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‘It is only a pinprick’ – (or is it?) – childhood vaccinations in general practice as ‘matter out of place’

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The analysis presented in this paper is part of a larger study, the aim of which is to describe the GPs’ everyday taken-for-granted working life. The study is based on multi-sited anthropological fieldwork in Danish general practices. This paper analyses consultations where children are vaccinated and the analysis shows the way these consultations differ from other consultations in relation to flow and communication. Neither parents nor doctors question the value of the vaccination, but the manner in which they talk about it and handle it in the flow of the consultation points to them experiencing it as being problematic. Taking inspiration from Mary Douglas’ theory on cultural classification the injection is interpreted as ‘matter out of place’. The analysis identifies the infliction of pain and the discomfort this brings to the doctor and the parent as problematic as well as a breach of the doctor–patient relationship. The aim of vaccination is to prevent potential diseases in the future, but its function in the consultation, besides being fulfilment of national guidelines, is not immediately apparent. It has no real function in the consultation and this makes it problematic in the present, causing the ambiguity that both doctors and parents express.

Keywords: immunisation; communication; Denmark; discipline; ambiguity

Introduction

The medical consultation, the daily practice of the clinician, gives insight into the medical profession as a cultural system (Rhodes 1990). This is especially true of consultations where the patient is not alone, such as when children are accompanied by parents or relatives, a situation that gives special insight into the interface between the life-world of the patient and the work of the GP.

Childhood immunisations¹ give a different insight into general practice than comes from other consultations. This is partly because they deal not with disease, but with the prevention of disease, and partly because the patient is a small child who is unable to make or help make the decisions and share the responsibility, both of which are allocated to the doctor and the parents. Furthermore, the act of immunisation causes the child pain and possible discomfort, should the immunisation have side effects.

The consultations analysed in this paper describe parents who have already chosen to have their children immunised. It does not deal with parents who have

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chosen not to immunise their children or parents who have not yet decided whether to have their child immunised. The media and public discourse focus on these parents, whose acts can be seen as 'resistance to biomedicine' (Rhodes 1990, 169).

Medical anthropology often points to the difference between the doctors' biomedical perspective (disease) and the patients' explanatory models, which are grounded in everyday life experiences (illness) (Rhodes 1990; Good 1995; Kleinman 1980). However, in the consultations on immunisation, doctor and patient use the same explanatory model: that the vaccination is something that has to be done, a necessity, the justification of which is not to be debated. The parents in this study do not oppose the decision by the state that all children should be immunised. Nevertheless, their reactions in the consultation mirror the discourse on risk in society, in particular the difficulty of thinking about a potential, but uncertain risk in the future. The disease(s), against which the child is immunised, may or may not present themselves or be present in the future. The child may or may not be subjected to infection. The child may or may not become ill. Immunisations may protect the child, but there are still other diseases, the child cannot be protected against.

According to Rhodes (1990, 170), '... illness entails an intensity and vulnerability that reveal the most basic attitudes of the society in which it occurs'. Thus, the immunisation is perceived as a cultural entity, relating to the cultural and social construction of meaning in everyday life, and analysing it will inform us on everyday meanings, as social life is 'fundamentally conceived as the negotiation of meanings' (Marcus and Fischer 1986, 26). According to Lock and Scheper-Hughes (1990, 49), 'All knowledge relating to the body, health, and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space'. The body is central in many doctor-patient consultations, as it is in the consultations in this study. It is the body that is examined, injected, and discussed. The body is central to the immunisations as it is the body that is injected into and which feels the pain. According to Lupton (1994, 20), the body is 'a social construction, vulnerable to ideological shifts, discursive processes and power struggles'. The body is perceived, interpreted, and represented in relation to history and culture.

The meeting between GP and patient is special compared with other encounters in the health care system. Primary health care is the doorway to the health care system in Denmark, as well as in other countries with a division in the health care system between primary and secondary health care. Being based on a list system, where patients choose a GP in their local area, makes a more lasting relationship between doctor and patient possible. Primary care is the place for preventive medicine, for instance childhood vaccinations. In Denmark, it is the GP who performs the actual injection into the child's body.

Lock and Scheper-Hughes (1990) see three different but interacting bodies: the individual, the social, and the body politic. The individual body is the phenomenological sense of the lived experience of the body-self. The social body is the symbolic, representational use of the body in concepts of nature, society and culture; and the body politic is the bio-politics of the state, visible in the way that the individual's body is controlled in order to have social stability through discipline in a state society.

