g., Asian-European) analysis.

A second transformation or reconfiguration arose with the decision to restrict my study to Korean *women*; only much later, in the context of his studies on the history of Western attitudes toward sex, did Foucault undertake anything like a specifically 'gendered' investigation (e.g., *The Uses of Pleasure* [Foucault 1992/1985] is mainly about free Greek men; hence the injunction to master oneself, such that one can master one's house and therefore show oneself to be a responsible citizen, has absolutely nothing to do with female subjectivity). My study therefore amounts to an extension of this nascent line of thought, i.e., attempting to comprehend forms of subjectivity and processes of trans-subjectivisation as specifically tied to gender, in particular to the unique life-experiences of women

In addition to making a contribution to the existing Foucauldian-oriented research, studying Korean migrant women living in the UK has several implications. First, there is hardly any research concerning Korean migrant women's health-seeking behaviours in the UK and especially concerning

their experiencing significant life-events including pregnancy and childbirth. Therefore this thesis supplements studies on ethnic migrant groups' health-seeking practices in the UK.

Second, Korea is a highly westernised and developed country where both biomedical and traditional medicines are officially recognised. Regardless of its high cost, Korean migrants' predisposition to use the traditional medicine, *hanbang*, has been recognised as a distinctive characteristic of Korean immigrants' health-seeking behaviours. (Kaiser Handbook 1999; Han 2001; 2000a) Accordingly the findings of this research could serve to contribute to the continued awareness and implementation of culturally competent care, i.e., strategies by which healthcare professionals aim to treat ethnic minority patients in ways that are sensitive to and respectful of their particular beliefs, practices, values and expectations.

Third, similarities between Western countries (such as the US or the UK) and Korea result in a more culturally nuanced migration experience, with respect to medicine and medical discourse, for Koreans as compared with other groups immigrating from countries that exhibit radically different socio-economic and political institutional structures. Likewise, differences in the way the Korean and Western medical systems operate result in different forms of desirable patient subjectivity as well as different cultural expectations for medical professionals with respect to their attitudes, consultations and services. The Korean medical system is public in that

everyone is automatically covered by a national healthcare system. In reality, however, it runs like a private system because of the heavy financial burden placed on patients, who are responsible for large co-payments (up to 50%). (Huh et al 2003) Hence, the thesis should provide insight into the ways in which migrant patients adopt and incorporate certain attitudes and practices in order to stay healthy.

The Korean women I interviewed, coming into the system, did not fully internalise the dominant form of medical subjectivity – viz. that of the active patient and/or healthy citizen (Lupton 1999; Petersen and Lupton 1996/2000) – until they had to go through childbirth in the UK. The concept of healthy citizens has several aspects: it implies that the citizens are able to self-regulate their behaviours to avoid risks; they are 'autonomous' subjects whose interests accord to the objectives of the government and other institutions; and they conform to the government imperatives of 'healthy living'. (Petersen and Lupton 1996/2000: 64-68) While migrants are not necessarily citizens, the political concept of citizenship assumes both rights and obligations of individuals conforming to the public imperatives of health.

Childbirth proved to be a transformative event in the strict sense that their subjectivity underwent the most profound displacement; it was when the subjective categories of active patient/healthy citizen began to be more or less internalised. They appropriated it for themselves, took it on as part of

their identity.

This thesis aims to unpack the long and complex process of Korean migrants' subjectivisation with respect to the domain of health and medicine, that is, the process by which these migrants, following their initial encounters with their GPs, eventually come to adopt and embody the British form of ideal medical subjectivity – active patient – over the course of their undergoing various major life-events, especially their experiences surrounding pregnancy, childbirth and child-rearing. This process of subjectivisation is not a strictly linear one; rather, the Korean migrant women I studied slowly confronted and appropriated new forms of subjectivity at certain moments even while they were shedding older ones, adopting the dominant forms of subjectivity or constructing new forms. This shows that migrant subjectivity is both 'nomadic' (Lash 2001 in Beck and Beck-Gernsheim 2001: xi), a subjectivity in transition, and what might be called 'palimpsestic', that is, a process of perpetual inscription, erasure and re-inscription.

The dominant public health discourse encourages individuals to take responsibility for their health and to avoid risks by adopting health-promoting activities such as 'specific dietary, exercise and therapeutic regimes' in daily life. (Binkley 2009: 95) This mode of subjectivity contains some notion of 'agency'. However, Foucault has little to say about the agential dimension of subjectivisation, and most of what he does say is

either dismissive or obscure. For Foucault, the subject is permanently caught up in a subjectivising process or processes, that is, is both being fabricated at the level of power relations and discourse as a certain form or forms of subject *and*, consequently, involved in certain relations toward itself that accord with these forms. There appears to be little room here for any rigorous notion of agency, for an agent would be by definition some 'thing' that somehow escapes these subjectivising processes, a kind of *pre-subject* that stands outside of all power, knowledge and discourse.

By contrast, the fluid and flexible nature of migrant subjectivity suggests that the process of subjectivisation is perhaps more akin to the phenomenon of individualisation described by Beck and Beck-Gernsheim – namely, the imperative for individuals to constantly construct their own identities, to engage in 'daily reshaping and renegotiating of their mutual engagements'. (Bauman 2001 in Beck and Beck-Gernsheim 2001: xiv). Identity is therefore something one must struggle to appropriate and maintain against external forces that seek to undermine it. Beck clearly gives more credit to the role of the agent in the subjectivising process – the subject must become what it is, even while this 'is' itself is nothing stable or unitary, nothing like an essence, a rational core, fully present to itself, self-possessed, transcendental. (Beck and Beck-Gernsheim 2001)

However, this only begs the very real question of whether, from a Foucauldian point of view, this so-called 'agent' is really an agent at all in

the sense of an autonomous, pre-subjectivised entity, or whether it is not simply one more form of subjectivisation itself, one that has nothing to do one way or another with any purported 'freedom' or 'autonomy' in a metaphysical sense. It therefore often seems as though, regardless of how my participants felt about their own *agential* autonomy and power to challenge expert medical knowledge, they are always, on a Foucauldian reading, doomed to submit to a process of subjectivisation over which they have no real control, in this case, a process of becoming 'healthy citizens' responsible and accountable for their own health. (Petersen and Lupton 1996/2000) Certainly this does not capture Korean migrant women's *experiences*, and at least in this sense it indicates a serious limit to the Foucauldian approach.

The summary of each chapter is as follows:

In chapter 2, I show that the vast majority of the literature on migrants' health-seeking behaviours, including the few studies that deal specifically with Korean migrants and health, is framed around the theme of choice and the factors associated with choice. However, this approach has proven largely unsuccessful in terms of what it was originally designed to accomplish; few of the identified factors exhibit regular and reliable correlations, and the available models have little if any explanatory power. What this suggests is that an understanding of migrants' health experiences and health-seeking behaviours is best sought irrespective of the questions of

choices and factors.

Chapter 3 outlines the theoretical framework I employ, which is heavily Foucauldian. Korean immigrant women are engaged in a perpetual power struggle with the medical professionals who relay medical knowledge. If subjects are socially situated objects, then migration from one society or culture to another necessarily entails a process of subjective transformation – or simply, one can no longer be the same sort of subject. Immigrants are inevitably pressured to conform to the parameters of a new and different mode of subjectivity corresponding to the particular truth regimes and power *dispositifs* that constitute the 'raw material' of subjectivity in the host country. To migrate is not to carry an isolated ego from one external situation to another, but to re-situate one's self, to be re-situated (these concepts will be explained in detail and their relevance to the investigation at hand made explicit).

Therefore, Korean migrant women are, to a certain extent, forced to undergo a process of subjectivisation in order to become a different kind of subject than what they usually regard as desirable. Since all of my participants except two have been living in the UK for between five and ten years, their accounts of their experiences with the British medical system reveal this transformation of subjectivity, this quiet process of 'subjection' or becoming-subject (which is not the same as domination). It is this process of becoming-subject that I aim to explore in my thesis. In order to do so, it is

essential to understand the dominant discourse of the institutional settings to which these Korean immigrant women are invited to conform – in particular, the way in which they are enticed to become desirable healthy subjects through the media of government policies, the medical system, and the medical professionals.

Chapter 4 deals with methodological considerations, particularly concerning the process of data collection. This chapter includes reflexive accounts of the twin processes of conducting qualitative interviews and participant recruitment, and also deals with the thorny issue of translation. In addition, it provides general information about the participants' background in order to help understand their socio-economic situation.

Chapter 5 provides an overview of how neo-Confucianism, a dominant philosophy since the Chosun dynasty in the 15th century, continues to govern the Korean people's relations to their bodies, particularly controlling women's bodies. This is followed by information about the contemporary Korean healthcare system – National Health Insurance System (NHIS). This chapter presents a structural understanding of the NHIS, the delivery of medical care, and the utilisation of medical care by Koreans.

Chapter 6 explores how my participants' concepts of health and illness changed since their migration to the UK. This chapter purposely bases its analysis on the experiences of the Korean women regarding their initial

medical encounters with the NHS. These early contacts with the GPs served as an alarm call for the Koreans to establish a sense of responsibility for their own health – whether as a form of conforming to or resisting against the British 'healthy citizen' model form of subjectivity. As a result, my participants' efforts to re-define their concepts of health and illness as immigrants have been discussed.

Chapter 7 deals with the most dynamic event of my participants' lives since migrating to the UK: pregnancy and childbirth. The Korean migrant women, coming into the system, did not fully internalise the forms of subjectivity of active patient and healthy citizen. This is when they had the most contact with the British medical system via medical professionals and midwives, and so this is when they described themselves as feeling trapped between the British and Korean systems of medical knowledge. This is also when they appreciated the British medical system least, and conformed to the Korean medical system. However, once they experienced childbirth, they began to change.

Chapter 8 deals with the changes in my participants' identities as mothers, and their struggles with conforming to the dual forms of identity of the 'good mother' and the guardian of the children's health. It seems like childbirth constituted the transformative event, the moment when their subjectivity underwent the most profound transformation, when the categories of subjectivity of active patient and healthy citizen began to be

more or less internalised. They appropriated it for themselves as part of their identity. They underwent more active forms of subjectivisation as part of a general strategy of pursuing their own health as well as their children's. They particularly developed a form of resistance which could be characterised as 'disguised conformity' to both Korean and British medical professionals' advice.

Chapter 9 concludes with my participants' strategies – both their lifestyle changes and medical practices – for living healthily in the UK as immigrant women, mothers and wives. By this time they had come to acquire dual health citizenship, making full use of both the Korean and British medical systems. This chapter examines how the various social characteristics of my participants led them to have different experiences of and throughout the process of subjectivisation, particularly focusing on the differences resulting from having married a British man and from the duration of their stay in the UK. At the end of this chapter, the major limitations of the Foucauldian approach are discussed, in particular the ambiguities inherent in the concepts of 'subject' and 'subjectivisation', likewise of the 'object' as that in terms of which subjectivisation occurs, as well as the indeterminacy of the crucial but largely invisible notions of agency and freedom.

Chapter 2: Literature review

The main intent of this thesis is to trace the process by which Korean migrant women living in the UK are subjectivised to the British medical system – that is, how they come to experience and to relate to themselves as the kinds of subjects that are fabricated, fostered and manipulated by the forms of medical power, and codified and reproduced in the medical discourse, of their host country. What I aim to show is that Korean migrant women are for the most part skeptical of British medical knowledge and resistant to the power of the British medical institutions and their representatives – in other words, that they refuse to submit to this particular power-knowledge regime, refuse to internalise its categories, norms and regulations and make them their own, to incorporate them into their own general outlook on life and give expression to them in their concrete actions – until they are forced to undergo some profoundly life-altering experience, which is usually, but not necessarily, the experience of pregnancy and childbirth. Childbirth is a transformative experience in more ways than one, but in one highly significant way in particular: namely, inasmuch as it constitutes a radical turning point in a personal subjective history, or the history of the subjectivity of the individual herself. It is at this point that the she begins, not simply to acquiesce to this power-knowledge regime, but to actively appropriate it and to conduct her life in accordance with it, which is to say, to *be* in a totally new way, to comport herself toward herself and

toward the world in a manner that directly reflects this new subjectivity, to assume and embrace it as an integral component of her own identity.

The next chapter will elucidate many of the distinctively Foucauldian concepts just mentioned and more (subjectivity and subjectivisation, power, knowledge and discourse), which will inform this work throughout. The purpose of the present chapter is to provide a review of the most recent and relevant literature on the topic of migrants', and especially Korean migrants', health-seeking behaviours. This review will comprise two general sections: the first negative, showing gaps in the present research that need to be filled; the second positive, laying the groundwork for the analysis to follow, establishing general points that will constitute a foundation of knowledge on which the work will steadily build.

Regarding the former section (2.1), there are three major deficiencies that need to be rectified:

(1) Hardly anything has been written on the topic of *specifically Korean* migrants living in the UK and health (Koreans are usually lumped into the much more general category of 'East Asians'), and further, virtually nothing has been written on the subject of Korean migrant women and childbirth.
(2) The few studies that do exist tend to focus on a very small set of topics, especially the problems associated with acculturation, and whether and

how Koreans decide to use biomedicine or Korean traditional medicine (*hanbang*). The problems with the latter topic are, first, that these studies tend to overemphasise Koreans' use of *hanbang*, and second, that focusing on the question of choice conceals the positive implications of their *not* choosing anything at all and obscures certain fundamental questions.

(3) Research on the health issues of migrants in general has tended to focus almost exclusively on the factors associated with their pluralistic health-seeking behaviours, with little success.

Regarding the latter section (2.2), I will draw on the relevant literature to establish the following two key background points:

(1) Migrants and natives exhibit different health-seeking behaviours just insofar as migrants bring along their own cultural understandings of health/illness and their own cultural practices to their host country.

(2) Women have different understandings of health/illness than men, largely because of their experiences with pregnancy and childbirth; in addition, migrant women may have less access to support during pregnancy and childbirth.

I will begin by outlining the lacunae in the current literature.

2.1 Lacunae in the current literature

The number of Koreans registered as residing in the UK as of May 2009 has quadrupled over the past decade, according to the Overseas Korean Foundation. Yet, while the Korean population in the UK represents one of the fastest growing ethnic minorities, little research has been conducted on the health issues of Korean immigrants residing in the UK, and almost no research has been conducted on Korean migrants in the UK and childbirth. The only public report I could find, commissioned by the Department of Health and published in 2005, examines ethnic groups' communication issues in relation to their use of healthcare services. It briefly cites Kim and associates' US report (2002) on the progress of a 4-year-long project investigating how bilingual health workers and community mediators have successfully helped provide under-served Korean immigrants in Chicago with culturally competent primary healthcare services tailored to their mental health needs. (Szczepura et al 2005: 53)

The fact that there is no research available on Korean immigrants in the UK shows a lack of understanding of the health status of ethnic minorities in the UK; health of ethnic minority groups is critical to the understanding of the population health. Such understanding could indicate areas requiring improvement or public intervention to get better overall population health because it is usually immigrants who suffer from health inequalities. (Benach et al 2009: 3) It also suggests that the British healthcare system

may not have been responding to Korean migrants' needs, and that British medical professionals probably lack an understanding of their Korean patients.

2.1.1 Studies on Korean (im)migrants

The existing literature has tended to focus on (1) problems with acculturation; and (2) how Koreans choose one form of care over another.

The process of acculturation is usually described as perfectly linear, progressing from the initial stage of realising and confronting difficulties to the final stage of becoming familiar with the host culture. (Cho and Lee 2005; Lee et al 2000) Health is usually discussed narrowly as one of the 'problems' or 'difficulties' hindering Korean migrants' full acculturation. This results in conveying negative accounts of Korean immigrants in relation to health (for example, the experience of pregnancy is referred to as a 'devastating experience'). (Cho and Lee 2005) Hence the researchers' focus is to identify and remove the obstacles preventing Korean migrants from accessing healthcare services. Communication problems between the Korean community and healthcare providers in the host society have been pointed out as a major obstacle. (Miller 1990; Pang 1989; Nah 1993) A four-year-long 'bilingual interdisciplinary primary healthcare project' set up to provide mental care needs for 'underserved' Korean migrants based in Chicago shows the importance of having bilingual healthcare providers or

community brokers as a key determining factor to the success of the project. (Kim et al 2002) Communication problems lead immigrants to feel powerless and disadvantaged: middle-aged Korean migrant women who experience menopause express that they feel more powerless and vulnerable than Canadian women because their lack of English limits accessing information and causes difficulties in understanding the doctor. (Elliott et al 2002) In other words, once these obstacles are circumvented, your health problems are likely to be solved; the more acculturated you are to the host society, the healthier you are. (Yang 2007; Lee et al 2000) Cultural perception of illness is identified as a powerful influence on healthcare-seeking patterns. Korean immigrants in the US tend to be underserved in mental care services due to the stigma associated with mentally ill patients in Korea. (Noh and Avison 1996; Shin 2002; Choi 2009) Discussion of menopause is taboo for Korean women, even though menopause itself is viewed as a 'normal' and natural' life process. They remain isolated without help from their family members or friends, and they resent it when their doctors are male. (Elliott et al 2002)

Scholars (many Korean) often draw attention to the fact that Korea, unlike most developed Western countries, equally recognises both biomedicine and *hanbang* (Korean traditional medicine) as mainstream treatments. Hence they underline the fact that Koreans living abroad simultaneously use biomedicine and *hanbang* even when they migrate to another society, regardless of the cost of *hanbang*; this is recognised as a distinctive

characteristic of Korean immigrants' health-related behaviours. This tendency has led many researchers to focus almost exclusively on this issue of the double-utilisation of biomedicine and *hanbang*. (Elliott et al 2002; Kim et al 2002; Kaiser Handbook 1999; Han 2001; 2000a; 2000b; Pourat et al 1999; Miller 1990; Pang 1989) In finding out when and how Korean immigrants decide to use different forms of medicine, Han (2000b) in Australia, Miller (1990) and Pang (1989) in the US, specifically looked at when Korean immigrants use traditional Korean medicine in their host societies, despite its high costs. Han (2000a; 2000b; 2001) found that male, working class Korean migrants in Australia were in fact spending hundreds of dollars in *boyak* (traditional restorative medicine) despite their financial difficulties. *Hanbang* doctors, in response to demand, sometimes negotiate with clients regarding treatment methods and sometimes modify them, taking biomedicine into consideration. (Pang 1989)

Several quantitative studies have been done in the US to try and isolate the factors influencing Korean migrants' health-seeking behaviours, including economic and political resources such as education, occupation and political status, as well as insurance coverage, types of health problems, social networks, emotional support, efficiency and preference of medicines. However, no significant statistical relations have yet been found. (Kim et al 2002; Miller 1988; Pourat et al 1999) Using qualitative methods such as interviews and participant observation, Pang (1989) argues that types of health problems, as well as the nature of the *hanbang* clinic itself (as a place

for social gathering, a kind of 'little Korea'), are both important factors leading Koreans to seek out a certain kind of medicine. (Pang 1989) For example, a Korean migrant with a disease like hypertension might go to a biomedical clinic to get her blood pressure checked, but go to a *hanbang* clinic for treatment, based on her own knowledge about her health condition and about the respective benefits of each type of medicine. She would, however, prefer biomedicine if she had an acute illness which required immediate treatment, as in the case of 'appendicitis, fractures, thyroid problems, chronic complicated respiratory symptoms' and other illnesses that can be treated by antibiotics. (Pang 1989: 879)

The most recent study by Lee et al (2010) shows another health-seeking tendency of Korean migrants in New Zealand. They interviewed six first-generation Korean immigrants who returned to Korea principally for surgical treatments over the past five years. Using a 'therapeutic landscape perspective', they show that, regardless of successful outcomes from the New Zealand health system, the Koreans sought medical services in Korea because they found the Korean medical system both more effective and more emotionally comforting. They found that dissatisfaction with the medical service in the host society was usually caused by holding the same expectations for the doctors of the host country as for those in Korea. (Han and Davies 2006) Although my research was not affected by this study due to its date of publication, there are some similarities. First, we both look at the experience of Korean immigrants within the domain of biomedicine,

without necessarily attributing to Korean traditional medicine the status of an 'alternative choice'. Second, New Zealand has a public healthcare system like the UK; thus it is not surprising that my participants reported similar experiences such as dissatisfaction with the referral system and long waiting times. Third, being first-generation immigrants, they show familiarity with both the host and home medical systems. However, the research interest is different: the participants in Lee and her associates' study were specifically selected for their diagnoses and treatments and were sufficiently well-off to afford to return to Korea just for medical treatment. On the contrary, my research looks at Korean migrants' daily experiences and practices in relation to health, including those involving their children, and explores their inter-generational healthcare changes over time.

In sum, although researchers have successfully established that *hanbang* is not an *alternative* choice that Korean immigrants are forced to use when they lack access to biomedicine, nevertheless, their studies focus almost exclusively on why one 'chooses' to see one doctor rather than another, to go to one clinic rather than another, to take an antibiotic rather than an herbal treatment, etc. This similar and predictable emphasis on choice has led to widely dissimilar and unpredictable assessments of the factors associated with this choice, which suggests that the entire choice model itself is inadequate for understanding migrants' health-seeking experiences and behaviours. In addition, it should be noted that the choice model tends to obscure the *positive* implications of not choosing any form of medicine at

all. For example, Hong (2001), exploring the status of *hanbang* in Korea, conducted a survey of the kinds of health treatments sought by Korean people in Korea. He found that 20% of people utilised more than one healthcare service; 40% sought biomedical treatment (including those who used other forms of medicine); and 19% sought *hanbang*. However, although his data also revealed that 40% responded 'no service sought', regardless of their symptoms, Hong did not address this fact at all. Likewise, while most researchers have studied Korean migrants' health-related choices, this issue of no choice has hardly been mentioned, which suggests that there is a larger story still to be told. Does their not choosing indicate an internalisation of the logic of the host system, or have they simply turned away from the host system while utilising the Korean system when they return to Korea?

2.1.2 Literature on migrants' health-seeking behaviours

Han (2000a) argues that either the social constructionist or the structuralist approach has usually been favoured by researchers studying different patterns of health-related behaviours of ethnic minorities. The social constructionist approach focuses on how individual health-seeking behaviours are negotiated and lead to a certain type of medical treatment. The leading factors influencing this choice are ethnicity, social network and/or perception of illness symptoms. (Berger and Luckman 1967; Kleinman 190; 1988; Herzlich 1973; Dingwall 1976; Calnan 1987) On the

other hand, the structuralist studies stress the politically and economically disadvantaged status of immigrants in society, which may constrain their access to proper healthcare services and hence make them less healthy than native citizens. (Ahonen et al 2007; Benach 2009) This approach examines income and education as key determining factors, and others such as possession of health insurance, publicly funded insurance, knowledge of available services, fluency of English and so on, as shaping migrants' health-seeking behaviours.

Many quantitative studies have been done to locate the factors associated with health-seeking behaviours of ethnic minority groups. Several factors have been examined including age, sex, household income (or economic stress), education, insurance coverage, access to a regular doctor, fluency of English, self-reported physical and/or psychological health, the individual's perception of health and illness, interpretation of symptoms, and recognition of a need to receive early medical intervention. (Adamson et al. 2003; Axén and Lindström 2002; Sproston et al. 2001) However, the results of these studies have been inconsistent: unlike Adamson and his colleagues (2003), who have found no strong relationships between gender and immediate healthcare seeking, and no interaction between either ethnicity or gender and age, Sproston and his colleagues (2001) showed that gender, age, self-assessed general health reports and fluency of English were all significant explanatory factors. Especially language, in their study, appeared to be a real barrier to access to primary healthcare for Chinese who do not speak

English. Axén and Lindström (2002), however, pointed out that isolated economic conditions as well as immigrants' different concepts of health had only a slight influence on access to healthcare, but they urged researchers to keep in mind that certain structural barriers such as a lack of healthcare centres in the communities with high proportions of ethnic minority groups can create false knowledge about access to healthcare. This is supported by Naish et al (1994), who compared narratives of non-English speaking women about seeing their general doctors for cervical screening. They found that the failure of the call and recall system and unpleasant past experiences prevent some women from taking a smear test; in addition, many women tended to have incorrect information about smear tests in general.

Similarly, many studies have tried to identify the factors preventing specifically Asian migrants from seeking institutional medical care and to measure the influence of those factors, which include: (1) Asian migrants' political-economic status; (2) social and cultural barriers such as language difficulties; and (3) the moral duty of the family to care for the sick member.

Regarding (1), many immigrants simply cannot access the kind of healthcare they need, even if they desire it. Oftentimes they cannot afford it or do not have insurance (or the right kind of insurance). For example, Chinese immigrants in Canada often utilise Western medicine since the cost of medical service is covered by government health insurance. However,

since traditional Chinese medicine is not covered by insurance, it is hardly affordable for most Chinese. (Lee et al 2001)

Regarding (2), immigrants often express frustration with their general biomedical doctors for not understanding their customs and beliefs pertaining to the aetiology and treatment of their illness, and are disappointed at the remedies that are offered to contribute to their convalescence. They regularly doubt that biomedical physicians and healthcare providers can help with their problems, even if their experiences are positive overall. Some immigrants may be aware of the cultural differences and develop certain strategies for being a patient in biomedical clinics and traditional clinics and some may not.

Finally regarding (3), health problems are not only attributed to the sick, but also involve the individual's extended network. This is especially true for Asian immigrants, for whom family relationships assume a great deal of importance:

> Decisions about healthcare use are often explained as individual choice. While all such choices are bounded by social context, it is likely more so for immigrants for whom social, cultural and family ties frame many major decisions. (Portes and Sensenbrenner 1993, cited in Leclere et al 1994: 371)

The role of family with respect to health-seeking behaviours particularly

stands out in the case of Korean and Chinese immigrants: the family network provides instrumental aid and advice; financial access tends to be family based; and children are introduced to and 'socialised' into certain cultural patterns of healthcare use by their parents. (Anderson 1986, 1987; Miller 1990; Leclere et al 1994) In general, family members are the ones whom the sick individual usually consults first, and they tend to mobilise their own resources and suggest their own remedies with little assistance from outside. (Shin 2002) The quality of support within the family network seems to matter more than the actual amount, and assessing the quality of family help can hardly be measured through quantitative research. (Mui 1996) However, the family network itself can be a source of health problems. For many Asians, mental illness is highly stigmatised, and it is a general cultural expectation that it should be overcome by sheer willpower. Thus Korean immigrants tend to tolerate their condition and/or share their health problems, *not* with family members, but rather with someone who is *not* close, because they are afraid that they may bring shame to the family and make their family members feel responsible. (Shin 2002) In this way migrants may develop a certain way of being sick. For example, some Chinese migrants who were suffering from somatic distress (especially fatigue and exhaustion) expressed frustration with their family because they were often misunderstood as being 'lazy' or 'pretending to be sick'. (Lee et al 2001)

Once again, however, as was shown above, this emphasis on 'non-help-

seeking-behaviour', described in terms of barriers, prevention and the like, implies that not receiving institutional care is undesirable in some way and thus suggests a way to 'educate' immigrants to access the mainstream healthcare system. (Yu et al 2004) There is already a value judgement placed on it. However, once the focus has shifted from the question of choice to that of subjectivisation, that same 'undesirable' non-health-seeking behaviour becomes instead something that can be meaningfully examined, understood and conceptualised by the researcher as another form of health-seeking behaviour. For example, the factors that lead Asian-North Americans away from institutional treatment also cause them to find relief methods on their own such as 'taking special foods and Chinese remedies to strengthen the *yang* force'; developing certain coping strategies such as 'trying not to thing about their current social problems or to reduce expectations of themselves; learning what they could about their illness through the mass media; changing lifestyles to develop a healthier diet, regular exercise, and time for relaxation; and seeking social and spiritual support from family, friends and self-help groups for new immigrants that operated from local community centres, and attending church or temple'. (Lee et al 2001)

2.2 Setting the context

2.2.1 Migrants' health-seeking behaviours

Contrary to those studies that have tried to isolate which factors are more influential than others, Messias's (2002) study of Brazilian migrant women is a welcome exception in that it focuses on the role of identity in relation to health-seeking behaviours. Messias points out that being an immigrant does not necessarily have a negative impact on the kinds of resources one has at one's disposal, and argues instead that the multi-national identities that migrants develop in the process of crossing between the home country and the host country can prompt them to adopt certain health-conscious behaviours and to seek out a specific type of medicine based on their knowledge. She frames the use of different forms of medicine by Brazilian migrant women in terms of 'transnational medication', and shows how women's transnational health perspectives, practices and resources reflect their experience in both their home and host countries through their gender, class, race, ethnicity, and immigration status. (Messias 2002: 184) Messias's study demonstrates clearly that women's identities become fluid and dynamic as they experience different cultures through migration, blurring the distinction between formal and informal healthcare systems; as she writes, 'being Brazilian' becomes 'not only an identity, but also a health resource'. (Messias 2002: 185)

2.2.2 Women's understandings of health/illness

Cross gender studies show that men and women have different understandings of health and illness. According to one study, in describing the state of health of another person, women tended to use more negative terms than men, such as 'never ill, no disease, never see a doctor'; men, on the other hand, used more positive terms like 'fit, strong, energetic, and physically active.' (Cox et al 1987, cited in Miles 1991: 39) However, when asked to describe the state of their own health, psychological terms such as 'feel good, happy, able to cope' were used both by men and women. (Blaxter 1987, cited in Miles 1991: 39) The difference between the sexes was also apparent in the way men and women each described the concept and the causes of illness. Women tended to consider womanly problems such as 'menstruation, childbirth, pregnancy and menopause' as 'health problems' rather than illnesses. (Miles 1991: 42) Also working class women in Scotland tended to attribute the causes of illness to external factors such as infection or the environment. (Blaxter 1983, cited in Miles 1991: 44) In seeking professional treatment women are more likely to consult doctors than men. (Miles 1991: 44) Further, Fullagar suggests that women's perspectives on health and illness and their health-seeking behaviours are constructed through public discourse. In Australian policy discourse, women are described as an 'inactive or sedentary population', and the discourse of physical activity is mainly biomedicine and epistemology-oriented and thus does not reflect 'the meaning, context and construction of

women's active leisure', drawn from sociological and/or feminist perspectives. (2003: 48) Other government-led policies that reveal the gendered discourses on health-promotion include the WHO's 'Active Living', the UK's 'Active for Life', the US's 'It's Everywhere You Go', and Australia's 'Active Australian campaign'. Women are encouraged to do more domestic work, since the 'home is a space where everyday physical activity levels can be increased through "doing more"', thereby structuring physical activity as a form of domestic 'work' needed to be done rather than as a set of 'pleasurable experiences'. (Fullagar 2003: 53)

Likewise, Korean men and women have different social responsibilities following the social and cultural norms prior to their migration. (Robinson et al 2004) Korean migrant women tend to be the caregivers and/or gatekeepers for their family's health; this is their responsibility as wives, mothers and daughters(-in-law), carried over from traditional cultural norms, and yet their stories are scarcely told. (Meleis et al 1994; Elliott et al 2002; Kim and Theis 2000; Jones et al 2002) Korean women also tend to confront more complex conflicts and difficulties in the process of acculturation than men. (Inman 2006; Sohng and Song 2004, cited in Shim and Schwartz 2007) Because Korean women must juggle the expectation to fulfil their traditional obligation to be 'wise mothers and good wives' with the new and additional expectation to bring financial support to the family (Im 2003; Kim and Hurh 1988), they are less likely than men to get involved in physical activities (Lee et al 2000) and thus more likely to ignore their own

health concerns, resulting in the deterioration of their mental and physical health. (Yang 2007) Women also suffer from their wounded image of motherhood: they see themselves as 'not effective mothers' overburdened with domestic labour and employment. (Chai 1987) For these reasons, Shim and Schwartz (2007) include sex as an independent variable in their research to capture different experiences of men and women. Han, whose research is sociologically driven, focused on Korean immigrant men's health-related behaviours in Australia. (Han 1999; 2000b) He concluded that their health-seeking behaviours were influenced by their perception of health: they consider themselves to be healthy if they have the 'capacity to continue to work'. (Han 2000b: 432) Han's findings call for further research on women's perceptions of health, since women may hold different views than men, particularly if they are likely to stay home.

2.2.3 Pregnancy and Childbirth

Pregnancy and childbirth involve physiological, psychological and interpersonal changes in a woman's life. However, pregnancy and childbirth have been medicalised and consequently made women feel isolated. Martin (1989), for example, moving beyond the simple mechanic metaphor of the body as machine, doctor as mechanic, shows how the women she interviewed felt isolated from their bodies and absent in the process of delivery because their emotions or opinions were disregarded and/or they were given contradictory or confusing information about their bodies. The

language in the medical textbooks considers a pregnant woman as a 'worker' whose aim is to produce an 'output', and the doctor is regarded as manager. This is well reflected in case of caesarean sections. Caesarean sections, which require the most 'management' by the doctor and the least labour by the woman, are favoured by medical practitioners for producing the most 'perfect' baby. In aggressive response to this medical intervention, some women desperately tried to maintain control over their bodies by attempting to deliver at home by themselves.

The exclusion of social, cultural, psychological, and behavioural dimensions of illness, the mechanistic metaphor of body and illness, and body-mind dualism together constitute the medical model. Its medicalisation of pregnancy and childbirth has been strongly and widely criticised by a number of scholars who have presented how women perceived their experiences of pregnancy and childbirth and attempted to regain control over their bodies. (Martin 1989; Nettleton 2006; Oakley 1980, 1993; Roberts 1985) The underlying assumption of the critiques of the medical model is that women prefer less medical or scientific interferences in their bodies.

On the contrary, Drugonas (1987)'s study showed that Greek women wished for more and constant contact with the doctors during the prenatal period. For them, the doctors were the means of obtaining information about what was happening in their pregnant bodies. They also emphasised that

having a steady relationship with the physician up to delivery gave them emotional support. Studies have shown that having female caregivers such as midwives, childbirth educators or specially trained lay people provides emotional support for pregnant women and hence brings positive childbirth experience for women. (Hodnett et al 2003)

The experience of pregnancy and childbirth is not necessarily constituted by positive emotions only; the emotions of pregnant women range from joy and happiness to frustration and psychological disorders. Birth anxiety, which refers to all emotional aspects during labour and delivery, can be as prevalent as from 23% to 64%. (Areskog, et al 1981; Lukesch 1983, both cited in Sieber et al 2006: 1200) Sieber and her colleagues showed that even psychologically and physically healthy women are affected by a low level of birth anxiety with respect to their physical and mental capacity to cope with pregnancy. The study emphasises that the emotional well-being of pregnant women can be greatly improved through social and emotional support from their partners, families and friends as well as through obtaining professional information on pregnancy, labour and delivery from medical professionals. (2006: 1204) If support from family and friends and knowledge of pregnancy, labour and delivery play a key role in the emotional state of pregnant women, it can be suggested that immigrant women may have less or limited access to those sources of support and information due to their circumstances.

Conclusion

This objectives of this chapter were, first, to set up the academic gap in the present literature, and second, to contexualise the existing literature to establish a groundwork for the following chapter. The next chapter will deal with Foucauldian concepts – subjectivity and subjectivisation, power, knowledge and discourse, which will guide this thesis.

Chapter 3: Theoretical Framework

As I showed in the previous chapter, the vast majority of the literature on migrants' health-seeking behaviours, including the few studies that deal specifically with Korean migrants and health, is framed around the theme of choice and the factors associated with choice. However, this approach has proven largely unsuccessful in terms of what it was originally designed to accomplish; few of the identified factors exhibit regular and reliable correlations, and the available models have little if any explanatory power. What this suggests is that an understanding of migrants' health experiences and health-seeking behaviours is best sought irrespective of the questions of choices and factors.

The present research aims to take a significant step in this new direction by *displacing* the problem of choice and focusing instead on the problem of subjectivity and subjectivisation. *Displacing* here does not mean refute or demolish; it is not that decision-making is false or chimerical. Rather it means identifying a condition that *precedes* and influences the choice-act and its multiplicity of determinants; all choices, in other words, point back to a more basic or foundational process that I am here calling, in a uniquely Foucauldian sense, a process of subjectivisation or 'becoming-subject'. (Deleuze 2006/1988) In a similar vein, Ong, based on her own ethnographic account of her experience of becoming a U.S. citizen, argues that citizenship

is a 'cultural processes of "subject-ification"', i.e. a twofold process of 'self-making' and being-made' by power-relations. (Ong 1996: 737) Inspired by her approach, I wish to argue that the process of migration itself is always and necessarily a *subjectivising* process – that is, a threefold process of absorbing or taking on certain categories and concepts from without (the individual is automatically defined in certain ways that are beyond his/her control), of appropriating and internalising those categories (making them one's own), and eventually of externalising them in outward behaviour (acting in full accordance with them). These categories and concepts can be either objective, in the sense that they constitute the objects and supports of particular and historically contingent power-knowledge regimes (e.g. man, population), or subjective in the sense that they constitute forms of self-relation, self-understanding and self-comportment, i.e. ways of addressing and working on oneself (e.g. free citizen, active patient) – or, indeed, both of these, objective and subjective, at once (e.g. homosexual, mentally ill, deviant). (McNay 1994: 122) Migration is thus a process whereby individuals assume and incorporate a set of foreign objective and subjective forms, and the extent to which this incorporation occurs is just the extent to which they have become enmeshed in the webwork of power-knowledge relations that defines, characterises and describes the host society.

