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Homes, Homeliness, and Otherness in Medical Anthropology “at Home”

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Since the 1990s, “medical anthropology at home” has been used to describe ethnographic research on health, illness, and care conducted in the anthropologist’s own society. While the notion has mainly been debated as a methodological issue within anthropology, it is perceived in this article as an analytical concern with broader relevance for discussions in qualitative health research. Drawing on ethnographic fieldwork conducted in Denmark, the article analyzes two empirical cases: one from research among people diagnosed with Irritable Bowel Syndrome (IBS) and one from research in the acute healthcare system. Focusing on concrete fieldwork situations, the article explores how experiences of being “at home”, “not at home”, and “not not *at home” are negotiated, shift, and intertwine in fieldwork situations that initially appear familiar. The article draws on Hartmut Rosa’s phenomenologically inspired conceptualization of “home” (2019) and Bernhard Waldenfels’ phenomenology of the alien (2011) as analytical resources for examining how familiarity, resonance, and otherness shape ethnographic knowledge production. Through this combination of empirical analysis and conceptual reflection, the article argues that “at home” can be understood as a situational, changeable, and relational condition that shapes what can be noticed, articulated, and known in ethnographic and qualitative studies*

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of health, illness, and care. By proposing a relational perspective that acknowledges that distinctions between "home" and "not home", "familiar" and "unfamiliar" are not always clear-cut, the article invites readers to reflect on researcher involvement and the epistemic conditions of knowledge production in familiar health research settings.

Hjem, Hjemlighed og Fremmedhed i Medicinsk Antropologi "Hjemme"

*Siden 1990'erne har begrebet medicinsk antropologi "hjemme" ("at home") været anvendt til at beskrive etnografisk forskning i sundhed, sygdom og behandling, der udføres i antropologens eget samfund. Selvom begrebet primært er blevet diskuteret som et metodisk anliggende inden for antropologien, anskues det i denne artikel som et analytisk spørgsmål med bredere relevans for diskussioner inden for kvalitativ sundhedsforskning. Med afsæt i etnografisk feltarbejde udført i Danmark analyserer artiklen to empiriske cases: én fra forskning blandt mennesker diagnosticeret med irritabel tyktarm (IBS) og én fra forskning i det akutte sundhedsvæsen. Med fokus på konkrete feltarbejdssituationer undersøger artiklen, hvordan erfaringer af at være "hjemme", "ikke hjemme" og "ikke-*ikke *hjemme" forhandles, skifter og flettes sammen i feltarbejdssituationer, der umiddelbart fremstår velkendte for forskeren. Artiklen trækker på Hartmut Rosas fænomenologisk inspirerede forståelse af "hjem" (2019) og Bernhard Waldenfels' fænomenologi om fremmedhed (das Fremde) (2011) som analytiske ressourcer til at undersøge, hvordan fortrolighed, resonans og fremmedhed former etnografisk vidensproduktion. Gennem denne kombination af empirisk analyse og begrebslig refleksion argumenterer artiklen for, at det at være "hjemme" kan forstås som en situeret, omskiftelig og relationel position, der former, hvad der kan iagttages, artikuleres og erkendes i etnografisk og kvalitativ forskning om sundhed, sygdom og omsorg. Ved at foreslå et relationelt perspektiv, som anerkender, at der ikke altid kan skelnes skarpt mellem "hjemme" og "ikke hjemme", og hvad der er "velkendt" og "ukendt", inviterer artiklen læseren til at reflektere over forskerens involvering og de epistemiske betingelser for vidensproduktion i sundhedskontekster, som forskeren kender personligt eller professionelt.*

Introduction

Around the 1990s, the concept of medical anthropology "at home" was discussed as a common denominator for research conducted in the anthropologist's own (often Western) society. The concept offered a common ground for discussing the

particularities of research conducted in settings familiar to the anthropologist. These discussions highlighted both advantages of familiarity (such as ease of access and shared language) and the challenges it posed, including the risk of overlooking patterns and taking norms, practices, and assumptions for granted (Hadolt, 1998; Van Dongen & Fainzang, 1998; Van Ginkel, 1998). However, the concept also gave rise to critical questions and debates. For example, Hadolt criticized the concept of "at home" for reproducing problematic dualisms between "us" and "them", the "West" and the "Rest" and for suppressing "'non-Western' anthropological voices, the interconnectedness and the relationships between 'we' and 'others', other forms of differences than cultural ones, and similarities which cut across the 'we-other' and 'home-abroad' division" (Hadolt, 1998, p. 321). Like Hadolt, Gullestad argued in favor of overcoming these dualisms. Reflecting on the contribution of Scandinavian anthropology, she wrote:

> *If anthropology is truly to become a comparative study of society and culture, modern Europe and the United States must become an integral part of the subject matter. It is necessary to overcome the now often inevitable opposition between "us" and "them," between anthropology "at home" and "abroad"* (Gullestad, 1989, p. 71).