In childhood vaccinations the three bodies are seen to be represented: the individual body (the patient/the child), the social body (enacted in the relation between parent and doctor), and the bio-politics of the state in the state decision that

all children are offered free vaccinations. According to Foucault (1976) the relation between the state and the individual body is a relation of power. He perceives the body and the individual handling of the body as a form of disciplining that the individual takes on consciously or unconsciously. In this study, it is the state's wish to avoid the diseases that the immunisations protect against, and this causes the state to establish a vaccination program for all, a program in which the state in turn expects everybody to participate. Accordingly, parents are perceived as problematic if they choose to not have their children immunized. To Foucault, the body is the ultimate site of political and ideological control, surveillance, and regulation, where the state acts via its institutions, such as the justice system (prisons), the educational system (schools), and the health care system (general practice, hospitals, asylums), which work through punishment and control. Interest in the child, its body, mind and development was established in the early twentieth century and is part of surveillance medicine, as defined by Foucault (Armstrong 1995, 394). Here, vaccinations of children become a means to ensure a healthy population. An example is Italy where the vaccination certificate is a condition for going to school.

The present analysis of vaccinations in general practice has been inspired by Mary Douglas. Douglas' interest is in cultural classification and demarcation and the way in which these classifications establish a semblance of order. Nevertheless, some things fall outside or between classifications; they are 'matter out of place' and 'cognitive discomfort is caused by ambiguity' (Douglas [1967] 2002, xi, 47).

Theory has been used as an inspirational tool in order to look for meaning with an aim to 'create a knowledge that changes our understanding of the known' (Fabian 2011). The analysis looked for cultural meaning expressed either verbally or tacit. Furthermore, anthropological work takes off from praxis, which the anthropologist shares with the informant and is grounded in inter-subjectivity and language. Anthropological work is always interpretative (Fabian 2001).

Fieldwork is 'the evaluation, articulation, thinking and rethinking of what one has already encountered, or what one is likely to encounter' (Marcus and Okely 2007, 354).

Childhood vaccinations in a medical context

Medical research interest in relation to childhood vaccinations is different from the anthropological interest.

In medical research, most attention has been on parents who resist vaccinations partially (specific vaccinations) or totally, and parents who accept vaccinations have only been studied in order to compare them with parents who resist vaccination (Gellatly, McVittie, and Tiliopoulos 2005; Benin et al. 2006; Wroe et al. 2005), in order to find ways to increase uptake. Social science studies are more concerned with parents who reject childhood vaccinations and their deliberations, whereas few studies look at the majority of parents, i.e. the reflections of parents who have chosen to have their children vaccinated (Raithatha et al. 2003; New and Senior 1991).

The long tradition for vaccinations means that today's parents do not have first-hand knowledge of the diseases that are vaccinated against, something that may influence immunisation uptake (Calandrillo 2006; Paulussen et al. 2006). On the other hand, the parents and the doctors have themselves been subjected to immunisations and carry with them their own memories of this. In Denmark,

immunisation participation has always been high. This means that nine out of ten adults have memories of their own immunisations (Østergaard et al. 2007).

Childhood vaccinations in a Danish context

In Denmark, vaccination against smallpox was made compulsory in 1810, and further vaccinations were introduced by the state in the 1900s (Holstein, Iversen, and Kristensen 1994, 39).

Denmark's long tradition of childhood vaccinations began both as a protective procedure for the individual in order to secure health and as a means for the state to avoid epidemics that might threaten its security. In Denmark, childhood vaccinations are offered free of charge. The health care system expects every child to be immunised, although this is not the case in practice. Childhood vaccinations are carried out by the family's general practitioner or his/her nurse. Children are vaccinated at the ages of 3, 5, and 12 months against Diphtheria-Tetanus-Whooping cough-Polio-Haemophilus influenza Type b. They are revaccinated against Diphtheria-Tetanus-Whooping Cough-Polio at 5 years. Further, they are immunised against Measles-Mumps-Rubella at 15 months and 12 years. The vaccinations administered when the child is 5 months, 12 months, and 5 years old take place in conjunction with a health check – 'which is part of the prophylactic provisions prescribed by law offered to preschool children' (Østergaard et al. 2007, 147).