At the same time, it would be false to maintain that the migration/subjectivisation process is a total one, that becoming-subject is merely a one-off exchange of one complex subjectivity for another. Rather,

the migrant's former or autochthonous forms of subjectivity are always present as *traces* of varying intensities, some more vivid than others, such that the migrant possesses an astonishingly rich and complicated subjective identity and consequently a wide and hardly ever homogenous or consistent array of strategies for relating to and working on him- or herself. When a Korean woman, for example, migrates to Britain, she does not enter into a linear process of subjective transference, trading off in stages her old subjectivity for a new one. Rather she slowly comes to adopt and appropriate new forms of subjectivity at the very moment that she sheds, little by little and according to no particular logic, older forms of subjectivity that, for whatever reason, have ceased to have any existential hold or appeal. Migrant subjectivity is thus not only 'nomadic' (Lash 2001 in Beck and Beck-Gernsheim 2001: xi), a subjectivity in transition, but more appropriately, *palimpsestic*, a pastiche of often contradictory and conflicting forms. Little wonder, then, that such neat entities as explanatory factors consistently fail to emerge, and that migrants' health-seeking behaviours cannot be explained by reference to choice and factors alone, for such factors, though they no doubt exist, are always conditioned by this pastiche of subjective forms.

Now if migration is understood in terms of subjectivisation, then it is easy to see why overlooking this primary force is hugely detrimental to any attempt to understand migrants' health-seeking behaviours. For one may identify as many factors as one likes – economic, political, educational, rational or

whatever – but if these are not already drawn back down to the level of the much more general process of becoming-subject, these factors are like so many random letters of an unknown alphabet. The aim of the present chapter, then, is to explicate some of the grounding concepts that will be employed throughout this study in order to comprehend the process of subjectivisation of Korean women migrants in the UK – including power, resistance, governmentality, active patient, healthy citizen(ship), and indeed subjectivisation itself and its attendants, subject and subjectivity.

To begin: what is a subject? For Foucault, a subject is nothing but a *compound object*, which is to say, an ensemble of categories codified in discourse and intersected by lines of force, or simply, by power relations. (Foucault 1997) This is not necessarily to say that the notion of a free human agency is a pure fiction for Foucault; it is only to say that agency as such – whatever it is and regardless of what role it plays in Foucault's own ethical reflections – does not in any way constitute subjectivity. At best, agency, to the extent that we can talk about it at all in the context of Foucault's work, is something like the *differential* of subjectivity, by which I mean simply the element that keeps subjectivity fluid and flexible and prevents it from drying up and ossifying.

These objects or categories that make up the subject are therefore that on which both power and knowledge *feed*, as it were, that on which they are set to work and by which they maintain themselves. For example, the object-

category of ‘sexuality’ is a construction neither of power nor of knowledge exclusively. Instead, as something like ‘sexuality’ begins to emerge, in a particular society and on the basis of any number of cultural and historical factors, an entire discourse is spun around it at the very same time that a multiplicity of tactics of intervention comes to penetrate, manipulate and control it. (Foucault 1992/1985) There is thus a kind of double legitimation at work: power and discourse (or knowledge) sustain the object just insofar as they work on it, while the object itself, by being worked on, sustains that very discourse and those very strategies of intervention. (Foucault 2000) To say that sexuality is a form of subjectivity is therefore to say that, for modern Europeans, sexuality has become an entire field for analysing, theorising, assessing, measuring, dissecting, probing, investigating, disciplining, controlling, monitoring and punishing actual individual human beings; it is one way in which European humanity has come to know and to manipulate itself. What is more, it is just for that reason a mode in which those very human beings have come to understand and to relate to themselves as subjects: they monitor their own sexuality or liberate it, embrace it or feel guilty about it, flaunt its potentiality or confess its wickedness, etc. Around sexuality, therefore, as an object or a mode of subjectivity, there arises a vast and complicated host of possible techniques for relating to and engaging with one’s own self as a sexual self, a sexualised subject. (Foucault 1992/1985)

For Foucault there is no escaping either power relations or subjectivity,

since there is no outside-power into which one could flee and take refuge. (Foucault 1997) It is always and only a matter of navigating between or among different power-knowledge regimes and thus different forms of subjectivity, or of creating openings for the production of new modes. Migration, in this sense, is not simply a movement across nations or across cultures, but equally a movement across a whole landscape of forms of subjectivity. For this reason migration is always more than simply a process of acculturation, which is more or less a becoming familiar and comfortable with the various ways of doing things and of conducting oneself in a new environment, i.e. a cultural adaptation. By contrast, the notion of migration as a process of subjectivisation implies something more – viz. an ontological dimension: the migrant actually *becomes*, to a degree and always more or less, a new subject altogether, i.e. actually *is* in a way in which s/he *was* not in the home society and therefore relates to him/herself in fresh and novel ways that accord with this new identity. Subjectivisation points to a much richer phenomenon than simple acculturation: it implies something deeper, less pragmatic. Acculturation can be seen as a kind of '*savoir faire*', a practical know-how, a getting used to things; subjectivisation is an ontological transition or transfiguration. In a quite literal sense, the migrant is a different person to the degree that s/he becomes subjectivised to or within the host society.

I have been using the term 'power relations' rather than simply 'power'; the reason for this is that power, for Foucault, is always a linking term between

two actions. It is any action that influences another action. Thus power is nothing like brute force, but rather simply manipulation or even control, in the most neutral sense of these words. It is not necessarily negative or prohibitive – although it certainly can be these things, too – but just as often productive and generative. The danger is never power itself – indeed this makes no sense, since power is simply the constant vibration that keeps social relations mobile and fluid – but rather the fixing or freezing of this vibration, which is what Foucault calls 'repression' or 'domination', the total absence of power. (Foucault 2000)

The kinds of power relations that Foucault is interested in are primarily those in which human subjectivity itself is at stake. For example, relations between parents and children are certainly relations of power, but Foucault is not interested in these kinds of relations *unless* and only to the extent that they involve some kind of transformation or imposition of a mode or modes of subjectivity (for example, when parents monitor their children because they fear they are not being sufficiently vigilant regarding their emerging and inherently dangerous 'sexuality'). (Foucault 2000: 121) Now Foucault's analyses show that the combination of subjective forms and power relations is not random; rather certain forms or modes of subjectivity arise within particular constellations of power relations, or tactics of power, that are organised into larger and more general technologies of power that are themselves components of broader historical truth regimes. There is thus a kind of hierarchy of formal organisation. A truth regime is simply an

ensemble of technologies (and thus tactics or techniques) of power, the concomitant objects of those technologies and the various discourses organised around those objects. For example, disciplinary power is a particular form or technology of power incorporating particular disciplinary tactics (e.g. surveillance, incarceration) and geared toward intervention into and engagement with particular disciplinary objects (e.g. deviants, abnormals) that are themselves the subjects of numerous domains of knowledge (legal, medical, juridical, psychological, religious, etc.). Put simply, forms or technologies of power, as organised ensembles of particular tactics for manipulating actions, are always correlated with particular objects that constitute the categories according to which human beings are both objectively and subjectively subjectivised. The goal, then, for any sociologist who aims to study migration as a phenomenon of subjectivisation, is to identify the power technologies and their attendant objects (forms of subjectivity) that are most relevant for their particular field of investigation. (Foucault 2000: 111-133)

Now, in the case of the present investigation into the health-seeking behaviours of Korean migrant women in the UK, the most relevant form of power is *governmentality*, and the most relevant categories or modes of subjectivity arising within the domain of governmentality are *active patient* and *healthy citizen*. Specifically, active patient/healthy citizen can be understood as the way in which individuals are subjectivised with respect to the domain of medicine within a society where governmentality is an

operative form of power. This is simply to say that – insofar as migration is subjectivisation – when Korean women migrate to a 'governmentalised' country such as the UK, they inevitably take on, appropriate and manifest the particular forms of subjectivity that accord with governmentality as a specific and historically contingent technology of power. No doubt this governmentalisation-subjectivisation occurs at any number of levels and within any number of concrete domains. (Rose and Miller 1992) But since the domain I am concerned with here is that of medicine, it will be necessary to bracket every other domain except this one, and to consider it in relative isolation. Thus if active patient and/or healthy citizen constitute the forms of medical subjectivisation proper to the power-form of governmentality, and if governmentality is characteristic of contemporary British society as the host society of these Korean migrants, the present research should be concerned with investigating the process by which these migrants assume, adopt and externalise these medical forms of subjectivity while simultaneously shedding or displacing other forms of medical subjectivity characteristic of their country of origin. In short, it should aim to describe the process of the formation of a *complex medical subjectivity* that precedes and exceeds the multiplicity of factors that scholars have tried, time and again, to link up with migrants' medical choice-acts.

In the rest of this chapter I shall provide a general theoretical orientation that will guide the rest of my research programme. Employing Foucault's concepts of governmentality and subjectivity, I shall proceed by setting out

the discrepancies between health as it is governed via public authorities and the health of individuals. I will first examine the public health discourses, including official NHS policies, and their practices to construct and reinforce 'healthy citizenship' as a desirable form of subjectivity, on the basis of Foucault's notion of governmentality. Second, in response to the techniques of governmentality, I will focus on individuals' experience of and efforts to construct and produce [alternative] forms of subjectivity. In doing so, I will explicate the particular feminist Foucauldian contribution to gendered subjectivity. I will complete the chapter by outlining my specific research questions in light of this approach.

3.1 Public Health vs Private Health

In the late 20th century, the medicalisation of biomedicine has been greatly challenged: first, the demands for complementary and alternative medicines have challenged the biomedical interpretation and treatments; second, neo-liberalism has shaped the political and economic agendas, with an emphasis on individuals; and third, consumerism has emerged and shifted the welfare state's agenda. (Nettleton 1995)

Within the sphere of public health, the patient used to be viewed as 'vulnerable' and a 'recipient of medical care' by doctors whose authority and decisions could hardly be challenged. (Lupton 1997a: 97) However, as neo-liberalism and consumerism started to shape the public agenda over the

past two decades, public health discourse also shifted. In the wake of this trend, notions such as ‘consumer patient’ (Lupton 1995), ‘active patient’ (Petersen 2003), and ‘reflective subject’ (Armstrong 1993) began to emerge.

Since the 1980s, the conservative government in the UK has been advocating for a more consumerist approach to health care delivery and to treat health care services as a commodity which can compete in the commercial market. This approach presumes that competition among the medical services will improve the quality of service, benefiting the patients qua consumers as the patients will be able to ‘shop around’ for the services that best fit into their demands. (Lupton 1997b) Neo-liberalist attitudes to contemporary public health require individuals to take personal responsibility for their own health, and face the consequences themselves for their own choices.

Underlying these two approaches is a certain way of regarding the individual, namely, as an ‘autonomous’, ‘self-reliant’, ‘enterprising’, ‘subjective’, ‘rational’, and ‘active’ self. (Rose 1990, 1992; Nettleton 1997: 209) The shift in the way patients are viewed, from passive and dependent recipient to active consumer, reflects changes obliging individuals to enter into new relationships with experts and the welfare state; while the state collects data and implements tactics to produce healthy and productive citizens, individuals are expected to adopt healthy practices and ‘self-govern’ themselves accordingly, based on a range of risks – moral, social,

economic, environmental, and biological – presented by experts. (Petersen 2003)

3.1.1 Governing the health of the public

Although the term 'active patient' is commonly used in public health discourse to refer to patients with active attitudes toward improving their health (Fox et al 2005), scholars seem to differ slightly in their assessment of what constitutes an 'active patient': some emphasise patients' degree of awareness, knowledge or expertise (Donaldson 2003; Ziebland 2004, Heldal and Tjora 2009), while others adopt the perspective of patient empowerment and consumerism, particularly treating patients as 'partners' of the medical professionals. (Lupton 1997b; Henwood et al 2003; McGregor 2006)

Similarly, individual citizens are expected to become part of the 'agencies' that aim to maximize the efficiency of healthcare by engaging in preventative activities to cut down the economic costs of treatment and by constantly monitoring their behaviours. Individual citizens are encouraged to examine their own bodies, which is key to constructing a 'new health citizenship' through governmentality. (Lupton 1999: 87) This 'health citizenship' has been constructed and reinforced through a number of programmes and strategies implemented by institutions at various levels, including the government, local communities, and social groups. (Lupton 1999: 87; Pryce 2000: 104)

This emphasis on the roles of the active patient coincides with another commonly used term in the new public health discourse – 'health promotion' – which is used in relation to managing and building the 'positive health' of the population, mostly through emphasis on illness prevention rather than treatment. (Tones 1986: 3, cited in Lupton 1995: 51)

Foucault's concept of 'governmentality' is useful here. Governmentality was previously thought under the more restricted concept of 'biopower'. In his lectures at the College de France from 1977 to 1978, he abandons the concept of biopower in favour of the more expansive concept of governmentality. (Foucault 2007) Governmentality signifies the ensemble of institutions, procedures, and techniques 'that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technical instrument'. (Foucault 2007: 108) The concept of governmentality is two-sided, 'simultaneously individualising and totalising'. (Macleod and Durrheim 2002: 45) It enables us to analyse both micro- and macro-impacts of power – on the one hand, the techniques used to incite target populations to conform to a certain mode of subjectivity and to be reflexive and self-monitoring, and on the other hand, the objectivisation, through tactics and strategies designed to regulate individual bodies, of the individual as a docile body. If the 'clinical gaze' once looked at the microscopic details of the body, it now focuses on the 'social-

psychological space' between bodies, which enables the 'medical surveillance' of the population. (Armstrong 1995) With respect to medicine and health, we can situate Korean immigrant women by looking at the strategies and techniques that the UK government employs to promote the overall health of the public.

The UK government's 1999 White Paper, *Saving Lives: Our Healthier Nation* states that the government will consider not just 'the social, economic and environmental factors' but the 'individuals' decisions' as affecting the output of the public health. The White Paper calls for 'a new balance' where the population, communities and the government work in partnership to improve health. (DoH 1999) It acknowledges that their past strategies were largely focused on 'lifestyle issues', and treated the public as passive recipients of information and education. Instead, a new strategic discourse aiming to engage with the public as 'active partners' has been adopted, which calls for 'mutual obligations' in the service of which, first, the government develops a number of mechanisms to influence individual decisions by providing access to expert information and advice, and second, communities tackle health via 'community factors' such as poverty, unemployment, low education, etc., and finally, individuals improve their health by changing their behaviours, which improves their health and reduces risks.

> **3.2** Past health strategies have tended to focus excessively on lifestyle issues. Yet paradoxically they have often failed to recognise how people can play a positive part in building healthy lives for themselves and in contributing to the health of other members of society. People were treated as passive recipients of information and services, rather than as active partners. This contributed to the widening of the health gap: we now know that the better off are more likely to act on health information to change behaviour and reduce the risks to their health. (DoH 1999: 3.2)

Thus strategies are developed to support 'self-care' by providing access to healthcare or health information at home via telephone, television, and the internet as the government's initiatives to establish partnerships with its citizens..

Individuals are encouraged to examine their own bodies and look for signs of risk, which encourages individuals to become 'active participant[s] in their own care'; further, individual behaviours are regulated through subtler methods of control such as incitement and persuasion rather than enforcement or coercion. (Foucault 1981; Hayter 2006: 34) As a power tactic, the creation of 'risk' is central to persuade patients to develop self-care practices. (Hayter 2006) In promoting health activities, risk is conceptualised as a consequence of 'lifestyle' choices, which puts the emphasis on self-control and self-management. This internally imposed conceptualisation of risk is different from Beck's risk, which mainly refers to external dangers and unintended consequences of industrialisation, such

as environmental hazards, nuclear threats, etc. (Lupton 1995: 81; Beck and Beck-Gernsheim 2001) This risk discourse lends an air of 'neutrality' and 'objectiveness' to biomedicine as a body of knowledge, and grants biomedicine the right to categorise 'risky' behaviours and identify bodies 'at risk'. (Lupton 1995: 81)

The impact of the internet has been identified as a major contributor to the creation of the 'expert patient' and the 'consumer patient': the fact that anyone can easily and instantly access expert-like health information on the web enables patients to become 'reflexive consumers' (Lupton 2002; Henwood et al 2003; Heldal and Tjora 2009) who can evaluate possible treatments, purchase drugs (with or without a prescription), and use web-based discussion forums for exchanging experiences, knowledge and information. (Fox et al 2005) This all contributes to patients' having 'agencies' to participate and make informed choices.

3.1.2 Foucault's subjectivity and the construction of 'healthy citizenship'

Foucault was always concerned with the ways in which the subject is formed as a 'possible, desirable or even indispensable object of knowledge' at a given time, in a given institutional context. (Foucault1997: 87) A subject, for Foucault, is an object of socially constructed knowledge; it is a point where multiple vectors of truth intersect to form an object. The subject

is thoroughly empirical in the sense that it is finite, historically determinate, and factically contingent. The subject is not a thing in itself, nor is it a transcendental consciousness which stands anterior to objects and comprehends them from some privileged perspective. It is in itself an object of truth and a site of intervention of power relations. The theme of the subject is constantly present throughout his oeuvre.

However, whereas in his earlier work Foucault concentrated on describing how the subject is shaped or 'fabricated' into a definite object of knowledge according to the different configurations of power relations operative at different moments in the history of Western societies, in his later work he tackled the problem of the fabrication of the subject from the reverse perspective, namely, the labour that the self performs on itself in a given historical situation, the ways in which it is possible and acceptable for the subject to work on itself as a subject of a certain kind (ways that, importantly, are themselves made possible by the very same power-knowledge matrix). In short, Foucault's focus changes from the 'fabrication' of the self to the 'self-fashioning' or 'care' of the self, or simply to an 'aesthetics of the self'. It is in the context of this shift of emphasis from an 'arche-ontology' of the subject to an 'ethics' of subjectivity that one must approach his concept of 'technologies of the self', i.e. techniques by which one governs oneself through reflecting 'on modes of living, on the choice of existence, on the way to regulate one's behaviour, to attach oneself to ends and means'. (Foucault 1997: 89) The word 'technology' connotes not simply

any activity or procedure one might carry out on oneself, but only those procedures carried out in conjunction with a certain form of self-knowledge – which is to say, the subject is not only an object of knowledge but also, and equally fundamentally, a knowledge of itself precisely inasmuch as it works on itself. In short, to work on oneself is always to know oneself *as* one *is* as some particular object of social knowledge.

As for 'subjectivisation', this has a double significance: when a subject is considered as an object, subjectivisation refers to the process by which this subject-object is constituted in discourse and maintained through power; when a subject is considered from the point of view of its relationship to itself, then, subjectivisation refers to the self-reproduction of a socially sanctioned mode of subjectivity. In other words, a subject does not dream up its own ideal subjectivity, but takes it from the broader social world in which it finds it as an object already available:

> the subject constitutes himself [sic] in an active fashion, by the practices of self, these practices are nevertheless not something that the individual invents by himself. They are patterns that he finds in his culture and which are proposed, suggested and imposed on him by his culture, his society and his social group.' (Foucault 1998: 11, cited in Nettleton 1997: 211)

The term 'active patient' is also related to the concept of the 'reflexive subject'. 'Self-governance' implies 'reflexivity' in postmodernity, where the self has become a 'reflexive project'. (Nettleton 1997: 220) Contemporary

health and healthcare are not limited to the domain of hospitals and clinics, but involve 'a whole array of agencies, institutions and settings'. (Nettleton 1997: 208) Individuals are expected to maintain or promote their own health by participating in a variety of health-related activities, such as diet and exercise, in order to monitor their lifestyle. While experts enumerate the various 'risks' for health, it is the individual's responsibility to calculate those risks and act accordingly, or else face the consequences. (Nettleton 1997) As patients become more informed and knowledgeable, they are encouraged to challenge the clinicians' rights and authority. These newly empowered patients and clinicians are then expected to construct a partnership and share the decision-making process.

Advocates for patient empowerment emphasise the importance of patients' rights (control over their own bodies) and capacity for autonomy. (Lupton 1997b: 373) With the transition from modern to post-modern society – which emphasises difference, cultural diversity and heterogeneity with respect to identity formation and lifestyle, and which thereby encourages relativisation and pluralism – patients have now become consumers and medicine just another 'commodity' (Eastwood and Correa 2000: 8); thus, as customers purchasing a product, patients start to demand more environmentally friendly medicine (such as complementary and alternative medicines) (Bakx 1991; Robertson 1992; Turner 1995; Anyinam 1990; Clavarino and Yates 1995; Lewis 1995, cited in Eastwood and Correa 2000: 2, 7); 'freedom of choice' (Sampson 1996, cited in Eastwood and Correa

2000: 7), as well as recognition by medical professionals of their status as subjects rather than objects in the doctor-patient relationship. Patients are able to *choose* whatever they think is most suitable for their illnesses based on their own health beliefs. And this is well reflected in the current UK government's political approach towards promoting active lay participation in health related policies: several terms such as 'user involvement', 'public consultation' (Harrison and Mort 1998), 'expert patient' (Wilson 2001), 'community participation (Milewa et al 1999) and 'active citizenship' (Milewa et al 1998; Pickard 1998; Rowe and Shepherd 2002) imply the UK government's attempt to democratise the process of health policy-making by taking the position that the state will serve to support the citizen's decision-making in choice of treatment.

Foucauldian analyses of the active patient model call into question the Marxist/liberal humanist discourse of 'empowerment' which implies a certain notion of 'liberation' as the extrication of the patient from a totalising, authoritarian situation. On this view, power is understood to be one-sided, thoroughly negative in character, and exercised in a top-down fashion that leaves no room for free choice for those at the bottom. 'Liberation', however, in whatever form it assumes, is something that Foucault is always highly suspicious of in his texts and something he cautions we ought to discuss only with extreme circumspection, for two main reasons: First, as he has amply demonstrated (for example, in *Discipline and Punish* as well as the first volume of *The History of Sexuality*

and elsewhere), power is never merely reactive, exclusionary and prohibitive, but is rather, and even primarily, positive, productive and constructive – it moulds and shapes reality rather than simply negating and denying it; it says 'yes' just as often as it says 'no'. Second, by conceptualising power as something external to subjectivity, something that can be owned, grasped or possessed in a self-assertive fashion by individuals or groups, Marxists/liberal humanists end up treating 'patients' as though they were unitary, autonomous in-dividuals who somehow stand outside of power, i.e. who are not thoroughly invested by power, themselves products *of* power. Therefore such discourse effectively sets up a false binary opposition between 'power' on the one hand as something that someone 'has', and 'patients' on the other hand as autonomous agents who are being prevented from taking charge of their own destinies.

The result of these two confusions is a conceptually dubious and politically feeble notion of 'empowerment' – a notion which, one could argue, actually serves more to reinscribe and reproduce the dominant discourse than to disrupt and displace it. 'Empowerment', on the Marxist/liberal humanist paradigm, in the end amounts to little more than emphasising the 'rights' of the autonomous agent to 'choose' his/her preferred method of treatment from among the many options that are available to him/her at any given moment. It is basically a juridical notion grounded in the sovereignty of the individual; thus it ignores the complex ways in which human existence is saturated with and structured by power. The active patient is certainly

‘empowered’, but for all that is no less subjectivised with respect to the broader power/knowledge regime.

But for anyone who is operating out of a more Foucauldian orientation, empowerment can never simply be a matter of rights and free choice, but has rather to occur at the level of the subject itself; it cannot merely be a matter of the autonomous agent seizing control over what is right-fully his or hers, a matter of taking back the freedom to choose that was effectively stolen from her by those on the higher strata of the hierarchy. Instead, empowerment has more to do with, first, identifying those places where power relations are excessively concentrated and where historically contingent values and norms have assumed the status of ultimate truths, and second, seeking out possible points of insertion where established borders can be crossed-over, and this with the goal, not of establishing unity and sameness, but rather of preserving difference, heterogeneity. For Foucault, and for those of us working out of the same toolbox, it is not a matter of the right to choose, but of challenging the legitimacy of established knowledge and truth in order to respect and maintain the singularity of the other and to keep ourselves open for the possibility of something new. It is in this sense that I find my project to have some practical, political applicability and relevance.

In describing how subjectivity is produced and reproduced, Foucault relies heavily, if at times implicitly, on the concepts of power relations and

resistance. Power, as action on action, is present in every human relationship where there is an effort to control or manipulate the behaviour of the other. Furthermore, the omnipresence of power is doubled by that of resistance, which is best characterised as the counter-pull of an opposing power. Since power relations, for Foucault, are necessarily elastic and dynamic rather than fixed and stable, reversible and modifiable rather than unidirectional and frozen, resistance can be thought of as the inverse tension exerted in any execution or deployment of power; where no tension exists, where it fails to actualise or is prevented from doing so, power vanishes and is usurped by domination. Resistance and power are mutually implicating, and hence, in order for power to operate qua power, i.e. to retain its fluidity and not contract into the fixity of repression, subjects must be free to a certain extent to alter their situation. (Foucault 1997: 167, 291-292) Resistance, then, as a continuous 'struggle' (which does not necessarily involve anything bad or evil), can exert just as profound an influence on the behaviour of the other, it being nothing other than the reciprocal exercise of power.

Just as power is productive rather than reductive (power generates and creates; it does not simply limit, prohibit, deny), resistance is also productive: the act of resistance develops certain practices or techniques to be adopted by individuals in the process of subjectivisation. Power relations are obliged to change (or not change as a result) in accordance with the act of resistance as long as free subjects are involved. The extent of the change is variable and often marginal, but also given, according to the logic of

power. A subject capable of resisting the power techniques employed to govern his or her behaviours can be understood as an agent possessing the capacity to act on his or her free will. A free subject has the ability to change or reverse power relations, which by their nature are unstable and flexible. (McNay 1992; Foucault 1991: 12)

Lupton identifies certain points where individuals decide to resist and establish alternative forms of subjectivity. One is when conflict arises between individuals' actually felt experiences and the 'official' experiences they are supposed to have, i.e., the gap between 'experience and representation'. (McNay 1992: 153, cited in Lupton 1995: 134) Another is when the various techniques of government deployed by the diverse array of social institutions do not harmonise; in this case their respective rationalities may not exactly represent those of the state's and so diverse discourses, sometimes competing with each other for their own imperatives, may well produce room for resistance and multiple subjectivities that do not coincide with the 'imperatives of public health'. (Lupton 1995: 134)

The multiple points of intersection between forces, rationalities, techniques and incitements used on every individual create the potential for individuals to assume alternative forms of subjectivity, whether consciously or unconsciously, and this 'interplay of repression, incitement and desire' has been theorised by sociologists and cultural studies scholars. (Lupton 1995: 135) Keeping the elasticity of power relations in mind helps us explore the

relationship between medical professionals and general patients – the unbalance of power (attached to expert knowledge) between experts and the general populace does not alter the relation of power/resistance to that of domination.

3.2 Limitations of the Active Patient Model

While studies on the discourses of public health and the active patient have contributed to analysing the forms of power used to construct the 'active patient' as a desirable form of subjectivity, they are nonetheless limited in a few important respects. First, these studies tend to overlook the importance of the very personal and often intangible experiences that patients may have, and their unconscious and inevitable dependence on medical experts while they are engaged in the 'ceaseless construction and reconstruction of subjectivity'. (Lupton 1997b: 379) Although patients' accounts reflect consumerist attitudes, they do not fully recognise themselves as consumers and medical treatments as commodities. (Lupton 1997b) They seem to practise simultaneously the 'patient role' as passive recipient and the 'active patient role' as consumer. They also express a willingness to develop rapport with a particular doctor that they feel they can trust.

Second, studies by Ferguson (1997) and Eysenbach (2000), who examined, respectively, the emergence of 'online self-helpers' and the desire of patients as consumers to take back control of their health, make the 'normative'

assumption that individuals *want* to take more responsibility for their own health through self-care. However, contrary to what one would expect given the discourse of the informed patient, individuals displayed a reluctance to take control, and were in fact aware of their inevitable dependence on medical professionals for their knowledge, skill and judgement. (McGregor 2006: 7; Peerson 1995) Thus, more knowledge and information do not necessarily translate to more active engagement and involvement in pursuing health. (Henwood et al 2003: 590; Heldal and Steinsbekk 2009)

Third, although widespread use of the internet was thought to transform the doctor-patient relationship by de-professionalising medicine and challenging medical expertise, doctors prefer to stay in control during consultations and employ a number of strategies to maintain power. Rather than perceiving informed patients as empowered and inviting them as partners in the decision-making process, in reality, doctors normalise and encourage patients to become passive in medical encounters. (Broom 2005; Massé et al 2001) Yet, this does not mean that lay people are trapped in medical rationalities. The self-starvers, for example, purposely go on starving to challenge the socially acceptable notion of 'beauty' along with scientific and medical rationalities and authorities. (Eckermann 1997) Rather, this critique reminds us that further research should explore the complex layers of experiences and practices that take place in inter-personal relations during medical encounters.

Thirdly, there is a limit on how much patients can be 'informed' and lay knowledge quite often does not stand up against independent expert knowledge. Biomedicine not only provides scientific and factual knowledge about diseases, it also frames cultural views about disease and illness. Lay people adopt and accept professional explanations, and thus their knowledge and beliefs embed expert rationality. (Shaw 2002) As 'active' citizens search for information, the very sources of information privilege biomedical interpretations as opposed to other forms of knowledge. (Dixon-Woods 2001) The information which is *supposed* to encourage active participation from patients may well serve the interests of medical professionals by offering 'information for compliance'. (Henwood et al 2003: 591)

3.3 Feminine subjectivity – Gendered subject

The 'active patient' as 'reflexive subject' presupposes an autonomous and rational consumer. Yet these concepts do not entail the aspects of gender or sexual identity. (Lupton 1997b: 374) The lack of a gender dimension in Foucault's analyses of power has been widely criticised by feminist scholars. (McNay 2000) If subjectivity is a reflection of the social, political and economic dimensions of the operation of power, the subject must always be considered as a gendered subject. Feminist theorists such as Luce Irigaray (1993) and Elizabeth Grosz (1994) have questioned how culturally specific, feminine subjectivity is fabricated and reinforced in the gendered power relations of the masculine-dominant culture. If the discourses of rational,

autonomous and reflexive subjectivity in relation to public health have produced the notion of healthy citizenship, it should also be noted that the same discourses have also fabricated subjectivity as gendered subjectivity, which reflects women's embodiment of 'responsible feminine citizenship'. (Fullagar 2003: 56) While disciplinary technologies are employed to regulate and normalise subjects, medical surveillance of the population takes place through the promotion of self-reflection practices; thus, exploring the feminine, gendered practices provides a lens through which to analyse the larger issue of gender oppression. (Macleod and Durrheim 2002: 48)

My thesis supports that the Korean women's experience of pregnancy and childbirth in the UK is a turning point for the women to start to internalise the process of subjectivisation not just to the British but also to Korean norms of prenatal and postnatal care. From the moment of their realisation of pregnancy, they are, in a way, forced to 'get in touch' with the British medical professionals, in which the differences between the Korean and British practices become superfluous. It is also the time when the Korean women felt powerless and entrapped in the British system.

Foucauldian perspectives provide insight to how pregnant women establish themselves as pregnant subjectivities: Root and Browner examines that the experience of pregnancy is a 'split subjectivity' of the biomedical, authoritative knowledge and the 'subjugated' knowledge. (2001: 196) The

pregnant women constitute their knowledge by constantly negotiating among their subjective, bodily experience, biomedically driven and political norms which all define what constitutes pregnancy. (Root and Browner 2001: 218) The assessment of the pregnant women's appropriate behaviours, therefore, ranges from a full conformity to resistance in relation to the biomedically driven norms of pregnancy.

Root and Browner note that the women's experience of pregnancy reflects a 'slippage' in 'pregnant subjectivities' between women's own subjective bodily experience and objective, biomedical knowledge as women internalise their experience in the framework of biomedicine.(Root and Browner 2001: 217)

The feminist critiques of subjectivity are in line with more widespread criticisms levelled at Foucauldian scholars who fail to recognise the ways in which medical professionals and lay people experience and practise medicine. An unbalanced focus on medical surveillance tends to overlook lay people's response to the clinical gaze. As Shilling says, bodies may be perceived through discourses, but they are not reducible to discourse. (Shilling 1991: 664, cited in Lupton 1997a: 103)

Such critiques of Foucauldian perspectives call for further studies that explore the 'embodied and affective experiences' of subjectivity that accommodate both conscious and unconscious processes of experience that

the subject undergoes. (Lupton 1997b: 380) These studies should also include the gender dimension to explore how lay people resist medical surveillance and rationalities by employing certain practices of the self.

Conclusion

To sum up, this chapter attempted to show how a Foucauldian approach could prove more valuable and reliable with respect to the question of migrants' health-seeking behaviours than an approach built around the themes of choices, factors and decision-making. The reason for this, I argued, is that all such choices and factors first need to be drawn back down to a more basic level – viz., that of the subjectivity of the subject itself – in which they are ultimately rooted. To this end I suggested it would prove instructive to construe migration as a process of subjectivisation rather than simple 'acculturation', which indicates more or less a kind of increasing practical know-how, managing or 'getting along'. Subjectivisation points to a much deeper process whereby individuals come to adopt, appropriate and manifest the subjective categories of their host country. In this sense subjectivity constitutes the 'background' on which all discourse of choices and factors must be situated, that to which choices, regardless of their sundry factors, always in some way refer. I also argued that the concepts of governmentality, as the dominant form or 'technology' of power operative in contemporary British society, and of 'active patient/healthy citizen', as the ideal form of medical subjectivity within this governmentalised society,

offer a trajectory and a goal: that is, for my participants, subjectivisation with respect to the domain of medicine involved a transition in the direction of the healthy citizen model as that which captures the most desirable mode of medical subjectivity. To become-subject with respect to the medical domain in the UK is to become (adopt, appropriate and manifest, both outwardly and inwardly) an active patient/healthy citizen, someone who takes care of his or her own health, who remains vigilant, self-aware, proactive, engaged and critical. Finally, I suggested that this process of becoming-subject, as the most accurate description of the process of migration, could never (or almost never) be complete, in the sense that one subjective identity were simply traded off for another one. Rather it is always a matter of a blending, co-mingling and *relative* preponderance of certain modes or others; to migrate is to take on some subjective forms as dominant and to let others slip away as they become undesirable, irrelevant, obsolete or forgotten. This is precisely the story I wish to tell regarding my Korean migrant women participants with respect to their steady exposure to, inevitable conflict with, and eventual acquiescence to the British medical system.

Chapter 4: Methodology

This chapter deals with methodological concerns pertaining to data collection, access negotiation, qualitative interviews, translation and the reflection on the development of theoretical framework.

4.1 Data Collection

4.1.1 Korean Immigrants, New Malden and Access Negotiation

There are approximately 25,000 Korean immigrants living in the UK and 20,000 of them live in the boroughs of London. New Malden in Surrey is a unique place both for Korean immigrants and my own research. It is the only place in the UK where you can find a majority of Korean-run businesses in one place – 21% out of the total number in the UK. (Korean Community in London 1998)

Although Korean immigrants make up 5% of New Malden's population (Korean Community in London 1998) – which is not small compared to other ethnic minority populations – New Malden more or less offers commercial service for Koreans living in the UK. It is a place where Koreans buy Korean products; a social place where they meet up to chat in Korean-run cafes; and a religious place where Korean churches offer services in Korean. In terms of medical services, New Malden is also

culturally diverse: four Korean traditional clinics are located – Seoul Han Clinic, Won Clinic, Korean Sooji Clinic Institute, and Complete Care Clinic – alongside British NHS clinics, Chinese and Indian traditional clinics, and other complementary and alternative medical clinics. Various medical products originated from China, Korea, Japan and India are easily accessible in the pharmacies in New Malden. It is at once a distinctly Korean and highly multicultural space, where Koreans can go for their healthcare needs, whether the products or services they are seeking are Korean, Chinese, Indian or British.

Without knowing any Koreans in New Malden, I decided to go through institutions such as Korean traditional clinics, attempting to recruit Koreans visiting the clinics. Although I contacted all the Korean clinics in New Malden, I was only successful in establishing a relationship with one of them. Mr Park, the therapist, and his wife were sympathetic to my research and allowed me to come in and observe his medical consultations with patients for a few days. While spending time at the clinic, I was able to build a good relationship with Mrs Park, who eventually became a gatekeeper to other Korean immigrant women living in London. Mrs Park has six female friends and they all get together once a month to hang out. When Mrs Park introduced me to the group, everyone was more interested in my personal life than in my project. After the first meeting, I realised I was regarded as a young female PhD student who came all the way to Britain and who is struggling to survive, living alone and ‘in need of some fresh air’. This way

they did not feel ‘too terribly guilty’ about calling me and asking me to spend time with them. I always let them talk freely about anything they wanted and paid great attention to their stories. I occasionally asked them if I could use their stories for my project, and took notes whenever I obtained their permission. Once I developed rapport with these women, fifteen other women were recruited via snowballing method.

4.1.2 General information of the participants

In total, twenty-one semi-structured interviews were conducted. All my participants had lived in the UK for more than five years, and nine participants for ten years or more. Among them, Mrs Kim and Mrs Soo were the only two in their mid fifties; Woo was twenty-nine years old, and the rest of 18 women were in their thirties. Among them, twelve women were thirty-five years old or older.