Reflecting on her many years of experience conducting research in her native country, Norway, Gullestad later added that anthropologists working "at home" are "seldom just insiders" (Lien & Melhuus, 2011, p. 140), and that making sharp distinctions between anthropology "at home" and "abroad" comes with the risk of missing the many connections between people living in different parts of the world. Indeed, in our globalizing world, we may ask ourselves what constitutes the difference between anthropology "at home" and "abroad" when both "home" and "abroad" are *glocal* settings. In this world, health issues continue to develop that cut across the "local" and the "global" (e.g., the COVID-19 pandemic), and healthcare systems often face similar challenges across geographical borders. These challenges include persistent shortages of health professionals, rising demands related to ageing populations and multimorbidity, and structural challenges such as overcrowded emergency departments and fragmented care pathways.

In this article, I revisit discussions of medical anthropology "at home", exploring what "at home" may mean when ethnographic research is increasingly conducted in glocal, personally and/or professionally familiar settings. In doing this, I seek to shift the discussion from questions of location and insider status towards an analytical examination of "home" as a situational and relational condition that shapes knowledge production about health, illness, and care. While anthropology's

history as a study of cultural otherness (Leistle, 2016) has rendered questions of research "abroad" and "at home" particularly salient within the discipline – sometimes normatively privileging the former as "more anthropological" than the latter (Anderson, 2021; Logan et al., 2023) – methodological and analytical considerations about being "at home" should not only interest anthropologists. As ethnographic approaches are taken up across disciplines – and as health professionals increasingly engage in qualitative research in settings they know well – reflections on the conditions under which knowledge is produced become highly important. This is especially so when attention is directed towards "patient perspectives" and "patient involvement" in efforts to address glocal health issues and structural healthcare challenges such as the ones mentioned above. While proximity and familiarity may ease access to study patient experiences, they do not in themselves facilitate unmediated insight into how experiences of illness, embodiment, and care are lived and articulated. By analyzing "at home" as a condition that is experienced and actively produced by researchers and interlocutors alike, this article shifts attention from accessing patient perspectives to examining the epistemic conditions under which such perspectives are produced.

In the following, I review discussions on medical anthropology "at home" before introducing my theoretical inspirations for rethinking the notion of "at home". These are Rosa's phenomenologically inspired, relational conceptualization of "home" (2019) and Waldenfels' phenomenological reflections on the entangled relationships between own and alien, homeliness and otherness (2011). I use these theoretical inspirations for thinking through ethnographic examples from conducting fieldwork in and near my hometown in Denmark. Specifically, I draw on ethnographic examples from my PhD project on everyday experiences of gut trouble (Laursen, 2023) and from my postdoc project on experiences of continuity and care coordination in the acute healthcare system (Laursen et al., In review). I analyze being "at home" not only as an experiential or emotional condition, but as something that is negotiated and sometimes strategically mobilized by both researchers and interlocutors in concrete fieldwork encounters, with consequences for what can be known. Overall, I argue for a non-dichotomous understanding of medical anthropology "at home", and for an understanding of "home" as referring to a resonant relationship with a segment of world (Rosa, 2019) rather than a fixed, geographical place. I point to the methodologically and analytically productive potentials of dwelling with the gaps, overlaps, and intertwinements between "home" and "not home" in ethnographic fieldwork.

Revisiting medical anthropology "at home"

While "at home" has been discussed broadly within the discipline of anthropology, medical anthropology "at home" arguably constitutes an analytically distinct area insofar as questions and challenges relating to being "at home" tend to be articulated differently and/or become intensified in studies of illness, embodiment, and care. According to Hadolt (1998), medical anthropology "at home" differs from anthropology "at home" because it often examines biomedicine – a globally standardized system of knowledge and practice – thereby complicating what can be considered research "at home" and "abroad". Other medical anthropologists have described how studying illness and suffering activates the researcher's own body, morality, and biography in unique ways (Reis, 1998; Zaman, 2008; Larsen & Schwennesen, 2024). Most people have experiences with illness and healthcare, yet they may not know biomedical language and practice, and therefore, healthcare institutions may appear "familiar yet unfamiliar" (Van Ginkel, 1998). Whether in a hospital or in a sick person's home, it is difficult not to become morally and bodily involved, like Zaman who, amid "life and death events" (2008, p. 148) in a Bangladeshi hospital ward could not help but console relatives waiting outside an operation room. In healthcare settings, a neutral presence often appears impossible (Zaman, 2008; Larsen & Schwennesen, 2024), as one's presence will always be evaluated and negotiated by clinic staff, patients, and relatives (Wind, 2008). As remarked by Van Ginkel (1998), getting access to doing research in a medical institution is difficult. This may be one of the reasons why many fieldworks in clinical settings are conducted by "insiders" who managed to gain access (e.g., Zaman, 2008; Larsen & Schwennesen, 2024).

A substantial part of the literature on (medical) anthropology "at home" consists of reflexive accounts in which ethnographers seek to position themselves, arguing for why they were "natives" or not, and which strategies they used to overcome the challenges of being "native" (e.g., Munthali, 2001; Qamar, 2021; Zaman, 2008). Such reflections on positionality and accompanying methodological pros and cons are important. However, the following review will rather focus on two arguments that also surface in the literature on (medical) anthropology "at home", and which are important to the question of what "at home" may mean when ethnographic research is increasingly conducted in personally and/or professionally familiar settings: Firstly, the argument that "home" is more than a geographical place, and secondly, the argument against dichotomous or dualist understandings of being "at home".