Fieldwork and field material

The empirical material for this paper is taken from a multi-sited anthropological field study (see Sanjek 1990; Spradley 1980; Emerson, Fretz, and Shaw 1995) of Danish general practice that focused on the general practitioner's everyday working life. As a phenomenological study, it is inspired by the work of Jackson (2003), Schutz (1970), and Schutz and Luckman (1989).

The work of 17 general practitioners was observed at least for an entire day. The doctors later received the transcripts of their consultations and they formed the basis for an interview on everyday working life in general practice. A total of 288 consultations were observed, audio taped and transcribed by the author. Patients were informed by the author on the aim of the study prior to observations. Four patients declined to participate. The consultations observed contained 70 children, of whom 25 underwent a vaccination and/or had a general health check. The impetus to analyse vaccinations came from one observation and verbal exchange between a parent and a GP. Consequently, all the consultations with immunisations were systematically analysed, using field notes, transcripts, and well as doctors' statements in the interviews concerning this type of consultations. The analysis looked for patterns and exceptions in the flow of the consultation and the communication. The consultations were then compared with the rest of the consultations. Quotes are taken directly from the transcripts in order to illustrate the analysis most clearly.

The injection is in focus before the consultation

That some medical examinations of children involve an injection is common knowledge in society. This means that the planned injection is on the agenda long before the actual consultation. Conversations during the consultation indicate that

the parents remember prior injections – and the child’s reaction. They try to prepare the child in order not to repeat any previous unpleasant vaccination experience.

‘Last time, she didn’t react at first when the needle went in. But when the doctor started injecting – and when she injected the second leg, she cried as the needle went in. How she objected, how she cried’² [Mor: sidst der gjorde hun, reagerede hun ikke da nålen kom ind, men da hun begyndte at sprøjte, og så da hun skulle til det andet ben, så var det allerede da nålen kom ind og du kan tro hun sagde til, nej hvor hun skreg] (Consultation A12, 5 months, mother’s comment to the GP).

However, this time the mother comes prepared.

‘I have given her plasters [plaster] [with local anaesthesia] [M: jeg har sat plaster på hende] – to prevent the pain’.

A mother who has waited in the waiting room with her 5-month-old child says in the consultation, ‘I could see that it [another child] looked the same age – it was probably another one to get an injection’ [Det var nok en der skulle ind og stikkes]. The parents indicate that they remember prior injections and prepare for this one – and it is apparent that the injection is never far away in their consciousness. The important thing is to prevent the pain, which makes the child cry, which is what the parents remember.

The parents in this study act as the disciplined parents that the state wants them to be, but at the same time they do not want to inflict pain on the child. Their use of the latest analgesics to prevent the pain is a way to handle this dilemma between choosing the vaccination and subjecting the child to pain.

The immunization in the flow of the consultation

All children were accompanied by at least one adult, most often a parent. The flow of the consultation is different when compared with other consultations because the injection is talked about early and several times throughout the consultation and it is carried out at the end of the consultation. In other consultations a problem is raised, it is handled, and the consultation moves on to the next problem. Thus, the flow of children’s immunisation consultations differs from all other consultations, but they share a common pattern, which is described below.

Talking about injections

The parents in the consultations use the word ‘vaccination’ [vaccination] and do not differentiate between different kinds. The injection is referred to by both doctors and parents with words indicating a perforation of the skin [et stik] and by diminutives such as ‘tiny [lille]’, ‘very tiny’ [lille bitte], ‘children’s’, [børneprik] or ‘mosquito bite’ [myggestik]. The words play down the significance of the injection and this is in contrast to the many times the injection is talked about in the consultation.

The injection in the flow of the consultation

The consultation has only just begun when the injection is introduced by the doctor or the parent, and regardless of who starts it the other party picks up the focus on the injection.

Doctor A: ‘Hello.’

Mother: 'It's a good thing that you don't know what is going to happen today.' [godt du ikke ved hvad der skal ske i dag]

Doctor A: 'you haven't said anything, have you?' [du har ikke fortalt noget, vel]

Mother: 'I have told her, but luckily . . . ' [jeg har fortalt hende det, men heldigvis så]
[She indicates that the child does not understand]

Doctor A: 'Has mother told you that you are to have a pinprick, in a while?' [har mor fortalt at du skal stikkes, om lidt?] (A 12). [In the transcription, A identifies the general practitioner and 12 indicate the specific consultation.]