Except Mrs Kim, Mrs Soo, JP and SE, everyone else experienced pregnancy and childbirth in the UK. Mrs Kim delivered her two sons in Korea, and JP and Mrs Soo in Japan and Hong Kong. These women stated that their experience of pregnancy and childbirth was too long ago and could not remember. Therefore, questions regarding pregnancy and childbirth were not further pursued. SE did not have any children, but she was the only one who suffered seriously while living in the UK: she was treated for low platelet count in Britain. Her story was valuable for this research because

her attitude toward health and illness had undergone major changes after her illness experience. Except these four women, most of my participants' children were aged five or under, and eight mothers experienced childbirth within one year of the interview, which enabled them to provide more lively and vivid recollection of what their experience was like.

All my participants classified themselves as middle-class and migrated to Britain due to their husbands' jobs. All my participants, except Mrs Kim, worked in Korea as career women before they came to Britain, but ten of them were housewives at the moment, four participants were professionally employed, and the rest were involved in part-time administrative work. Seven women were married to non-Korean husbands – six to British and one (JP) to Japanese. The rest of fourteen women were married to Korean husbands. Appendix A shows brief demographics of my participants – age, duration of stay in the UK, family members, employment, and so on.

When I was recruiting for participants, I wanted Korean women who have lived here for more than five years, and who are planning to settle down in the UK permanently. Not all women have British citizenships, but most women were entitled to permanent residency in the UK except CHA whose husband was an Anglican priest. CHA's family has been living in the UK for five years on her husband's working permit, but they were planning to apply for permanent residency in a following year.

Due to the fact that most of my participants had children under ten, the interviews had to be conducted in several stages, whenever they were available. Prior to conducting interviews, a memoir was produced, which consisted of sets of themes and example questions to guide the interviews.

In total, ten broad themes and questions were initially developed for the interview. These included the perception of the current health status of themselves and their families, health concerns, their early impressions with the GP, their health-promoting activities such as diet, exercise, their experience of pregnancy and delivery, medications, concerns for their children's health, health information, and the use of Korean traditional medicine, *hanbang*.

1. Perception of health and current health conditions of the participant and her family
    1.1 Chronic illness
    1.2 Description of current health status
    1.3 How to maintain health
2. Medication practices and their use of NHS
    2.1 Management of minor illnesses such as cold, headache
    2.2 Medication practices before and after migration
    2.3 Experience of the NHS
    2.5 Encounters with the GPs – conflicts, satisfaction,
    2.6 Perceptions of health, medicine or illness since migration

3. Use of the Korean traditional medicine, *hanbang,* in the UK

   3.1 Use of *hanbang* in Korea

   3.2 Use of *hanbang* in the UK

4. Regimen of health – foods and exercise

   4.1 Diet habit and management of health

   4.2 Exercise habit and management of health

5. Experience of pregnancy and childbirth in the UK

   5.1 General experience of pregnancy and childbirth

   5.2 Differences between Korean and British practices of pregnancy and childbirth

6. Childrearing in the UK

   6.1 Experience of the NHS for child's health

   6.2 Lifestyle changes for children

7. Stress

   7.1 Health and stress

   7.2 How to release stress

8. Health maintenance

   8.1 Health-related behaviours

   8.2 Comparison of health status between British and Koreans

9. Health-related information

   9.1. Source of health-related information

   9.2. Characteristics – Korean or British – of healthcare information

10. Language difficulties

The memoir was constantly revised and revisted as the interviews were taking place. Particularly the sections – pregnancy and childbirth – were most extended and developed because most of my participants had experienced pregnancy and childbirth in the UK. The extended memoir is attached in Appendix B.

4.2 Qualitative interview

4.2.1 Epistemology and reflexivity

Before discussing my method, ethnographic interview, I would like to lay out three different approaches to data interpretation: positivism, naturalism and constructionism. Positivism sees data as 'facts' and holds that theories can be tested and confirmed or falsified with certainty. It emphasises standardised, highly structured interviews and recommends that the interviewer be objective and emotionally distant. Naturalism, on the other hand, points out that human behaviours are not drawn in a rigidly mechanical way by some kind of 'law', but suggests that they are always in the process of being constructed and reconstructed according to people's interpretation of a situation. Therefore naturalists suggest that the social world should be studied in its 'naturally occurring setting'. Both positions are questioned by constructionists concerning to what extent the *researcher* could possibly represent the social world; in other words, they do not consider the researcher as part of the social world that she is studying.

Hence, the epistemological problem – 'knowledge of others' – lies in the way that 'interpretations are constructed and represented as objective discourse about subjects on (or among) whom research is conducted' and therefore 'the activity of cross-cultural representation' is questioned. (Clifford, 1983: 118, cited in Woolgar 1988: 24) This critique is in line with the concept of reflexivity:

> Reflexivity…implies that the orientations of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them. What this represents is a rejection of the data that social research is, or can be, carried out in some autonomous realm that is insulated from the wider society and from the particular biography of the researcher, in such a way that its findings can be unaffected by social processes and personal characteristics. (Hammersley and Atkinson 1983: 16)

Reflexivity is also the 'critical self-scrutiny' of the researcher, her asking of herself about her role at every stage of the research. Reflexivity in the interview especially departs from the mechanical style of the survey/questionnaire interview, which highlights the researcher as a neutral, objective, and detached observer. (Byrne 2004: 183; Oakley 2004 [1987]: 262) At this stage, the emphasis on reflexivity and the critiques of the mechanical 'malestream' interview make the distinction between qualitative interview and ethnography small; they share great similarities: both emphasise the researcher's reflexivity; aim to capture the context; and require building rapport between researcher and participants. (Hammersley

& Atkinson 1983: 141-143) Even this small distinction becomes greatly reduced when considering Oakley's discussion of a desirable interview:

> An anthropologist has to 'get inside the culture'; participant observation means 'that…the observer participates in the daily life of the people under study, either openly in the role of researcher or covertly in some disguised role'. (Becker and Geer 1957: 28) A feminist interviewing women is by definition both 'inside' the culture and participating in that which she is observing. (2004 [1987]: 266)

By sharing personal experiences with interviewees, the researcher is able to build up and/or increase the level of trust between her and her interviewees, and thereby can obtain more reliable information. Having said that qualitative interviews and participant observation share similarities, especially considering the fact that participant observation includes interviews as well, the ethnographer's approach can be very different from a researcher who takes the interview as her sole method. For the nature of ethnography, the ethnographer tends to be more open and flexible in terms of the topics and questions that she brings to the fieldwork. (Hammersley & Atkinson, 1983: 152)

However, fieldwork relations are, and ought to be, different from the kinds of relationships we maintain in everyday social life. Hammersley and Atkinson confine their discussions about fieldwork relations to 'impression management' skills that are necessary to *get the research done*: all obstacles to information access or to people 'must be avoided' or 'countered as far as

possible'. (1995: 83) They also acknowledge 'ascribed' characteristics of the researcher that cannot be managed or avoided, such as gender, age, ethnicity or race. Therefore, the ideal role of the researcher, in order to monitor how his/her 'ascribed characteristics' affect the research, is to keep intellectual 'distance.' 'marginality' or 'strangeness' from the informants and to acknowledge 'over-rapport', 'over-familiarity' or 'going native' as a threat to conducting analytic ethnographic research. For them, reflexivity can be obtained only through social distanciation from the informants, which can be referred to the self-consciousness of a research identity. (Hammersley and Atkinson 1995: 92)

However, their approach reduces fieldwork relations to a 'self-crafting' means of getting the research done, and fails to address how fieldwork shapes and constructs relations and identities in an epistemological sense. (Coffey 1999: 2-8) My roles as a researcher were constantly being created, modified, and compromised during my interactions with my participants, and I was always adjusting my behaviours according to what I felt was appropriate given the particular situation. Roles were always *made* in and through the situations themselves, and were always mutually produced by everyone involved. (Coffey 1999) My participants were constantly defining and redefining me, and clearly the setting influenced these definitions to a certain degree, which were then reflected back in their attitudes toward me qua observer. Most of the time, my participants completely ignored my identity as a researcher – I was never quite able to establish myself as a bona

fide researcher. For them, I was a young, unmarried Korean woman. At the same time, they were aware of what I was mostly interested in – listening to their stories about health, their experience with the GP. One participant, Mrs DEE, whom I hung out with for six months, asked if I wanted to come along to see the GP because she felt a lump in her breast. I ended up attending the medical consultations with the GP, specialist, and even went along on the day of removing the lump as her 'sister'.

For these reasons I find the ethnographic interview to be the most useful method for my type of research. Ethnographic interview can be defined as:

> projects in which researchers have established respectful, on-going relationships with their interviewees, including enough rapport for there to be a genuine exchange of views and enough time and openness in the interviews for the interviewees to explore purposefully with the researcher the meanings they place on events in their words. (Heyl 2001: 369)

Ethnographic interview is different from other forms of interviews in that it requires a high level of rapport between researcher and interviewees. The 'duration and frequency of contact' and 'the quality of the emerging relationship' between researcher and interviewees provide an open environment to exchange the 'meanings they place on events in their worlds'. It also 'empower[s] interviewees to shape, according to their world-views, the question being asked and possibly even the focus of the research study'. (Heyl 2001: 370)

4.2.2 Strength of the interview

The term 'interview' means here the 'qualitative interview'. This includes in-depth, loosely or semi-structured interviews characterised as 'conversations with a purpose'. (Burgess, cited in Byrne, 2004: 181) These are useful especially when the topic is related to accessing something that cannot be quantified – e.g. attitudes or values. One strength is that it allows interviewees to 'speak in their own voices' with 'their own language'. (Byrne, 2004: 182) Oakley (2004 [1987]), for example, considers the interview in a political sense as a way of having women's voices heard in society; thus the interviewer needs to 'get inside' rather than 'conduct an interview' in the literal sense. Another strength is that researchers gain access to the rich contexts of meanings that make up the social world they are studying. This also helps interviewees to formulate their taken-for-granted assumptions or unnoticed meanings in the process of conceptualisation. Both of these involve finding the gap between an academic framework and a real life one:

> For to understand other persons' constructions of reality we would do well to ask them (rather than assume we can know merely by observing their overt behaviour) and to ask them in such a way that they can tell us in their terms (rather than those imposed rigidly and a priori by ourselves) and in a depth which addresses the rich context that is the substance of their meanings (rather than through isolated fragments squeezed onto a few lines of paper). (Jones 2004 [1985]: 258)

However, this also implies the weakness of the interview as well: the interviewer has no choice but to rely on the interviewees. In the next section, I would like to discuss both the weakness of the interview and the strength of ethnography.

4.2.3 Weakness of the interview and strength of ethnography

This discussion of the strength of ethnography is based on the arguments made by Becker and Geer (2004). The first strength of ethnography is that it gives the researcher more chances (than does an interview) to correct misunderstandings gone unnoticed. Especially when the interview is done in a familiar setting – the researcher speaking the same language and sharing the same cultural background – the researcher is likely to think that she understands the participants fully. Therefore, while conducting ethnography, Becker and Geer recommend 'learning the native language' because in daily conversation these errors can be quickly revealed and corrected by the participants. (2004b [1969]: 247) In addition to language learning, non-verbal practices – e.g. gestures or attitudes that reflect cultural norms – help to capture the context.

Second, when conducting an interview, the researcher inevitably relies on the interviewees; the researcher can only guess about things that the interviewees are unwilling or unable to talk about. On the contrary, one

strength of ethnography is that it provides insight into these kinds of matters. Interviewees are not bound to say everything; they can always refuse to tell, or can even lie. Also they may not discuss certain things because they consider them to be unimportant, trivial, or they do not even notice them. However, an ethnographer who spends a great amount of time with the participants can notice or even identify which issues are openly discussed and hidden, and even have participants confront their taken-for-granted matters. (Becker and Geer 2004b [1969]: 247-248)

In addition, ethnography gives the researcher the chance to check when accounts are made from 'distorting lenses': people in different social relationships may have different views and give different accounts for the same situation. If the ethnographer is present in the situation, she is more likely to be free from distorted accounts made by interviewees. Also the more she spends time with her participants, the more she can observe changes in their behaviours, the events which have caused the changes, and the process of the changes over the period of time. (Becker and Geer 2004b [1969]: 248-249)

4.2.4 Producing and negotiating roles

In both medical and non-medical settings, I experienced great difficulty switching between my simultaneous roles of participant-as-observer and observer-as-participant, due to my Korean nationality as well as to the

nature of the settings. (Junker 2004 [1960]) Walsh recommends becoming a 'marginal native' in order to gain the best possible observational position (2004: 230); Goward suggests that the researcher try to 'fade into the background' by doing what 'insiders' do, as if there was no 'outsider'. (1984: 102)

However, roles were constantly being created, modified, and compromised during all of my interactions with my participants, and I was always adjusting my behaviours in accordance with what I felt was appropriate given the particular situation. I, as a researcher, never 'decided' which roles to take *alone*; rather, roles were always *made* in and through the situations themselves, were always mutually produced by everyone involved. (Olesen & Whittaker 1970 [1967]: 383) This is because the observer is not the only one who observes, but is in turn observed by her participants, as well; my participants were constantly defining and redefining me, and their (re-)definitions were always more complex than any simplistic 'insider-outsider' binary distinction can capture. Clearly the setting influenced these analyses and definitions to a certain degree, which were then reflected back in their attitudes toward me qua observer. Also, oftentimes I felt there was a great discrepancy between my intentions and their perceptions of me; but here it is hard to put their attitudes into one coherent logical framework, since they were hardly homogenous and changed several times.

It seems clear that various roles were *produced* during the course of the interactions with my participants, and not simply decided on by one individual or party; further, there can be, as in my own case, some discrepancy between my intentions and my participants' expectations. Negotiating among the multiplicity of roles that disclose themselves involves conformity and rejection. One more point I should make here is that these reflections are bound to the very nature of ethnography: if I had only interviewed my participants, I could have quite easily misunderstood them, and this could have gone unrecognised. (Becker and Geer 2004[1969])

4.3 Translation: researcher as translator

Since both researcher and participants were Korean, the participants mentioned they felt more comfortable speaking Korean than English. Therefore, I transcribed the interviews in Korean and later translated them into English. Here I realised that my role as a researcher and translator influenced the way I approached knowledge during the interview as well as the way I produced knowledge in the process of translation. This suggests that translation is an activity of *constructing* data, an epistemological position that requires high reflexivity.

Sarsby points out that when the researcher is doing ethnography in a familiar setting, she has the advantage of understanding hidden values and

assumptions, but 'must have the *detachment* of the trained observer'. (Ellen ed. 1984: 129, my emphasis) Cohen calls this '*intellectual* detachment'. (Ellen ed. 1984: 227, original emphasis) I adopted this strategy and tried to move flexibly between empathy and detachment from the taken-for-granted meanings in the Korean language. When I played this role well, I was able to see the process of the participants' constructive conceptualisation of pain.

One example of a successful case was when, halfway through an interview, I noticed the participant interchangeably using the Korean words '*apum*' and '*gohtong*' for the English word 'pain'. Even though both words mean pain, their connotations are slightly different: according to the Naver Korean-English dictionary, '*apum'* means an ache, smart, sore, grief, or sorrow; and '*gohtong'* suffering, agony, or anguish. When she was talking about a cold as a physical pain, I explicitly asked her how she would define 'pain' in Korean. She explained what she meant by '*apum*' and '*gohtong*' – the feeling of aching and annoying respectively – and she conceptualised both as 'pain':

> HYU: …if you catch a cold, you know there are stages. At first, your throat hurts, and then, it hurts even more when you sneeze, because it stimulates here [touching her throat]…then runny nose, can't really breathe and cough… especially when your throat hurts, that's really I think it's physically painful…but in the case of a runny nose, you don't really feel any pain but you get annoyed because you couldn't breathe well…so that is rather than a pain well, but I am not sure if I am understanding the term pain well enough though. Because it's kind of bothering

> and runny nose and no breathing and sneezing all these are very annoying. Then, I think those are one of pains, '*gohtong*' in Korean, but I don't know about in English.

At first she seemed confused whether the feeling of annoyance (such as when having a runny nose) could be a pain. However, she went on by saying:

> HYU: when we say 'pain' in English, I feel it '*apum*', I feel '*apum*', but when we translate it as '*gohtong*' I think of it as those that are annoying as a pain too.

In the end she clarified that she also thought of annoyance as pain. This suggests that when the participant encounters unexpected questions from the researcher, the participant conceptualises the word by deconstructing meaning *in* the word, constructing an understanding of meaning *between* the two languages. Once the researcher sees this constructive process on the part of the participant, she confronts another issue: how should I, as the researcher, translate '*apum*' and '*gohtong*' into English? Being familiar with both English and Korean expressions, I first struggled whether to translate Korean literally into English, or to try to maintain certain cultural differences in order to make the texts more readable and understandable for native readers/speakers of English. In this matter, I did not translate '*apum*' and '*gohtong*' into English in order to distinguish the participant's conceptualisation of pain.

However, these technical questions – how to translate *correctly* – became less meaningful as I found myself highly involved in constructing meaning based on my own interpretation of the participant's voice and of the two languages while translating. Can there be a single correct translation? Confronting this issue, Simon suggests:

> The solutions to many of the translator's dilemmas are not to be found in dictionaries, but rather in an understanding of the way language is tied to local realities, to literary forms and to changing identities. Translators must constantly make decisions about the cultural meanings which language carries, and evaluate the degree to which the two different words they inhibit are 'the same'. These are not technical difficulties, they are not the domain of specialists in obscure or quaint vocabularies. (Simon 1996: 137-8, cited from Temple and Young 2004: 165)

Through the process of transcribing the interview in the same spoken language, interpreting the transcription (the participant's voice), and translating it into another language, meaning is produced/constructed in the interplay between the languages by the researcher and even between the texts and the readers. Acquiring 'conceptual equivalence across languages' is almost impossible because any form of communication, whether it is spoken or silent, carries conscious and unconscious assumptions, values and feelings. (Temple and Young 2004: 165)

In the same way that meaning is linguistically constructed, examining the

participant's gestures also provides insight into cultural meanings. Even though I was trying to be reflexive during the interview by maintaining intellectual detachment, I still failed to notice some of the participant's gestures and therefore missed the mark in my analysis. While I was analysing the text after translation, I recalled that one participant's gestures did not coincide with her words when talking about how psychological pain was transformed into physical pain: the actual part of the body that hurt was different from the part that she was referring to. The following quotes are extracted from the interview:

> HYU: …about that kind of psychological pain, I think that when you are really in pain psychologically, you feel the physical pain as well…I mean, for example, (laugh) well, when I broke up with my ex-boyfriend, it was really heart-breaking, and here (hitting her sternum) I really felt the pain…The way of expression in Korea, my heart breaks, no, I mean, if it [mind] hurts really bad, then I feel a physical pain in my heart.

As the participant was talking about her heart breaking, meaning she was extremely sad, she said directly that her 'heart' was in physical pain. However, contrary to her intention to point to the location where her organ 'heart' was, she hit her sternum, which is above the heart. Regretfully I failed to notice this during the interview and took it naturally because that is how Korean people express pain and refer to the heart through gesture.

4.4 Reflection on the development of theoretical framework

Because the concept of the practice of the self only served theoretically: once the task of data collection was complete, it became evident that the concept was too vague to fully capture the experience of the Korean woman immigrants.

In order to reach this current mode of theoretical concern, my initial framework has undergone several stages of development and progress, which might be the ineluctable destiny of any PhD journey. Therefore, I find it necessary to reflect on the development of my current theoretical framework here. My initial theoretical framework aspired to capture the experience of the Korean woman immigrants living in the UK as medical subjects by using Foucault's concept of the practice of the self. Motivated by the same question that Foucault himself was asking when writing *The History of Sexuality*, I framed my research question in terms of a certain Foucauldian vocabulary found particularly in the second volume, *The Use of Pleasure*. Foucault was interested in the question of how human beings, in different ages and civilizations, have been able to relate to and experience themselves as subjects of a certain kind, with respect to a particular dimension of human activity in those spheres of life where such relations to self can be shown to occur. Besides time and place, which would always be some determinate historical situation, Foucault identified in such a question four main elements. In Foucault's lexicon, the four 'ethical' elements –

'ethics' taken in the broad sense as a possible form of self-relation – are the ethical substance, the mode of subjectivisation, the self-forming activity, and the telos.

Now, how much further could I legitimately proceed in this direction in terms of filling in the variables of the general question regarding Korean woman immigrants' medical experience in the UK? Since I had not started any data collection then, I could not provide the ethical substance, the self-forming activity, and the *telos*, since these could only be determined over the course of the entire investigation. However, it *was* possible to provide the mode of subjectivisation – for example, *a healthy life*. Yet, it was already presupposed that the mode of subjectivisation would emerge as something different, something that could not be reduced to familiar (Western) categories of 'health' and 'illness' over the course of the fieldwork, although it was possible to say, provisionally and generically, that all human societies must have some concept of and relationship to something roughly equivalent to what we call health and illness. In short, at this point the only thing that could be established for certain was the target group and its socio-historical position. It seemed almost impossible to formulate, at the outset, even a working hypothesis. Instead, I had to content myself simply with exploring a certain set of relationships that must exist but that are not by any means *guaranteed* to emerge.

Therefore, going back to the initial general question, a new, re-formulated question could be formulated as follows: if, given a certain time and place, one wants to live a certain kind of life or exist as a certain kind of person, what would one have to *do* to in order to achieve or actualize that life or existence – what procedures, rules, codes, etc. would one have to put into play – and why would one have to do *those* things rather than others, and according to what logic, what reasoning, what metaphysics?

Given my interest in looking at the concepts of health and illness as well as the health-seeking behaviours of Korean immigrants living in the UK, my research question was reworked as follows: In order for Korean women living in the UK for over five years to live a certain kind of life or existence (pertaining broadly to the themes of health and illness), what do those women have to do, at home and in society at large, and what is the goal that such action accomplishes for them in the end? In other words, what does it mean for the group to be subjected to or subjectivised in terms of the generic dimension of health and illness? What is real for them? What is true in their experience? What does it mean to understand health and illness in that way? What do they have to do to actualize those truths and approximate that reality? The intended goal of the analysis was not to identify the factors associated with Korean women's health-seeking behaviours and the concomitant 'decisions' they make on a daily basis. It was, on the contrary, to try and establish the truth, the reality of a certain subjective experience.

My focal point was Foucault's concepts of subjectivisation and technologies of the self and how these concepts contributed to understanding Korean women immigrants' experience as medical subjects in the UK.

However, immediately after having formulated my research questions in Foucauldian language, there were a few divergences between Foucault's mode of investigation and mine that I had to deal with: historical investigation vs. social scientific project; sexuality vs. health and illness; genealogy vs. ethnographic interview; and finally, texts (archive) vs. interview transcripts.

First, Foucault was a historian; he was fascinated with facts, with particulars, with events, the thick 'stuff' of history. But more than that, Foucault was also a philosopher of history, a theorist; he was very much invested in the ways in which that thick stuff of history was conceptualised and represented (see, for example, his *Archaeology of Knowledge*). But my methods, in contradistinction to Foucault's, were sociological and anthropological in nature rather than historical. It seemed plausible to voice concerns pertaining to the adoption of a method that was initially intended for a historical investigation and its redeployment within a more social-scientific project and discourse. However, if it could also be agreed upon that no method or methodology had a monopoly over its object; that no theoretical discourse was tailored specifically to its thematic domain and provided exclusive and unrestricted access to it; that concepts as well as theories were

both fluid and dynamic, constantly in flux, spilling over their own borders and opening themselves to difference and differentiation in a highly un-dogmatic and nonpartisan fashion – if all of those caveats were granted, then in consequence one could proceed on the assumption that all theories, methods and concepts are like particular tools that a handyperson selects for a particular job. A tool is acceptable insofar as it gets the job done. There is, then, without a doubt, a hierarchy of tools, but that hierarchy is constantly shifting according to the object of the research and the approach for dealing with that object. It is a hierarchy based neither on the metaphysical superiority of one theory or conceptuality over others, nor on the natural correspondence of a given theory to its object.

It is precisely for this reason that Foucault himself explicitly referred to his methods of analysis as 'tools' which could be applied to an array of problems within widely divergent fields of study, from academic philosophy to the history of science, from ethics to literary analysis. The 'tools' are available for anyone to use in any way he or she sees fit:

> I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area…I would like [my work] to be useful to an educator, a warden, a magistrate, a conscientious objector. I don't write for an audience, I write for users, not readers. (Foucault 1994: 523-524, cited in Rahimi 2006: 1)

It was, then, a matter of picking and choosing, of selecting and ignoring, of practical relevance for the matter at hand. In other words, Foucault was not out to construct some grand, hyper-theoretical 'system' to which one must subscribe in a thoroughgoing, 'all-or-none' fashion. As always, Foucault's emphasis was on the local as opposed to the global, the singular as opposed to the universal; different problems required different modes, tactics and strategies of investigation, not some generic, all-encompassing and homogenising framework.

The second major difference I needed to articulate had to do with our preferred topics or themes – sex for Foucault (and not 'sexuality,' at least in the works I was drawing on for my study), and health and illness for myself. What was important to see was that, whereas Foucault was starting out with something 'given,' a brute fact of human existence, I, on the contrary, was starting out with a cultural construct. For the purposes of his study, Foucault did not problematise sex itself or sexual acts – not that sex could not be so problematised, but in this case it is a matter of how the ancient Greeks themselves problematised sex, how for them sex had gotten made into an issue, how it had become, broadly speaking, an object of concern and solicitude. In contrast I was starting with something that was clearly a discursive object, a word that does not signify any raw, bare reality but is instead infused from the beginning with a surplus of meanings – physical, psychological, moral, social, and political. Therefore I could not simply start out with some bald concept 'health', and then work my way systematically

to a series of more or less well-defined domains of investigation (dietetics, economics, and so on). Instead I had to try to figure out: when health becomes an issue for Korean female immigrants, when it has become a matter of concern, then how exactly is 'health' (and consequently 'illness') being understood and experienced? I would have to proceed, then, according to a kind of back-and-forth movement, oscillating between the question of the meaning of health/illness and the question of the formation of a certain mode of subjectivity, the ways in which these subjects relate to themselves *as* these sorts of subjects. Each question will inform the other, as two sides to one and the same coin.

The third divergence was that in my research there was the absence of genealogy in the Foucauldian sense. In *The History of Sexuality* Foucault is attempting to write a 'genealogy of ethics', a possible form of self-relation. Foucault tried to ask the following question: throughout and underneath all the explicit codes dealing with sexual behaviour in the history of the West, how had it been possible to relate to oneself as a sexual subject? And he found that, from the time of the ancient Greeks to the early centuries of the Christian era, there was actually little difference with respect to the external, codified rules and norms (what was allowed, prohibited, punishable by law or social exclusion, etc.); however, beneath that moral code there was a subtle shift in the way in which it was possible to relate to oneself ethically with respect to sex, and it is this underlying and often overlooked *ethical* difference that Foucault tried to chart as he proceeds from 'the use of

pleasure' to 'the care of the self' and eventually to 'the confessions of the flesh' (the title of the unpublished fourth volume of the series).

In contrast to the genealogical approach, the research on Korean women immigrants aimed to focus on cross-cultural or inter-cultural differences; its intention was not to trace the history of modes of self-relation over time, but rather to isolate a mode of self-relation in a given time that could be seen to represent a *clash* or a confrontation of modes of self-relation with respect to the concepts of, provisionally, health and illness. In other words, the group was already divided against itself; its identity was already fractured, and my research aimed to situate itself inside this fracture and to analyse it from within. There seemed to be no *theoretical* reason why a Foucauldian conceptuality could not support a non-genealogical investigation; fundamentally there seemed to be little difference between, on the one hand, describing a mode of subjectivity for a particular group at a very specific period in history, and on the other hand, tracing the history of modes of subjectivity over several centuries for a society at large.

The forth and last divergence was the nature of data. Since Foucault analysed ancient civilizations, he had necessarily to rely on written documents. And since he was interested in reconstructing the 'archive' for that particular epoch, he was less concerned with the authorship or 'authenticity' of the texts and more interested in what they *actually said*. In other words, Foucault did not 'deconstruct' his texts, if that means isolating

a moment that threatens to undo the purported self-presence or closure of the text and running with it as far as possible; rather, he was interested in what was clearly *stated* ('enunciated'), immediately and on the surface, and not in the play of traces that were the condition of possibility for any meaning whatsoever. Foucault wanted to establish, not what was always already written and erased alongside and in the margins of the text that ostensibly presented itself as the complete and definitive one, but instead what it was possible to say, and what in fact was said, at some given moment in history. For the purposes of the research on Korean women immigrants, this priority of the statement over the trace would have to be observed and maintained. It was not as though the notion of the trace [or the *grammè*] was false or incorrect; rather, it was simply not pertinent for establishing how Korean women living in the UK were capable of experiencing themselves as 'healthy', 'sick', etc. The recognition that all discourse harbours logocentric tendencies and prejudices does not negate the fact that certain concepts and values do come to presence, do present themselves at a certain time and in a certain way – i.e. are produced or presented as *truth*. It is this concern, not with the de-construction, but with the actual production of truth in discourse that is central to any Foucauldian-inspired investigation.

But the question of logocentrism intrudes in another respect – namely, that of the prioritisation of the phoneme over the grapheme, the spoken over the written word, the voice over inscription. In effect, the transposition of the

theoretical apparatus to the present time involves a shift from written to oral data, from 'mediate' to 'immediate' communication. Does the fact that archival research will be replaced by interviews and ethnography have any implication for the research on Korean women? Does it render the Foucauldian 'tools' any less applicable to and relevant for the project at hand?

It is here that Derridean concepts and tools can be legitimately applied – also in good 'bricoleur' fashion. Thanks to deconstruction, we have learned that the suppression of writing by speech is unjustified, that all speech is inhabited by the presence-absence structure of the trace (i.e. writing in the broad sense), and that therefore speech is writing before it is speech (and hence before it is 'writing' in the narrow sense of physical or material inscription).

The fact that the data will be, at least initially, oral in nature, does not have any bearing on the fact that both speech and writing are essentially *textual*, that neither one escapes the structure of *differance*. Any ethnographic observation will have to be *produced* in the form of field notes; and those notes, truncated and incomplete by definition, will have to be elaborated on, worked over, homogenised, etc. Even more obvious is the condition that any personal interviews will have to be recorded (written down or taped, i.e. transcribed) and hence digitised, archived; that they will most likely be given in Korean; that the Korean will have to be re-transcribed and

subsequently translated into English (re-re-transcribed); that the English will have to be interpreted, always on the basis of and with reference to the Korean 'original,' hence involving the Korean and the English in an incessant back-and-forth movement of reference and counter-reference; that the English will be inserted and interwoven into a much larger written work where it will assume new dimensions, take on new meanings and form unforeseen connections; etc.

All of this could just as well be ignored, since even if the entire project were to take place in Korean, one would still be no closer to the secret 'origin' of the text where meaning would dissolve into an infinite transparency (the 'consciousness' of the subjects, their 'true intentions', and so on). Even speech itself is always already 'mediate'; there is no 'im-mediate' language that could bring forth 'the things themselves' into the brightness of absolute presence and truth. We are always dealing with texts, with a play of significations, whether in the form of dusty old books, gestures made with the hand, face or eyes, spoken words, or whatever. In principle, archival and ethnographic modes of research are operationally equivalent. Regarding the research on Korean women, the goal will be to establish, *in the text that is produced in/through/by/as the data*, what is stated in connection with the objects of the analysis.

This was the way in which my theoretical journey unfolded before I began data collection through interviews. One after another, as the interviews were

conducted, I realised that I had to re-frame my theoretical approach. During the interviews regarding their experience in the NHS, the Korean woman immigrants I spoke with recalled the difficulties they encountered meeting specialists and managing the gate-keeping roles of the GPs; they were in part forced to quickly accept dissimilarities in terms of the concepts of health and illness and methods of treatment. All these experiences led them to employ *certain* techniques to become *certain* 'medical subjects', which is desirable in the context of the British medical system. It is in this milieu that I have shifted my focus from the experience of subjection to the process of subjectivisation, i.e. 'becoming-subject', and have decided to rely on Foucault's concepts of power relations and resistance to describe how subjectivity is produced and reproduced.

Chapter 5:
Traditional/Modern Korean Medical Systems

In the previous chapter, I provided general information on Korean immigrants living in the UK and my participants. Contrary to my expectation that New Malden in Surrey would provide a culturally distinctive ethnographic setting, my initial contact took place in a Korean clinic whose patients were more likely to be non-Koreans than Koreans. By using a snow-balling method as well as my own social network, I developed rapport with twenty-one Korean immigrant women who have been living in the UK for more than five years and who are planning to settle in the UK permanently. In order to succeed in carrying out my research from a specifically Foucauldian perspective, I conducted ethnographic interviews which emphasised building sufficient rapport with my participants so that the relationships enabled a 'genuine exchange of views' (Heyl 2001: 369) between researcher and participants. Other methodological concerns with respect to translation were also reflected in the previous chapter.

While the previous chapter addressed issues directly related to my research – such as my participants, research analyses and so on – this chapter aims to elucidate the broader context from which my participants, the Korean women, are coming. Without understanding the societal background of the home country, the interpretation and understanding of the experience of the Korean women would only be half complete.

Hence, the chapter consists of three parts. The first part discusses neo-Confucianism, a philosophy that has greatly influenced the way Koreans view their bodies for over 500 years since the Chosun dynasty. (Noh 2003) Neo-Confucianism continues to govern the Korean people's relationship to their bodies, and its body techniques have been employed to control women's bodies. (T.Kim 2003) The second part provides general information about the current Korean medical system, looking mainly at the major reform carried out in 2000, which dramatically changed the medical practices of both Koreans and medical practitioners. This is followed by a discussion of changes in the delivery system of medical care as well as in patterns of Korean people's use of medical service evidenced by officially available factual data.

In addition to the factual data presented in the first two parts, I include an autobiographical account of my own experiences encountering both the British medical system, when I first came to Britain in 2004, and the Korean system, when I went back to Korea in 2007, in a somewhat unorthodox fashion. There are two reasons why I have decided to add this part: first, my ethnographic account tells a first-hand story of the experience and provides a superficial comparison of the two medical systems. Second, it was this experience that helped me to realise my own care for my body, which is a multi-national site encompassing Korean, American and British techniques to stay healthy. My first experience in the surgery in the UK in a way

warned me that I should alter my own self-care in order to stay healthy if I were to settle down in the UK. For the same illness, when I went to see the Korean doctor in Korea three years later, I had a very different experience, which made me notice that I had undergone, to a certain extent, a process of subjectivisation in Britain. I have since become familiarised with both medical systems and socio-cultural norms in relation to health. As I listened to my participants' stories, I was familiar enough to relate to their feelings, and yet 'marginal' enough so that I was 'not taking everything for granted' at the same time. (Walsh 2004: 230) My experience hints to what might be the experience of migrants who simultaneously situate their selves and bodies in both home and host countries and thus whose subjectivity encompasses the double process of 'self-making' and 'being-made' by multi-trans-national settings. (Levitt and Schiller 2004, Ong 1996)

It is important to note that my interviewees are not only familiar with the 2000 reform, because most of them came to Britain 7-8 years ago, but they are also making use of the Korean medical system either for themselves or their babies; hence they inhabit both medical systems simultaneously, oscillating between the two subjectivities, which will be discussed in more detail in subsequent chapters.

5.1 Neo-Confucianist body

Korean history has been marked by a succession of three ruling ideological paradigms – Shamanism, Buddhism and neo-Confucianism – each dominating the practices and mindset of the Korean people for over 500 years, long enough for Koreans to internalise each ideology such that the residues of past ideologies have survived up until the present. While all these ideologies have contributed to the syncretic and complex religious and philosophical landscape that characterises modern Korean society, the influence of neo-Confucianism since the Chosun dynasty in the 16th century is the most prevalent, even now. (Ahn 2003; T.Kim 2003)

Neo-Confucianism had been the mainstream philosophy and religion since the 15th century in Korea, and used to govern the politics, social relations, and aesthetics of the aristocracy. Against the then-existing ruling ideology, Buddhism, neo-Confucianism was adopted to serve as the state ideology for the newly erected kingdom, the Chosun dynasty. (Ahn 2003) Given its emphasis on human ethics, it defined social orders according to a strict class system, which was used to govern and control the society. According to neo-Confucianism, two elements – *li* ('principle of existence') and *ki* ('material force') – are the essential components of everything, including humans. The concept *ki* became a central topic among neo-Confucianist scholars, eventually coming to be taken as the fundamental concept for understanding the relationship between material things (including humans) and the cosmos.