Discussing the notion of "medical anthropology at home", Hadolt argues that as a relational term, "'at home' receives its meanings in relation to its counterparts,

most prominently ‘abroad’, the ‘Rest’, everything which is not ‘home’” (1998, p. 316). In this context, he raises a series of questions about what “home” might mean – ranging from place and social relations to political and ideological connotations – without further unfolding them. In line with this questioning, other anthropologists emphasize that “home” has multiple meanings (Van Dongen & Fainzang, 1998, p. 245), and that “‘[at] homeness’ involves more aspects of one’s life than the geographical or cultural” (Reis, 1998, p. 307). According to Reis, being “at home” is about emotions, shared experiences, and processes of identification; it is about feeling “at home” and sharing experiences with one’s interlocutors through “emotional resonance” (1998, p. 304). Madden understands “home” as “a small gemeinschaftlich environment” (1999, p. 261), encompassing geographical, cultural, social, and emotional dimensions that appear familiar to someone. Nordquest (2007) distinguishes between being “at home” and being “in the field”, representing the difference between the two as a switch in one’s state of mind between “doing ethnography” and “regular life”. Similarly, Caronia (2018) argues that being “at home” and being “abroad” are epistemic positions between which the anthropologist makes cognitive shifts. Larsen and Schwennesen’s study (2024) in a Danish orthopedic surgical department adds that shifts between “home” and “not home” are not simply cognitive but also grounded in embodied and material conditions, and that the researcher’s geographical, social, and professional “at homeness” is a productive part of knowledge generation.

As indicated above, “home” is often framed in opposition to “not home”. Against this, Madden has argued that “difference and similarity, familiarity and unfamiliarity, should be seen as being inextricably linked, as ‘inseparable modalities of the same phenomenon’” (1999, p. 269). During his hometown fieldwork, Madden experienced the “familiar” and the “unfamiliar” as co-present. Similarly, Anderson (2021) describes “home” as an unstable category, marked by ambivalence and the simultaneous feeling of being both “at home” and “not at home”. Tsuda, writing from her position as a “semi-native” Japanese American, argues that anthropologists are best understood as “partial outsiders and partial insiders who experience various degrees of acceptance and cultural insight” (2015, 15). Likewise, Zhao (2017) shows how the same places may appear as both “home” and “field”, depending on one’s study object and interlocutors. With the expression “field-home”, Bilgen and Fábos propose to completely dissolve the distinction between “field” and “home”, conceptualizing “home” as “an assemblage of life stories, relationships and experiences we accumulate at different places, times and levels throughout our lives” (2024, p. 949).

While the above-mentioned literature highlights that “home” is more than a geographical place and that insider/outsider positions are always partial and

shifting, less attention has been paid to how homeliness is situationally produced and transformed, and to the consequences of these processes for ethnographic knowledge production. Rather than treating homeliness as a methodological problem to be managed, this article explores how moments of resonance and alienation may emerge within "at home" fieldwork, conditioning what can be known.

Home, resonance, and the alien

In discussions about medical anthropology "at home", notions of being "familiar" and "at home" are sometimes used interchangeably. However, as I will show in the analysis, being familiar with (in the sense of knowing based on previous experience) a place, person, practice, object, or situation does not always translate into being "at home". In fieldwork situations, ethnographers may be intimately familiar with the research topic, setting, or the interlocutors prior to and beyond the fieldwork. During fieldwork, such "background" familiarities may come into play, but they do not in themselves produce experiences of being "at home". When I turn to phenomenologically informed conceptions of "home" in the following, it is not to engage in philosophical discussions about what "home" is, but to develop an analytical lens through which the ethnographic category of "at home" can be rethought. I find the works of the German sociologist Hartmut Rosa (2019) and the German philosopher Bernhard Waldenfels (2011) particularly helpful because they enable an analytical shift from treating "at home" as a methodological position to examining being "at home" as a relational and situational experience that can be negotiated and shapes how knowledge is generated amid familiarity and otherness.

Contrary to common definitions of "home", which are often tied to concepts of place or residence, as implied in the opposition to "abroad", Rosa's conceptualization of home is bound up with his idea of "resonance" as a mode or quality of human relationships to the world. While Rosa's work is often positioned within critical social theory, I approach his concept of resonance as phenomenologically informed, drawing particularly on its affinities with thinkers such as Waldenfels. Rosa suggests that the concept of home refers to:

> *[A] specific* form of reference or relation *to a segment of world that has been adaptively transformed – in the classic sense, a place where* things speak to us *and say something to us: the trees, the river, our house, or even the gas station, the industrial chimney stacks, and the local fast food restaurant. They speak because they*

> *trigger resonances in our own biographical memory and the people with whom we are connected by a shared history* (Rosa, 2019, p. 359, italics original).