In the above example, it is the mother of a 5-month-old girl who brings the injection into focus at the very beginning of the consultation. She does it indirectly, not referring to the actual injection but by talking almost conspiratorially about something unpleasant. It is typical that the doctor plays along, ending his comment with 'Have you?' indicating the conspiracy. In another example the mother says to the child in her arms, 'Honey, are you running away?' [skat, stikker du nu af] and the doctor comments, 'That shows he is a clever child, he smells a rat' [det viser at det er et klogt barn, han har lugtet luntten] (M5, 15 months).

Another way to consider the injection is to focus on the way the doctor and parent talk about the role allotted to the parent who is to hold the child during the ordeal. The doctor says to the father. 'Sit down, you're going to have the unfair position to hold' [sæt dig, du skal have en urimelig position og holde] (J8, 3 months).

Again, the unpleasantness is accentuated and it happens within the first minute of the consultation. With very small children, who have no remembrance of an injection it is the grown-ups who bring it and its discomfort to the fore, and doctors and parents assist each other doing this. They do it with humour and cheer, but focus on expressing the discomfort almost ritualistically.

With older children, too, the injection is a focus at the very beginning of the consultation, even though the injection is carried out at the very end.

Doctor J: 'Do you know what we are going to do today at your 5-years examination? We are going to find out how tall you have become, and we are going to measure . . . ' [Ved du godt hvad vi skal lave i dag til 5 års børneundersøgelse? Vi skal bare se hvor stor du er blevet og vi skal måle . . .]

Patient: (interrupts) 'and we are going to have a pinprick in the arm.' [- og vi skal også stikkes på armen]

Doctor J: 'Yes that is right, we will do that last, right' [ja, det er rigtigt, det gør vi til sidst, ikke] (J18).

In this example, it is the child who brings up the injection, interrupting the doctor. The interruption and the conversation indicate that she probably has been prepared beforehand for the injection.

The consultation turns to something else

After the injection and its unpleasantness is brought forward, the consultation turns to other things. The doctor talks about eating habits, head measurements, development. The child is measured and checked (teeth, hips, testicles, etc). The doctor shows the parents charts of how the child grows and what is considered normal development. The parents bring up other subjects: the child's delicateness or

having a cold as a consideration, asking whether the child may be too sick for vaccination.

Back to the injection

The consultation has now reached the time for the vaccination. Again, the injection is talked about, as in the beginning of the consultation, as something the doctor reluctantly does.

Doctor D: 'Let's take the plunge' [så, jeg synes at vi skal kaste os ud i det] (D6, 5 months)

Doctor D: 'It is a bit troublesome' he says towards the child [ja, det er lidt træls, det er lidt træls, siger han henvendt til barnet] (D15, 15 months).

And they talk about where the injection is going to be given, how many times the child is to be injected, the clothes that have to be taken off and who must do 'the honours' [have æren] (not honourable, though) and hold the child. The doctor talks about side-effects and the child's previous reactions. Several of the doctors raise their voice when they talk just prior to the injection. Where the conversation about small children is between parents and doctor, the older children are drawn into the conversation and their cooperation is sought.

After the injection

Immediately after the injection some doctors indicate that it is all over by saying, 'It is over'. Small children are praised regardless of whether they cry or not. Only half of the children cry and only for a short time. Girls are praised for being 'big girls' whereas boys are praised for being 'little men'. The praise is either directed to the child or expressed indirectly between parent and doctor.

Doctor M: 'Finished!'

Mother: 'It is over, finished [det er slut, færdig!], Peter.'³ (F3, 5 months)

Doctor D [reads aloud from file]: 'Grows well! Didn't cry.' (D6, 5 months)

Doctor Q: 'And it's over.' [så er det overstået] (Q21, 3½ months)

The end of the vaccination is emphasised by the doctor or the parent. Praising the child marks the vaccination as a deed accomplished and not as a trifle, as indicated earlier by the words used.

The doctor reflects on the doctor-patient relationship

Apart from the injections' frequent and prominent place, another feature distinguishes these consultations from other consultations. That is the doctor's specific talk about the doctor-patient relationship as he/she speaks directly to or on the relationship to the patient, who is a small child.