Neo-Confucianist scholars believed that a man, by cultivating its theory and putting it into practice, could achieve the ultimate goal of the unity of self and cosmos. (Kim 2007; Oh and Arditi 2010) A number of disciplines or methods for self-cultivation were developed and followed in order to return to the 'Supreme Ultimate', the 'origin of all things'. (Oh and Arditi 2010: 22)

Even nowadays, *ki* is still prevalent in modern Korean language, and used rather intuitively by contemporary Koreans to describe their health-related physical and mental conditions in daily life. Kim (1996) points out that *ki*, regardless of how ambiguous the concept might be to Koreans, is a key word that characterises the Korean culture, and there are over 400 words related to *ki* in Korean. (Kim 1996, cited in Kim 2008: 445) Therefore, it is necessary to trace back how the people of the Chosun dynasty viewed their own relationships with their bodies, what practices were engaged in to reach the ultimate goal – or what Foucault calls the *telos* – and where women were situated within the neo-Confucianist discourse. In fact, the practices adopted by neo-Confucians for self-cultivation have been captured in Foucauldian language by a handful of scholars. (Oh and Arditi 2010; T.Kim 2003) While Foucauldian practices of the self involve subjects acting upon themselves, leading them to 'develop an understanding of themselves, and an experience of themselves, as "clinical" subjects', the neo-Confucianist practices of the self involve 'see[ing] oneself in terms of the degree to which one is in proper alignment with an existing network of social relationships,

according to one's position in that network'. (Oh and Arditi 2010: 26) The gender relations were no exception.

Neo-Confucianism and patriarchy have served historically to enhance and perpetuate each other: on the neo-Confucian view, only men can become fully ethical beings while women's being is always subordinate to men (Choi 1992; Ahn 2003; Min 2001). For example, a woman can only establish her identity through her husband. The patriarchal neo-Confucianism of the Chosun dynasty saw a wife's relationship to her husband as equivalent to that of an aristocrat to a king. Only women's sexuality was controlled: a woman who remained faithful to her diseased husband and/or who sacrificed herself for her family-in-law was praised highly. A woman's role was to bear a son who could maintain the family lineage. (Cho 2002) M. Kim describes it as the 'existential extinction' of women. (my translation, M.Kim 2004) Thus, the most desirable space for a woman was in the home, where she served her husband, family-in-law and their ancestors; she could only gain status and exercise power within the boundary of the family if she performed her filial piety. (M.Kim 2004)

Thus while men cultivated themselves to achieve ethical perfection, women cultivated themselves to maintain their proper station and charge. As far as women's health was concerned within neo-Confucianism, women's specific techniques of self-cultivation were reduced to enhancing their reproductive functions. Therefore, 'women were mostly bodies' and in fact 'subjectless

bodies' (T.Kim 2003: 101); their bodies were strictly controlled so that they could become perfect containers for the foetus, particularly for a male child. Consequently a number of rules and regulations for pregnancy were developed at that time the function of which was to build a perfect 'home' for the male foetus both physically and mentally:

> [A woman] was expected to behave with the strictest decorum in the smallest minutiae of her conduct; she was not to think evil thoughts or to utter evil words; she was to recite poetry at night and to speak of proper things. (DeBary and Haboush, 1985: 169, cited in T.Kim 2003: 101)

Even in modern Korea, prenatal education involves practices to establish the optimal environment for the foetus; such practices are still prevalent and followed by modern Korean women as part of a general regime of prenatal care that stresses the woman's self-sacrifice for the sake of her baby. This will be dealt with in greater detail in Chapter 7.

Following the Chosun dynasty, Korea was colonised by Japan from 1910 until the end of World War II. After the Korean War (1950-1953), Korea underwent radical modernisation and industrialisation, during which time women were considered a critical part of the work force. Women were encouraged to leave the home and work in factories and at the same time were promoted to reproduce human resources. During this period of rapid modernisation, neo-Confucianism was further extended as it served to

develop a collective Korean identity, successfully establishing itself as a symbol of 'Korean-ness'. (Moon 1998) At the same time, a new emphasis on a woman's role as a 'wise mother and good wife' was appeared, forcing most women who were working prior to marriage to quit their jobs. (Kim 2009; Min 2001) Although the expectations imposed on women during this time were different from those of traditional neo-Confucianism – women were no longer seen purely and simply as bodies for reproduction – nonetheless they re-inscribed women's status firmly within the patriarchal family system, and so are understood by scholars as being in line with neo-Confucianism and/or patriarchy. (Kim 2009)

Neo-Confucianism continues to play an important role in modern Korean society, despite Korea's rapid and intense modernisation and the accompanying phenomena of globalisation and cultural integration and assimilation. Its philosophical and ethical concepts, principles and norms are still prevalent in many sectors of Korean life – social, religious and cultural – and it continues to represent national identity as the dominant ideology.

5.2 The Korean National Health Insurance System and the 2000 reform

The healthcare system in Korea is unique in the way in which it is both public and private: every Korean is entitled to insurance benefits under the healthcare security system, yet over 90% of the total medical services are

provided in the private sector. The government has been the sole body controlling medical fee schedules, drug price standards and other guidelines for medical institutions through the Ministry of Health and Welfare (MOHW). Medical costs are almost equally (50%) shared by the sick and the governmental insurer body – the National Health Insurance Corporation (NHIC): medical institutions receive a partial payment from the sick for medical treatments or diagnoses and a reimbursement from the NHIC. (Huh et al 2003)

The birth of South Korea's national health insurance system reflects the circumstances of the country's unique relation to North Korea. Right after the Korean War (1950-1953), both South Korea and North Korea were financially damaged, but North Korea was more affluent than South Korea. South Korea's GDP in the 1960s was only $79, similar to Ghana or Sudan, and Korea was one of the poorest countries in the world. (Sege ilbo, 2006) However, the dictator Park, who ruled South Korea from 1964 to 1979 until he was assassinated, turned the agriculture-based economy into an industry-based one through his '5-Year Economic Development Plans' and achieved a great economic advancement.

Although economic prosperity was accomplished in South Korea, North Korea was then providing medical care to everyone free of charge. The great tension and fear between the two countries were magnified as both countries sent spies and thousands of leaflets in balloons to each other, causing

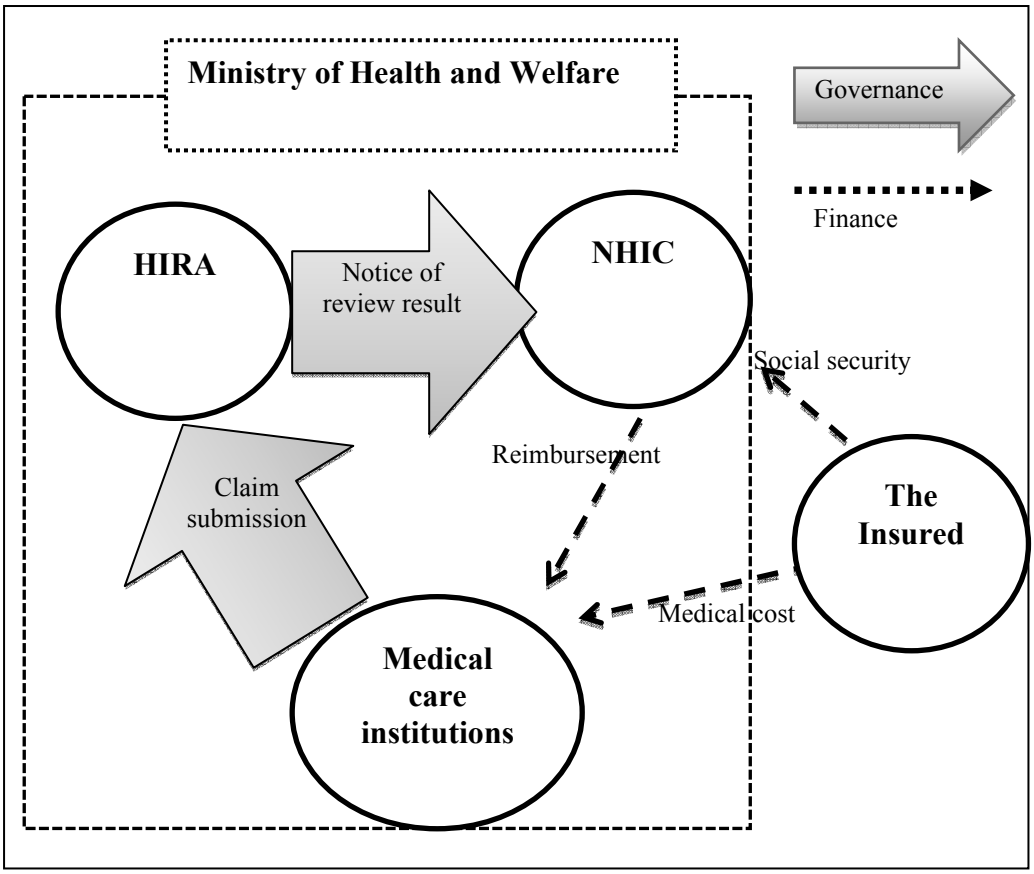
distraction and chaos for the population. The dictator Park rushed to provide healthcare insurance when he saw a leaflet from North Korea showing an image of a South Korean woman crying with her sick baby in her arms because she could not afford medical treatment for her child. The leaflet asked 'Where is your country?' The message was powerful enough to question and threaten the justification of the dictatorship, whose legitimacy lay in national security. Thus Park hastily copied the Japanese healthcare system. (Lee 2000: 21)

The first compulsory health insurance was applied to salary people in large corporations with more than 500 employers in 1977. Legislation to extend the compulsoriness and applicability of health insurance was passed, gradually extending coverage to more people. In 1989, coverage of the entire population was accomplished with a minimum of financial support from the government. (Kim and Kim 2005; Kwon 2003)

The Korean healthcare security system consists of two apparatuses – the Health Insurance System (HIS), funded through compulsory social security contributions, covering 97% of the population; and the Medical Aid Programme (MAP) for the poor, funded by the government as the Livelihood Protection System, insuring the remaining 3% of the population. (HIRA 2007)

When a Korean gets ill and requires medical care, s/he receives medical

treatment directly from medical care institutions such as clinics or hospitals. These institutions then submit a claim for the medical fees provided to the patient to the Health Insurance Review and Assessment Service (HIRA) for its review. Once HIRA reviews the claim, it notifies the National Health Insurance Corporation (NHIC) and then NHIC reimburses the fee claims to the care providers based on the results by HIRA. HIRA, NHIC and medical care providers are governed and supervised by the Ministry of Health and Welfare, which also establishes regulations. The insured are required to share a certain portion of the medical cost incurred when receiving medical care.



The 2000 reform changed the Korean medical system in two respects – administration and practices of the medical care delivery system. In terms of administration, the NHIC was appointed as the sole body responsible for finance and management of the National Health Insurance System. In terms of medical practices, 'separation reform' took place, which separately assigned the roles of prescribing and dispensing drugs to doctors and pharmacists respectively. (Lee et al 2005) This separation reform has changed the roles of physicians and pharmacists by restricting their responsibilities and by classifying drugs.

The new policy, which became effective on July 2000, no longer permitted physicians to dispense medicines to outpatients in their clinics and pharmacists to prescribe medicines. Medicines were classified into two categories – general or over-the-counter drugs, which could be dispensed by pharmacists without prescription, and professional or prescription drugs, which constituted 61.5% of the drugs as of 2000. (Jeong 2005: 136)

Before the separation reform, both physicians and pharmacists were able to prescribe and dispense medicines. Patients usually expected to receive drugs or injections as a form of treatment when visiting physicians. Drugs were dispensed by nurses or quasi-nurses assisting doctors in clinics. In addition, it was also common practice for Koreans to see the pharmacists when they felt their diseases were not serious. Pharmacists used to dispense drugs freely after hearing patients' symptoms. Although drugs prescribed by

doctors and pharmacists had been covered by health insurance, they rarely sold drugs under health insurance coverage and the general public was kept unaware of this fact. (Jeong 2005)

This was a lucrative business for physicians and pharmacists because their costs of purchase were much less than reimbursement after the sale. The government estimated that over 40% of the total income of physicians was from selling medicines. (Korean Ministry of Health and Welfare, Internal Report, 2000, cited from Jeong 2005) Consequently, this duplicate practice caused problems of overuse and misuse of medicines. Therefore, the separation reform intended to solve the problems of overuse and misuse of drugs by patients and healthcare providers, and it was expected to save costs of drugs and provide better care. (Kang et al 2002)

As the separation reform separated professional roles of physicians and pharmacists, it caused institutional separation between medical institutions and pharmacies. Immediately, physicians felt financially threatened and went on nation-wide strikes, five times, paralysing the entire medical system in the end. To compensate them, the government agreed to increase medical fees by 40% and the right to give injections to patients was returned to physicians. (Jeong 2005)

Kwon (2003) concluded that the merger actually brought some equity in healthcare financing: after the merger, 62.2% of households paid less

monthly contribution (4,574 won) and 37.8% paid greater contribution (6,749 won) than those before the merger. The increase in contribution took place in the wealthiest counties in Seoul. Also the merger led to better balance among industrial workers: after the merger, those who made less than 1,540,000 won (about £750) experienced decrease in their contributions and those who made more than 1,540,000 won experienced increase in their contributions. Large corporations with more than 1,000 employees were required to pay 19.4% more whereas small firms with fewer than 10 employees were to pay 17% less than the contributions they made before the merger. Also the merger reduced administrative costs by cutting personnel from 10,849 to 9,073 in 2000, which led to strong resistance resistance from the trade union; as a result, it failed to meet its original goal of downsizing. Still, Kwon believes that a merger into larger insurers rather than a single one might have been a better solution to reducing administrative costs, since each insurer could decide their managerial size according to their own measurement of efficiency and responsiveness to consumer needs. In theory, a single insurer system (i.e., monopoly purchaser of healthcare) should have great market power in negotiating healthcare expenditure with healthcare providers. However, since the health insurance societies, prior to the merger, did not have to compete to attract insured people, healthcare providers were already subject to a uniform payment.

5.2.1 Delivery of medical care

Although the NHI system restricts patients to certain health service providers, this restriction has hardly been practised by patients or enforced by medical care institutions. Hospitals particularly fear that the enforcement of this regulation may cause a loss of revenue. Therefore, most patients are free to choose hospitals or clinics. (Yang et al 2008: 180) It is estimated that over 90% of the healthcare service is delivered by the private sector.

Medical care institutions are categorised into three kinds: (1) clinics, the smallest units whose facilities include less than 30 beds, such as biomedical clinics, *hanbang* clinics and public health centres; (2) hospitals, whose number of beds is more than 30, including hospitals, general hospitals, dental hospitals, Korean traditional medical (*hanbang* in Korean) hospitals, and tertiary hospitals (with more than 400 beds); and (3) pharmacies. All medical care institutions provide both outpatient and inpatient services. Overwhelmingly, clinics, the smallest medical institution, are almost all private (99.8%), and they constitute 95% of the entire medical care institutions in Korea. In other words, they are the first contact for Koreans who feel ill, and most accessible for Koreans. Even for hospitals and tertiary hospitals, who require referrals from physicians in clinics, operate mostly as private (88% for hospitals, and 79% for tertiary hospitals). (Annual Statistics NHIC 2006, cited by Yang 2008)

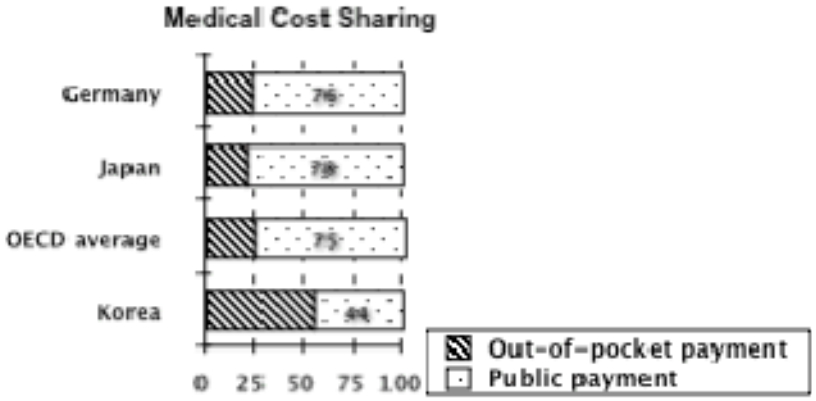
Following the number of each medical care institution, 42% of the total medical claims for outpatient treatment were made by pharmacies and 49% by clinics (including dental clinics), which indicates that pharmacies and clinics provided the overwhelming majority of outpatient care in 2004. In the case of inpatient treatment, 45% of the total medical claims were made by hospitals and general hospitals, compared to 29% by tertiary hospitals and 26% by clinics. (Source: HIRA 2007 Statistics)

While both *hanbang* and biomedicine are equally recognised by the Korean government, most delivery of medical service is conducted by biomedicine. Most medical practitioners (53%) are biomedical physicians as of the end of 2007. *Hanbang* practitioners constitute a relatively small portion (14%), and pharmacists constitute almost a quarter of medical practitioners, which reflects the tendency of Koreans to consult pharmacists and seek medicine without physicians' prescriptions. Unlike in the UK, most physicians in Korea are specialists, which indicates Koreans' unfamiliarity with the British medical system, where patients cannot access specialists without GPs' referrals. (HIRA Year Book 2007: 43-44)

5.2.2 Cost-sharing

In fact, compared with other OECD countries, Koreans seem to share a greater portion of their medical costs. The average medical cost sharing for OECD countries showed that 25% came from out-of-pocket payments,

whereas the rest of the medical cost, 75%, was publicly funded. In contrast, Koreans paid 56% of medical costs from out-of-pocket money.



OECD, cited in Huh et al 2003: 30

Since August 2007, the co-payment scheme of the NHI system has changed: patients are now expected to pay 30% of all treatment costs including medical examinations, in the clinics, allocated in the cities, when the cost exceeds 15,000 Korean won, equivalent to approximately £7.50 (£1 = 2,003 Korean won as of 2009). If it is less than 15,000 Korean won, the cost for the patient is fixed at 3,000 Korean won (£1.50) or 1,500 won for the elderly over 65. The cost-share is the same for dental clinics except the fixed cost for the patient is 3,500 Korean won (£1.70). In the case of receiving treatment from hospitals in urban areas, the patient is required to pay 40% of the total medical costs, and in general hospitals, 50%. For tertiary hospitals in urban areas, the patient is required to pay for the full consultation fee in addition to the 50% of the rest of the medical cost. (HIRA 2007 Cost Sharing)

Once the physician prescribes medicine for treatment, the patient is required to take the prescription to the pharmacy. For drugs not exceeding 10,000 Korean won, the patient should pay the fixed price of 1,500 won (1,200 won for the elderly over 65). For drugs that cost more than 10,000 won, the patient should pay 30% of the total cost. If patients seek medicine without a prescription and the medicine does not exceed 4,000 won, she or he is to pay 1,400 won for each day's worth of medicine up to 3 days. If the medicine costs more than 4,000 won, the patient should pay 40% of the price of the medicine.

Medical benefits do not cover services such as cosmetic surgery, treatment for fatigue, warts or freckles and so on, which cause no 'functional problem in one's everyday life'. (Health Insurance Review & Assessment Service [HIRA] 2007)

5.2.3 Overuse of medical resources

In 2001, Koreans averaged 12.3 outpatient visits, compared with 5.8 for the US and 5.4 for the UK. (Huh et al 2003: 41) According to the most recent news report by *Kyunghyang* on 27 November 2008, the average days of visits to clinics or hospitals for Koreans for the past year was 16.6 days: the average day for hospitalisation was 1.6 days per person per year and the rest (15 days) were for treatments for outpatients. For outpatients, the most common reason for visiting hospitals was related to 'acute bronchitis' for

which about 9.6 million made a visit to clinics and hospitals. The second common disease was 'acute tonsillitis' (8.16 million) followed by periodontal diseases (6.2 million) and acute upper respiratory tract infection (6 million). (Kyunghyang 2008)

MacKenzie's 'Public Opinion Survey of the Korean Health Insurance System' conducted in 2002 showed that Koreans were, in general, highly dissatisfied with the system. 46% of the Koreans who participated in the survey said that they were dissatisfied with the system; 38% expressed a neutral attitude and only 16% were satisfied with the system. The main reason (52%) cited was expensive medical costs: in particular, Koreans felt that the national insurance benefits did not sufficiently provide much benefit; their mandatory medical insurance contributions were too high given their average number of hospital visits; and they pointed out that the financial burden had become greater since the 2000 separation reform in drug dispensing, because Koreans had to pay separately for examination and medicine fees to physicians and pharmacists (respectively). (Huh et al 2003: 28-31) Due to the burden that the patient co-share over half of the medical costs, Koreans consider national health insurance as a 'discount coupon' rather than proper insurance. (Huh et al 2003: 28)

The second reason for dissatisfaction (31%) was the unkind attitude of medical practitioners, and the last (17%) was a long waiting time to see the doctor. (Huh et al 2003: 28-31) The average waiting times in the clinics and

hospitals showed 24 minutes and 53 minutes respectively and the consultation times showed 5 minutes and 14 minutes, accordingly. (MacKenzie, 2002, Public Opinion Survey on the Korean Health Insurance System, Cited in Huh et al 2003: 31)

The statistics on the number of outpatients that one Korean physician treats per year was 7,333; in contrast, one physician in the US, on average, sees less than one third of that amount. Inevitably this contributes to less consultation time and hence a poorer quality of service for the patient. For example, one Korean paediatrician examines around 21,500 patients per year, which works out to 80 patients per day on average. Thus even if physicians work ten hours per day without taking a break, each patient is still only allotted 7.5 minutes maximum. (Huh et al 2003: 36-37)

The OECD data shows that although overall health expenditure of Korea is less than the OECD average, when the pharmaceutical expenditure is examined, unlike other OECD countries whose pharmaceutical expenditure constitutes average of 20% of the total health expenditure, Korea spent 30% of its health expenditure on pharmaceutical expenditure. (OECD Health Policy Studies 2008: 28)

5.3 Autobiographic account

In order to provide a more vivid picture of Korean people's ordinary visits to clinics, I will compare my own experiences when I saw the physician in Korea and the GP in Britain for the same illness, a cold.

When I first came to England 4 years ago, I sensed that I was coming down with a cold – I felt a sore throat and high fever. Wanting to keep from getting sick, I went straight to the campus medical centre, which had a 'walk-in' service from 1 to 3. I had to wait for nearly half an hour to see the GP. Despite my long wait, the GP saw me for 2 minutes, during which he told me to rest and drink lots of water. He did not examine me or use a stethoscope and I was given no medicine. When I demanded some kind of medicine, the GP told me that it would be best for me to rest. The medical service was free of charge and I suffered from sore throat, violent coughing, and high fever for about a week.

My first encounter with the British medical system was, no doubt, discouraging. Since then, I have not seen the GP for cold or headache, which I would have done in Korea. However, when I went back to Korea in winter, 2007, I came down with a cold again. I had the usual symptoms for a cold – sore throat, slight fever and coughing. I stayed in bed until my mother found me sick in bed. Despite my complaint that nothing could be done, my mother dragged me to the nearest clinic. In Korea, patients are

free to choose whichever physician they like, and there are at least five clinics in a 10-minute walking distance from my house. I made no appointment, waited about 15 minutes and saw the physician. I answered some questions for 5 minutes and was led to another room where I was given an injection by the nurse. The physician prescribed five drugs for me to pick up from the pharmacist, which was located in the next building to the clinic. I was told to take them right after every meal for three days. I paid 3,000 Korean won to the physician, which is equivalent to £1.50. When I picked up my medicine from the pharmacist, I paid 1,500 won, which is £0.70. In total I paid £2.10 for the medicine and medical service that I received.

To summarise my medical encounters with the British GP and the Korean physician are as follows:

British GP	**vs**	**Korean Physician**
No appointment; waited for 30 minutes	Appointment	No appointment; waited for 15 minutes
Throat	Examination	Throat and stethoscope
No medication given; Told to 'rest in bed' and 'drink lots of water'	Medication	1 injection and 5 drugs; told to take all drugs as scheduled for 3 days
£0.00	Payment	4,500won (£2.25)
Suffered for one week	Output	Felt better on the next day

I came home with the five prescribed drugs, and I took the medicines as told for two days, but I felt uncomfortable because I was given too many drugs

when the GP in Britain did not give me any medicine for the same symptoms. A quick calculation was done in my head that I would need to take 15 drugs per day for three days.

The five medicines that the physician prescribed were as follows[1]:

1	Setopen E R	Paracetamol (=Acetaminophen), made in Korea
2	U3	For stomach digestion, (Alibendol), made in Korea
3	Amoxicillin + Potassium Clavulanate	Similar to Antibiotics Potassium Clavulanate, combined with penicillin group of antibiotics, here Amoxicillin, is used to overcome certain types of antibiotic resistance. Amoxicillin is a moderate-spectrum beta-lactam antibiotic used to treat bacterial infections caused by susceptible microorganisms. Made in Korea
4	SCD SD	Dissolve mucus (Acetylcysteine), made in Korea
5	MESULAN	Reduce pain, fever and inflammation (Nimesulide) Nimesulide is a non-steroidal anti-inflammatory drug (NSAID) with analgesic and antipyretic properties. Made in Korea

All of a sudden, taking 45 pills seemed too much and even unnecessary. Although I felt well enough to get on with my life on the third day, I did not take the medicine on the last day, thinking that 30 pills were enough.

In general, for the most common symptoms for cold, like fever and muscle

[1] All information regarding the drugs was from the website, BITDruginfo who specialises in providing comprehensive medical information: http://www.druginfo.co.kr/detail/product.aspx?pid=8129

ache, patients in Korea are usually given aspirin, paracetamol (Tylenol), ibuprofen (Burufen), or naproxen. If there are additional symptoms, they are given extra medicines to treat those symptoms. For example, for runny nose, antihistamine, chlorpheniramine, Zyrtec (cetirizine HCl), and for stuffy nose, pseudoephedrine HCl are prescribed, additionally. When the symptoms are severe and show sore throat (tonsillitis), that makes it difficult to swallow foods, acute sinus infection, or middle-ear infection, doctors will prescribe antibiotics. Some medical experts have continued to warn the over-usage of antibiotics in Korea: they point out that now it has become difficult to treat cold, flu, pneumonia, tuberculosis (TB), bladder infection, or bronchitis due to the over-dosage of antibiotic. (Seoul News, 22 Dec 2008)

Conclusion

This chapter mostly provided contextual background information to support the understanding of the experience of the Korean immigrant women as medical subjects in the UK in the subsequent chapters. The traditional ideology and contemporary healthcare system govern Koreans' relations to their bodies and affect their perceptions of health and illness and medical practices. The characteristics of the contemporary Korean medical system are (1) private healthcare delivery system; (2) high cost-sharing between the individual and the government; and lastly (3) overuse of medical resources. The private-driven healthcare system of Korea stands opposite to the public healthcare system of Britain. Therefore, the autobiographic account in the

last section provided a brief experience reflecting on the differences between the two medical systems. In what follows, I explore the early encounters of the Korean immigrant women with the NHS and the emergence of the sense of 'responsibility' for their own health and health of the family. It is the theme of this thesis that the Korean immigrant women do not seem to begin to appropriate the active patient model of subjectivity until they experienced pregnancy and childbirth, during which time they had most contacts with the NHS.

Chapter 6:
Concepts of health and illness of Korean immigrant women

The aim of the previous chapter was to provide contextual background information that can further enhance the understanding of my participants' experience: it started with the Neo-Confucianist ideology of the body, progressed to the operation of the current healthcare system, and concluded with my auto-ethnography of my own experience of both the British and Korean doctors. Neo-Confucianist ideology provides a pathway to understanding Korean people's relationship to their bodies, and it continues to control women's bodies through its bodily discipline in contemporary Korea. (T. Kim 2003) Within Neo-Confucianism, a woman's body was viewed only for its reproductive function, which enabled the lineage of the family by bearing a son. (T.Kim 2003) The second part examined the current Korean medical system – National Health Insurance system – and its major reform conducted in 2000. The 2000 reform was discussed for two reasons: first, it changed the medical practices of both healthcare professionals and lay people in Korea; and second, my participants were familiar with the reform and the new practices, and they continued to utilise the Korean medical system, which will be discussed in this chapter and chapter 9. Lastly, the autobiographic account offered a quick comparison of the two very different medical systems, which I believe is a good re-construction of the early experience that my Korean participants might have had, as I myself am a Korean migrant.

The essence of the public health discourse is for citizens to take responsibility for their own bodies and health and also to confront risks. One of the roles of public health experts is to educate the populace about risks, shape their thoughts and behaviours so that they participate in health-promoting activities, and make them 'governable'. (Petersen and Lupton 1996: 15) Rose and Miller point out that experts mediate between the political authorities and individuals: they problematise on behalf of the political authorities, and analyse the 'problematics' of government while they also guide individuals by presenting and calculating risks as consequences of their decisions and providing them with techniques for improvement. (Rose and Miller 1992)

Regardless of how many technologies of government are employed at the level of individuals, for the Korean immigrant women, their initial encounter with the NHS took place when they went to see the GP. Medical consultations are essential because, while patients interact with medical professionals, they are engaged in continuous construction and reconstruction of subjectivity. (Lupton 1997b) The research shows that these early contacts with the GP were in fact critical for the Koreans as they first became aware of the 'difference' between the NHS and the Korean medical care system. For my participants, this dissonance was an alarm that things were not going to be the same as they used to be in Korea if they wanted to maintain their health in this country.

Therefore, this chapter aims to explore the initial experience of the Korean migrant women when they began to feel uncomfortable about the way their health problems were treated in the UK based on their initial contacts with the GP. Their remarks at the time reflect the clashes between the very different techniques of government in the home and host countries, which consequently led to the process by which they began to appropriate the active patient/healthy citizen model of subjectivity. This chapter consists of three sections: the first section deals with the clashes that the Korean immigrant women experienced in their early stage of settlement in the UK, particularly the GPs' refusal to treat illnesses such as 'colds', 'flu' or 'headaches'. The second section explores how, as a reaction to these initial clashes, they started to develop a sense of 'responsibility', which resulted either in conforming to the UK's 'healthy citizen' model of subjectivity or in resisting against British expert knowledge and adopting certain techniques to solve their health issues. The last section discusses how they re-established their definitions of health and illness based on their initial contacts with the GP in the UK.

6.1 First medical encounter with the NHS (medical consultations)

From a Foucauldian perspective, medical consultations provide a setting for medical experts to regulate individuals' behaviours and establish them as desirable subjects – namely, as active patients. Although most of the light

illnesses my participants had required few ‘medical consultations’, the GP’s refusal to prescribe any medicine reflects how medical experts are deployed to exercise power over the populace and to construct individuals as ‘compliant, docile bodies’. (Hearfield 1996)

When asked to describe their impressions of the NHS, the Korean woman expressed frustration, shock and disbelief: they found it inconvenient that they always had to book an appointment with the GP, and that they still had to wait as long as 20 minutes to get in; they also pointed out that a long wait seems common should they require special treatment through the NHS; and lastly they expressed frustration toward the ‘laid-back attitude’ of the medical practitioners who could only tell them to either ‘take paracetamol’ or ‘rest at home’ and ‘drink lots of water’. As for the Korean women who were used to getting an average of 5-7 drugs in addition to an injection for diseases like cold, fever, and muscle pain, the British physicians’ response did not live up to their expectations at all.

The first aspect of this dissonance between the Korean women’s expectations and reality (their own experiences) involved the GP’s *deconstruction* of their identity as patient, and *normalisation* of their illness. The second aspect involved the dissonance between their and the GP’s concepts of preventive care. Here, the GPs set themselves up as ‘gatekeepers’ for the medical services. Both of these forms of dissonance brought about a sense of responsibility for my participants in that they had

to change their attitudes toward their health.

6.1.1 Normalising 'Illness'

Because local hospitals are easily accessible in Korea, my participants found it frustrating that GPs in the UK were not as helpful as they expected them to be. They were used to getting medicine as well as injections, even for small illnesses like colds, when they saw the doctors in Korea. However, whenever they went to see the GP, they were either told to stay home and rest, or that there was nothing wrong with them.

The Korean women voiced unanimously that they were shocked when they went to see the GP for medicine for the flu or a headache, which was what they all used to do in Korea:

> SE: They don't even give any medicine here, from the hospital…When I was in Korea, I took lots of pills, whenever I went to see the doctor. Or even from the pharmacies. That was now a long time ago. I used to go straight to the hospital if I sensed that I would come down with a cold. I got a shot. But, here, you can never do it.

Although they were frustrated with the GP's response, they were also confused by the GP's use of terms such as 'normal' or 'OK'. They visited the clinic because they had already constructed their identity as 'patients', but the GP almost totally dismissed their identity by telling them that their

conditions were ‘normal’, creating tension over the precise definition of ‘normality’:

> Yae: Here in Britain the doctor always says it’s OK or it’s normal. There are too many things that are normal or OK here. So you can’t trust everything [doctors say].

> RYU: You know, when I had to drag (emphasis) my body to the GP, and the GP said it was fine and he didn’t sympathise with my illness, I got scared. How could it be normal if I was suffering from so much pain? At that time, I thought to myself, what if this was a serious disease? But, then of course I felt better after resting.

For the Korean women, the definition of normality that the GP held seemed to be the very first thing that they regarded as foreign. While describing their physical symptoms when they were coming down with a cold, they said:

> GOH: Whenever the GP said ‘normal’, I mean, as soon as I heard the word ‘normal’ uttered from the GP’s mouth, I used to get hysterical, because it was not [normal]! Fine, having a headache, flu, cold, all these, they are not serious diseases. But, that doesn’t mean my body is normal.

> Mrs Soo: When my physical condition gets bad, and I am about to catch a cold, I sense the symptoms – like your head is banging, or your body feels chilled. These symptoms…but these are still diseases, they are not normal. Of course I understand that everyone suffers from these.

Between the Korean women and the GP, there was no agreement regarding the normality of the physical condition and what constituted being a proper patient. My participants understood that they were the patients because they were suffering from an illness. But because their illness was not something that the GPs considered worth treating, they could not recognise themselves as patients, either.

> Woo: I thought the doctor would prescribe medicine here. I expected that they would give me some special advice or something like that, but they didn't. And then, they said I should just suffer through it. What a word for the doctor to say to a patient.

The main reason for this clash was due to their understanding that their physical condition required medical treatment in contrast to the GP's reaction to their 'illness':

> BM: [In Korea I] could go straight to the hospital and get treated. But, it's different here…the doctor here keeps telling you the same thing over and over – you are fine, you will get better soon. I didn't like it.

This kind of reaction from the Korean women is understandable, given the medical practices in Korea. The Korean senate members of the Health, Welfare and Family Affairs Committee criticised certain clinics and hospitals in Seoul for 'over-treating' patients for colds by seeing patients for

more than 20 days and prescribing an average of four pills. The common cold, categorised as a light disease, requires no more than an average of 1.47 days. (MoneyToday News 13 October 2009) Putting aside the criticism of over-treatment, it is generally understood by the public and experts that cold symptoms can be treated to relieve pain.

Relatively speaking, comparative statistics show that Koreans utilise medical treatments more often than Americans or British. According to data from 2001, Koreans averaged 12.3 outpatient visits, compared with 5.8 for US Americans and 5.4 for British. (Huh et al 2003: 41) A more recent news report by *Kyunghyang*, published on 27 November 2008, stated that the most common reason for Koreans' outpatient visits was related to 'acute bronchitis' (i.e. coughing) for which about 9.6 million made a visit to clinics and hospitals. The next common disease was 'acute tonsillitis' (i.e. sore throat) (8.16 million) followed by 'acute upper respiratory tract infection' (i.e. cold) (6 million). (Kyunghyang 2008)

In contrast to this, the NHS Direct states that these diseases can be easily treated at home and do not require medications. On the NHS Direct Online homepage, there is a section called 'Get health advice now' where individuals can check their symptoms and receive medical advice. Before checking physical symptoms for cold and flu, it is clearly stated that:

> Colds and flu affect 15 million people each year in the UK. Often people make

> unnecessary trips to their GP when they should be resting at home. (NHS Direct Online: 'Colds and Flue')

While the same biomedical knowledge referred them to different practices, the Korean women were left to deal with their health issues on their own by either conforming to or resisting against British biomedical knowledge.

6.1.2 Preventive care in the NHS

The other aspect of my participants' initial contact concerned their perception of 'preventive medicine'. For Koreans, preventive care involves receiving a medical examination when there is doubt about their physical condition. Since over 95% of medical care in Korea is private, there is no reason for private clinics to reject patients' requests for medical examinations. Unlike in Korea, however, GPs in Britain do not willingly provide medical examinations based on patients' demands.

> MI: When I was getting an X-ray, the actual part that was in pain was in fact the back of my ankle. So I thought I should get an X-ray taken of the whole part of my left leg but he said he was only instructed to take the waist part so that was all he was going to do. He said if I wanted other parts like my leg or foot, I should make another appointment again. But if it was Korea, since we are paying for it, if I had requested anything on the spot, I would have got it.

MI complained about the procedure for medical check-ups in the NHS and

was told to make another appointment if she wanted to get an X-ray of other parts of her body than what was scheduled. JP, who has lived in Britain for five years, expressed her frustration and anger over the lack of 'preventive care' in Britain. She claimed she had to 'raise her disease' to receive proper medical treatment in the UK. The expression 'raising your disease' is a common Korean expression, referring to the failure to take appropriate actions to cure a disease in its early stages before it becomes serious.