In this understanding, being "at home" is not to be in a specific, fixed geographical place. Rather, it is a way of relating to a "segment of world"; a relation that implies that something speaks to us by striking a chord with, for example, our identity or memories of past experiences. As formulated by Rosa: "It is the experience of a dichotomy between segments of world that have been adaptively transformed and those that remain foreign and indifferent which gives *home* meaning" (2019, p. 359, italics original). According to Rosa, there are four characteristics of resonance as a mode of being-in-the-world. Firstly, when we resonate with some part of the world (e.g., a place, an object, or another person), we are affected or touched by it. Secondly, we respond to this call by reaching out to the "segment of world" that affected us. This response need not be verbal; it can also be subtle bodily responses such as goosebumps or a high breathing rate. Thirdly, resonance affects adaptive transformation. When we resonate with someone or something, we are transformed (in more or less visible, more or less temporary ways). Rosa writes that "resonant experiences also significantly change inanimate objects (if only *for us*)" (Rosa, 2019, p. 35, italics original). He gives the example of a mountain that changes for a person when she has climbed it, compared to when she had only seen it on TV. Climbing a mountain, however, may also not cause any transformation, and in that case, the relationship is not resonant. Finally, resonant relationships are uncontrollable; we cannot plan or arrange resonance, and we cannot predict the result of adaptive transformation. For the understanding of "home", this implies that there will always be something about "home" that we cannot fully grasp or control.

Rosa's thinking takes inspiration from Waldenfels (2011), in particular his key point that humans are responsive beings who are required (and unable not to) respond to that which challenges us and calls upon us. Waldenfels distinguishes between "other" and "alien", both of which could be considered counterparts to "home". Whereas "other" refers to a difference, e.g., that a brick house is not the same as a wooden house, the "alien" (in German: "fremd") is not simply different. The alien affects us; it is "something which seeks us out in our home (German *heimsuchen*) by disturbing, enticing, or terrifying us, by surpassing our expectations and eluding our grasp" (Waldenfels, 2011, p. 3, italics original). Referencing Freud's point that the uncanny permeates the home, Waldenfels writes that the alien begins in ourselves and that we are therefore never entirely "at home" with ourselves (2011, pp. 76–77). The alien appears as something unfamiliar in the familiar. It distinguishes itself from our sphere of ownness, yet

the own and the alien are interwoven rather than opposed. In this sense, "home" and "alien" can be read as mutually constitutive.

Together, Rosa's and Waldenfels' perspectives frame "home" and being "at home" as relational and situational rather than stable or pre-given. When analyzing two fieldwork situations in the following, I use their perspectives as analytical lenses to examine how homeliness and unhomeliness are produced, overlap, and transform in concrete fieldwork encounters. Before I present the ethnographic examples, however, I will introduce the fieldworks and reflect on my position as an anthropologist "at home".

An anthropologist "at home"?

The empirical material presented in this article is drawn from ethnographic fieldwork conducted in the Central Denmark Region between 2016 and 2023. It is not the aim of this article to present each research project's findings; they have been described in further detail elsewhere (Laursen, 2023; Laursen et al., In review).

I have often argued that I was doing something different than my parents when I chose to study anthropology. My parents work as a doctor and a nurse, and I have always been more familiar with the healthcare system than most people are when they simply encounter it as patients. When I began working with issues of health and illness as an anthropologist, it felt intuitive and homely. As part of my PhD project on the experience and everyday management of troublesome gut sensations diagnosed as Irritable Bowel Syndrome (IBS), I conducted fieldwork at two gastroenterology outpatient clinics and among 18 people diagnosed with IBS. When I first entered one of the clinics in 2016, I had an intuitive sense of how to speak and behave, and one of my gatekeepers (an experienced nurse) seemed to relax and consider me an "insider" when I told her that my parents worked in the healthcare system. However, I often still felt like a stranger: I did not wear a uniform, I did not have a work identity at the hospital, and I did not (at least in the beginning) speak the language of gastroenterology.

In 2022, I became employed as a postdoctoral researcher at the Prehospital Emergency Medical Services (EMS) in the Central Denmark Region. This position as a researcher in a healthcare organization provided unique insights into as well as access to the acute healthcare system, where I explored citizens' experiences of acute care and factors affecting continuity of care. Although the Prehospital EMS now constituted my everyday research environment, the acute healthcare system

did not exactly feel like "home" to me. When I accompanied health professionals driving emergency vehicles, I took on the role of a ride-along (Seim, 2021), wearing a bright yellow vest with the tag "observer". At times, I assisted the staff, e.g., by carrying equipment, and at times I moved around and observed staff, afflicted citizens, relatives, and bystanders. During some moments, I felt as if I was part of the prehospital staff. During other moments, I felt more "at home" with the citizens we met. Conducting research in emergency situations, I constantly judged what was appropriate for me to do and take part in according to the context and situation. My positionality could be characterized by what Wind has referred to as "negotiated interactive observation" (2008), in that my participation and observation in particular situations were not simply decided by myself but negotiated in interaction with the professionals and citizens present.

In her study on epilepsy care in The Netherlands, Reis (1998) describes how she had to make herself "a home" in an "epilepsy world" that was previously unknown to her. There are many ways in which an "IBS world" differs from an "emergency care world". In this sense, the fieldworks I have just described required two different kinds of "homemaking". Rather than being community studies, each research project was oriented towards a specific health challenge. While such projects receive funding and could be argued to be part of the raison d'être of today's medical anthropology (Logan et al., 2023; Van Ginkel, 1998), they may also bring about challenges for the researcher who seeks to make herself "a home" while moving from one problem-oriented project to another.

In the following, I present two fieldwork situations: one from my PhD fieldwork, in which I visit and interview Natasha, a young woman troubled by diarrhea diagnosed as IBS, and one from my postdoc fieldwork in which I drive with a rapid response vehicle to help an unconscious woman. I have chosen to present these two situations because homeliness and unhomeliness, familiarity and familiarity are particularly at stake, making them relevant for discussing experiences and negotiations of being "at home".