One doctor does it in instalments:

Doctor F: 'You will never come back, I am sorry, I have a bad conscience.'
[du kommer aldrig igen, jeg får helt dårlig samvittighed]

Mother: 'But the "customer" said thank you.' [kunden sagde tak] (F3, 18 months)

Another doctor says:

Doctor D: 'We are not being nice to you.' [vi er også slemme ved dig, vi er så slemme ved dig]

Father: 'She'll forget it. [det glemmer hun nok igen] I think we can manage now' [så nu tror jeg vi klarer den nu] (D15, 15 months).

The doctors talk about the harm they have done to the child and how it may influence their future relationship. The parents do not go along with this concern but express the necessity of the injection. The conspiratorial conversation between doctor and parent(s) seen at the beginning of the consultation is not repeated here.

There are consultations that do not follow this pattern. They are few and they resemble each other in tending to involve more important concerns that become the focus of the consultation. Other consultations – which are more directly comparable – are immunisations where sugar [poliosukker], the carrier of the vaccine, is given orally. Until recently, vaccinations against polio using sugar cubes were given when the child was 2, 3 and 4 years old. This form of vaccination was discontinued on 1 September 2003 (Sundhedsstyrelsen 2004). In consultations, the sugar cube with the immunisation was talked about as something sweet and desirable. It was described as something good and it was given to the child at the beginning of the consultation. There was no talk by the doctor to the child about the doctor–patient relationship, indicating indirectly that the sugar-cube immunisation process is something different from immunisation by injection.

The behaviour among the GPs in this study is remarkably uniform, with no differences being observed that might be related to the factors used to select them, i.e. gender, age, location, or format of the practice. In subsequent interviews with the GPs on the theme of how they classify their consultations, not one mentioned immunisations of children as something special.

The interesting thing about the injection here is the way it is present throughout the consultation and the way it overshadowed the other elements in the consultation: the child's development and well-being as well as the joy and small talk and familiarity that is normally present in consultations in which a child is not vaccinated.

Blood which is not really blood

It is not only the flow of the consultation that can be interpreted as disturbed by something ambiguous. In the injection, the skin that is perforated and the issuing blood, which is talked about as 'not being real blood, it is only a little blood, because it [the skin] is already closed', [nej, det er ikke rigtig blod, det er jo kun lidt blod. Fordi der er jo lukket igen] presents another discrepancy in relation to childhood immunisations. Human interest in the boundaries of the body and the ways used to protect the boundaries have been described by, for instance, Douglas ([1967] 2002) and Lupton (1994). Lupton shows that conceptions about what is dangerous in relation to body boundaries reflect contemporary ideas and thus change over time. Douglas points to the way that the orifices of the body symbolise its especially vulnerable points. She writes 'Matter issuing from them is marginal stuff of the most obvious kind. Spittle, blood, milk, urine, faeces, and tears by simply issuing forth have traversed the boundary of the body' (Douglas [1967] 2002, 150). If the skin is

seen as the boundary of the body, and the hole made into it by the injection is perceived as an artificial opening, through which flows an important, but also dangerous bodily fluid: the blood, then the appearance of the blood on the skin creates disorder, which has to be controlled. The blood is defined as not being real blood, something ambiguous. In a similar way, the phrase, 'it is over' indicates that something has been out of place and the order is re-established and the liminality that was present has been overcome.

The blood, like the immunisation, is something that is and will be interpreted differently according to the perspective in which it is perceived; for example, the individual perspective, the health care system, and the state, and these are surrounded by ambiguity and discomfort.

The injection as 'matter out of place'

Returning to the words and the cultural meaning they convey, it is worth noting that neither doctor nor parents use the word 'vaccination' – in relation to the specific one they are to partake in – they use it as an overall category. They do not distinguish between different vaccinations nor talk about the function of vaccinations. They focus not on the vaccination and its potential merits but on the injection and they do it in a perceptive way. The injection is referred to as something insignificant, and at the same time, it is mentioned all the time. This creates a disparity between the words and the talk. That the injection fills the space of the consultation if it is the only item is natural, but it also fills the space in consultations where it is combined with other prophylactic undertakings. It underlines that the injections are problematic and painful. In contrast, immunisation by sugar cube is talked about differently, and is placed differently in the flow of the consultation since it is not painful.