> JP: Is there no such concept as preventive care in this country? Do they not know the term?...The British way is, if you can only see the GP when you have the symptoms, basically, you are raising the disease in your body…this is the limit of the British medical system. People have to let the disease grow [deteriorate your health]…I wanted to take a medical examination, but I was given medicine. I was told that I should take the medicine first and wait and see how my body reacts…But, mentally, if you are suspicious that there's something wrong, you simply get a medical check-up and rest assured.'

For Koreans, prevention involves getting regular 'check-ups', a simple, routine and accurate procedure. However, as my participants' demands for check-ups were often rejected by the GPs because their symptoms were described as 'normal', they felt like there was no preventive care in Britain. This seems particularly important because it discloses both an act of resistance and a process of subjectivisation.

6.2 Awakening a sense of responsibility

My participants' initial experience with the GP was mostly negative: their illness was not taken seriously; their pains were not medically treated; and their expectation of the GP's role was not met.

When their anticipation of treatment was not met, their health became problematised: when asked about how immigration affected their health or care for their bodies, some of my participants replied by invoking a new sense of responsibility:

> HYU: When I was told by the doctor that I should just go home and rest, and things would be fine, I was really in despair. That was not the reason that I went all the way to see the doctor. That's not their job. They were trained to give treatment, not to advise us to go home and rest. Now, I have to do their part. I need to take the responsibility for my health.

The participants pointed out that health was a non-issue when they were in Korea because they could easily run to the doctor, the hospital being only a couple blocks away, or go to the pharmacist, which was also available everywhere. They did not have to worry about health at all.

> Mrs Kim: In relation to health, I knew nothing about health, I was ignorant. I didn't worry about it at all. I only worry about language a lot.

> Woo: If I was in Korea, I could just go to the doctor, right? But, here, that is not the case. So, I get to examine how the condition of my body is very carefully…this is because I live in Britain…I think I should manage, take care of my body myself now.

Woo mentioned the new sense of responsibility that she felt, meaning that she, not the doctor, needed to take care of her body. In fact, the respondents' accounts of 'just going to the doctor' or 'running to the doctor' implied that their responsibility for their health in Korea went as far as bringing their bodies before the eyes of medical experts. However, the new sense of responsibility that they developed in the UK was different; it referred to a heightened awareness of their bodily symptoms and accountability for them. Although this sense of 'responsibility' first seemed to fit nicely with the healthy citizen/active patient model, for my participants it stemmed from their 'distrust' of the GP and from their perception that they were doing the 'doctor's job', which is different from the desirable behaviours of 'active patient'.

In addition to this sense of responsibility, my respondents expressed that they were embarrassed to find out how 'ignorant' they were. SE, who suffered from a low platelet count, also pointed out that she was completely 'ignorant' and 'lacking common knowledge about health' before and that she used to run to see the GP even when she had just a light feeling of sickness. GOH mentioned that she did not know that she had to finish the whole cycle of antibiotics until her British husband told her. She noted that

‘British people here seem to have lots of common knowledge about this sort of thing’ compared to Korean people. Her ignorance in general brought her great embarrassment when she went to A&E.

> GOH: When I was wrapping up my thesis, I didn’t go to the bathroom for almost a week at that time, probably because of stress…I didn’t even think about the fact that I didn’t go to the bathroom. I was too busy writing my thesis. It was Christmas Eve, and suddenly I felt enormous, unbearable pain in my stomach. So, I was taken to the A&E by ambulance. I didn’t know it was because of constipation. I felt a huge, huge pain, so I called the ambulance. The doctor took an X-ray and told me that it was constipation. He was laughing as he was saying it. I felt really embarrassed. I would never let that happen…I might have felt slightly better if I didn’t call the ambulance and walked in by myself.

From that experience, she felt that in the UK everyone was encouraged to know a lot more about their physical health than in Korea and not to waste medical resources. Once they started to forge a new sense of responsibility, the next move for them was to change their attitudes and behaviours toward their health.

The Foucauldian perspective enables us to criticise the autonomous, reflexive subject of liberal humanism without necessarily turning the subject into a hopeless, powerless being. In his later work, Foucault did acknowledge that the self has a sense of autonomy and can escape from disciplinary power. Foucault’s subject is

> …a subject that is both autonomous and disciplined, both actively self-forming and passively self-constructed, as he left us to think about the emergence of a modern state whose exercising of pastoral power both totalizes and individualizes. (Schrift 1995: 34, cited in Bunton and Petersen 1997: 8)

The responses from those participants who were denied expected medical treatment and examinations reflect their beginning to develop certain technologies in response to the GPs' and society's regulation. Foucault's concept of governmentality is insightful, which is described as a 'contact point between technologies of domination (including discourse) and technologies of the self'. (Foucault 1988: 19, cited in Bunton and Petersen 1997: 7)

In what follows, analyses of the technologies that the Korean women have adopted are stated.

6.2.1 Conforming to the 'healthy citizen' mode of subjectivity

When their requests for medical treatment and examinations were rejected, the Korean women did not pursue it further with the GP. Instead, they expressed a passive form of conformity to the GPs by saying they had no other choice but to accept. This initial conformity can be represented by not seeing the GP for light diseases, which they would easily receive treatment

for should they go in Korea. A more active form of conformity was expressed when they decided not to take any medicine. The fact that the GP did not give any medication provoked them to re-think their medication practices although the GP did not necessarily say not to take any medicine. Some of my participants stated that they decided to 'suffer through' the whole course of the illness rather than purchase over-the-counter drugs.

Their frustration with the GP resulted in their refraining from the British medical system for certain minor illnesses, as instructed by the GP. They became more reserved when seeking medical treatment and they would only see the GP when they thought they really needed to, i.e. when the pain was unbearable. MI stated that, although she did not seek medical treatment for colds, and in fact internalised it as unnecessary to seek medical care for light illnesses, she sensed that she was not entirely released from worry:

> MI: Of course my whole thoughts on health and illness have changed. Before [in Korea], even when I felt a little sick, I always ran to the hospital to get a medical examination. Here, you can't do that at all, so inevitably, I give my body some time to recover by itself. In case of colds and other things, I try to solve them by resting or something like that. Of course since I can't go to the hospital, I do feel distressed because I don't know how and why my body is feeling sick. So I have a desire for a comprehensive medical check-up occasionally. But, usually, now I give myself some time to examine my body rather than going straight to the hospital when I feel sick…I think this is OK for a cold or not too serious disease.

Mrs Soo also expressed the same health attitude:

> Mrs Soo: When I first came to Britain, I went to see the GP all the time. If I felt sick just a little bit, I went straight to the GP very often. I ran to him. But then the GP told me that I should just drink water, drink water and take a rest, and have a proper diet and so on. They always said this. So, I didn't [see the doctor] any more, not for little illness.

SE, who recovered from a low platelet count five years ago, said she regretted how she did not listen to her body's call:

> SE: That [illness] was actually an alarm for me to think about health. Because, when I was ill, I didn't feel any symptoms…I was on business trips to Korea, China, Taiwan, Hong Kong, and then Warwick…I was hospitalised on the following Thursday and I basically experienced the peak and the bottom of my life within a week…and I thought, how come I did not know when my body was this sick? The doctors were really surprised too. They were shocked…how could I not know? But I thought, I don't feel any pain, but I am actually really sick…I had been feeling really sleepy, and I had a big wrinkle around my eyes, and huge, big dark circles around my eyes. But I thought it was jet lag…I thought I should get a massage or something, but that was actually because I was seriously ill. I just thought I was tired. You don't really think being tired is being sick, but that was because I was ill…and I said to myself, I should really listen, listen to my body.

As mentioned above by SE and others, my participants started to distinguish between the light and serious illnesses and to develop different strategies to deal with them.

Expert knowledge represents neutrality and objectivity, and when the two expert knowledges – Korean and British – offer different solutions to the same phenomenon, lay people 'try out' each solution and rationalise it accordingly.

> YON: I think it's better that I don't take any medicine even though I am suffering from a cold…often I get a headache and pain…It's not that I am too sick but I am not taking any medicine, but I am sick a little, but it's OK. Before, I would have taken medicine…We Koreans have a tendency to habitually take a pill. If you try to tolerate it, you can. But, we are like, ah, headache, let's take medicine.

SAH also found a similar tendency among Koreans and decided to drink water and rest instead of taking medicine.

> SAH: Compared to British people, I think Koreans are taking medicine much more often. Every household has an 'emergency medicine'. There are many advertisements for drugs, so you make your own judgement as if you were a pharmacist and take many medicines. You hear slogans everywhere – *Insadol* for 'gum health', *madecassol* for 'new flesh' and so on. It's like a cookie…too much I think. I don't think British people take as much medicine as Koreans…What can I do when the doctor does not prescribe medicine? I just thought he wouldn't do it unless it was good for the people. So, I tried [not taking the medicine].

Although some Korean women might have started to conform to the GP's advice with a somewhat passive and reluctant attitude, most of them

eventually found the trial to be reasonable and furthermore, positive.

> KA: I think it's good, actually. I think they are not giving us much medicine so that the body can have some resistance…Here, they seem to prefer a 'natural healing' to medical treatment…after all, medicines are chemicals, you know. My own grandmother used to take many, many medicines, and she was always sick. Now that I think about it, if taking medicine was that good, how come she was constantly sick?

Following the GP's advice has given them the opportunity to reflect on their past practices, and to reason the pros and cons. Mrs Soo also agreed that it would be better not to take medicine. She thought her own 'intuition' was the best doctor of all and knew her body best. She feared that if she used medicine frequently, her body would get used to it and her intuition would fail to catch her bodily reaction.

6.2.2 Resisting against the British expert knowledge

Not all of my participants showed a willingness to conform to the doctors' expertise right away, although they quickly realised that once the GP said no, they had practically exhausted all the means within the NHS. Instead of listening to the GP's advice that colds, the flu or light pains did not require medical treatments, some of the Korean women sought Korean medical treatment, and remained as the desired medical subject in the Korean medical system, whose responsibility is to seek medical treatments for any

illness. They expressed no willingness to engage further with the British medical system. While these Korean women resisted accommodating the British practices, they were resisting to British medical knowledge in two ways: first they made use of their social network to obtain Korean medicines, and second, they dismissed the medical authority of the GPs in Britain and showed low respect for their medical knowledge.

JIN recalled how quickly she contacted her sister-in-law, who was a pharmacist in Korea:

> JIN: I was grateful that my sister-in-law is a pharmacist. Otherwise, I wouldn't have known what to do. I didn't know that I would have this problem. I thought to myself that I should have studied about the medical care system here before I decided to migrate. Now, my sister-in-law and my sister, who is also a pharmacist, send me boxes of Korean medicines. It's been a few years.

JIN was able to quickly solve the 'problem' because of her familial network. CHA was better informed about the British medical practices through her sister, who studied in Manchester for two years. Her parents, a gynaecologist and paediatrician, also made her better 'prepared':

> CHA: My sister got hurt while climbing and she said she was hardly treated. As a matter of fact, her wound was infected and she described how the A&E staff were unprofessional. She said I had to really prepare for this problem. I knew that the GP doesn't really give you any medicine for flu. So, I brought boxes of Korean

> medicine, and I had always been taking medicines for a cold because of my mom. So, when I had a sore throat, I took the medicine, usually antibiotics that I had been having since I was a little child, or if I wasn't sure, I would call my mom.

Her sister's alarm that CHA had to be 'prepared' prevented her from having any further contact with the British medical system until she was pregnant. Unlike YON or SAH, who were willing to 'experiment' with the GP's advice, CHA and JIN had no motivation to change their practices at first, which they continued for awhile until they experienced pregnancy and childbirth. Due to their extra resources and extended network, they maintained their form of Korean medical subjectivity, which is desirable in the Korean medical system. The heavy consumption of medical treatment was noted several times by the participants as main characteristics of the Korean medical practice. After childbirth, however, CHA became more open to the British medical system and JIN began actively to engage with her GP and often challenged his medical knowledge based on the possible Korean medical practice for the same illness. This later form of subjectivisation to the British medical system will be discussed in the subsequent chapters.

The other form of resistance to the British medical experts involved challenging their medical expertise by refusing to take any notice of their knowledge. The term GP – General Practitioner – contributed to lessen the doctors' medical authority, which was exacerbated by the GPs' routine

practice and the surgery environment:

> JP: At first, my first call was to the GP. I had to see the GP first when I wasn't sure of my body or my daughters…But, I was really disappointed. My GP, one time, typed my illness on the internet and he practically read it in front of me. I was like, 'how should I trust this person?' It was so odd for me that GPs here do not wear white doctor gowns and have stethoscope around their necks. The GP stands for general practitioner, not like the specialised doctors that we have in Korea.

JP rationalised her dismissal of the GP here because the term 'general' implied less expertise than 'specialist', and his attitudes were not like those of a proper doctor: he looked up the medical information in front of her, which indicated his incompetence as a professional doctor and he even shared the medical information with the patient. In addition, he did not wear the iconic stethoscope around his neck, which is a symbol of the scientific medical gaze peering into the body. Even *hanbang* doctors in the US, who do not need stethoscopes, tend to wear them to show the scientific strength of the traditional *hanbang* medical knowledge to Koreans and Americans. (Pang 1989) In addition, in Britain the GPs are the first point of contact, and often restrict access to hospitals and specialists unless the patient's condition requires medical intervention. However, there is no concept of 'GP' in Korea, and private specialists are the first contact point for Koreans in primary and secondary care. (Matthews and Jung 2006) All this contributed to make their expert knowledge vulnerable. The systematic differences in the delivery of medical care between Korea and the UK served to

discriminate against the GP's expertise as being more subject to criticism and distrust than the Korean specialists, and as a consequence, some of my participants placed more trust in the Korean doctors.

6.3 Re-defining health and illness

The only concern regarding health for JIN when she was in Korea was 'losing weight', as being thin is regarded highly in Korea. Now all this has to be changed after migration to the UK.

The report by Better Health Commission (1986) 'describes health as a "resource for everyday life, not the object for living"', i.e. 'a state that facilitates enjoyment of life rather than as something to be achieved for its own sake' and concludes that 'health choices are not made entirely freely and are constrained with the socio-economic environment'. (Lupton 1995**:** 73)

Nettleton (2006) summarises lay people's multi-dimensional definition of health in terms of four categories – negative, positive, functional and experiential. (1) The negative definition of health is the absence of disease; (2) the positive definition is the one adopted by the WHO report, viz. 'a state of complete physical, mental and social well-being'; (3) the functional definition of health indicates the capacity to participate in normal social roles, usually shared among the working class (Blaxter and Peterson, 1982;

Pill and Stott 1982; Blaxter 1983a); and lastly (4) the experiential definition of health is revealed through the examination of people's perception of health. (Nettleton 2006: 38-39) Herzlich (1973) and Williams (1983) share the first three dimensions of health similarly: Herzlich defined health as health in a vacuum; as the biological capacity to resist or cope with illness; and as equilibrium. Similarly, Williams (1983) concluded that lay concepts of health were defined in terms of the absence of disease; dimensions of strength, weakness and exhaustion; and functional fitness.

Other scholars have contributed extra dimensions. For example, Flick (2000), applying Herzlich's definitions, added a fourth category: health as lifestyle in relation to fitness, nutrition and so on. In addition, health can impose a social-moral obligation, which seems to be the case among West German women who expressed that they felt 'forced to health'. (Flick 2000; Nettleton 2006: 39) Emotional states are also pointed to as being relevant to health: Prior et al (2002) showed that Chinese immigrants in the UK understood health to be 'fundamentally related to happiness and inner contentment'. For them, happiness is equal to and essential for achieving health. (Nettleton 2006: 40-41)

All of these various dimensions of the notion of health were conspicuous in the accounts of my participants when they discussed their concept of health. However, most of the time what followed these definitions of health was their active re-construction of the concept of health and illness initiated by

their early contacts with the GP. All of a sudden, their lifestyles had to be reviewed and with their increasing sense of personal responsibility, health matters were found everywhere in 'a whole array of agencies, institutions and settings'. (Nettleton 1997: 208) They were enticed to practise health-promoting activities and consume health-related products. This is not to say that they were never conscious of their health or that they were never involved in health promoting activities in Korea. Rather, it is to show how they were influenced to review their lives, which they never questioned before, and to adopt new techniques.

How do Korean migrant women living in the UK experience themselves as medical subjects? What does it mean for Korean migrant women in the UK to be healthy or ill? Did their perceptions of health and illness change after migration and if so, how? These are the general themes that I had in mind when I was conducting the interviews.

Asking about the definition of health is not an easy thing for a researcher. Knowing that there are many dimensions to health, to ask directly 'what is health?' makes both researcher and participants speechless: at the very least it is an ignorant question without acknowledging the multidimensionality of health, and it makes the participants uncomfortable as they do not know where to start. As one solution to this, I started with how they would assess their health.

Although only two participants (Mrs Kim and BM) mentioned that they were not healthy, everyone, except Mrs Kim and Mrs Soo, talked about how much they had become concerned about their health due to their bodily changes. Having migrated to Britain, their adjustment to British society – mostly to the British diet – affected their body inevitably. More vigourous changes occurred after they delivered a child, which will be explored in subsequent chapters.

However, even those of my participants who actually responded that they were healthy seemed to have some kind of ambiguity about defining their exact condition in terms of health.

> RYU: If you ask me if I *have* become healthy, I don't think so. I am certainly tolerating it [pain] better, mentally, but I don't think I have become any healthier…when I was in Korea, I went to the pharmacy often, and took medicine as soon as I felt muscle pain…here they [medical professionals] don't give any medicine and then I had to breastfeed, so didn't take any medicine for a while…and I think it [my health] is OK.

HOE called her tolerance 'dullness' and revisited her definition of illness. She articulated that while all illnesses in Korea are subject to medical treatment, she began to distinguish light illness that she was able to tolerate from those she could not:

> HOE: I don't know how to say this, but I feel that my body has become better in

> terms of health, but at the same time, it has become dull…It seems like I am used to the dullness and I feel I am getting healthy too…I think this is part of health…If I was really sick, then, I would have gone to the GP. But now, if I have a so-called needle-poking pain on my head, I just lay back thinking it will become better eventually…if I have a pain that I can actually tolerate, or should I say, I have become capable of tolerating, then, maybe in Korea, we are giving too much meaning to colds, headaches, muscle pains.

This distinction was made by many of my participants regardless of whether they took medicine or not for light illness. But for those who did not take any medicine for light illness, they intended to become healthier in the long run:

> KA: I think if you take medicine, you will need more medicine later. If you start with one pill, you will need two pills eventually for the same symptom. I have lots of people around me who love medicines in Korea. I don't like it at all. One of my closest friends always had to take a sleeping pill before bed. When the sleeping pills were available over the counter, she eventually had to take a few pills to fall asleep. My sister-in-law is crazy about '*Gebohrin*', a pill for headaches. So she would take three small packs at once…I don't really take medicines for that kind of little illness.

They felt that constant use of medicine would eventually weaken the body and make it dependent, without necessarily giving it strength to fight against the pain. They were careful to frame their abstinence as an 'aversion' to medicine and pointed out that they would seek medical care if necessary.

BM, who claimed that she did not feel healthy in general, said that the NHS system actually fosters the distinction:

> BM: My husband told me that if I were to live in Britain, I should either be really healthy or really sick. He told me not to be in the middle.

An additional aspect of health that they did not really internalise while in Korea was the importance of mental aspects of health, and that physical fitness does not exactly refer to health:

> JIN: My concept of health has changed. In Korea, I used to think that the healthy person is active, thin, not too fatty, focusing on physical aspects. But, in Britain, I think they consider mental aspect more important.

They pointed out that working out does not necessarily make them healthy and therefore, health should be distinguished from fitness.

> JEA: I was working out when I was in Korea. I went to the gym regularly, and I swam. But my body has never got better in Korea, now that I think about it. I was always suffering from chronic constipation. But, since we migrated here, my health has become so much better. People say that I look healthier now.

SE also made the distinction between health and fitness:

> SE: Being healthy is different from being fit. [Before I had a low platelet count,] I was fit: I was able to carry heavy stuff and I was able to stay up all night and was

> fine on the following day. But after my illness, I realised that those are actually two different things. You work out a lot and become fit. You can control your fitness, but your health, you can't. How are you supposed to prevent yourself from getting cancer?!

Health could only be dictated to a certain extent, whereas fitness, on the other hand, could be totally controlled and managed. Anyone can become fit through regular exercise or dieting, but health can still be threatened at any time. SE said there was no such thing as being 'fully prepared for ill health' or totally preventing diseases. Although she agreed that being fit contributes to achieving health overall and speeds up recovery from ill health, her account reflected that the concepts of health and illness had become murky and confused.

Along with the physical and mental aspects of health, SE, whose husband was treated for a nasal inflammation for a few years, pointed out that she learned how important environmental factors are for health:

> SE: We first thought it was nasal inflammation, so he took the medicine. And then the GP said it was hay fever, so he was on another medication. But, none of the pills helped. We arranged a special diet. Nothing. And then, we moved to a house with lots of sun light, and he got better immediately in two months. Imagine all the pills piled up in his body. It really upsets us and makes us mad. Who knew that the environment was that important.

The last dimension of health and illness is their perpetual immigrant status.

They pointed out that there is an ambiguity with their condition of health and illness because of their immigration status:

> MI: I heard that most people feel that they have got to be strong [health-wise] because you live here [abroad]. But as soon as you go back to Korea, you get extremely sick. So your body has been – both consciously and unconsciously – pressured and has become tense whist you live here. But that body, once back in Korea, relieves its tension because it knows that it can trust [that it will be looked after by my family]. I think this is what it is.

MI and others emphasised the constant presence of stress due to living in a foreign country. This pressures the body mentally but does not create any physically severe symptoms until you go back to Korea where there are other people who can look after you when you are sick.

Reflecting on those influences, what would be the ideal state of health for Koreans? On the one hand, health can be defined in terms as broad as having no 'uncomfortableness' in life, whether mental or physical:

> YU: If I could only run a marathon. If I can be full of vitality and feel fine after running a marathon, then I will consider myself to be ideally healthy – both mentally and physically…the ideal condition of health for me would be not getting exhausted raising my children, and sleeping well…I think this is the ideal type of health for me – having no uncomfortableness whilst living. Health in general does not indicate physical health only, you know.

JP also mentioned specifically about how she pictured a healthy life:

> JP: Whenever I saw Japanese people, I always wondered how come they were so healthy. The elderly who were over 60 were running around in the street or cycling. Their bodies looked very light. Their faces were very bright too…but hardly any Japanese are on herbal medicine like Koreans. You know Korean people eat anything that is good for health? That's not going to help their health. When I see elderly Koreans, their faces are very much withered and they have ill health.

On the other hand, health can mean that the body is free from either severe diseases or constant slight sicknesses such as colds. For GOH, colds were the most common small sickness. So the fact that she had hardly caught any colds since she migrated five years ago led her towards a general belief that she was healthy.

> SON: Health becomes a matter of concern when I get a cold again soon after. It is when my body feels tired and my children bring some kind of virus infection, and it hits me much more seriously than it does my children. When I come down with a cold, have a sore throat or headache often, and if they last for a long time, then I am worried that there may be something wrong with my health.

In the same manner, although one may overlook a cold itself, when it continues to happen all the time, it questions the condition of health.

Conclusion

To sum up, this chapter looked at my participants' initial encounters with the British medical system and especially at their consultation sessions with the GPs. It showed how they slowly began to problematise the concepts of health and illness that they had brought with them from Korea, and to adopt a set of new practices and techniques for working on themselves (for example, altering their self-medication habits because of their shifting views regarding the correlation between healthiness or well-being and reliance on medication). These changes in both concepts and practice are indications of a crack or division in what was formerly a relatively stable and homogeneous medical subjectivity; it shows that they are beginning to undergo the process of subjectivisation with respect to their identities as medical subjects or subjects of medical discourse, and that they are opening themselves up little by little to the British subjective ideal of the active patient/healthy citizen. Nevertheless, at this early stage, this opening up proved to be the occasion for the mobilisation of numerous forms of resistance on several fronts – whether procuring the desired medication from Korea, challenging the physicians' knowledge or even delegitimising and disregarding their status as medical professionals altogether. At this point, therefore, the most that can be said is that there is only a fragile and tenuous co-mingling of subjective forms; the active patient/healthy citizen ideal has not been integrated to any significant extent. In the following chapters I shall try to show how this blending of subjective forms becomes

at once more stable and fluid, less a matter of a breach and resistance and more a matter of a flexible ambivalence and constant vacillation.

Chapter 7: Pregnancy and Childbirth in the UK

In the previous chapter, I showed that my participants' early encounters with the GP involved mostly a resistance to becoming subjectivised to the British medical system. Although the Korean women started to construct the concept of responsibility for their health, their accounts still carry a sense of reluctance and doubt. The majority of the Korean women refused to accept the GP's interpretation of their bodily condition as 'normal' when they had colds, the flu or light pain, and in fact returned to the form of subjectivity characteristic of the Korean medical system by pursuing Korean medical treatment when they became sick and conducting medical check-ups when they visited their families back in Korea rather than engaging in any active re-constitution of health, illness and health-promoting behaviours. However, some of the Korean women who no longer sought the GP's knowledge for their light illnesses seemed to internalise some aspects of the British system and accept the GPs' concept of 'normal', insofar as they started to draw a distinction between light and serious illnesses on the basis of medical treatment required.

In this chapter, I deal with the women's experience of pregnancy and childbirth in the UK, and their reception of antenatal and postpartum care. For healthy women, the experience of pregnancy and childbirth is the time

when the most contact with the British medical system occurs. It is a period of transition between being a passive recipient of care to being an active, responsible citizen.

I argue that although they are physically pregnant in Britain and hence their pregnancies and childbirth are regulated by the British practices, the Korean women also situate their pregnant bodies within Korean society, making it subject to Korean medical surveillance – the periods of pregnancy, childbirth and postnatal care are described by the Korean women as reconstituting their bodies, which oscillate between the two dominant, omnipresent Korean and British medical knowledges. While those biomedical knowledges claim their authenticity, expertise and objectivity, when they exhibit contradicting 'truths', along with the social norms brought by the Koreans and their mothers, the women were torn between these three forms of knowledge, for when they internalised one discourse of knowledge, they inevitably abandoned the others which all equally had legitimate power to scrutinise and punish them for not following.

7.1 Pregnant subjectivities

Foucauldian perspectives provide insight into how pregnant women establish themselves as pregnant subjectivities: Root and Browner argue that the experience of pregnancy is a 'split subjectivity' that reflects a 'slippage'

between authoritative biomedical knowledge on the one hand and 'subjugated' or non-authoritative knowledge on the other (e.g. personal experience). (2001: 196, 217) Pregnant women constitute their prenatal knowledge by constantly negotiating between these two kinds of knowledge as well as political norms (e.g. the imperative to be a 'good mother'), all of which define what constitutes pregnancy. (Root and Browner 2001: 218) Pregnant women's appropriate behaviours, therefore, range from full conformity to resistance in relation to both biomedical knowledge and political norms.

However, while Root and Browner describe the process of subjectivisation as a kind of negotiation between two different kinds of knowledge, the process of subjectivisation that the Korean women migrants went through did not involve simply latching onto one kind of knowledge. While the British biomedical system enters formally to regulate the Korean women's pregnancy, in addition there is the omnipresence of a whole new Korean system of knowledge that the Korean women invite into their experience of pregnancy. Therefore, the Korean women's pregnant subjectivity is constituted by oscillating between the two authoritative objective biomedicines, the two social, culturally specific norms, and their own bodily experiences, all of which define what constitutes a 'healthy pregnancy'.

In order to understand the dominant discourses of pregnancy, I have consulted both the UK Pregnancy Book (2009) and the NICE guideline on

prenatal care, and the Korean website, http://miznet.daum.net/mizmom

The main aim of the UK Pregnancy Book, published by the NHS, is to bring 'together everything you need to know to have a healthy and happy pregnancy, and to make sure you get the care that is right for you…so it's important to get up-to-date, trusted advice so that you can make the *right decisions and choices*'. (My emphasis, The Pregnancy Book, 2009: 4) The Pregnancy Book represents biomedically driven knowledge and norms for pregnancy, and it uses the language of the 'active patient' model to present the individual with up-to-date information so that she can make an informed decision.

7.1.1 Planning pregnancy

The experience of pregnancy in both Korea and the UK is relatively similar with respect to the necessity of conforming to a fairly rigid schedule of examinations and procedures, as if pregnancy was a 'normal illness', subject to constant medical monitoring and regulation. (Ussher 2006: 17) Nevertheless, the Korean migrant women felt that they were not getting enough specifically *medical* care, which made them feel insecure throughout the entire pregnancy process.

The experience of pregnancy in Korea and Britain is highly 'public': from the planning of pregnancy until childbirth, the woman's body is monitored

and regulated by a number of scheduled examinations and rules regarding ‘what to do’ and ‘not to do’ during pregnancy. In addition to this are publicly accepted norms to which pregnant women must adhere. Women are subject to ‘public surveillance’ for their conformity to the discourses of ‘good motherhood’ and those women who fail to do so suffer from punishment or a sense of guilt. (Fox et al 2009)

While the Pregnancy Book starts its information about lifestyle changes as a preparation for pregnancy, the very first stage of preparation for Korean women, on the contrary, is to find the right ‘gynaecologist’ near the home and evaluate their current health condition. Both men and women are encouraged to consult the gynaecologists for a health examination if they plan a pregnancy, but it is usually the women who consult the doctor. Gynaecologists will advise both men and women to ‘make their mind and bodies ready’ by improving their health to create an optimal environment for the foetus: men are usually told to cut down smoking and drinking, and women to be fit. The ideal planning time for pregnancy is between three months and a year. During this planning period, the medical check-ups prior to pregnancy include examinations for anemia, hepatitis B, syphilis, toxoplasmosis, and rubella, as well as a routine blood test. (Daum, Mizmom)

Once a woman in Britain informs her GP of her pregnancy, she is likely to receive up to 10 antenatal appointments for the first child; women can

receive antenatal care at home, at the Children's Centre, GP's surgery or hospital. (The Pregnancy Book, 2009) Most antenatal care is provided by the midwife, who will guide the pregnancy through regarding the general health of the woman, growth of the foetus, and scheduled medical examinations, and the relationship between the midwife and the pregnant woman lasts until childbirth. In Korea, by contrast, pregnant women visit the gynaecologist monthly and these regular visits consist of urinalysis, blood pressure, weight checks, ultrasound scans after four months of pregnancy, and diagnostic checks for diabetes. The expense for these monthly check-ups ranges from 15,000 won (£7.50) to 30,000 won (£15). In addition, special tests for congenital malformation can cost up to 100,000 won (£50) per visit. (Daum, *Miznet*) The relationship between the obstetrician / gynaecologist and the pregnant woman lasts until childbirth.

The moment the Korean women planned or realised that they were pregnant marked an important turning point because it was also the time when the internalisation process or their willingness to 'understand' the British practices started.

When asked how she felt about becoming pregnant and going through childbirth in the UK due to her initial encounters with the GP, BM replied:

> BM: Of course I was worried! [raising her voice] But, then my husband said, 'Don't make a fuss about it. We are not living out in the Amazon'. I thought I

> couldn't really compare [childbirth] with flu. As long as women here deliver in the hospital, it couldn't go too wrong, I thought…and I could do more – I could look up information, I could pay more attention, more attention to my body and see if there's any sign and so on.

SAH's response shows that she was ready to understand the practices in Britain:

> SAH: It's not like we are planning to go back to Korea [in the future]. We have made a decision to live here…I thought to myself, after all, it's pregnancy and childbirth. I can't do it without doctor's help…Everyone else seems to be delivering fine…So, I said to myself, all right, whatever comes, I am ready to accept it as long as they don't make me deliver on the street'. I better not get stressed out about everything.

KA also replied:

> KA: I asked my husband (British) how women here deliver. He knew what I meant, so he teased me by saying 'Honey, what do you mean? We don't have such a thing as a medical system, no hospital, no doctors here. You are on your own.' Of course he was joking. So, I thought after all, how different could it be? My kid is going to be half Korean and half British so, I better change my attitude toward the system here.

This attitude showed that they were willing to open to the British practices of pregnancy, while acknowledging that they were in a way left with no

choice. But, throughout the pregnancy and childbirth experience, the women's accounts start to reveal the internalisation of the whole logic of the British medical system. As they have more contact with the British system, they vacillate between resistance and conformity to both British and Korean modes of medical subjectivity.

In Britain, maternaty care for pregnancy and childbirth are conducted by midwives and promote normal childbirth. The midwifery-centred maternity care is 'non-interventionist' and desinged to encourage women to have demedicalised childbirth experience. (Kitzinger 2004) Where midwifery-led environment is not the norm, choosing to labour with midwives is conceptualised as resistance to the medicalisation of pregnancy and childbirth. (Parry 2008)

Their resistance to the British code often means their conformity to the Korean practice, and vice versa. The patterns show – they refuse to give medical authority to the midwives who represent antenatal care in Britain, they dismiss the doctors' advice and act on their own, understand ultrasound scans rather than medical examinations as a means to see their children and create a bond, and go back to Korea for medical examinations. Their conformity to the British code includes their interpretation and defence of the British procedure.

The Korean migrant women's active information gathering was the first

indication that they were beginning to internalise and embody the 'active patient' mode of subjectivity. While they formally partook of the British medical system from the moment they registered with the midwife, they began the deeper process of reconstituting their knowledge and subjectivity as they sought out diverse forms of knowledge that provided information regarding prenatal care and advice on how to behave, including books and websites (in both Korean and English), leaflets, as well as friends and family members. However, there seems to be no agreement on which information was privileged over the other and on what basis. JIN privileged the Korean practice:

> JIN: I obtained information from my Korean friends around me…there were many Korean women around my age who got pregnant around that time…so we exchanged information. I also went to the GP who referred me to the midwife. So I often asked the midwife if I had any queries…I obtained Korean information a lot. Even though I've lived here long enough, I was thinking that after all my physical constitution was Korean, so was my baby…If Korean people said 'don't do that', I didn't do it. I also read a Korean book about pregnancy and childrearing.

GOH, on the other hand, privileged the British way:

> GOH: I didn't exactly follow what the Korean information says. It was only for reference purposes, because, I live here in Britain, first of all. The information is different – what Korean information says I should do, there were many that I couldn't follow, and my husband was skeptical about the Korean information too.

> He said, ‘how are you supposed to trust this?’ because he trusts the NHS 100%. Oh well, so I thought I would just trust the British information. It wouldn’t say anything bad, I thought.

MI trusted most those who had experienced childbirth in the UK:

> MI: mostly from Korean people around me and from families in Korea. Or, I asked the elderly for advice like ‘my bodily condition is this, what do you think?’. Rather than doctors, the people who gave birth to a child have more accurate information a lot of times.

While collecting information, JIN expressed that she did not blindly follow the precepts of one set of knowledge: she found some information contradictory or complementary:

> JIN: about diet, in Korea, pregnant women eat lots of nuts because nuts help balanced development of foetus. Almonds and peanuts are highly recommended, but here there are many people who are allergic to nuts, so one of the foods, as a pregnant woman, you are advised to be cautious about nuts. I am not allergic to nuts, so it doesn’t matter to me, but I think maybe it is because of the weather, here that more people develop allergy to nuts…so in case my son, since he was going to be born here, I didn’t eat any nuts.

When asked why she did not take any nuts although they were recommended for pregnant women in Korea, JIN’s response was similar to the others’: they reconstitute their knowledge based on one aim: ‘what is

best for my baby':

> ..Really, as a mother, mother wants to give everything to her child. That was, and still is how I feel. Not me, because I could tolerate it, but what would be best for my baby was always the question that I asked myself. If I had any doubt on certain information or what to do, I didn't take a risk. I just didn't do it.

Most of the Korean women pointed out that the attitude of the GPs, who told them that light illnesses did not require treatment and that everything was normal, could characterise the British medical system's attitude to pregnancy, which foreshadows their later belief that pregnancy and childbirth in the UK are 'natural' and 'normal' phenomena:

> SON: Korean information tends to be very minute. Korean books will have very much detailed information about any possible, as low as 1%, problems. So pregnant women are *warned* and they have become conscious of what possible problems are there. In comparison, British books are, put simply, 'relaxed' [her word in English]. For example, Down's Syndrome is taken very seriously in Korea, so if the ultrasonograph shows a little bit of the possibility, people will take more thorough tests right away. But here you are told, 'if you want to take a test to find out, go ahead, it's entirely up to you.' It's difficult for me to understand given my cultural background…if the ultrasonograph showed that my baby might have Down's Syndrome, I would think the doctor should give more specific information as soon as possible.

The British structure of antenatal care – which can be characterised as less

ultrasound scanning and care being provided by midwives rather than gynaecologists – produces uncertainty and ambiguity with respect to the condition of their babies and their health for the Korean women. As a consequence, the diverse patterns of resistance and conformity behaviours occur throughout the period of pregnancy and childbirth based on how this concept of risk is being solved.

7.1.2 Midwives and healthcare professionals

From a Foucauldian perspective, the relationship between pregnant women and healthcare providers (whether midwives or doctors) is a mutually dependent one: women rely on the expert knowledge of health professionals for their bodies in the course of pregnancy, and the power of health professionals depends on the compliance of women who acknowledge the authority of biomedical knowledge. (Root and Browner 2001) However, from the perspective of the Korean migrant women, this mutual relationship did not hold. The reason for this is that, while they received most of their antenatal care from midwives, they did not recognise midwives as legitimate medical authorities. Hence this constituted their first form of resistance.