On gut trouble and what it means to be "at home"

Although the fieldwork that became the basis for my PhD dissertation began near my Danish hometown in 2016, one could also argue that the fieldwork began in Nepal in 2013, when I got a severe stomach infection in Kathmandu and went to a biomedical clinic where I became enrolled in a survey on traveler's diarrhea and its possible long-term effects, including IBS. Although I never got a diagnosis, I did

continue to be troubled by my gut for years. In 2014, I was referred to a colonoscopy at a Danish private clinic, where the gastroenterologist said he wondered why so many young people, especially young women like me, complained about problems such as constipation, bloating, stomach pain, and diarrhea. Although my gut, weirdly enough, seemed to "reset" after I got another stomach infection in Nicaragua in 2015, the questions stayed with me: What was going on with this gut trouble, and why would it seem to affect young women in particular?

Fast forward to October 2016, when I am sitting in Natasha's house in a rural village in Jutland, Denmark. At the time, Natasha is in her twenties; two years older than me. We have met during a consultation at a gastroenterology clinic, where she told the doctor about her stomach cramps and many visits to the toilet. Natasha's troubles began when she was pregnant with the youngest of her three children. On the day of our first interview appointment, one of her daughters is at home sick, and as we sit and talk in the living room, the five-year-old girl cuddles up to her mother in the sofa, pulling up her duvet. Natasha tells me that she rarely visits her friends because she does not like to have to use their toilets often. "I don't think that it's fun to do it other places than at home. Well, it's just a bit, you know… I prefer to do it at home", she says, pausing to signal that she does not mean to elaborate on this statement.

> Natasha: *You know, shit is just not a very charming thing to talk about [lort er da bare ikke særlig charmerende at tale om[1]]. That's just how it is. You know, it's not a topic that you think [det er* da *ikke sådan et emne,* man *tænker]… "Today, I would like to talk about that." Anyway, people who know me and people whom I'm close to know it, of course, but people I talk to once in a while, you know, the kinds of people you meet in Føtex [a Danish supermarket] or in the kindergarten or something like that. They're not the ones that you tell about it, I think [det er* jo *ikke sådan nogle,* man *står og fortæller det til, synes jeg ikke].*
>
> Camilla: *No, it's not really the first thing you say in the supermarket? (smiling)*
>
> Natasha: *Not really (laughing).*
>
> Camilla: *And this thing you told me about finding it difficult to visit other people, is that because… I mean, do you think that's embarrassing, or?*

1. The interview was conducted in Danish. I provide some Danish quotes and italicize certain words to highlight linguistic nuances that are difficult to convey through translated quotes. This version of the interview extract was also presented in my unpublished PhD dissertation (Laursen, 2023).

> Natasha: *Well, it's a bit embarrassing. But it's also just that thing about… You know, when you have an upset stomach, then it sometimes makes noise and it smells, and in that situation, it's just not very nice to be together with other people. Well, I think it's a bit, you know [Altså, jeg synes det er sådan lidt,* du ved*]… It's a bit embarrassing, it smells, and it makes noise. For sure, I don't think that it's particularly funny.*

The interview extract thematizes being "at home" in different ways. We are in Natasha's home – a small, grey house – talking about episodes of diarrhea that she considers so intimate and embarrassing that she prefers to keep them within the confines of her home. Rather than simply expressing a preference for being at home, Natasha actively produces home as a protected space. Through her distinctions between people who are close to her and know her, and peripheral social relations (people encountered in the supermarket or kindergarten), she draws boundaries around who may enter specific domains of bodily exposure and conversation. By inviting me into her physical home and into a conversation about a topic that she otherwise considers private, Natasha actively transforms the interview into a "homely" space of trust and familiarity. This transformation is sustained through humor, shared norms of embarrassment, and my responses as a listener who signals recognition. Like Natasha and most other people in Denmark, I grew up with the understanding that it is preferable to defecate at home (Thomsen & Pröschold, 2019), and that gut-related matters are taboo in everyday conversation (an understanding that is not culturally universal, as demonstrated by, for example, Ecks' study on gut relations in India (2003)). Natasha's repeated use of the Danish expression "du ved" ("you know") implies that she appeals to my understanding or expects that I already know what she is talking about. Furthermore, with the small words "jo", "da", and "man" (the latter coming close to "one" or "you" in English), she creates a generalizing distance to her own utterance, thus underplaying her own preferences and habits, and making her relation to (talking about) gut trouble appear as a matter of fact. More than indicators of shared understanding, however, words such as "jo", "da", and "man" can be argued to function strategically. Through these linguistic markers, Natasha calibrates the degree of familiarity between us and invites resonance.