Talk about the injection is important, as is the fact that it is done at the end of the consultation. This may be a good thing if the child cries a lot, but on the other hand, the discomfort of the injection is something that the parent or older children will carry with them to the next consultation. One way of interpreting the way some of the GPs raise their voices just prior to the injection is as a non-verbal communication of the discomfort to come. It is the injection and the discomfort and pain it brings that make the injection a culturally problematic element. It is problematic because the patient is a small child, not yet socialized in how to handle pain. It is a pain inflicted on the child, who is unable to understand what is going on, and unable to play a culturally relevant part in the social interaction. The 'stiff upper lip' (Helman 2000) (not showing pain, making no exclamations when the injection is performed), is a reaction that is seen only in consultations with injections of adults.

There are cultural classifications in all cultures, where they create order in the life of the individual and in collective life. But every culture contains elements that are difficult to classify – a category termed 'matter out of place' (*mop*) by M. Douglas [1967] (2002). The argument will be, that it is not the immunisation in itself that is problematic, which becomes clear comparing immunisations with sugar to vaccinations with an injection. And it is not causing the child pain, as other consultations where children are subjected to pain, i.e. the removal of sutures, etc, do not resemble injections in relation to flow and verbal exchanges. It is the injection as a preventive measure causing the child pain that is *mop*. As with other immunisations, it does not have a function here and now but has its potential usefulness in an unknown future.

At the same time, the injection involves the emotions of both the doctor and the parent, which further are related to prior episodes (Wroe et al. 2005). Parents and doctors are particular in talking about the injection as if to control it through talking about it. By doing this they indirectly classify this consultation as different from other consultations. Another thing that emphasises the injection as *mop* is the way the GPs talk about their future relation to the patient. They never do it in other kinds of consultations regardless of who the patient is. The fact that they do it in relation to children, including very small children, supports the *mop* of the vaccination.

Douglas herself only uses the category matter *out* of place (*mop*), in her analysis of pollution and defilement (Douglas [1967] 2002, 44) although she does explain that 'when something is firmly classed as anomalous, the outline of the set in which it is not a member is clarified' (Douglas [1967] 2002, 47). The cultural classification *mop* indirectly says something on the content of its opposite classification, which might be named 'matter *in* place' (*mip*). The classification of *mop* thus points to the classificatory content of *mip* in relation to the doctor–patient relationship: a good relation to last a long time. Thus, the injection, a means of inflicting unnecessary pain on a child, becomes a breach of the normative order. An injection for immunisation means to do something unpleasant without a relation to a present sickness problem; this may be interpreted as transgressing a moral boundary. In relation to injections, it is interesting that doctors and parents in communication make it apparent that they share cultural values on the injection. The usual difference between illness and disease is not found here.

Comparing immunisations of children and immunisations of adults makes it clear that they are different. With the adults, the injection is handled as a discomfort, but is carried out without many comments from patient and doctor. In relation to adults, there is no *mop*, as the injection is almost non-existent in the consultations. This once more points to the *mop* of childhood vaccinations.

Conclusion

This study contributes to the corpus of work that uses observation and thus prioritises action rather than attitude. It looks at what takes place, combined with how actions relate to discourse, and the cultural meaning and values attached.

The meeting between doctor and parents in the analysed consultations is not a meeting between different explanatory models or viewpoints; it is not a negotiation of different views, or a study on how biomedical points of view are communicated. The parents want to have their children immunised, they live in a system with a very long tradition for state initiated vaccinations, they are disciplined – and yet there is something alarming about injections and hurting the child. And this notion is shared between professionals (doctors) and parents.

Everyday life in the Western world is probably the least studied in comparison to the unique, dramatical and spectacular. The everyday life's taken-for-grantedness makes it almost invisible. Yet it is in the everyday life that both sickness and health is experienced and decisions regarding it taken and communications between GP and patients take place. Further, the special or spectacular can be understood through insight into the trivial. Knowing the ambiguities that parents and doctors express in relation to childhood immunisations may in turn contribute to our understanding parents who decide not to have their children vaccinated.

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Conflict of interest: none.

Notes

1. In the paper the words immunisation and vaccination are used to mean the same, just as the term doctor and GP are used for general practitioners.
2. The original wording in Danish is placed in [] after the English translation.
3. All names have been changed.

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