The Pregnancy Book states that the role of midwives is to provide antenatal care, particularly to give information to help the pregnant woman make informed choices and carry ‘healthy pregnancy’. (The Pregnancy Book, 4) Hence visits from midwives were the first form of British medical

regulation to enter the site of their pregnancy to regulate and monitor their private bodies. Midwives provided *emotional* support during the time of pregnancy, which the Korean women appreciated highly, but as *healthcare* providers they left them feeling insecure. When they found out that they would not be seeing the gynaecologists unless there was something wrong with the pregnancy, they felt their pregnancy was always at risk. Most Korean woman immigrants said the midwives made a good impression: they were friendly, comfortable, non-authoritative, and encouraging. Greek women who wanted more medical intervention also appreciated their relationship with the midwives as they provided intimacy and comfort. (Drugonas 1987) However, the Korean women also pointed out that they were lacking professionalism. Most women stated that their first contact for any enquiries regarding their pregnancy or procedures pertaining to the care was their midwives, but the midwives did not have the same expertise required to remove the risks that the Korean women felt:

> Kyung Ae: I only saw the doctor when I was getting a C-Section...everything else was done by the midwife…she made me feel comfortable. It's very scary when you are about to deliver a baby…But the midwife constantly encouraged me: she told me that everyone could do it so there was no reason for me not to be able to. She also made me laugh by making a few jokes…But, there isn't much that she's doing in terms of treatment. She just listened and I felt that I wasn't alone. If you really need help, you can meet the specialist, too. The midwife made me feel that I was being cared…you know, this kind of little support that you appreciate.

SAH, who was seen by a team of midwives, more frequently than other pregnant women because her urine test showed protein, also pointed out how they seemed less professional and made her feel insecure:

> SAH: My urine showed much protein. When the midwife came, she always checked for my urine. Sometimes, I had midwives coming twice a week, and then once a week, and then every fortnight…they are very kind, but from our [Korean's] perspectives, I do find some of them were not professional enough. That made me a little worried, insecure.

The presence of the midwives was generally seen from an emotional aspect and their ambiguities and risk about the health of their pregnancy could not be solved by the midwives, on some occasions increasing the insecurity of their pregnancy.

7.1.3 Ultrasound scan

While the Korean migrant women had a more or less uniform opinion of the midwives and resisted their perceived lack of medical authority, when it came to their ultrasound scans they had divergent views. The first thing that the Korean women pointed out as a characteristic of the antenatal care was only receiving two ultrasound scans throughout the entire duration of their pregnancy – one, a 'dating scan', at 8 to 14 weeks for estimating the due date and the physical development of the baby, and the other, an 'anomaly

scan', at 18 to 20 weeks to check the physical development of the baby for any structural abnormalities. (The Pregnancy Book: 42) Both scans are for medical purposes. On the contrary, in Korea, every visit to the obstetrician / gynaecologist usually consists of ultrasound scans.

JEA, who came to the UK when she was six months pregnant, explained that she felt secure after ultrasound scanning in Korea and the practice in Britain increased her worries:

> JEA: In Korea, doctors constantly provide medical check-ups and this gives psychological comfort to women…the doctor leads you to take check-ups, non-stop. Since I was six months pregnant, I even did the 'specialised ultrasound'. That shows the very details of the baby – how many fingers and toes the baby has, whether or not his eyes, nose and mouth are placed nicely. When I came here (I was in my 6th month), I asked the midwife when I can get the ultrasound scanning, and she said the time for ultrasound scanning was passed for me, but if I want, she can arrange for it, just once. That was a great shock for me… If I didn't know about the Korean way of pregnancy, I wouldn't have been shocked too much. But, I was told to come every 2-3 weeks in Korea.

She pointed out that all of a sudden she was left alone, which made her worried about the condition of her pregnancy. Unlike the medical consultations that she received in Korea, in which she was subject to aggressive medical regulation, pregnancy in the UK was not comforting, especially when the midwife and the obstetrician were incompetent in her

opinion:

> JEA: Here, medical professionals always say normal…I thought my baby was getting too big, so I kept asking my midwife and obstetrician, but they said it was normal. When my baby was born, he was actually over 4kg! So, I asked them how this could be normal. They were surprised at the baby, too. The Korean side, scientific check-ups give psychological comfort before your eyes, but doctor's words give stress. The British side, doctor's words give comfort but you may be misled when you actually see with your eyes.

Some Korean women dismissed the medical purposes of ultrasound scans during pregnancy. The technology was to provide her with a means to bond with the foetus.

> KA: What I didn't like about here is that in Korea, although you have to pay, you get an ultrasound scan every time you go see the doctor, right? I only found out that I was pregnant when I was visiting my family in Korea…So, I got the ultrasound scan every time I saw the doctor…in addition, the doctor recorded the sounds and the images, the whole things about my baby, not just photos but the movements as well, on the CD, every month. So you bring an empty CD to the doctor every visit, and by the end of your pregnancy, you will have seven to ten CDs. Even the conversation between the mother and the doctor would be recorded. So when the baby is grown, you can show the CDs and the baby can find out what sorts of things that her mother was worried about or talked about when she had her inside. Isn't this nice?! So when I came back in August, I wanted to continue. I asked my GP and of course he said no…in Korea, you can

> get whatever you want by paying some money, which isn't that much compared to what I can get.

The visual image of how the babies are positioned and moving inside their womb offers an emotional bonding moment between the babies and the mothers.

Over time the Korean women began to become more receptive to the British model and to criticise the Korean model for its overactive intervention. For example, GOH pointed out that she was first feeling nervous about the antenatal care that she received, but after the baby was born, she thought Koreans were perhaps 'overreacting':

> GOH: After 20 weeks, you don't get to have any ultrasound scan. The midwife just listened to the sound of the heart, and repeats, 'everything's fine'. When I asked my pregnant friends in Korea, they seem to be getting the scan every time they visit the doctor. So, I was getting nervous. I asked the midwife how tall my baby was going to be, and she measured my belly using a tape, pressing hard, and said my baby would be around some cm tall, and some kg heavy. In the end, a lot of people were commenting that my belly looked smaller than normal. So, I asked my midwife many, many times if my baby was too small. And she said no, the baby would be normal, and asked how much big baby I wanted. She said my baby would be around 2.8kg, and he was born at 3.0kg. So, pretty similar. I was really nervous at first, but I thought maybe Korean people are overreacting.

Similarly, RYU remarked:

> RYU: There are great differences between the two systems…My friends in Korea started seeing the gynaecologist as soon as they became pregnant, got ultrasound scans. They have done it too often, and it's useless. The experience of Korean pregnancy is full of conducting useless tests…for example, one of my friend was advised to have her water tested in 6 weeks. But, if you conduct that kind of test, it can be dangerous to the foetus because you stick in a needle to take out some water. So, actually, you are risking your baby's life.

When asked why she thought the amniocentesis could be dangerous, she replied that she asked the GP and she agreed. RYU added that she looked up the information in order to verify it for herself. JEA also thought that Korean physicians used fear to legitimise the performing of unnecessary tests.

> JEA: you know the specialised ultrasound scan that I received…when I asked my gynaecologist friend later on, she said it could be actually quite painful for the foetus. The ultrasound scan is done through very low sound, and the foetus is very sensitive at sounds, so she would be running away…

7.1.4 Medication during pregnancy

The most common conflict between the Korean woman immigrants and the British medical professionals occurred when they were told that it would be safe to take certain medicines.

YAE: No, nothing, I didn't even take iron. For three months, I only took folic acid. Folic acid helps prevent deformity of the baby so you take it for three months even prior to pregnancy. It is a kind of vitamin. When I first told my GP that I was pregnant, he prescribed that to me first. Here, all pregnant women are prescribed with folic acid and they take it all. Prior to conception, they said you could start taking it if you were planning for pregnancy…I caught a cold twice during my pregnancy. But I didn't take any medicine. Because I am pregnant. It was in the early stage, first as soon as I got pregnant and the second was when I was five months along. But I didn't take any medicines then either.

Researcher: you thought the medicine wouldn't be good for your baby?

YAE: Yes. I think it's possible. In case it could be bad for my baby. In case it becomes a problem, mentally and physically. In case it affects my baby. So, I didn't take any medicine at all…The midwife told me that paracetamol was fine, but there are so many things that's okay in this country. [laughter] So, there are things that they are very thorough with, but with others, they are not.

When asked why she didn't take medicine she said, in case the medicine has a negative impact on the baby either mentally or physically. Even though she was told that paracetamol would be fine, she said she could not trust the British information in that regard because there were simply 'too many things' that British people were fine with. They did not want to take any slight chance of risk by taking medicine because medicines are 'chemicals'.

SAH: At first, I took folic acid and then later iron a little bit. I told them I had an ache around my waist and they told me to take paracetamol. But I didn't think it

> would be good for my baby and I was able to tolerate the pain too so I didn't take it. I tolerated it until the end of my pregnancy…I think Korean people in general think that taking medicine, especially pain killers, during pregnancy would have a negative impact on the baby. Here they said paracetamol is okay but, as a mother, if you can tolerate it, right? If it has a little possibility of having a bad impact on my baby, I think I can tolerate anything. So that's why I didn't take any medicines.

Although their behaviour of not taking any medicines during the pregnancy was not based on any medical experts' knowledge – and in fact, the medical experts did assure them that certain medicines would not affect the babies – the women chose to tolerate any pains, showing a strong desire to block any possibility of risks that might result in a negative output.

The two exceptions to this case are GOH and BM. GOH had an infection and so could not avoid taking a cycle of antibiotics. When asked if she did not feel uneasy about it, she said:

> GOH: Of course I did! [she raised her voice very loudly] So I asked if this would be fine even though I was pregnant and the doctor said he wouldn't give it to me unless it was fine. So I took it once…I guess it was okay. Even whilst taking it, I was very suspicious but what could I do? It would be worse for the baby if the infection got him.

BM, who suffered from severe morning sickness, took medicine that removes morning sickness.

> BM: I was suffering so badly from morning sickness so the doctor said I could really trust this medicine. I was a little suspicious but I was suffering too much. The medicine was to remove morning sickness, but it was more like a sleeping pill. It is also used in Korea too…I took it for two months whenever I needed it. I was assured that it would not affect my baby. I was suffering so much. I tried not to take it as much as possible but I just couldn't bear the pain. Then I got better.

However, BM regretted taking the medication because she thought it stunted her child's growth, which made her feel guilty. Accordingly, when she was pregnant with her second child, she did not take any medicine.

> BM: But when I was pregnant with my second child, I didn't take any medicines, not even iron. Just in case. I was suffering so much when I was pregnant with my first kid but the second time the pain was tolerable. So I decided not to take medicine and handle the pain as much as possible. So I ended up not taking the medicine. You know, my first kid is a little smaller than those of his age. I know there are many reasons for it but I am just thinking that it might be because of the medicines that I took during the pregnancy.

The most radical form of resistance was to reject the diagnosis from the British specialist and fly back to Korea for medical check-ups. In the case of BM, who reported extreme symptoms of morning sickness, such as tight chest, dizziness, and blurry vision, she was told by the GP that those symptoms were due to lack of exercise. She disagreed with the diagnosis after carefully examining her body and flew to Korea:

> BM: It was because I had low blood pressure. When I was pregnant with my second child, I felt so dizzy and I didn't know it was due to low blood pressure…I stayed in Korea for three months because of that crazy morning sickness that I had and, when I went to the hospital there, I was told that it was due to low blood pressure…once I discovered the cause, I was taught how to behave such as lifting my legs whilst lying down and so on.

7.2 Childbirth and Postpartum Care

The clashes between the two different cultures reached a climatic point when the Korean immigrant women experienced childbirth. The Korean women's relationship to both the British and Korean medical systems encountered a major turning point as they began actively to adjust their behaviours in accordance with their detachment from and suspension between both systems; they began to drift toward the adoption of, and to embrace as an integral component of their identity, the new mode of subjectivity of 'active patient/healthy citizen'.

The Korean women conceptualised pregnancy and childbirth in Britain as a 'normal procedure' and thus thought that there was no reason for specially tailored postpartum care. This is reinforced by their observation of British women who acted like nothing happened. Without dismissing the British practices after childbirth, the Korean women nonetheless claimed that

normalising childbirth does not work for them because of the bodily differences that they noticed. In other words, even though they recognised childbirth as something normal, they still could not fully embrace the British way because they felt there were basic and irreducible physical or bodily differences between them and British women (the nationalisation of the body).

The postpartum care period refers to the time required for a woman's body to fully recover the physical, emotional, and social functions that it used to have prior to pregnancy. The duration is usually six weeks after delivery. It is often pointed out in the Korean literature that besides the fact that the first few weeks are critical for neonatal care, this period is also important because it is a time for the family to adapt to and feel responsible for the new member. How the mother spends this period determines the health of both her and the baby (Kim et al. 2002).

In contrast to the US or the UK, where nurses or health-visitors make a visit to each household and provide information and care for health and child rearing, Korean women lose contact with medical expertise as soon as they are discharged from the hospital after five to ten days of hospitalisation. However, it is culturally accepted that women after childbirth require postpartum care: the knowledge and beliefs of postpartum care has been orally transmitted and traditionally practised. Up to six weeks after childbirth, women are told to stay in bed, keep their bodies warm, and not

drink or touch anything cold. The care was usually provided by their own mothers or mothers-in-law at home, by taking care of the household work and the newborn.

The first postpartum care centre was established in Korea in 1997 and the care has become professionalised and increasingly commercialised. In 2001, the Korean Department of Health[2] estimated that there were about 300 postpartum care centres. Most postpartum care consists of providing a space for woman to rest and restore her energy, and also assisting the first couple of weeks of looking after their babies. The care is mostly provided by the non-medical staff. The proportions for each staff in a postpartum care centre, in general, are 66.5% non-medical practitioners, 21.3% nurses, 8.7% midwives, 2% of its staff as doctors and 1.6% *hanbang* doctors. The average cost for two weeks is 842,000 won (equivalent to about 420 pounds). It has become widely popular in Korea for women to enter postpartum care centres and spend a few weeks receiving care from the staff in the centres. (Kim et al. 2002; Han 2004)

The importance of postpartum care was highly acknowledged by the Korean migrant women. Most of the women reported that their mothers flew to Britain and stayed for four to eight weeks. Their mothers helped them rest or keep them away from their daily duties by doing housework, cooking, and looking after their babies by sleeping with them at night. In those cases

[2] http://epic.kdi.re.kr/epic/epic_view_source.jsp?num=55508&menu=1

where their mothers were not available, they received support from their husbands (husbands usually took paternity leave) or friends in the Korean community. Chinese, for example, also consider new mothers to be in a particularly risky and vulnerable state of health during the postpartum period. They have sets of traditional practices for new mothers, including specific dietary regimens, based on the yin-yang principle. This tradition not only aims to improve the health of a woman after childbirth but it functions as a reward for her reproduction, especially when she delivered a son. A study on Chinese women immigrants in Australia found that the postnatal support that Chinese women receive from their family and community contributed positively to their recovery and helped them prevent or cope with postnatal depression. (Chu 2005)

7.2.1 Normalising childbirth

As the Korean women were hospitalised with British women who also went through childbirth, the Korean women made a connection between the hospital care and the behaviours of the British women. CHA, whose parents are a gynaecologist and a paediatrician, criticised the way that Korean women are subject to childbirth:

> CHA: I really admired the way that British people have childbirth…In Korea, doctors make women deliver as if she was through a serious surgery. Here, they make you feel like you are delivering from home. I liked it. I felt like it was

> something that all the women naturally go through.

CHA's understanding of childbirth in Britain is also repeated by other Korean women. JIN, who had a natural birth, noted that she could have been easily discharged on the same day of delivery if she did not give birth at night. She described how shocked she was to see the behaviours of the British women:

> JIN: Although my body was recovering quickly, I wasn't able to get up and walk around or use the bathroom right away like an ordinary woman. But, when I looked around in the hospital, the British women, who were hospitalised with me, just got off the bed and they started to walk like nothing had happened to them!

JIN distinguished women who had just delivered from 'ordinary women', and as she observed British women acting like 'nothing had happened', she thought they were more akin to ordinary women than to women who had just delivered. If the British women could act like 'nothing had happened', then, as CHA said, pregnancy is not much of an 'illness' requiring a lot of medical attention like in Korea.

The examination of differences in terms of how the hospital treats the women after childbirth as well as the behaviours of the British women provoked her to step out of the Korean postpartum care for a little while:

> JIN: When I came home [from the hospital], I felt extremely hot…My mom was

> here to give postpartum care so she turned on the heat and I just couldn't bear it. So I thought to myself, 'well, now I am living in Britain, do I really need to have this much extreme postpartum care?!' So I ran out and cooled my body whenever I felt hot.

JEA also said that she took the ice cream from the hospital, but she had to keep it from her mom who was reinforcing her to behave properly like a woman who delivered a child:

> JEA: They gave me ice cream. Even before childbirth, they gave me a cup of tea. There is lots of caffeine in British tea. In Korea, pregnant women don't even drink coffee or tea. They gave me ice cream saying, after childbirth, I had to restore hydration and calories. My mom was really shocked and said 'Don't eat it, you are going to loose all your teeth!', but I ate it anyway. I ate it every time when my mom was not around. It was tasty…And my teeth are fine. Nothing happened to them.

Yae, on the other hand, strongly disagreed with the hospital care that she was given. She had an emergency caesarean operation, and she was told to take a shower on the following day. She refused to take a shower following the Korean practice:

> YAE: What I really couldn't understand was that we don't really let women touch water in Korea after the operation, right? But here, they told me to take a shower on the day following the operation…So I said no, and they constantly asked why I didn't want to take a shower, almost enforcing. They looked at me as if I was an alien.

The different practices of British subjectivity could create a conflict between the Korean women and their mothers who reinforced the Korean subjectivity of how the women should behave after childbirth:

> GOH: I delivered my child in summer so it was even more difficult. My mom came and the weather was extremely hot, it went up around 30°C…when I was breastfeeding my baby, I felt even hotter because two bodies were close together. So, I breastfed my baby while having the fan on right next to me. My mom said I was nuts, and asked what I would do if the wind gets into the bones [getting chilled]. She even forced me to wear socks when I was hot to death. So we fought a lot.

However, as they were commenting on their current bodily condition after childbirth, backlash to the British subjectivity occurred as they admitted that they should have followed the Korean practices. Almost all of them claimed that they felt that their bodies had greatly changed since childbirth. Their bodies were 'not the same', as they put it: their shoulders felt stiff; their fingers sore; their waist hurt; the inside of their body was cold which, for them, was an indication that they had become physically weaker overall. In addition, they felt like they were waking up on the wrong side of the bed in the morning and that they had semi-permanently co-existing fatigue. When asked what they thought was the cause of these symptoms, they did not hesitate to single out one – the poor postpartum care that they had received.

7.2.2 Nationalising bodies – 'Korean' body and 'British' body

The constant fatigue the Korean migrant women felt forced them to revisit the care they had received as well as their observations of British women who had just delivered. As they tried to answer the question, 'What went wrong with my body?', they began to establish a distinction between two radically different bodies: a Korean body and a British body.

Therefore, this lasting pain and fatigue that they have obtained from their bodily knowledge confirmed that they should have sought postpartum care. The Korean women also started to distinguish their bodies from themselves by interchangeably using the terms – I and 'my body'. The lasting pain has become a constant reminder to them that they failed to 'give' their bodies the kind of proper postpartum care that they could have received in Korea.

> YU: I really *gave* my body nothing. I didn't even have the thick beef soup, for God's sake! You know you've got to give yourself postpartum care after delivery. Especially since I had C-sections, I should have stayed on the bed longer than others; I should have refrained from moving my body…and of course, my body has gotten worse.

> JIN: Yes, I [followed the British way] and now I really regret it. I was totally wrong. My wrist feels sore and I feel like the wind is penetrating my skin, moving between my bones, when the weather is windy. I realised, yes, of course I am Korean, I should have listened to my ancestors' wisdom…I was focusing on

> my baby first, so I didn't really realise which parts of my body was feeling sick or painful. Even when I did locate the pain…I didn't pay much attention. Now it's been a while since delivery, and yet my pains are still there. So I know these are due to poor postpartum care.

SON went even further and denied that the normalisation of illness is not quite the case with British people.

> SON: When I delivered my second child with C-section, the nurse told me that I could get on with my life from the afternoon. I could do everything. She said I could drive home. So, I told her that I was too exhausted to drive home. But, I was told that since they prescribed painkiller, I could take the painkiller and drive. I think if I need to take a painkiller to get on with my life, I should rest. They acted like childbirth is no big deal, but it is a big deal. I don't think I need to get on with my life with the help from painkillers.

SON acknowledged that there are not only biological but also cultural differences, including basic lifestyle practices that contribute to the bodily difference:

> The British people can live healthy in this culture and climate without 'protecting' their bodies like us, whereas we cannot live healthy without it. These people seem to have something genetic, biological, or culturally built to stay tough, but our culture is to protect our bodies.

DEE stressed that, because Koreans have different bodies, they ought to

receive different treatment:

> When I had a chat with other Korean women who delivered here, some of them said their vagina was torn while delivering a baby. In Korea, the doctors will tear the vagina a litte bit so that it can be easier for the woman to push and the baby to come out. The British people and the Korean women are physically different, so they could have admitted it and tear a little bit. But, they don't, and the Korean women ended up suffering. I think the Korean way is more concentrating on the convenience and over-reaction, which caused women to become weaker and reliant, so that's a negative side.

Although most women did not seek any further medical treatment, GOH sought *hanbang* care. The description of her symptoms was not much different from those of the others, yet the fact that her house was not properly heated worsened her bodily condition beyond the 'natural' state of symptoms caused by poor postpartum care. She used the term, 'postpartum ache':

> YON: I had *hanbang*. My house temperature is usually low but after I delivered my child, when I was having the seaweed soup, which was not too hot, I started to sweat a lot. So I asked my sister and the people around here and they said after childbirth, you tend to get sweatier when you eat the same foods that you always had prior to delivery. So I was sweating for two days or so and although I turned on the heat, my house was still a little cold. So I got the postpartum ache. This postpartum ache is, you feel chilled to the bone as if the wind was going through inside of your knees or shoulders…your body feels cold…So I went to the Korean *hanbang* doctor in New Malden and he said I was indeed suffering from

the postpartum ache.

Unlike other symptoms that were taken for granted as having been caused by poor postpartum care, once she diagnosed herself as having a 'postpartum ache', it became a disease that required medical attention right away. Her self-diagnosis was confirmed by the Korean *hanbang* doctor and she was treated with herbal medicine.

It was necessary for women, whether Korean or British, to receive the appropriate postpartum care.

> JIN: Yes, I think it is necessary to have postpartum care…I think it helps you adapt quickly to the new member of the family. Because when your body is too sick, it would be difficult to take good care of your kid. So I think it's best that you quickly receive proper postpartum care and quickly become healthy. That way, you can provide good care to your baby with all happiness.

However, even though they suggested that their current poor health was due to the insufficient postpartum care that they received, again, seeing British women who did not seem to have the concept of postpartum care and yet hardly affected by pregnancy and childbirth makes them reconsider the meaning of health

> JEA: When I see British people, I think they are much healthier than Korean women in Korea…When I see my Korean female friends here, I always think

> Korean women are weaker health-wise. These [British] women do all things by themselves. For example, you know those baby baskets for car seats? I couldn't carry it so I asked my husband to do it for me. But these British women just carry them around, as if they were carrying nothing. They seem to have no problem breastfeeding…maybe this is the difference due to physical constitutions but when I see Korean women here, I really think we are weaker. They even look very tired walking to the nursery, but you can see British mothers walking with three kids. To tell you the truth, it makes me think that they are stronger because they didn't receive postpartum care.

> HOE: I think British women are healthier than us. I don't know why. Maybe they are used to this because they don't have any concept of postpartum care. When we get pregnant, our husbands are expected to take good care of us wives, right? But it's not like that here.

Both JEA and GOH's remarks reflect that the Korean practice of postpartum care actually makes the overall health of Korean women weaker.

Conclusion

The experience of pregnancy and childbirth for the Korean women marked a transitional point as the Korean women oscillate between the two, very different, pregnant subjectivities: the Korean women conceptualised that while the Korean pregnant subjectivity requires pregnant women to be under aggressive medical surveillance, the British pregnant subjectivity involves taking more active and less regulated roles. The antenatal care

provided by midwives in Britain did not provide sufficient security to manage ‘healthy pregnancy’. This insecurity decreased as the Korean women adopted the British practices of pregnancy and childbirth, which they described as a normal, natural part of life, which did not require as much intervention as given by the Korean system. This led them to distance themselves from strict Korean regime of postpartum care, which caused them to experience chronic pain and fatigue. As the Korean women distinguished their bodies from British bodies, they began to embody the ideal of healthy citizenship by adopting the attitude of more conscious care and careful examination of their own body. In the next chapter, this actively taking responsibility for their own care becomes visible in their concern for their children’s health.

Chapter 8:
Mothers as Health Ambassadors of the Family

In the previous chapter I detailed the Korean migrant women's experiences of pregnancy and childbirth as well as their reception of antenatal and postpartum care in the UK. My participants' narratives reflected the fact that they were still simultaneously in Korea and Britain, and thus that they were endlessly constituting and re-constituting themselves as medical subjects as they navigated among the two authoritative Korean and British medical knowledge systems as well as social and cultural norms, equally powerful, all of which served to define what constitutes a 'healthy pregnancy' and 'normal childbirth'.

The period of pregnancy and childbirth marked a critical turning point, not only for their own personal histories, but also with respect to their subjectivisation to the 'healthy citizen' model. Unlike other women's experiences of childbirth with midwives – which is usually advocated as a way of empowering women by allowing them to experience a demedicalised, normal, and self-controlled childbirth (Parry 2008) – my participants' experience of pregnancy and childbirth with midwives was marked by feelings of insecurity and powerlessness. While most of them felt isolated from their bodies and foetus because they were unable to request more ultrasound scans, almost all of them later on romanticised their pregnancy experience as 'normal' and 'natural', which represented for them

what is desirable in the UK. After childbirth, most of my participants had their mothers for a couple of months to provide postpartum care. The importance of postpartum care was prevalent in their accounts and they distinguished their bodies from 'British bodies', Korean bodies thus requiring Korean care practices.

This chapter will show the ways in which the Korean migrant women's mothering practices start to accord, more or less, with the medical imperative to be an active patient/healthy citizen. It will be seen that, although they appear to conform, and do in fact conform, more and more to the healthy citizen model, still there are points of resistance which indicate the presence of a different ideal of motherhood tied to a lingering adherence to their former, autochthonous form of medical subjectivity (i.e. the Korean model of the 'good patient'). This conformity and resistance is framed in terms of their adoption of the role of the family's health ambassador.

The first section explores how my participants' felt responsibility toward their children forced them to alter their own self-care practices, i.e. the changes in the way in which they related to themselves (both medical and non-medical) after childbirth. The second section details how they were forced to become educated, doctor-like mothers, which indicates another mode of conformity to the healthy citizen model insofar as they continued to challenge the GPs' and the Korean doctors' knowledge and advice. This chapter directly responds to the following chapter, which discusses how the

Korean migrant women dealt with their own health and that of their children in their daily routines.

8.1 Healthcare for mothers

8.1.1 Parental responsibility and passive healthy citizen

While women are in general considered the primary carers of their children's health, (Doucet 2009; Moon 2003) my participants tended to amplify the extent of their parental responsibility due to the lack of support they were able to receive from their social network. This was all the more severe to the extent that their husbands did not equally share the childrearing burden, forcing them to resort to hasty actions to restore their health. This led them to conform passively to the healthy citizen model.

Their realisation of their parental responsibility forced them to alter their lifestyles to improve their health. SON noted that from the moment she delivered her child she was compelled to be responsible for the baby; this made her realise not only her parental responsibility but also her almost total isolation from her familiar socio-familial support network:

> SON: Since there are no other family members who can support the childrearing, so it is just the two of us taking care of our children, also working full time, there is an enormous amount of stress from this infinite responsibility. My husband has high

> cholesterol, and he used to ignore that. But after childbirth, I told him, 'it's just the two of us. If you continue to not control your diet, imagine, it's just going to be me and our two children.'

SON stated that she was able to change her husband's diet effectively by appealing to the fact that there was only herself and her husband who could look after the children. Without any support from relatives or families, my participants ended up retreating into an 'isolated and privatised mothering'. (Moon 2003) Further, as SON noted, this led to the feeling of being burdened by an 'infinite responsibility'. Because they had no extended support network, they were led to adopt more and more the healthy citizen model and thereby to conform to the ideal form of medical subjectivity in the UK. At least in part, therefore, conformity to the healthy citizen model arises, not through active acceptance, but indeed through bare necessity; paradoxically, it is a form of passivity, of acquiescence, that nudges them little by little in the direction of the desired active patient/healthy citizen model. Thus, among the various responsibilities of childrearing, looking after the health of the child becomes the most important concern:

> JIN: Ever since my son was born, my life has been re-arranged according to his schedule. When he sleeps, I can sleep…if my son falls sick all of a sudden, my life is put on hold. If it was me, I could still do things, maybe a little slower than the original plan. But, when he becomes sick suddenly, two or three days straight are all devoted to him. That's the biggest change after childbirth. When my child falls sick, my life's out of control.

JIN acknowledged that she had to put her life 'on hold' to cope with her son's illness. JEA recalled how her mother reinforced her sense of maternal responsibility for her child's health:

> JEA: My mother said to me, 'If you face a situation where you are feeling really depressed, you say to yourself, "I am the mother of *Hwanyung*, therefore, I should be healthy and my child will grow healthily. The mother's mental health will determine the child's mental health."' My mom said I should raise my son with this mission. And I think she's right.

Her mother used the term 'mission' to refer to the parental duty to care for her son's health, which magnified the sense of responsibility that JEA might already have had. Although her mother empahsised the importance of maintaining JEA's own health, 'health' here did not necessarily mean the ideal health; rather it seemed to refer to the state in which JEA could guard the health of her child. This led some of the Korean women to alter their medication practices.

8.1.2 Health imperatives

Being the primary carer for their children's health caused some of my participants to adopt different practices of maintaining their own health:

> JIN: Before [childbirth], I could afford to get sick. I tried to let the whole cycle of my cold go through, for example. But now that I have a kid, a mother does not

> have any time to get ill. If you see a household with children, mothers do not have time to get sick. Mothers must not fall ill.

JIN noted that she did not have time to fall sick. Having no 'time to be ill' does not necessarily mean that they are healthy; it only means they are looking for a quick solution to become functional again. YU, for example, pointed out that she took medicine immediately she detected symptoms of illness:

> YU: I take medicine. I have a box at my work. If my throat feels sick a little bit, I just take it. Then, I feel better in a day or two, rather than spreading to my body. It's really effective. I can't get sick. I have two kids and I am working full time. It would be a disaster. So, if I sense a symptom, I take a pill. This, I think, is desirable as a mother and parent. I have to keep healthy to be able to look after my daughters.

YU mentioned that her effort to stay healthy was due to her obligation as a mother and full-time employee. She relied on medication so that she could look after her daughters and go to work. Her perception of health seemed to carry the sense more of a functional capability: if she were really ill, she could not move to look after her children and go to work. (Pill and Stott 1982: 50) While this activity of relying on medication was a short-term solution that freed her up to perform her duties as a mother, YU also had long-term plans to improve her health. To this end she was drastically reducing the amount of pills she had been taking since she delivered, as well as carefully examining her body:

> YU: I am really paying a lot of attention to my body. I try my best to sense the bodily reaction. Before, when I got sick, I just dismissed my sickness, thinking I would recover eventually. Now that I have two daughters, that doesn't happen, I remain sick. So I am really concerned for my health, for my diet…Of course I buy all the medicines from pharmacies in Korea, but I am taking much less medicine now.

MI noticed that, after childbirth, she was forced to alter her medication habits. While she used to take medicine as a quick fix for any light illness, now she began to start out with a smaller dosage than stated on the package:

> MI: I take medicine when I think I will become ill. As soon as I sense a cold, I take medicine right away. There's no point going to the GP here…He will just say rest and take paracetamol…But, I try to use fewer pills now. If the instructions on the paracetamol box recommend two pills, I tend to take just one…I tried one pill only and I felt better.

As a responsible mother, MI, like YU, took medicine as a quick solution. However, she only partially complied with the instructions on the box, taking half the dosage. Further, not only did she change her medication habits, she also carefully examined her bodily reactions to her new medication practice.

Parental responsibility for the health of the child can influence the health of the whole family both positively and negatively. Woo noted that her entire

family's health improved ever since she started to cook, focusing on her child:

> Woo: My eating habit changed after childbirth. Before my son, we used to have bread, and now we are having rice for all three meals. There's a huge difference between when you have a baby and when you don't…our meal plans are totally for the sake of my son…I didn't really like vegetables and now I am having fresh vegetables every meal because I want my son to eat everything healthy…I think my husband benefited the most from this.

On the other hand, it can become a great source of stress for some mothers, worsening their mental health:

> MI: You are practically glued to your baby all day. Sometimes, I wish I could breathe without worrying about my baby just for one hour, even if it means just going outside of the house and taking a walk by myself. I need to have at least some amount of time solely devoted to myself, but I don't have that at all. Twenty-four hours I am with my baby.

Similar to MI, JIN pointed out that her 'endless love' for her child extended only as far as the limit of her own health:

> JIN: I don't think the stress is caused because I'm looking after my baby. I think the stress is a side effect from not being able to look after my own body. As mother, my body gets tired, and when you are tired, you get extremely sensitive even at very trivial things, and your stress gets accumulated. And of course it goes to the baby.

> Stress is a side effect from mother's effort to do her best for the child…you will know if you raise your own kid. There is nothing that you can't do for your child, *only* if you are healthy. You give endless love to your child but then when your body gets tired suddenly, your endless love reaches the end and I become hysterical.

While the Korean migrant women were forced to take care of and be responsible for their own health in addition to the health of their children, some acted in ways that conflicted with general Korean social norms and expectations for motherhood. YU, for example, reversed traditional gender roles with her Hong Kong-British husband. When they had their first daughter, she first took six months of maternal leave and went back to work, and subsequently her husband took six months of paternal leave. YU's husband is now working at home, mostly in charge of domestic work including picking up their children from nursery every day. JIN, who was completing her Master's degree right after childbirth, eventually had to send her eight-month-old son to Korea for about ten months, where he was cared for by her mother. Aware of the Korean community's expectations of the proper motherhood role, she had to keep it secret. JEA also sent her son to nursery as soon as he was six months old, knowingly risking her reputation as a mother within the Korean community. She said she was able to cope with childrearing stress because 'instead of getting stressed out for twenty-four hours, I will have three to four hours of my time every day, and provide better quality care for my baby'. These women resisted, even while risking their reputations as good mothers within the Korean community, which

functions to reinforce traditional gender roles for migrants. (Cho et al 2005; Um and Dancy 1999)

Having a child makes a great deal of difference to the family. As immigrant mothers, the Korean migrant women seemed to change their health practices in response to the needs of caring for their children's health.

8.2 Healthcare for children

In addition to altering the ways in which they were able to relate to themselves, the Korean migrant women started to construct themselves as educated, doctor-like mothers, which coincides with their emerging subjectivity as healthy citizens who could challenge the GPs' and the Korean doctors' knowledge and advice.

8.2.1 Breastfeeding subject

In the first instance, my participants were forced into the mother role by being drawn into the British norm of breastfeeding after childbirth. YU recalled:

> YU: As soon as you deliver your baby, the mother and the baby are separated in Korea, so that the mother can rest [from childbirth]. But here, despite the fact that I did an emergency caesarean, they put my daughter right in my room. My husband

> could not stay overnight in the hospital. I delivered my baby at 11.30 at night, and I had to get up and breastfeed my baby at dawn. It wasn't over!…It was really harsh on me. I wondered why I had a child and thought I never wanted to get pregnant again…I cried a lot for the whole three days in the hospital. I wasn't ready for it [mothering], but I had to.

YU's remark – 'it wasn't over!' – was a sign that she expected to be free from any further regulations. Instead, she was subjected to the necessity of breastfeeding as a requirement of good mothering. (Crossley 2009; Shaw 2004) RYU also felt that breastfeeding was emphasised, 'a must', in the UK. She had her first child when she was 35 years old, and thus she was not really thinking about breastfeeding:

> RYU: I was too old, and I just didn't think my breasts would have enough milk. Here, the midwife came in the first week and then the health visitor, and they were just emphasising how important it was to breastfeed my baby. I told them that I might not have enough milk, but that was simply dismissed.

Breastfeeding has been greatly promoted by the UK government as the 'best form of nutrition for infants' for the first 26 weeks. (DoH 2010) Breastfeeding is considered a 'moral imperative' (Crossley 2009) and thus is usually used to judge whether mothers are 'good' or 'bad'. (Lee and Furedi 2005) Most of my participants breastfed; however, the ones who did not breastfeed did not seem very bothered by it.

SON pointed out that she was ignorant of the impact of breastfeeding until she was informed by her health visitor:

> SON: I think every time the health visitor came, she was asking about what I was eating, because she wanted to make sure I had enough milk. How ignorant I was about breastfeeding. I doubt many Koreans know.