Using the image of two tuning forks, Rosa explains his idea of resonance by emphasizing how it is produced when the vibration of one body makes another vibrate at its own frequency (Rosa, 2019, p. 165). Thinking with this image, Natasha's story of gut trouble affected me by calling upon my own experiences, and although this made me relate to her experiences and get a sense of what she meant, I still did not know exactly how she felt because we, like two separate tuning forks, were both vibrating but did not share the same frequency. Although

Natasha and I were both young, Danish women, and we shared experiences of gut trouble, our lives were also very different. At the time, we both lived off public benefits, but while I received the Danish state educational support (SU) as a university student, she received cash benefits (kontanthjælp) as an unemployed person having unsuccessfully tried to find a job that she could manage with her many health problems. While I had never been hospitalized, she was hospitalized once a month or every second month. As she said: "I do feel that I am affected, you know, with the asthma, the lungs, the stomach, the back, and the wrists." Natasha lived in the countryside, while I lived in a city. At the time, she had three children and an ex-husband, while I was unmarried and had no children. With Merrild's words, we lived "parallel lives". Based on her comparative study of lower working class and higher middle-class people in Denmark, Merrild (2015) uses the expression to refer to the different lives that take place within the same cultural and discursive context, but which never intersect. Likewise, I felt that my life was running parallel with some of my interlocutors' lives. I often explained this to the interlocutors, sometimes strategically mobilizing my own story of gut trouble, by stating that I recognized their feelings, but that I was curious to know what it meant to them and why they felt that way. This helped me in my attempt to balance the merits of mutual understanding with efforts to continue exploring their lived experiences without simply appearing as "a foolish person asking silly questions" (Munthali, 2001, p. 114); a common challenge for ethnographers working "at home". Acknowledging recognition while explicitly suspending claims to full understanding formed part of an ongoing negotiation of homeliness in my fieldwork.

In another article, Meinert, Grøn, and I have analyzed the lived, embodied experience of IBS as being characterized by shifts between the gut appearing as "me", "not-me", and "not-not-me" (2022). Our analysis was inspired by Willerslev's analysis of hunting practices in Siberia (2004). Willerslev explains that the Yukaghir hunters keep a "double perspective": They strategically assume the animals' point of view while maintaining their own perspectives as hunters. By making themselves move, smell, and look in certain ways, they mimic the animals, yet they never forget their intention to kill them. In this way, they are not animals, but at the same time, they are not *not* animals. In line with this, my fieldwork could be characterized by a double perspective of being not *not* "at home". When I interviewed Natasha, I sometimes felt and acted like being "at home" (e.g., I knew the language, the places she spoke about, and I could relate to her everyday experiences of gut trouble), and at other times "not at home" (e.g., I had never been to her house before and lived quite a different life). When I visited Natasha, I felt

that I was in the "field". Then, gradually, the further I drove away from her house and towards my own apartment, the more I felt that I left the "field" to go "home". When I was physically "at home", I did not perceive myself to be on fieldwork, but nevertheless, I was not *not* on fieldwork, either, as I would sometimes make field observations during my "regular life". Nordquest (2007) has referred to this peculiar situation as a process of "switching hats", arguing that "going on fieldwork" can be understood as a shift in one's mindset. With inspiration from Willerslev (2004), I would rather say that I was wearing different hats at the same time, balancing between states of homeliness and unhomeliness that were always implicated in each other. Turning to the next empirical example, I will elaborate on this state of in-betweenness and how the unfamiliar may appear within the familiar.

On an unconscious woman and the intertwining of familiar and unfamiliar

While conducting fieldwork as a postdoc employed at the Prehospital EMS, I sometimes joined emergency vehicles that were driving around in my hometown. One afternoon in May 2023, I was sitting in the back seat of a physician-staffed rapid response vehicle. I had never been inside such a car before or even interacted with one. The sirens were on, and it was difficult for me to hear where we were going, to whom, and what had happened. However, I grasped some of the short messages that the medical doctor and paramedic read aloud from the screen between them: "A woman in a blue car", "allergic reaction", "unconscious", "known heart disease", "does not respond to pain stimulation". These were messages from the Emergency Medical Coordination Center, which had received the call to 1-1-2 (the national emergency helpline) and dispatched an ambulance and the rapid response vehicle in which we were sitting. I looked out of the window and suddenly recognized the suburban neighborhood. We were close to the primary school that I attended, and many of my classmates used to live in this area. When I went to play with them after school, we would stroll the sidewalks with our colorful school bags. While chatting about everything and nothing in particular, we would pass one brick house after another; one well-trimmed garden after the other. Sometimes, we would play a game of not stepping on the lines between the sidewalk tiles. I remember my time in the neighborhood as enjoyable; the streets felt nice and quiet, and there was an atmosphere of comfortable slowness.

On this sunny afternoon in 2023, the quiet atmosphere is contrasted by the flashing blue lights and sirens of the rapid response vehicle and the ambulance that arrived just before us. The two men from the ambulance lift a middle-aged woman out of a blue car. Her body hangs limply down, and white foam appears from her mouth. Her face is as grey as the sidewalk that they carefully place her on. The doctor from the rapid response vehicle kneels, shakes the woman by her shoulders, and shouts her name. The woman does not move, and her eyes are closed. Two women stand beside her hugging each other. They have tears in their eyes and stare anxiously at the unconscious woman whom they seem to know. One of the women has a stethoscope around her neck. She explains that the woman suddenly got sick when they were driving home from a flower shop. She talked about a burning sensation and wondered whether she could have touched some poisonous plant. Then, she suddenly passed out, and the woman driving the car quickly called 1-1-2.