In fact, the breastfeeding rate in Korea is very low: it used to be 95% in the 1960s and 94% in the 1970s, but it dramatically decreased to 35.4% in the 1990s. (Lee 1995) Other statistics show that it was as low as 14% in 1997 and in 2001, the breastfeeding rate during the first month of childbirth was 57%, in three months, 40%, and in 6 months, 33%. (Lee, Song and Kang 2008) Usually, women give up breastfeeding because of lack of milk. (Kim, Cho et al 2004) In accordance with the low breastfeeding rate in Korea, Korean women in general seem to be less informed about the impact of breastfeeding on the health of the child and mother, and only half of the women surveyed thought breast milk was better than artificial milk, resulting in demands for more aggressive campaigns led by the Government to promote breastfeeding and educate women. (Lee, Song and Kang 2008)

8.2.2 Becoming a responsible mother in Britain

Similar to the breastfeeding performance, my participants noted that they were forced to become a ‘responsible’ mother in a different way than in Korea. While in Korea, the health of children can well rest in the hands of

paediatricians, which constructs the notion of 'responsibility' as taking the sick child to the hospital. However, in the UK, the Korean women felt that they were forced to learn like doctors to become responsible mothers. Some of my participants linger in the Korean way of being a responsible mother as they take the child to the GP, knowing the outcome, while some have chosen to actively engage in a discussion with the GPs, and establish themselves as independent from both Korean and British medical experts.

The health-related behaviours of mothers can change based on whether they are related to the health of children or those of mothers themselves.

> Mrs Soo: Children can't explain, and you can't really act based on your kids' words either, so I ran to the doctor no matter what. I relied on the opinions of doctor-experts. When I am sick, I don't really see the doctor, but when my child [gets sick], I rush to the GP or emergency room, whichever.

Mrs Soo noted that she went to the GP or A&E so that she could rely on the doctors for the care of her children's health; she went to the A&E so that she could consult the doctor and 'be on the safe side'. (Nettleton 2006: 142) BM also described her experience of going to the A&E department and complained that it was useless. Her son had a rash over his whole body and a high fever, but they had to wait for four hours until they were seen by any medical professional:

> BM: Not even a doctor, but some kind of assistant came. He just put a stethoscope

> and said my son was fine, so we could go home. There's no reason to go to the hospital then. I diagnose my children's illness and give medicine myself. If you want to live here as a mother, you have to have guts. In Korea, if your child is sick, you just run to the doctor and the doctor takes care of your children's health even if the mother doesn't know anything.

BM mentioned that in Korea children's health was dealt with in such a way that the mothers themselves did not necessarily need to know anything. SON concurred, remarking that for Korean mothers 'the responsibility as a mother for the health of her child only extends as far as taking the child to the doctor'. In the UK, 'mothers are required to do more', and to some extent, 'you are forced to do more'. For the symptoms that BM's son had, the NHS self-help guide advises calling NHS Direct. When BM was informed of the NHS Direct self-help guide, she said she would consult the NHS website from now on, but she raised her voice and asked, 'what is the point of having a doctor here then? If I am doing everything, what are they [medical professionals] doing?' Similarly, Woo shared her experience of going to the A&E just the day before the interview:

> Woo: I went to A&E yesterday. My son had a very high fever last night. The symptoms were just like having inflammation of the small intestine. He suffered from diarrhoea, vomiting, he vomited in the middle of sleep. So, I got really scared and ran to the hospital. The doctor said he just had to suffer for a few days. No medicine. So, we came back. We did nothing but wait.

She was certain that if they were in Korea, her son, who is 22 months old, would have received proper medical treatment:

> Woo: In Korea, they would have done something right away…Setting aside my feeling about here, in Korea, they do give out medicine for this. He's still suffering from diarrhoea. I don't think doctors in Korea would have left him suffering like this.

When asked how she knew, Woo said she checked the Korean website and then complained, 'I have to know all this now'. If she were in Korea, she would have done her part. Although her active role did go as far as checking the Korean website, when asked if she consulted the NHS Direct website as well, she said no, because it was 'too complicated'. When Woo and I accessed the NHS Direct self-help guide for diarrhoea in babies and toddlers, we had to tick eight 'no' boxes and finally one 'yes' for the only symptom that matched the situation – having 'more than 4 nappies of loose watery faeces'. For her 22-month-old son, the result showed that she could call and receive advice from an NHS Direct nurse. This does not require taking the baby to the A&E. However, half way through, we were both exhausted and Woo pointed out that she would already have gone to the A&E before 'finishing the ticking'. Even though she was aware of the website, she doubted that this would prevent her from getting involved or taking an active attitude. (Heldal and Steinsbekk, 2009)

YON defended her going to the surgery because she was already doing more

than she should:

> YON: You're going to the GP because your baby is not just sick, but sick enough to require some kind of treatment from the doctor. The doctor here doesn't really diagnose clearly, and says things that I already know. I just say, OK, and that's it. There's really no point then.

When asked if she would not trust the GP's decision, she quickly retreated and said, 'Oh, no, no. Of course I trust the GP's judgement. They are the experts. Then I think maybe it wasn't as serious as I thought.' As shown, frustration with the GPs' responses toward their children's health was often followed by questioning the very existence of the GPs and their roles, yet this does not necessarily cause them to question their authority. These young mothers were aware that they were expected to do much more than their current attitude required. However, they were consciously resisting to the imperative to become informed and to take responsibility by making the 'right choice', based on the NHS Direct self-help guide. (Henwood 2003) For them, it was 'too complicated', it was 'not their job' or it was simply easier for them to see the GP or go to the A&E.

Their frustration with the GP could be compensated by the role of the health visitors. Instead of seeing the health visitor's role as disciplining their mothering, some of my participants appreciated their visits. (Peckover 2002)

> CHA: I really liked the health visitor system. My health visitor supported

> breastfeeding, she was examining my baby very well…For one month after childbirth, I was constantly getting leaflets – information needed for childrearing…my health visitor found that there was a sound from my baby's hips so she booked an appointment with the GP herself….that was a great benefit for me.

My participants appreciated the health visitors for their availability and valuable information particularly when they had no one else to turn to for advice:

> HYU: My daughter's eyes were getting too gummy and in a week, she couldn't open one eye because of the mucus. I was going to the GP, but my health visitor called to let me know that she would be visiting me. I asked her about it and she instructed me that I could try to wipe her eye with warm water first and then drop a tiny water drop onto her eye. She told me to call in two to three days, which I did. And she visited me and showed me how to do it properly.

The services provided by the health visitors were helpful to these migrant mothers when no other family members were present for support or advice. JEA said she used to call her mother in Korea and cried a lot because her son was suffering from colic.

> JEA: Just two to three weeks after his birth, he was crying constantly, without any reason. My health visitor told me that it was colic. I could either give medicine or hug him, and there is no other way. My health visitor advised me that it wouldn't be a good idea to start with medication when the baby was too young, which I agreed with. So, I didn't give any medicine. I was really stressed out and cried a lot, but I

didn't give any medicine at that time, and I try not to raise my kid on medication.

JEA recalled how her decision not to give any medicine led to conflict with her parents in Korea. She noticed how her practices were different from those in Korea when her mother and mother-in-law fed her son '*Gi-Eung-Hwan*', which is known to be used for calming down, controlling fever and improving digestion (sold in pharmacies in Korea). Although many people have the misconception that it is a traditional Korean medicine, it was actually made in Japan and both paediatricians and traditional *hanbang* doctors reject its effectiveness. (Doctor Korea.com[3])

JEA: As soon as we got off the plane, my mom and my mother-in-law gave him *Gi-Eung-Hwan*. He was only four months old and that was the first thing he ate in Korea. They said he *could have been* shocked. It happened so suddenly and he was fine…While I raise my child here, my thoughts have changed and as I speak with health professionals, I tend to follow their [British] ways…I'd be even more stressed out if my mom raises my second child.

JEA pointed out that she mostly listened to the advice of the British healthcare professionals, and that she was trying to learn things on her own. BM criticised mothers for relying too much on the health visitors:

BM: What I emphasise most [to other Korean women living in the UK] is that we

3 The information is retrieved from the website, Doctor Korea, Health Community, which provides online medical information: http://duser.doctorkorea.com/consult/subject_oldin.asp?ck2_num=3&cl_num=19&idx=60870

> shouldn't rely too much on health visitors. I know many mothers with children and they follow exactly what the health visitors say. Each child has a different development. You have to change according to your child, according to the circumstance, it all depends. They are not robots.

These mothers purposely provided false information to their GPs in an attempt to receive the treatment they wanted. For example, GOH expressed how she fully 'complied' with the GP's words until her son received the treatment she wanted:

> GOH: My son had a nettle rash on his neck, like atopy. It was so much that I got very worried, and went straight to the hospital. The doctor said, 'this happens, no need for medicine', and you know E-45? It is totally ineffective. He told me to use that cream. I really didn't like him.

GOH simply dismissed the GP's advice that her son did not require any medicine. However, she still went to Boots to purchase the E-45 ointment, which she already knew to be totally ineffective. She then went back to the GP:

> GOH: I told the GP that I put E-45 on my son's neck and it didn't work. I knew the doctor would give me just a little better one than E-45, but still totally ineffective. I didn't even bother to try that one. I knew what I wanted. What can I do? I am not a doctor. So I went back, again and again, so eventually I got the cream with antibiotics. Then, it [the rash] disappeared.

GOH said she bought the E-45 cream to 'prove' that she had complied with the GP's advice and pointed out that it was ineffective. Although her remark, 'what can I do?', expressed her sense of helplessness as a non-expert in the presence of authority, she did not totally submit to the doctor's power. Instead, she continued to 'bother' him until she received the treatment she desired. Although she seemed to have a clear idea of what she wanted, and thus indirectly challenged the GP's knowledge, it is hard to say whether her behaviour was in accordance with the model of the 'active patient' who assumes responsibility for her own health (or, in this case, her children's health) and challenges expert knowledge with her own lay knowledge in order to negotiate the treatment options for her children. (Dickinson and Dignam 2002) When asked why she pursued so much, GOH replied:

> GOH: Yes, I went again and again because the baby can't speak and you feel sympathy. Mothers go until they get what they want because of their children. If it was me, I could do something else...I had to do something. Here, they don't seriously think about diseases – small ones. I think I am eventually following their attitude. The GPs here are trying to brainwash me.

GOH acknowledged that she agreed with the GP, although she called it 'brainwashing'. HYU recognised a similar pattern when negotiating treatment for her young daughter:

> HYU: Yes, I went to the GP all the time until my daughter turned three. I knew what the GP would do and in a way, I knew I was slowly starting to agree with him. It

> takes time for me as a mother to be okay to be around my daughter crying and suffering. So I always started getting ready to take my daughter to the GP or A&E, crying together with my daughter. It's still tough. But, I know it's nothing serious.

Her act of going to the GP or even getting ready to go provided HYU with some sense of comfort that she was doing something as a mother. For some of my participants it was almost like a routine part of the process of adopting the new British style and practices. By exhibiting similar attitudes to Korean mothers in Korea, they were comforted that they were fulfilling their responsibilities as good mothers until the time when they managed to incorporate fully the British practices, thus becoming more able to distinguish when to see the GP and when not.

While some of the Korean migrant women slowly developed a more active sense of responsibility for their children's health through the medical encounters with the GP, some switched their medical behaviours after realising the stark cultural differences in medical practices between Korea and Britain. JEA pointed out that her experience with the paediatrician in Korea made her listen to the GP more when she realised that her son, who was 13 months old at that time, was given too many pills for a cold.

> JEA: He got very sick, had a very high fever. So we went to the hospital and the doctor gave six different kinds of pills to my baby. Here, you get two antifebriles and that's it. All of a sudden, my baby was given too many…antibiotics, a pill for nose-running at night, a pill for nasal inflammation, allergy pill, and so on. I first

> gave the medicines as told, and he was only awake for two hours for the whole day. He was sleeping constantly, being practically *drunk* by the medicines…That was madness. That does not seem right to me…So we came back to England and I followed the British way for my baby…now he is even healthier, doesn't really get sick.

JEA's outrage at the Korean doctor was evident as she described her son as 'drunk' by an overdose of medicine. It also implies that she had already appropriated the passive medication practices encouraged in Britain. Korean medical practices were often described as 'intrusive' and 'dependent on medication', whereas the British way was often referred to as 'natural' and 'refraining from medication'. The different biomedical practices of the two countries thus influenced them to self-medicate their children, not necessarily complying with either practice fully. HYU regretted that she left her son with her parents in Korea for about a year. Afterward she thought that her son's body had become immune to antibiotics that are even stronger than those used in Britain:

> HYU: I do think Koreans are using strong medication…When my son was given antibiotics, he didn't recover as quickly as the GP expected. So, I went back to the GP and my GP didn't know why the antibiotics didn't work for him. He once said to himself, 'that's odd. Why is this not working?' and I feel guilty…the Korean paediatricians prescribe much stronger medicines…so his body is probably immunised to strong antibiotics now. So, I always have to be equipped with Korean medicines as well as British ones because the British ones may not work on his body.

HYU's self-medication practice was similarly exhibited by JIN, who sent her son to Korea for ten months. The conflicting information presented by the Korean and the British doctors led them to become 'independent' from medical advice. Their independence did not involve a total dismissal of all expert knowledge (all medical professionals, whether Korean or British). Rather, they had to utilise both practices at once, medicating according to their judgements as they carefully examined their children's condition. JIN, whose sister and sister-in-law are pharmacists and whose uncle is a paediatrician, said she gets plenty of Korean medicines from Korea. But, she still goes to the GP:

> JIN: If I come down with a flu, I know I have inflammation in my throat and I know it's going away shortly. But I can't do that with my child. So, I go to the GP to discuss it. If I just need some medicine, I have them all in my cabinet…When I discuss with my family members, who are medical practitioners, they say I should give the medicine to my son, but here the GP says no. So, I have to think carefully – what should I do to raise my child healthily without overusing the medicine? That's why I'm going to the GP to talk about this.

JIN stated that she actively engages in discussions with the GP, and often challenges his practice by informing him of the Korean practice for the same symptom:

> JIN: There are really times that I need medicine for my son. My son often gets ear inflammation, and I want to treat it with medicine. When I go to the GP here, he doesn't give a medicine for it. So, I tell him that in Korea, the paediatrician will

> prescribe so and so medicine. Then, he replies that 'however you practise in Korea, that medicine is not the proper treatment here, and that is not the way that we treat such illness. So don't give that medicine and just use paracetamol'. Then, we get into an argument. I constantly ask him, 'are you sure that you are right, what is the right case', like that. If he's right, he should be able to persuade me.

JIN challenged the GP's expert knowledge by asking him to 'persuade' her if he was 'right'. Her primary purpose was not to acquire medication as she can easily obtain whatever she wants through her family network. YU also took a more active attitude toward her children's health by searching and comparing the information she received from the GP. YU discovered that the GP seemed to prescribe antibiotics too easily, which made her question her trust of the GP:

> YU: When I see the GP prescribing antibiotics for my daughters, it makes me wonder, isn't he giving out antibiotics too easily?...My first daughter had serious eczema, and the GP prescribed the cream with steroid…I didn't think it was good to use that kind of cream. So we didn't use it…she was less than three months old, but he gave a very strong steroid. My husband and I are very interested in medicines, and we found that the cream was not recommended to be used on the face. The GP really put me off.

When asked if she challenged the GP, she said:

> YU: Yes, next time when I went to the GP, I did, but he said it was fine. But, I asked around for advice and they all discouraged me to put it on my daughter's

face. Even the impact of the steroid is temporary. It's fine for a bit, and then the symptom appears again, so I didn't use it.

YU was also aware of the NHS Direct phone number and she visited the website occasionally to look for information. YU and JIN were probably the most active in engaging in discussions with the GPs and informing themselves. This may be because they both have lived in the UK for about 10 years. YU also has a Chinese-British husband, which might have allowed her more freedom when seeking out medical information. Unlike them, CHA, whose parents are a gynaecologist and paediatrician and who thus might have had as much agency as YU and JIN, did not show active engagement with the GP. Though CHA has been living in the UK for five years, she relied on her parents mostly. She said she always kept as many medicines as a pharmacy and was a good source of medical supplies for other Koreans. However, she noted that she had greatly decreased the amount of medication, but still that her first reaction to her ten-month-old daughter's sickness was 'picking up the phone' to call the GP or her parents. This was very much similar to the practices of other Korean mothers with young children who were in the process of transformation.

Conclusion

To conclude, this chapter explored how my participants' mothering practices began to reflect the imperative to be an active patient/healthy

citizen. Their transformation took place not through active acceptance but through passive necessity, moving slowly in the direction of the ideal form of medical subjectivity as they constructed themselves as educated, doctor-like mothers. As the transformation proceeded, there were moments of resistance originating from their lingering adherence to their former medical subjectivity, which demanded a quite different kind of 'activity' in the sense of handing over their children's health to the medical practitioners.

Chapter 9: Construction of Dual Health Citizenship

The previous chapters (chapters 6-8) have followed the subjectivisation process of my participants from their initial contacts with the GP, experience of pregnancy and childbirth, and reception of antenatal and postpartum care, to the changes in their medical practices carried out on themselves and their children. The Korean women, entering into the new system, do not fully internalise the form of subjectivity of active patient/healthy citizen until they experience pregnancy and childbirth in the UK. In particular, the previous chapter dealt with how my participants appropriated the subjective category of active patient, taking it on as part of their identity.

This final chapter examines the techniques that the Korean women employed in order to maintain their health and their family's health while in the UK. More precisely, the chapter investigates both the non-medical, lifestyle-oriented and medical practices that the Korean women utilised in such a way as to maximise their agency. The Foucauldian framework has been useful to understand the processes that my participants underwent as immigrant women, as they vacillated between the two very different forms of medical subjectivity of good patient and active patient. However, the Foucauldian framework makes it difficult to grasp the subtleties of their experiences, inasmuch as their personal narratives reflect a sense of

empowerment and agency as they challenge medical expertise in both countries. Through their reflexive narratives, they reconstruct their own selves and subjectivity. To what extent are they still being subjectivised to the active patient/healthy citizen subjective ideal?

9.1 Lifestyle changes: British way vs Korean way

When YU was asked to conceptualise what would be the most ideal form of health for her, she replied:

> YU: If I could only run a marathon. If I can be full of vitality and feel fine after running a marathon, then I will consider myself to be ideally healthy – both mentally and physically…the ideal condition of health for me would be not getting exhausted raising my children, and sleeping well…I think this is the ideal type of health for me – having no uncomfortableness while living. Health in general does not indicate physical health only.

Her facial expression was as if the ideal health, her telos, could never be achieved. Health was a mirage for her. Why?

What does being healthy mean for Korean migrant women living in the UK? How do they pursue health for their own sakes and that of their family in the UK? These were the general themes that I had in mind when I began my PhD. I wanted to explore how their status as immigrants affected their experiences as medical subjects in the UK – to what extent do these Korean

women resist against the British form of medical subjectivity, which encourages them to be 'healthy citizens' in the sense that they are capable of making informed health choices and of taking responsibility for their own health, or conversely, to what extent do they conform to the Korean medical subjectivity model as 'consumers' in the sense of heavily seeking medical treatments, constructed through the private health care delivery system?

In an attempt to answer to these questions, this section deals with the lifestyle-oriented choices that my participants practised as they took on more responsibility for and control over their health.

In 2003, the Department of Health (DoH), in its White Paper, '*Choosing Health*', set out the principles that drove the public health policy to improve the health of the UK population: the UK government would provide information so that the public could make informed choices for health and encourage partnership among individuals, the NHS and other public bodies, the volunteer and community sector, communities, employers and the media. (DoH 2004) It intends to empower the public by helping people make healthy lifestyle choices. (Green et al 2007) When my participants were asked to what extent they were aware of the UK government's objectives to promote healthy choices through lifestyle changes, none of them said they were aware of any specifics in their local communities. Moreover, they expressed disbelief and pointed out that the British lifestyle did not lead them to health; on the other hand, they admitted that the Korean lifestyle did

not necessarily lead to health either.

As HYU said, it was ‘a matter of how much you execute’ the healthy lifestyles. As my participants developed a sense of responsibility for their own health since migration, as shown in Chapter 6, their lifestyles also changed accordingly as well as their perceptions of those lifestyles. A coherent theme was found in the narratives of the Korean women that, unlike restricted access to medical choices, lifestyle choices are totally under their control. The Korean women have developed their own theories to pursue and maintain health for themselves and their families by trial and error. In what follows, I discuss my participants’ lifestyle choices in relation to their diet and exercise including their concept of ‘moving body’.

The Korean women perceived diet as the aspect of daily life most crucial for the maintenance of health. Except YU, who does not cook, all my participants were solely or mainly responsible for preparing meals at home and pointed out how important the impact of a healthy diet is. For example, JP, who had lived in Japan for ten years prior to coming to Britain, affirmed that ‘eating is the basis for health’. The importance of diet perceived by immigrants was nothing new: for example, Chinese people conceptualise foods according to their traditional concepts of ‘hot/cold’, ‘wet/dry’ and monitor their diet to balance out yin and yang energies. (Chau and Yu 2004) For Chinese women, the impact of managing a proper, balanced diet is just as important as medicine. (Green et al 2006) Although Neo-Confucianism,

which originated in China, perceives bodily constitution based on yin and yang, similar to Chinese, my participants did not conceptualise or plan their meals based on any traditional concepts.

A few Korean women pointed out that they purposely adopted the British diet when they first immigrated, with the hope of adjusting quickly to British society. This is not a new phenomenon. For example, migration to Canada is associated with weight gain as immigrants choose to follow the Canadian diet in an attempt to speed up their adjustment to the new society. (McDonald and Kennedy 2005)

Those Korean women who adopted the British diet as part of their active decision to adjust to British society described how they realised the importance of diet as an initial but key step to gain health. SE recalled how her decision to 'eat like the British' led her to ruin her body. After staying away from Korean food for months, she suffered from severe stomach aches. At a private hospital she was recommended to take a test to find out what she should and should not eat. The test result showed that she was allergic to dairy products and eggs. It was a shock for her because she had been eating dairy products for thirty years in Korea. She explained:

> SE: When I was living in Korea…I had never felt that I should not eat these. I was trying my best to adjust to the lifestyle here, so I hardly ate the foods that I used to eat…[and wanted to live] the lifestyle here…I guess it was too excessive

> for my body…I did drink milk when I was in Korea but I don't think it was like how I drank here, every day. People here eat cereal with milk for breakfast, and then sandwich for lunch, and there's always cheese, butter or margarine. For dinner, I cooked pasta with cream sauce a lot…it became a problem when I did it for 3/7 and 365 days. Eventually I had to use my private insurance to find out what was wrong.

SE, who worked for a design company, said was lucky to have private insurance through her employment. This experience led her to reflect on her diet and bodily reactions and to change her eating habits accordingly. CHA also mentioned that having a British diet made her gain weight and she now monitors what she eats:

> CHA: Because my diet changed while living abroad, I got to eat foods that I never did in Korea. So for example, I gain weight because I ate more fatty foods. This made me feel tired…this country is full of 'coffee and chocolate culture' (her expression in English)…When I stayed in Korea for a month or two, I returned feeling my body was much lighter. I didn't drink much coffee or eat chocolate but drank lots of green tea when I was in Korea. Also I ate Korean foods. It is the way of living that can really change your health…

Trying to adjust to the new society, SE and CHA ate excessively what they understood as 'British' foods. However, after severe illness and change of environment, both re-visited their eating habits. Although similar recollections have been mentioned by a few more Korean women, this did not cause them to set on eating exclusively Korean meals either. Just like the

British foods, Korean foods were also scrutinised.

For some of the women, Korean foods were not completely healthy either and accordingly they had to change their styles of cooking. RYU pointed out that every time she spoke on the phone with her mother in Korea, one of the key topics was food:

> RYU: Every time I speak with my mom, she still asks me what I have eaten for lunch or dinner…sometimes pasta, sometimes steak, sometimes Korean soup, it varies…and my mom never gets tired of reminding me that I and my family are Korean and therefore I should cook more Korean food. She thinks if I don't feed my family Korean foods, our health would eventually fall apart. The thing is even if I cook Korean foods, they are not exactly *real* Korean foods.

RYU was confident that most Korean women who cook in Britain would probably cook similar to her. In the same vein, SON explained how her 'Korean' style of cooking had been altered:

> SON: I can no longer cook meals with too much chilli powder. Now that we've lived here for ten years, our taste itself has changed: the Korean foods that we [immigrants] say we cook are different from those cooked by Korean people in Korea. I think our style of cooking is slightly altered, sort of in-between Korean and Western styles. Of course we eat Kimchee, but the taste is not as strong [spicy] as the one in Korea. It's the same with other foods. I think this is why when I go back to Korea, I suffer from strong tastes for the first couple of days.

JP agreed that she still enjoyed the Korean foods but she is now more cautious because the strong flavours in Korean foods are due to an excessive use of spices. So, she started to put less spices and always add a 'westernised' fresh vegetable salad on the table when her family had Korean meals.

> JP: I know it's not exactly Korean custom to have a westernised salad dish like you would find here. But, I am always putting a bowl of salad on the table. Just the other day, I had a Korean guest and we had Bulgogi [marinated beef dish] with a bowl of salad, and he [the guest] thought it was 'interesting'. Imagine having a fresh baby tomato with Bulgoki.

It is not only eating or cooking styles that have changed but attitudes toward cooking or choosing ingredients have also been changed. HOE stated that she now carefully looks at the ingredients and calories of the products that she buys:

> HOE: In ready-made roasted chicken, or chicken pie, there is tons of saturated fat. I didn't know about it. I read it in the book and now I always look at the back of the package for ingredients. I was so shocked to find out all the artificial chemicals in the foods that we buy here. Now, I am too grossed out to buy a chicken pie…Korea should also adopt this policy so that everyone knows what they are eating.

HOE, who did not pay attention to the labels for ingredients, always observed them when she purchased groceries. Similar practices were

recalled by a few other women with a sense of empowerment, as it showed they knew more and therefore were able to make more conscious choices than before. When I met Mrs Kim at Waitrose, she criticised some of the women who purchased ready-meals and 'junk food':

> Mrs Kim: Young mothers, whether British or Korean, are so irresponsible. Look at their carts. If they actually take a look at the label, I am sure they won't feed those products. They can easily control their diet and choose healthy foods for their families, and they are just too lazy. Some Koreans think that Korean foods are the best, which isn't true. Every time I visit Korea, I give a speech to my relatives about what to eat and not, and they are just amazed how much I know.

Mrs Kim's remark accorded with the Department of Health's objectives: she believed that she knew much more than other Koreans, which made her feel empowered and able to make responsible choices for herself and her family to improve their health. SON also noted what a 'good feeling' it was to be ensured that she was making the right choice. However, she admitted that on and off, she and her husband looked for spicy Korean foods like rameon. She and her husband always cooked rameon when they came back from holiday trips. She said there was a difference between just eating rameon and eating it knowing that it was not a healthy food.

> SON: I know rameon is bad, of course. But, at least, now I know how bad it is. I think there is a big difference, because I am in control of how bad or how good what I eat is. When I was in Korea, this was never a matter of concern. You can

hardly find a product with information on precise ingredients and so on in Korea.

For SON, even if she was eating something unhealthy, she still felt empowered because there was a difference between knowing and not knowing. She felt that she was in control of her eating habits and therefore able to manage her bodily condition.

The other healthy lifestyle choice that some of my participants were conscious of was exercise. While diet was mostly associated with migration and adjustment to the new society, those of my participants who delivered children in Britain pointed out that they started to exercise after childbirth. They noted that drastic changes in their bodies occurred after giving birth. Many felt that their bodies were 'not the same': their bodies had grown weaker because their recovery after childbirth was slow. They continued to suffer from 'unidentifiable' pains throughout their entire body. YU, who once worked like a 'workaholic', said she used to be able to 'tough it out' when she became sick. She never required extensive medicine and she was able to wait until the pain went away. However, after having two children, her body was very different:

YU: I got extremely stressed about my health and my body after I delivered my baby. My body had certainly changed after delivery. Before, I would work for 24 hours straight and that was nothing for me. I hadn't caught a cold. Before I delivered my baby, I was never on sick leave. But after the first kid, I suffered so much from colds for two years. Eventually I got better and then I delivered my

> second child. So for a year, my whole body, especially my waist, ached…it seems like my immune system had gotten weaker. From the point of my delivery, my body has changed so greatly… my whole body constantly aches [laugh]. But it has gotten a lot better now.

For YU, her bodily symptoms caught her attention and then she was more concerned about her health and had become sensitive towards her bodily reactions. MI noted similar changes in her body after delivery. This was because, she said, in a literal sense, 'all the bones and muscles were expanded' during pregnancy. She was not sure if her body could 'ever recover'. CHA also mentioned that after delivery she felt like all the muscles in her hands and feet were tightened. They went to the GPs for these bodily symptoms but they were only told that there was nothing specifically wrong with their bodies. They pointed to the fact that they did not have proper postpartum care, which led to those symptoms. So, they turned to exercise to strengthen their bodies both mentally and physically.

> MI: When I was in Korea, the purpose of exercise was to lose weight so that I could keep my body thin. That was really the sole reason. I didn't think much about strength until I saw the British women who freely walked around after childbirth. I try to go to the gym so that I can get bodily strength.

YU recalled that her bodily pains disappeared after going to the gym. However, this was not the only reason for her to go to the gym:

> YU: Exercise makes me healthy. It gives lots of energy as well as vitality. Since I started going to the gym, I don't feel much pain anymore. Before, I had needle-poking pains in my arms and waist but I don't feel as much anymore. I am fine walking a lot or holding my children. It used to tire me out…I think there are more psychological factors that drive me to go to the gym. Well, actually, I think these are the only reasons why I go to the gym, [not] for physical reasons.

While acknowledging the physical benefits of going to the gym, she was more motivated for psychological reasons. YU initially recognised that exercise gave her physical strength, but she put more emphasis on the mental well-being that she could achieve from exercise. SON agreed with YU:

> SON: I really try to exercise regularly…After giving birth to two children, my whole body aches all the time. I don't know if I am thinking of my overall health when I go to the gym. But certainly my body gets tired after exercise but it doesn't ache anymore. It gives lots of vitality to my life too. I guess I agree that it helps your health. I feel tired but don't feel depressed any more.

CHA used to practise yoga before and during pregnancy. She could not practise yoga after childbirth, but she said yoga made her feel that she 'owned' her health and she said 'health was my thing'. When I asked her to further elaborate, she said:

> CHA: As an immigrant, maybe it's because it hasn't been too long since we settled here, but as an immigrant, you have this sense of not belonging. You can't

> help it. Every time when I am on the phone with my friends or family in Korea, they always emphasise health and say health is the most important thing. I doubt though if they are healthier than me when I was in good shape. I don't know. When everything is or doesn't look like yours, health seems like the only thing that I can totally have – healthy body.

In contrast to her sense of 'not-belonging' to British society, yoga made her feel that she possessed health and she was in full control of her body when she felt nothing else belonged to her as completely as her body.

The two Korean women who were in their mid-fifties – Mrs Kim and Mrs Soo – pointed out that their bodies started to change greatly after they passed 45. Their bodies were 'getting old': they feared that they were gradually losing control over their bodies; their bodies reacted sensitively towards any artificial ingredients; and they started to get 'unidentifiable' symptoms.

> Mrs Soo: I wasn't really worried about my body to be honest with you. But when I hit mid-forties, my body started to gain so much weight. Before, when I ate a lot and moved my body more actively, my weight went back down. Basically, I think it's the menopause coming. After that, it is very difficult to control my weight so I started to pay attention to the diet…When I don't use any flavour enhancers, my stomach seems to feel better. Before, I used to eat rameon quite often, but now when I eat it, I feel no good afterwards: I can't use the bathroom very well, or my stomach feels like the wind is inside irrupting my tummy or something. I didn't feel this when I was young, but now I do because I have gotten older.

Mrs Kim, who sees the GP whenever she catches a slight symptom, always comes back with no specific treatments. After failing to obtain the immediate help that she sought, she turned to her Korean friends and concluded that her body is gradually getting old and slow.

> Mrs Kim: When you are over 50, you know that time when you are preparing for menopause? I think that's what I am going through right now. So sometimes I do get a headache and I get sweaty while sleeping…recently, from the beginning of this year, I did start to get those symptoms – I get a little headache and tightness in my chest… when I had a chat with my Korean friends, I told them about my symptoms and they said, 'hey, that's the symptom for climacteric. So I think they are right about it…as I lived here and I started to get older, I got to think that I should check my body and maintain health. I don't think I was thinking about this when I was in my mid 40s. I think I started it since I was in my late 40s.

As they became aware of their bodily changes, their awareness led to more cautious care for themselves and their bodies than when they were young. As a way of getting control of their bodies again, they pointed out that they tried to 'move their bodies' as much as they could. A few other women also considered it as a way to achieve health.

> Mrs Soo: I try to move my body on purpose. I try not to sit around and look for things to do outside [instead]. I go for a walk, for example. Even when I am on holiday, I like to go for a walk. I am doing it on purpose. My body feels much lighter after moving my limbs.

YON, who had to quit exercising in order to raise her seven-month-old daughter, said she tried to do more domestic work every day rather than put it aside. Although she knew that it was not exercise but labour, her increased body movement was so far the best option available for her health. SON mentioned that she always tried to find activities to motivate her and her children to move their bodies:

> SON: Now that my children have grown a little…they've started to do more activities, which helps build a strong immune system…I always look for what my children like to do; my boys like to run a lot. So when they are done with a certain activity which uses their bodies a lot, not only does it make them happy, they are a little tired, so they get to sleep well, [and] once they sleep well, they eat well and they are happy again. So I try to find things so that my children can always use their bodies more. If they don't, they end up watching TV or doing something on the floor. Rather than these, I think other activities that make you move your body more are better mentally as well as physically.

Although a positive correlation between physical activity and health has been reported, the focus has mostly been on exercise, walking or leisure activities. (Yang et al 2007; Yang 2005) Korean immigrants are particularly known to engage in less physical activity compared to other immigrants. (Hofstetter et al 2008) The Korean women's expression 'moving body' referred to all physical activities such as exercise, walking, domestic labour, including literally moving one's body parts.

This section has dealt with the Korean women's lifestyle choices as part of their health-seeking behaviours. The Korean women developed their own technologies of pursuing health, including preparing and eating a fusion diet, examining ingredients and calories, exercise, and cultivating a moving body. These behavioural changes represent how much the Korean women have become conscious of their health and bodily changes as responsible healthy citizens.

9.2 Medical practices: Dual health citizenship

While the lifestyle changes that the Korean women have made since migration are voluntary and have made them feel empowered, the fundamental differences of the Korean and British medical systems have caused more radical and distinctive changes. The difference in medical systems led many of my participants to develop more active and responsible attitudes to maintain their health in Britain. As they became more open to the dominant British form of medical subjectivity, which promotes the creation healthy citizens that make health-conscious choices, the Korean migrant women exhibited a blending of subjective forms which became ever more fluid and elastic. For them, both the British and Korean medical systems had their pros and cons, and they had to be active in pursuing their health by utilising both medical systems flexibly. Their subjectivity became less a matter of resistance but more a matter of a flexible ambivalence and

constant vacillation.

Not all of my participants saw this in a strictly positive light. JP mentioned that it was not what she signed up for:

> JP: I came here to live better, give a better opportunity for my children. But, many things, starting with the medical system here, are not quite up to my expectation. The worst is the hospital system here…I thought I could get a medical check-up whenever I wanted since it was free…when I go back to Korea or Japan, I feel like the doctors are just giving me medicine to make money, not really treating my illness. I can't blindly trust doctors in Korea, Japan or Britain…which means, I have to do so much more than when I was in Korea or Japan…I have to be so active. This wasn't what I signed up for.

JP stated that she initially misunderstood the British health care system. However, she did not trust either system blindly. She had to be on her own to care for her self. This led to a certain reflexivity when working on her own body – what she called 'disciplining'. Disciplining the body, for her, referred to the way in which she related to her body so that she could quickly distinguish or catch any significant signs from her body, and to the fact that her body was sensitive enough to detect any subtle or even potential harms. This required constant observation of her body and close monitoring of her bodily reactions so that she could be aware exactly what was going on with her body, could carefully differentiate her bodily reactions and decide whether or not she should take medicine, and if so,

how much.

> JP: I had hay fever while I was visiting the States, and my friend gave me medicine, and it almost killed me. What I didn't think at that time was that each country might have a different medication practice…Americans are huge, so I should have tried a half portion, but I didn't and my body was going crazy. Everyone's body is different and we should medicate accordingly.

Mrs Kim also pointed out how she carefully controlled her medication:

> Mrs Kim: I try to tolerate my pain as much as I can, but I know when to take medicine. I hardly use painkillers except paracetamol…usually an ordinary person will use 1000mg, but I tried the dosage and my body didn't like it…my body felt somehow really uncomfortable, so I tried 500mg and it was so much better. Now I always use 500mg, which is really enough for me to tolerate most of my body ache.

Rather than blindly following the dosage recommended on the package, Mrs Kim and JP understood that each body was different and therefore that the techniques for the care for the self should also be different. JEA realised that her body had already developed immunity toward strong medicines and so no longer responded to the 'weak' British medicines:

> JEA: I always have Korean medicines. I don't think paracetamol works for me, and the GP does not really prescribe antibiotics either here. My close friend in Korea is a pharmacist, so I brought all antibiotics…In my case…paracetamol

> doesn't really suite me…my pharmacist friend said a person who has taken Korean antibiotics is not likely to get better by paracetamol, so she recommended taking antibiotics if I have a high fever. So I did and I got better in two days.

JEA felt that she had to equip her cabinet with Korean medicines because it was too late for her to alter her body. However, it was a different matter for her son:

> JEA: I raise my son totally different. I think the body can be changed if it starts from scratch. I have been very careful about how I medicate my son, and I follow the GP's advice as much as I can. He's five years old and I think he's very much like British. The British antibiotics work for him. His body is British, but not mine. So I have to medicate differently.

JEA understood that bodies are culturally constructed and thus that she could manipulate her son's body through medical practices. Using a similar line of reasoning, CHA and YU, who also kept Korean medicines in their house, concurred that, no matter how much they appreciated the British medical practice of using less medicine than is customary in Korea, their bodies were still Korean.

The techniques that the Korean women employed in order to obtain knowledge from their bodies empowered them in the sense that they became experts regarding their bodies. They were empowered in the sense that they presented themselves as the very opposite of passive recipients of medical

care; they could be partners with the medical professionals; and indeed could challenge their medical expertise. SON stated how she made an impression on the Korean doctor:

> SON: I am the one who knows the best about my body, I am the one who can know about my body the most…When I go back to Korea, I gave many reasons, the whole process of my body condition, to the Korean doctors and ask for certain, certain medical check-ups. And I get asked if I am working in the field of medicine in Britain. I say no, but that, as I have lived abroad, I have had to become a 'half doctor' about my body, so I compare my bodily condition against all the information I've collected…I don't think I would have done the same if I was living in Korea with its medical system there.

SON saw that this empowered her. She felt that she was taken more seriously by the GP and doctors in Korea. She also actively discussed treatment options with her GP:

> SON: The GP told me that I had a migraine and prescribed medicine. But, I told him that I would try to control my stress and if that doesn't work, then I would use the medicine. The GP said, he was not trying to force me to use the prescribed medicine, and he was just informing me that this medicine was an option, and I should be the one who decides. So, I have been working hard to control my stress level.

SON seemed to have more control over the medical consultations than the rest of my participants. The empowerment that Mrs Kim felt came from a

different source. She had been trying to identify her pain for a long time, and thought that there was something seriously wrong with her body, which made her force the GP to refer her to the specialist. She also went to Korea for a comprehensive medical check-up:

> Mrs Kim: I have this unbearable pain in my hips. It is so severe that I get blacked out. Just this weekend, we went to Southwark where my son works and as we were grabbing a light snack, the pain hit me again. I had to lie down on the bench for 10 minutes or so…The GP at first didn't refer me to the specialist, so I practically threatened him that if I die, my husband would sue him…so he got me an exam and nothing. He wasn't sure why. I went to Korea for medical check-up and nothing showed up…I think some symptoms cannot be caught through medical check-ups, or maybe it's not as serious as I think and my body's telling me that I should be cautious...I got to think that I should check my body and maintain health. I started looking after my body when I was 45. I am still young, you know.

Contrary to Mrs Kim's assertion that there was something wrong with her body, none of the medical examinations showed any particular disease. However, Mrs Kim concluded that her bodily knowledge told her that it was a warning from her body. Rather than relying on the medical knowledge, her bodily knowledge carried just as much weight and authority as official authoritative medical knowledge.

Some local practices of resistance were sufficient to deliver the output that my participants wanted. Some of them employed various tactics to give the

appearance that they had fully conformed to the British medical knowledge and in that way ended up getting the medical treatment that they first wanted.

> JP: Yes, I wanted to take a test but he prescribed me some kind of medicine. He said I should first take the medicine and then I could get the endoscope…any reasonable person feels that's not right; if there's something wrong, you have to get the test first and see what is exactly wrong.

JP's anger increased when she was told by the GP that she would not get an endoscope until she took the prescribed medicine. She felt that she could only feel comfortable if she knew for sure that there was nothing wrong with her body by getting a visible image of her body (endoscope). Instead of taking the medicine, she consulted a few Korean friends in the UK regarding this matter. She then went back to the GP and falsely reported that she took the medicine and yet the colour of her feces was still dark brown. Eventually, she was given an endoscope.

Alternately, instead of pursuing the GP, some of my participants were able to foresee the undesirable outcome and chose to find alternative routes when they thought medical treatments were required. GOH mentioned that she did not bother to contact the GP when she was seriously ill from infectious mastitis. Instead of going to the GP, she decided to seek medical care from CHA's father.

> GOH: When I was breastfeeding my baby, I suffered severely from infectious

> mastitis (inflammation of breast tissue)…my fever went up to 39˚C…it was really painful…you know, CHA's dad is a gynaecologist, so he prescribed medicine and brought the medicine from Korea, so I took the medicine for 10 days, and I got better…I was thinking about going to the GP, but then I thought the GP wouldn't do anything. I asked one British woman and she agreed. So, why should I?

However, non-infectious mastitis can be treated by a number of self-help techniques, while infectious mastitis requires prompt medical attention, as stated on the NHS Direct webpage.[4] So, GOH might have been medically treated for her symptoms.

Interestingly, the Korean migrant women did not experience any extraordinary difficulty coming to terms with their illness in English. Unlike Chinese women, for example, whose verbal failure to describe their symptoms or term their illnesses within the frame of the Western medical system led to searching for doctors in their home country, my participants made use of the Korean medical system, not because of their poor command of English, but because they found it necessary for their health concerns. (Green et al 2006)

Despite the fact that my participants showed much openness to the British medical practices, they still believed that it was important to have access to their bodies; this demand is easily met via the Korean medical system. No matter how they reflexively related to their bodies, some of the Korean

[4] Direct link is available here: http://www.nhs.uk/conditions/Mastitis/Pages/Introduction.aspx

women said that access was limited, and that they did not want to live in ambiguity and doubt. Scientific assurance – medical gaze – was for them necessary to live healthily and this empowered them. SE often utilised her private insurance, but most of my participants went back to Korea and got medical check-ups there. It should be noted that, in Korea, comprehensive medical check-ups are usually conducted for the elderly. Therefore this is a new phenomenon, and one that my participants adopted since their migration to Britain. While Korean immigrants in New Zealand fled to Korea to seek medical operations, my Korean participants only went for medical examinations. (J.Y Lee et al 2010)

Medical check-ups were often used to push the GP to provide further medical treatments available from specialists when they were not convinced by the GP's initial diagnosis.

> BM: I had thyroiditis in my throat. It was nothing serious but when I was pregnant with my first child, I got so stressed out that I got an acute lump in my throat. It was very small. I found this out in Korea, so I went to the doctor to get some more examination here in Britain but I was told that I could not have any since there was no special symptom. Of course I feel nothing wrong usually. So when I went to Korea again this time, I got all the photos taken. I showed them the evidence and only then the GP referred me to a specialist. Huh. No wonder I feel so impatient with them. There are good things about the NHS but it is really bad for us Koreans. We say this system is 'raising' the disease. But once the symptom does appear, they quickly treat it…the symptom has to come, here.

The importance of making it a ‘routine’ to get medical check-ups when they visit Korea was repeatedly mentioned as a strategy to stay healthy. JIN said:

> JIN: When I was sick in Korea, I just went to the hospital. Never once did I think that I should get a medical check-up periodically like now. Here, if you feel sick, you are never given a full explanation of why you are sick or even the name of your disease. So whenever I go back to Korea, once a year. I always feel urged to get medical check-ups periodically. So I always take one there and come back. So, if the test finds something wrong, I get to know very quickly and I get treatment very quickly, and then come back. I have to do this. This, I think, is the only way to live healthily in this country.

Most of my participants emphasised the importance of gaining access to the medico-scientific gaze directed toward their bodies for the purpose of identification of symptoms, particularly as the most efficient means of influencing the GPs.

This section has dealt with the medical practices that the Korean women employed for their health: while acknowledging the pros and cons of the two medical systems, the Korean women migrants exhibited several proactive strategies to maximise the potential health benefits of both systems. While they used the Korean medical system to gain instant access to their bodies, they also benefited from free-of-charge medical treatments in the UK. They also demonstrated that they do not blindly trust medical

professionals – whether Korean or British. Their flexible oscillation between the two medical systems reflects how they have come to embody the desirable medical subjectivity model of the UK, living in a state of dual health citizenship.

9.3 Social characteristics and individual experiences of the process of subjectivisation

I started my thesis by bracketing the question of how and which social, economic and cultural factors lead to certain health-seeking behaviours of Korean migrant women in the UK. Nevertheless, this does not mean that these socio-economic characteristics are irrelevant to the overall subjectivisation process. Indeed immigrants' level of health and education, language fluency and economic status should all be considered key factors, along with culture, affecting access to healthcare and general health status. (Sproston et al 2001; Kandula et al 2004)

My participants represent a more or less homogeneous group: they are all at least university-educated and they all stated that they had worked prior to migration to the UK. None of them considered language as an obstacle to accessing healthcare. In fact, language issues were never mentioned until I brought the issue up during the interviews. They also classified themselves as middle class and stated that they did not have any financial difficulties. This was the case regardless of their working status.

However, there are differences in their demographics. First, seven of them have non-Korean husbands. JP has a Japanese husband and they lived in Japan for 10 years. YU has a British-Hong Kong-origin husband; however, her husband was born in the UK and they have never lived in Hong Kong. SE, KA, Mrs Soo, HOE and RYU are all married to British men. Living with non-Koreans has no doubt affected their subjectivisation experiences.

Those married to British husbands pointed out that having a British family helps reinforce their judgment regarding health professionals. KA stated that she did not like her health visitor because of her pronunciation:

> KA: I wasn't used to English medical terms so I had an English dictionary and I asked her to repeat what she said if I didn't understand it. But I really couldn't understand what she was saying so I brought my mother-in-law one day and my mother-in-law only saw her once but she didn't like her at all and told me to find someone else right away…So I did.

KA mentioned that it 'helped to have someone else confirm her opinion' and she felt more confident about her attitudes toward the healthcare providers. This usually led the Korean women to become more receptive and to adapt more quickly to the British way of taking charge of health:

> KA: I was really amazed by my husband. He impressed me by all his knowledge. I didn't know that I had to finish the whole cycle of antibiotics…I think Korean

> people are in general ignorant about this kind of thing. We rely too much on the doctors, because they are readily accessible. I was shocked to see my husband actually reading those leaflets that are in the medicine cases!

After seeing how her husband 'takes care of his own body', KA started to think negatively about how dependent Korean people were on the doctors, and about how she never questioned their medical knowledge. JP recalled a similar experience about her Korean friend, who had a brain tumour:

> JP: When my friend was hospitalised for months because of her brain tumour, her husband was right next to her all the time…She said she really changed her attitude toward the NHS; before she didn't think she could do anything because it was, after all, provided free of charge. She didn't know enough to complain or whatever. Her British husband really made the difference. He was there, arranging everything for her, complaining to the doctors and nurses on behalf of her, and explaining everything over and over until she understood it…she said he complained so much that the nurses started to avoid him, and actually listened to her instead. We don't have the same resource; we've got to fight for ourselves. So this makes me depressed. How are we supposed to win?

JP acknowledged that having a British husband was a valuable resource who could provide first-hand know-how on dealing with medical professionals. The Korean women with British husbands agreed that the changes in their attitudes toward the NHS and the GPs were significantly due to their husbands. SE, who suffered from a low platelet count, mentioned that she

had also become more receptive to the British way of being responsible due to her husband.

> SE: My husband really hates seeing the GP. He doesn't really go to the hospital unless it's really critical. He used to make fun of me whenever I complained about how doctors here didn't prescribe medicine as easily as Korean doctors. When he does get sick, he sees the GP, and takes medicine. He always said that I used to take too much medicine, and he basically taught me about what to do and what not. He is healthier than me, so I thought I would listen to him…now I am like him.

While the Korean women with British husbands reported relatively positive transformative experiences, the women with Korean husbands spoke in more war-like terms. Both the education level and the length of stay in Britain did seem to influence their experiences as medical subjects. Those who were more educated, i.e., above the MA level – JEA, SON and YON – described their experience as being as rigorous as academic work.

> SON: …I can see that my GP is taking me more seriously than before. But it was not easy. Just like I am doing my PhD, I had to study! Study rigorously! I couldn't just go to the GP unprepared. I had to look up my symptoms, find out basically what diseases I might be suffering from…it's almost like I know what disease I've got, and all the GP is doing is just confirming, really…I feel proud, no doubt. It's the same when I go back to Korea and I can impress the Korean doctors easily…

They were also able to look up information on the NHS Direct website or to consult the NHS Direct self-help guide. YON pointed out that it was like 'academic work' insofar as you had to 'persuade the people in the room and justify your research'. She said:

> YON: I have to justify that I have exhausted all my options and now it's your [GP's] turn to do something. If I can't prove that I have taken all responsible activities to restore my health, the GP won't give me what I've asked. I first felt really frustrated and I almost gave up, but after my daughter was born, I am geared up now like a warrior.

Although YON sounded like she was making a joke, clinching her fists in mock fighting mode, her metaphor of the 'warrior' captures her experience well. The longer the stay in the UK, the more engagement with the medical professionals seems to occur. YU and JIN, who have lived in the UK for about 10 years, came closest to fully attaining the active patient/ healthy citizen model: they were aware of the NHS Direct phone number and the NHS website, and they used both sources to look for information. They said they always engaged in discussions with the GPs.

One unusual case was CHA, whose mother was a paediatrician and father a gynaecologist. Due to her parents, she has never been sufficiently motivated to engage with the GPs as actively as the other Korean women. Her first contact for health enquiries was her parents: her Korean friends used her as a source of medical supplies because she had as many medicines as a

pharmacy. Although she commented that she does use less medicine than before, she admitted that she does not feel any urgency to engage actively with the GPs as much as her Korean friends do.

Gender, age, self-assessed health conditions, fluency of English, acculturation and culture have all been found to be significant factors influencing immigrants' health practices and health status. (Sproston et al 2001; Dijkshoorn et al 2008) As stated in the beginning, my participants were relatively uniform in terms of their high education level, financial situation and language fluency. However, those who were married to British men seemed to have a comparatively smoother experience of subjective transformation and appeared to be more receptive toward taking responsibility for their own health than those who were married to Koreans. In addition, staying longer in the UK led to a greater willingness to actively seek out information and to engage with the GPs compared with those who had lived in the UK for a shorter amount of time.

9.4 Limitations of Foucauldian approach

The Foucauldian framework has proven useful for understanding the processes that my participants underwent as immigrant women, as they vacillated between the two very different forms of medical subjectivity of good patient and active patient. However, there are some limitations to this Foucauldian approach that must be noted: first, the ambiguity of the very

notion of a subject and subjectivity; second, the ambiguity of the object, i.e., that which shapes this subject; and lastly the indeterminacy of the status and role of agency and freedom. My participants' personal narratives reflect a sense of empowerment and agency, which they acquired through challenging medical expertise in both countries; through these reflexive narratives, they reconstructed their own selves and subjectivity. Are they still being subjectivised to the active/healthy citizen subjective ideal?

9.4.1 Ambiguity of the subject

The term 'subjectivisation' contains within it a reference to a 'subject', but nowhere in his work does Foucault provide anything close to an ontology or a hermeneutics of the subject itself. (McNay 2000) This begs the further question as to whether there is anything like a subject or subjects at all or rather only subjectivities, that is, not subject-entities but only a multiplicity of so-called subjective states and experiences. Indeed the entire phenomenon of subjectivisation is something of a mystery. What does it mean, really, to 'be subjectivised', to undergo a 'process of subjectivisation'? Does this involve something like a strange 'mental' transformation, a way of 'thinking' about or 'understanding' oneself? And in that case, what is the meaning of the 'mental', of 'thinking', of 'understanding'? Or does it simply refer to the actual, particular actions and behaviours carried out and exhibited by human agents? But here again, is

subjectivity a purely behavioural concept that lacks a correlate in 'thought' or in 'consciousness'? Can an individual 'be subjectivised' simply by doing whatever one does, whatever it is acceptable to do? Further problems arise when we consider such phenomena as acting, dissimulating, the unconscious or even false consciousness. Can a subject not act in such a way that suggests total 'subjectivisation' and yet remain entirely unconvinced of the appropriateness of the action at the level of consciousness? On the contrary, can a subject not appear to resist while in fact being a true believer?

Foucault is adamant that the subject is not a secret centre, such as in traditional phenomenology (a pure transcendental ego) or psychoanalysis (a bundle of unconscious drives) – but it is not at all clear whether or how the human subject can be considered purely externally, i.e., as pure surface, lacking all depth and interiority. Do I *know* when and how I have been subjectivised? Foucault never elaborated on the 'mechanisms whereby the subject is formed in submission but is never reducible to it'. (McNay 2000: 34)

These kinds of basic, grounding philosophical questions cannot simply be brushed aside, or can be postponed or displaced only for so long, before they become serious impediments to both scholarly analysis and practical intervention.

9.4.2 Ambiguity of the object

In a similar way, the status of the various 'objects' or categories of subjectivisation is also murky and problematic. What, for example, 'is' something like a telos? As a concept, such a thing is perfectly comprehensible. But does such a thing actually exist anywhere in society, and if so, where, at what level? If we speak, for instance, of the active patient/healthy citizen model or ideal subjectivity, does this mean anything other than that this phrase appears in certain texts, is spoken in certain contexts? If it is an *ideal* that constitutes something like the destination of a subjectivising process, then certainly this does not mean that this phrase or notion is held in the mind as something toward which a thinking is directed, especially given the fact that most people have no comprehension of the ideal as an ideal.

The Korean women emphasised that they felt they had begun to embody a new sense of responsibility for their own health through their initial contacts with their GPs (mostly for light illnesses). They began to reflect on the distinctly Korean form of medical subjectivity – i.e., being a good patient by actively seeking medical treatment – precisely because the GPs refused to provide any treatment for these minor illnesses. However, although their attitudes revealed that they had come to internalise the ideal medical subject-form of 'active patient/ healthy citizen', none of them were at all familiar with the general public health discourse and its specific themes,

requirements, suggestions and imperatives. The purportedly fundamental notions of 'active patient' and 'responsible healthy citizenship' were completely unknown to them. But if the subjects themselves have no comprehension of these categories, which supposedly constitute that toward which the process of subjectivisation is ultimately directed, then in what sense can it really be said that these categories structure their experience? (McNay 1994)

It is a very real problem to establish how it can be determined whether an action is simply an action or rather evidence of a subjectivisation. How could one ever decide with any degree of certainty whether a regimen was the outcome of a subjective transformation or simply a resigned 'going along with…', a more or less conscious decision to try and act like the natives as best as possible? Are there any criteria here? Put another way, inasmuch as Foucault himself – and perhaps precisely for some such reasons as these – restricted his research to 'archives', bodies of 'statements' in discourse, we have every right to ask whether Foucault's findings apply to anything other than discourse itself. To be sure, actions and interventions – e.g., on bodies, through tactics of force and discipline – are real, but how real are the 'forms' to which they are supposed to correspond?

9.4.3 Indeterminacy of agency and freedom

At the root of all this there lies a more general problem, namely, how to think the nature of the human itself as a worldly being. Presumably subjectivisation is not deterministic; rather there is tension and resistance at every stage. But if the human is nothing more than the sum of its manifold modes of subjectivity, then where is the locus of this tension? What is it that resists, and what exactly is resisted against? Foucault might respond that inasmuch as a power relation is always an action carried out on another action, there are nothing but actions. But are there not free agents at the source of these actions? Are human beings simply the material substance through which a perpetual play of actions is actualised in the world?

To be more precise in relation to my own research, while it is true that the Foucauldian framework has, in general, been useful for understanding the processes that my participants underwent as migrant women, vacillating between the two very different forms of medical subjectivity of 'good patient' (in Korea) and 'active patient/healthy citizen' (in the UK), nonetheless, the overall ambiguity and commonsense character of many of the most operative concepts often makes it extremely difficult to grasp and comprehend the subtleties of their actual experiences. It is true that their personal narratives reflect a sense of empowerment and agency won through their struggles with the medical institutions, personnel and forms of expertise in both societies, and that, through these narratives, they are able

to constitute or re-constitute their selves and subjectivity to a certain extent, but it is difficult to establish with certainty whether and when they are being subjectivised to that particular ideal, i.e., whether an when some actual 'process of subjectivisation' has occurred.

Conclusion

To conclude, the final chapter looked at the techniques that the Korean women employed while they maximised their agency to maintain their health and their family's health through the lifestyle-oriented and medical practices. The Foucauldian framework used in this thesis has allowed me to capture the Korean women's process of migration, especially their vacillation between two very different forms of medical subjectivity, that of the good patient and that of the active patient. However, some limitations in the Foucauldian framework were identified as their narratives contained a sense of empowerment and agency as they challenged medical expertise in both countries. Their fluid and flexible subjectivity constitute their nomadic identity as dual health citizens.

Chapter 10: Conclusion

The thesis has attempted to capture what Korean migrant women in the UK do in order to stay healthy, as well as the nature of their experiences of being subjected to and by the medical system in the UK. Research into migrants' health-seeking behaviours has commonly focused on their choice of different forms of medicine and the elements or factors leading to certain form of medicine, whether social, economic or cultural. However, this research started by bracketing the question of why and how migrants decide which health practices to employ, and attempted instead to examine these experiences through a Foucauldian lens. By conducting Foucauldian-oriented research on Korean migrant women's health-seeking behaviours in the UK, this thesis has endeavoured to expose both the benefits and the challenges that Foucault's later research on the subject and processes of subjectivisation presents for capturing and understanding these experiences.

In what follows, several major findings of this research and their implications for policy and future academic research are noted.

First, the Korean migrant women did not actively change their mode of medical subjectivity until they went through some significant life-event such as a critical illness or, usually, the process of pregnancy and childbirth. These women's early encounters with the GP revealed that they experienced

radical differences in the concepts and practices of health between the UK and Korea, and that they began to problematise their sense of responsibility and health practices the longer they were exposed to the British public health discourse.

This public health discourse encourages members of the population to take responsibility for their own health; the roles of medical professional experts are both to inform individuals of risks as consequences of their decisions and to govern them by encouraging them to adopt health-promoting practices. (Petersen and Lupton 1996; Rose and Miller 1992) Therefore, the GPs constituted the first point of contact for the Korean migrants to learn techniques to improve their health. While engaging in medical consultations with the GPs, these migrant women's medical subjectivity also underwent construction and reconstruction, particularly with respect to their growing sense of responsibility for health. (Lupton 1997b)

Through these initial encounters, the Korean women became aware of a new sense of responsibility: when in Korea, their responsibility for their health involved actively seeking out medical experts' help and advice, whereas in Britain they were expected to know their symptoms, to search for information and to medicate themselves, if possible. Their reflection on the differences between the British and Korean techniques of government demonstrated the co-existence of two different medical subjectivities and

indicated that they had just begun to undergo the process of subjectivisation with respect to the British public discourse of health – i.e., to become an active patient/healthy citizen.

This transformation of subjectivity became radical and active as they eventually adopted certain techniques in the course of undergoing pregnancy and childbirth for the purpose of pursuing the health of both themselves and their children, and it was mainly in this way that they came to internalise the ideal active patient/healthy citizen model of medical subjectivity. The differences between the two medical systems were most evident through the care and treatment given pregnant women: while pregnant women in Korea are subjected to aggressive medical intervention as 'subjectless' pregnant bodies, (T.Kim 2003: 101) the demedicalised experience of pregnancy and childbirth in the UK, led by midwives, resulted in their becoming critical of the Korean medical system. This was a transitional period for the Korean migrant women, from the Korean medical subjectivity, as a passive recipient of care, to the British medical subjectivity, as an active, responsible health citizen. Throughout this period, the Korean women eventually constructed a dual health citizenship whereby their medical subjectivity became flexible and 'nomadic' in nature, (Lash 2001 in Beck and Beck-Gernsheim 2001: xi) while their agency was maximised to challenge medical expertise in both countries.

Second, these transformative experiences suggest that the overall experiences of Korean migrant women are very different from those of other Asian ethnic groups. Koreans are usually lumped into 'East Asian' or 'Chinese/Other' as opposed to 'South Asian' or 'African' by the Department of Health. (DoH 2009b) However, while Korean traditional medicine, *hanbang,* originated from China and thus contains traces of Chinese cosmology and yin/yang principles, and follows practices of Chinese traditional medicine (Lee 1996), my participants did not exhibit a similar health belief system to the Chinese. Both Chinese and Koreans consider diet to be fundamental to maintaining health in daily life. However, the notion of yin and yang is heavily applied to foods in Chinese culture: Chinese people conceptualise their foods according to the division of hot/cold and wet/dry and balance their diet accordingly and for them, maintaining the balance of the diet is as critical as taking medicine. (Chau and Yu 2004; Green et al 2006) The Korean migrant women's diet, on the other hand, was a Western-Korean hybrid based on a combination of nutrition, ingredients and calories. No reference to yin and yang were made while describing their diet.

Differences in health beliefs and practices, sometimes contrasting, among Asians are far from unknown; divergent health beliefs, perceptions of health-related benefits and risks, and behaviours were found among South Asians in the UK with respect to cardiovascular health. (Beishon and

Nazroo 1997) My thesis, as well, challenges the current practice of lumping different ethnic groups together into homogeneous categories.

Third, while language barriers are known to be one of the major obstacles to immigrants' access to healthcare in their host countries, my participants did not consider language to be much of an issue. (Sproston et al 2001) This, however, does not mean they did not encounter any problems: in fact, most pointed out that English medical terms as well as medical professionals' regional dialects posed challenges for them. Despite this, they showed several methods for overcoming these issues: they took dictionaries to the GPs, asked medical professionals to repeat words until they understood, or wrote down difficult terms which they looked up at home, so that the language difficulties did not hinder their pursuit of health. This proactive attitude may be related to their educational and socio-economic background.

Fourth, despite Koreans' well-known proclivity to use a number of different kinds of medicine instantaneously, only one participant utilised *hanbang* – albeit involuntarily, when administered by her mother, right after childbirth. Studies on Korean immigrants have mostly focused on their combined use of both biomedicine and *hanbang* regardless of their cost implications. Koreans are known for using *hanbang* for chronic diseases and biomedicine for acute symptoms (Pang 1989; Hong 2001; Lee 1996); this 'polypharmacy' for Koreans is 'the norm rather than the exception'. (Lee

1996: 30) However, my participants did not utilise *hanbang*; instead, they were inclined to follow the non-medical, traditional folk knowledge of antenatal and postnatal care mostly stemming from neo-Confucianism. Use of *hanbang* by Korean immigrants and its medical cosmology have been politically associated with providing culturally competent care that goes 'beyond awareness and sensitivity in the active incorporation of cultural factors in the planning, implementation, and delivery of health services'. (Tripp-Reimer 1999: 236) This is not to suggest that there is divergence only across different ethnic groups, and research of homogeneous ethnic groups may hinder providing culturally competent care. (Chau and Yu 2009) However, this research suggests that the use of *hanbang* by Korean immigrants may be over-emphasised due to researchers' advance intention to study Korean migrants' pluralistic health practices. In addition, it implies that culturally competent care for Korean migrants transcends the two officially recognised kinds of medicine in Korea – biomedicine and *hanbang* – and that their attitudes toward health, pregnancy and childbirth are deeply rooted in the non-medical, philosophical ideology of neo-Confucianism. Clearly, culturally competent care can only be meaningful if it meets the health needs of immigrants, beyond mainstream biomedical healthcare. (Chau and Yu 2009)

Fifth, this thesis has also discovered a few weaknesses of a strictly Foucauldian approach. For one, studying migrant women who have

experienced pregnancy and childbirth automatically carries gender implications and assumptions. (Irigaray 1993; Grosz 1994) While exploring the experience of medical subjectivity, this subjectivity also includes a gendered dimension; in other words, if the public health discourse has produced the notion of responsible healthy citizenship, it means – for example, for my participants – a responsible and healthy '*feminine* citizenship'. (my italics, Fullagar 2003: 56) Through the subjectivising process, these Korean migrant women came to embody a dual gendered health citizenship, which was fabricated within the gendered power relations of patriarchal neo-Confucianism.

This was especially noticeable while they were pregnant, insofar as they conformed to the neo-Confucianist pregnant subjectivity. Although they became aware and critical of the commercialised characteristics of the Korean medical system, which resulted in their having more receptive and positive attitudes toward the NHS for less medical intervention, the output was not entirely positive for my participants. From the moment they realised they were pregnant, the Korean women were forced to identify themselves in terms of a 'pregnant subjectivity'. (Root and Browner 2001) While Korean pregnant subjectivity is governed by aggressive medical surveillance, British pregnant subjectivity is largely de-medicalised, and therefore my participants did not think it would guarantee a healthy pregnancy. However, the demedicalisation of childbirth also led them to opt

out of the strict, traditional Korean-style postnatal care right after childbirth. However, they regretted this greatly and attributed their dissatisfaction with their current health condition precisely to their failure to follow the traditional postnatal care regimen. This marked a transition point for my participants as they started to nationalise their bodies as Korean, distinguishing them from their children's bodies, which were British.

Overall this thesis attempts to document the transformative experience of becoming-subject of Korean migrant women who are utilising biomedicine in both countries while developing their own strategies to look after the health of themselves and their families. Unlike the Korean migrants in New Zealand, who traveled back to Korea to satisfy their expectations for doctors and medical services, (Lee et al 2010) my participants underwent a completely different process of subjectivisation through their struggles with the GPs and by internalising and accepting the desirable active patient model, which demands that individuals take charge of their own health. The experience of pregnancy and childbirth was the turning point in a process of subjectivisation in the direction of a dual health citizenship. The Korean migrant women demonstrated that the process of subjectivisation was non-linear, involving constant re-negotiation and reflective deliberation as they internalised the British medical subjective ideal. However, they also distinguished their bodies as Korean from those of their children as British. For the health of their children, the Korean women tended to submit almost

fully to the British medical model, recognising that although their children were ethnically Korean, their bodies were originally British and demanded British treatment. The inter-generational health practices of the Korean migrant women suggest that they have become more cognizant of their health-seeking behaviours, bringing them more fully in line with the ideal form of medical subjectivity of the active patient/ healthy citizen. The analysis of the Korean migrant women in this thesis does not necessarily represent all Korean migrants in the UK. The participants are distinguished by the fact that they classify themselves as middle class and that they are highly educated. Future research may attempt to refine the modes of subjectivisation of the same ethnic group according to their socio-economic attributes and capture the various experiences of different demographics.

Appendix A: Demographics of Participants

	Name	Duration (yrs)	Age	Family members	children	Occupation	Other Details
1	Mrs Park	5	35	Kor husband; 1 son; 1 daughter	4, 3yrs old, born in the uk	housewife	never worked; went back to Korea
2	JP	5	late 30s	Jap husband; 2 daughters	8 yrs; 3yrs old; born in Japan	part-time Kor teacher	lived in Japan for 10 years
3	SE	8.5	35	Brit husband	no children	working for a British company	MBA at Warwick
4	KA	5	32	Brit husband; 1 daughter	4 months	housewife	
5	Mrs Kim	13	mid 50s	Kor husband; 2 sons	both in their 20s	housewife	lived in South Africa before coming to Britain
6	CHA	5	mid 30s	Kor husband; 1 daughter	10 months old	researcher at Queen Mary's	PhD; her mother – pediatrician; her father – gynaecologist
7	YON	5	34	Kor husband; 1 daugther	7 months old	housewife	Master's; worked in Korea
8	SON	10	37	Kor husband; 2 sons	5 years old; 3.5 years old; both born in the UK	PhD student in Graphic Design at Kingston College	Husband lived in the UK for 22 years; Son has Master's degree and worked for 6.5 years
9	YU	10	34	Brit/Hong Kong husband 2 daughters	5 years old; 1 year old; both born in the UK	working for BBC as a computer graphic designer	Husband's family and relatives in Britain; YU has a Master's degree
10	Mrs Soo	18	54	British husband 1 son	25 yrs old; born in HongKong	part-time sales assistant at Korean grocery store.	came to Britain after retirement, but working part-time

11	MI	9.5	late 30s	Kor husband 1 daughter	2 years old; born in the UK	quit after pregnancy	worked as a preschool teacher for two years; worked for KFC in the UK
12	BM	5	32	Kor husband 2 sons	3.5; 2 month; born in the UK	quit after marriage	Husband works for a British company
13	HOE	9	late 30s	Brit husband; 1 son	13 months; born in UK	assistant at Sheffield university	husband had a heart infection 1.5 yrs ago
14	SAH	5	33	Kor husband; 1 daughter	1 year old; born in UK	Carer (3yrs)	husband studying
15	JIN	9	35	Kor husband 1 son	3 yrs old; born in UK	own an oriental shop	sis-in-law: pharmacist; uncle is a pediatrician
16	RYU	10	36	Brit husband 1 daughter	9months; born in UK	housewife; was a teacher	
17	YAE	3.5	33	Kor husband 1 son	2 months old; born in UK	housewife	husband studying architecture; has a gallstone
18	WOO	5	29	Kor husband 1 son	22months old; born in UK	housewife	husband studying
19	JEA	5	35	Kor husband 1 son	5yrs old, born in the UK	Master's student	came to Britain when she was 6 months pregnant
20	DEE	6	36	Kor husband 1 son	5yrs old, born in the UK	housewife	husband working for a korean company in Britain
21	HYU	7	37	Kor husband 1 daugther	4yrs old, born in the uk	housewife	husband working for a korean company in Britain

Appendix B: Interview Memoir

Date: _____

Name: _____

1. General information

1-1 Who do you live with? Family members – nationality of her husband, age of child(ren)

1-2 Duration of stay in the UK

1-3 Participant's age and employment

1-4 Reason for migration

2. Perception of health and current health conditions of the participant and her family

2-1 Do you or your family have any chronic illness?

2-2 Do you consider yourself or your family to be healthy? In what ways?

2-3 What do you do mostly to maintain the health of yourself and your family?

2-4 When do you worry about health?

2-5 Is there anything you (or your family) specifically do (or avoid) for health?

3. Medication practices and their use of NHS

3-1 Do you often get minor illnesses such as cold, headache?

3-2 How do you deal with them? (e.g. taking medicine, seeing the GP, rest, tolerate, or get on with life)

3-3 Has your perception of medicine changed since migration?

3-4 When do you usually see the GP?

3-5 Have you been hospitalised?

3-6 What is your impression of the NHS?

3-7 Have you had any conflict with the GP? Why? How did you solve it?

3-8. Have your perceptions of health, medicine or illness changed since migration?

4. Use of the Korean traditional medicine – *hanbang* – in the UK

4-1. Have you used *hanbang* in Korea?

4-2. Have you used *hanbang* in the UK? Why and how did you find it effective?

5. Diet and health

5-1 Do you tend to cook yourself or eat out? What do you usually cook? Whom do you care most when you are planning a meal for your family?

5-2 Has your diet changed since migration? If so, how?

5-3 Have you felt any difference in your body since you changed your diet?

5-4 Is there any food that you intentionally eat (or avoid) for health?

5-5 Do you take any vitamin or health supplementary product?

6. Exercise and health

6-1 Do you exercise? How often?

6-2 How do you think exercise contributes to health?

6-3 If you don't exercise, is there anything that you do in general for health? (e.g. walking a lot or doing domestic work?)

7. Experience of pregnancy in the UK

7-1 General experience of pregnancy in the UK

7-2 Where do you obtain most of information regarding pregnancy and childbirth in the UK?

7-3 What do you find most different from the Korean practice during your pregnancy?

7-4 What do you think about midwives?

7-5 What can you do or not do while pregnant? Why? E.g. taking medicine

8. Experience of childbirth in the UK

8-1 Experience of childbirth in the UK

8-2 Have you noticed any difference compared to childbirth experience in Korea?

8-3 How did you practise postpartum care?

8-4 Do you think we (both Korean and British) need postpartum care after childbirth?

8-5 Do you feel that your body has changed after childbirth?

8-6.Do you think British women have different bodies from Korean women?

9. Childrearing

9-1 What is most difficult when raising a child?

9-2. Have you seen the GP because of your child?

9-3. Is there a difference between practices for your health and your children's health?

9-4. How has your lifestyle changed after childbirth? – diet, exercise, etc

9-5. How do you keep your child healthy?

10. Stress

10-1. Stress – migration: when do you get most stressed out?

10-2. How do you think your stress is affecting your health?

10-3 What do you do to release your stress?

11. Health maintenance

11-1. Do you think British are healthier than Korean in general? Why?

11-2. What are your most concerns about health since migration?

11-3. What do you mean to be healthy in Britain?

11-4. What is your ideal state of health?

12. Acquiring health-related information

12-1. What is your source of health information?

12-2. Is there any information is really ‘Korean’ or British?

13. Language difficulties

13-1 Do you face language problems because of your English when you encounter medical professionals in the UK?

13-2 How do you overcome those difficulties?

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