While the professionals unpack medical equipment and prepare a stretcher, a few people pass by, keeping distance while directing curious gazes towards the two bright yellow emergency vehicles. I imagine where those people may be going. Some young boys look as if they are on their way home from school. A young man with a child in a cargo bike drives the other way. Perhaps he has picked up his son from the after-school center where two of my best friends used to go. I walked this stretch of sidewalk with one of those friends last summer. It was a nostalgic, but not exactly cozy walk. Her father had just died unexpectedly, much too early. It was a shock for everyone. As we walked past all the places in the neighborhood where we grew up and got to know each other, we talked about our memories of him.

I look at the health professionals, who are measuring the unconscious woman's blood pressure. It appears to be very low. They pull her shirt to the sides and attach wires to her chest. The wires are connected to a machine that measures her heart rhythms. The professionals work together to get the woman up on the stretcher and into the ambulance. They ask me to carry some equipment, and I consider where to place myself. Since I am with the professionals, I want to be close to them and the patient rather than the two women who stand around three meters away from the ambulance. At the same time, I do not want to be in the way in the ambulance in this critical situation. I end up standing around one meter from the open ambulance door. The paramedic explains to me that they are giving the woman a dose of adrenalin. I can see how she slowly opens her eyes. She looks confused and gradually begins to answer the questions posed to her by the doctor. She says that she feels nauseous and dizzy. Three of the health

professionals are in the ambulance, examining the sick woman. A lot of things are going on at the same time. They check her heart rate, measure her blood pressure, take notes to the medical record, and press down her stomach to check for internal bleeding. I look towards the two women, who are still standing on the sidewalk a couple of meters away, talking about the situation. One of them says: "It's lucky that we are so close to a hospital and that the ambulance arrived so quickly." The other woman agrees. A third woman has appeared from a nearby garden, asking what has happened. I cannot help telling them that the woman in the ambulance has opened her eyes. I know that it is not my responsibility, but it feels like an obvious thing to do.

This example illustrates how fieldworks conducted in healthcare settings particularly activate the researcher's own body, morality, and biography (Reis, 1998; Zaman, 2008; Larsen & Schwennesen, 2024). By telling the women that the patient had opened her eyes, I acted on my moral involvement in the situation. I momentarily stepped into an intermediary role, drawing on my sense of being "at home" with both the professionals and the bystanders. In the situation, I felt as if different worlds met: The stretch of sidewalk that I associated with my childhood, and the prehospital world of ambulances and rapid response vehicles in which my everyday work life unfolded. In Rosa's terms, this stretch of sidewalk had been "adaptively transformed" (Rosa, 2019) to appear as a homely place for me. I felt connected to it, and it made me recall memories of the place. However, on this day in May 2023, it transformed into a scene of accident (in Danish: "skadessted"), as formulated in the medical record. Centering on the unconscious woman, the sidewalk was suddenly a (temporary) caring place where health professionals worked, and people around the unconscious woman did their best to care for her and each other. It no longer appeared as an ordinary stretch of sidewalk that people would simply pass, but as a place for medical equipment, work plans, hugs, and worries. In this situation, my partial at-homeness in the prehospital organization functioned as a resource that allowed me to move quite freely, to be asked to carry equipment, to receive informal explanations from the professionals, and to take notes about their procedures and collaboration that I would never have noticed if I had simply passed the scene in my everyday life. Although both the street and the rapid response vehicle were familiar to me, the place appeared unhomely and strange. As a "home", the street was not a place that belonged to me or that I could control. It felt as if it was taking multiple shapes at the same time. I was not *not* home, but I was not completely "at home" either. In line with Waldenfels' thinking (2011), the unfamiliar arose within that which was otherwise familiar, and the familiar emerged in the middle of the unfamiliar. In other words, strangeness and

unfamiliarity did not emerge from me keeping a distance to what I was studying; it emerged from within the homely and familiar.

There was something uncanny about the experience of conducting this fieldwork "at home". Driving with an emergency vehicle, I had no impact on where in the city I would go, and while we were on our way, I could not always see where we were going. This meant that I would often feel thrown into a place or situation. I might suddenly find myself in a place that appeared foreign to me, to help a person I had never seen before, but I might as well encounter my own grandmother. At one point during fieldwork, this uncanniness and collapse of the "field" and my "home" was epitomized in a dream that woke me up: I dreamt that I was in a huge venue, waiting for some show to begin when I suddenly heard someone shouting for help. People were asking around for someone familiar with resuscitation. In the dream, I rushed to help, feeling proud that I knew about emergency care and had recently taken a mandatory first aid course. I kneeled beside a person who was lying on the floor, and began the routines I had learned, pushing down rhythmically on the chest while humming Queen's "Another One Bites the Dust" inside my head. I had been doing it for a while when someone asked if I realized who the person was. Only at that point, I saw that it was my father.

Concluding discussion

In this article, I have revisited the concept of medical anthropology "at home". Drawing on ethnographic fieldwork conducted in personally/professionally familiar settings, I have argued for understanding being "at home" as a situational and relational condition that shapes ethnographic attention and knowledge production about health, illness, and care.

Empirically, I have drawn on two fieldwork examples: one from my PhD research among people diagnosed with IBS, and one from my postdoctoral research in the acute healthcare system. These fieldwork situations are local, yet entangled with global contemporary healthcare. Conditions such as IBS are defined through globally circulating biomedical categories, diagnostic criteria, and treatment guidelines, while acute care systems are structured through organizational models that travel across national contexts. In this way, doing medical anthropology "at home" does not mean studying bounded local worlds, but engaging with glocal configurations. The two fieldwork examples illustrate that at-homeness is not a given, even when research is conducted in settings that initially appear familiar. In the case of Natasha, shared language, norms, and everyday references facilitated

resonance and trust, enabling intimate conversations about gut trouble. At the same time, these shared points of reference did not erase difference, but co-existed with divergent life trajectories, embodied experiences, and social positions. The prehospital case, by contrast, exemplifies how familiar places such as a childhood neighborhood may suddenly appear transformed and unhomely when it becomes a site of emergency care. Across both cases, being "at home" appeared not as a stable position but as characterized by shifts between feeling and acting like being "at home", "not at home", and "not *not* at home".

Thinking with Rosa's phenomenologically inspired conceptualization of "home" as a resonant relationship to a segment of world (2019), I have suggested that being "at home" emerges through processes of adaptive transformation: A place may feel homely in one situation and unhomely in another, or even both simultaneously. Waldenfels' phenomenology of the alien (2011) further illuminates how experiences of otherness may arise from within the familiar. As exemplified in the prehospital case, homeliness and otherness are not opposing states; they may co-exist and intertwine. Taken together, my analyses support a relational, non-dichotomous understanding of medical anthropology "at home" that foregrounds the conditions that shape what can be noticed, articulated, and known in ethnographic studies of health, illness, and care.

Towards a relational understanding of medical anthropology "at home"

At the turn of the millennium, anthropologists debated the concept of medical anthropology "at home" in light of broader concerns about the discipline's future. Some questioned whether research conducted in the anthropologist's own society would replace radical encounters with alterity (Peirano, 1998), while others worried about "home blindness" when working as an "insider" (Van Ginkel, 1998). Today, medical anthropology "at home" has demonstrated its viability, e.g., in the face of the COVID-19 pandemic that urged studies of health and illness in socio-cultural contexts but restricted travels to distant field sites (Logan et al., 2023). Supporting calls for a more inclusive discipline in which diverse methodologies and field sites can be recognized as "anthropological enough" (Logan et al., 2023), I do not suggest discarding the notion of "at home", nor to stop discussions of key anthropological concepts such as "distance", "field", or "home". Rather, I extend earlier work that emphasizes that "home" is more than a geographical place, and that insider and outsider positions are partial and shifting (Reis, 1998; Larsen & Schwennesen,

2024; Caronia, 2018; Tsuda, 2015; Zhao, 2017; Bilgen & Fábos, 2024; Madden, 1999). I do so by proposing a relational understanding of being "at home". By this, I mean an understanding of "at home" as a situational condition that emerges through negotiation in concrete interactions and is constituted through entangled relationships of "own" and "alien", "familiar" and "unfamiliar", "homeliness" and "otherness". In this understanding, medical anthropology "at home" is not defined by contrast to what it is not (i.e., medical anthropology "abroad"), but by attention to the relational dynamics through which "home" and "not home" are continuously produced, unsettled, and reconfigured in practice.

Approached in this way, "at home" is neither a background condition that precedes fieldwork nor a stable positional attribute that grants privileged access or threatens analytical distance. Instead, it appears as a situational achievement that may emerge, falter, or transform as researchers and interlocutors engage with one another, with places, and with embodied experiences of health, illness, and care. This relational understanding allows us to move beyond binary oppositions between proximity and distance or familiarity and estrangement, and to focus instead on how these dimensions are co-produced in practice, with consequences for what can be sensed, articulated, and known. By conceptualizing home as a resonant relationship (Rosa, 2019) and foregrounding the intertwining of the own and the alien (Waldenfels, 2011), the article reframes earlier concerns about "home blindness" and loss of alterity. Rather than treating proximity as a methodological and analytical obstacle, it shows how alterity may appear not despite, but from within, fieldwork conducted "at home".

Implications for health research and healthcare

The analysis presented in this article has potential implications beyond anthropological debates about ethnographic knowledge production. It highlights the importance of not taking homeliness for granted in either health research or healthcare practice. As healthcare increasingly moves beyond clinical institutions and into citizens' homes and everyday settings through home-based, mobile, and community-centered services, questions about homeliness become more salient. The current Danish political focus on "proximity care" (Carstensen et al., 2025) constitutes a response to rising healthcare demands, workforce shortages, and fragmentation that challenge healthcare systems across Europe, yet the ways in which these transnational health challenges are lived and managed differ. Situated at the intersection of global healthcare rationalities and local everyday worlds,

ethnographic studies can produce knowledge about the cultural specificities of how places are adaptively transformed to both be homes and caring places. As my empirical cases indicate, neither private homes nor public spaces automatically function as caring places, nor do they necessarily remain homely once mobilized for care.

This concluding perspective invites further inquiry into how shifts between homeliness and otherness characterize patient experiences (e.g., of bodies and everyday lives that, with the onset of illness, suddenly appear unfamiliar), and shape care relations and organizational practices. For such inquiries, this article offers a conceptual vocabulary for analyzing and reflecting upon matters of homeliness and otherness that are essential to the understanding of health, illness, and care.

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