CARE/PLACE
Unsettling place in healthcare

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Zorg/Plaats
Ontregelen plaats in de zorg

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"To write is to struggle and resist; to write is to become; to write is to draw a map: 'I am a cartographer'."
Gilles Deleuze, Foucault (1986)[1]

1 Published by Continuum.

Chapter 1

Introduction:
Placing care, opening up place

A Place of Birth

The town where I was born began its life as a Roman fort in the 1st century AD. It was built under emperor Tiberius as part of a fortification system along the river Danube,[2] which protected the Roman provinces of Moesia from northern invasion. The reason this spot was fortified and given a name (they called it *Almus*) was because it lay on the banks of the Danube – Europe's second longest river and once upon a time the long-standing frontier of the Roman Empire. Today, as back then, the Danube is the town's most significant attribute and its most revered characteristic. The harbor, the beach, and the fishermen's boats – none of these would exist without the river. Every postcard, every official building, and every locally produced bottle of beer depicts the blue waves of the Danube. As a child, I would drag my index finger over the map and follow the blue line west, until it stopped somewhere far away, in a place called Black Forest. I knew, just as every other child and adult in my town, that the Danube originates in the mountains of Germany; that it flows southeast for 2850 kilometers, passing through 10 countries; and that it is the most important and beautiful river in the world.

For a long time, I imagined its origin location to be mysterious and steeped in black mist, high and impenetrable among mountain ridges, where foxes and deer hide behind evergreen shrubs. In my childhood imagination, it did not seem like a place one may *visit*. And yet, it is. The origin of the Danube is a fascinating story about care[3] and place: about how places are made and become, the efforts and affect of placemaking and the care that underpins this process. Nowadays, the Danube's origin basin is a tourist attraction in the German town Donaueschingen, in the state of Baden-Württemberg. The town lies just east of the confluence of two rivers – the Brigach and the Breg, which are the main source tributaries of the Danube. The source of a third, tiny stream joining this confluence – Donaubach, conveniently located in the center of town, is considered today the source of the Danube. Called *Donauquelle*, this karst spring is modeled into a pool, overlooked by two statues, depicting a mother and her daughter the Danube, being shown the way. Tourists gather around the iron balcony above the pool, many throwing a coin in the basin or taking selfies. No

2 This fortification system is known today as Limes Moesiae and includes all forts between Panonia (present day Hungary) and the Black Sea (cf. Wacher 2002).

3 I would like to distinguish the use of 'care' in this dissertation from healthcare systems and policies, which I will refer to as healthcare.

deer or foxes in sight. And yet, the location of the Danube's origins may not be here at all. Hydrologically the source of the river Breg, being the larger of the two formative streams, is also the origin of the Danube (de Volkskrant 2004). Breg's source is located near another small town, called Furtwangen. Beginning in the 1950s, there was an active rivalry between the municipalities of Donaueschingen and Furtwangen for the honor of being the 'official' source town. Following investigations on the matter, city council meetings and lobbying, the Ministry of the Interior proclaimed Donauschingen 'the winner' in 1981. Furtwangen could no longer be labeled Donauquelle in official maps (Everke 1995). Yet, in 1982 the former minister for agriculture and forestry wrote: "*Getting back to the issue regarding the source of the Danube, I can once again confirm that the so-called source of the Danube in Donaueschingen is certainly not the real source of the river Danube, if analysed with geographical and hydrological criteria*." (Badische Zeitung 2002). This seems to matter little to the throngs of visitors in Donaueschingen, where the tiny water pool reflects the copper shine of many coins. The river's place of birth *matters differently* to these visitors, to the officials, to hydrologists, to the towns of Donauschingen and Furtwangen, to the people in the small Bulgarian town and to me. This is why this birthplace story is not about the one true place of origin of the Danube, but about small towns, local governments, about history and identity, and about childhood memories. This is also why I chose to open the book with this story – it shows how place is a matter of science, of politics, of commerce, of materialities, and of imagination. These are the themes and the questions at stake in this dissertation. It will take the reader to many different places in an attempt to open up questions about how places are produced, configured and enacted together with care. In this introduction I tell the stories of two birthplaces – a hydrological origin and city hospitals – in order to make these themes tangible, real and welcome the reader into the project of *mapping care differently*.

The second birthplace story is a topic of raw, affective care. In the Netherlands the place of birth recorded in a child's passport may be of considerable importance. Some parents go to great lengths to give birth in a hospital, located in the municipality of their choice. Amsterdam is a case in point. The city's obstetrics departments are permanently full, due to hospital closures, concentration of specialized departments and personnel shortages (NRC 2019), meaning that many women are redirected to hospitals in nearby towns. The result: a different place of birth in the baby's passport and disappointed parents. Since the Sloter-

vaart medical centre in Amsterdam West closed in 2018, more and more women are redirected to Amstelveen, a few kilometres south of Amsterdam. Receiving many reluctant parents, who had expected to welcome Amsterdammertjes[4] into the world, the hospital Amstelland in Amstelveen even considered turning some of its delivery rooms into official Amsterdam territory, in order to deliver "good care" (Het Parool 2017a). In 2017, the newspaper Het Parool (2017b) spoke to Amsterdam parents, who have had to deliver their child in a different city. A mother of twins recounted how having her two daughters in Zaandam[5], still pains her: "*Every time they [her daughters] have to explain that they were not born in Amsterdam. I was born in Haarlem, but from the moment I set foot in Amsterdam, I knew I belonged here. When I walk through the Jordaan and see the Westerkerk tower over the roofs, I am overjoyed. […] I know it is just a formality, that it is just a piece of paper, but it is gnawing."*

This birthplace story is not simply a matter of emotions, but rather it is strongly related to healthcare policies and their underlying values; places of care are not 'out there' but come to be (partly) through governance actions. The RIVM[6] concluded that the number of acute obstetrics departments in Dutch hospitals has been steadily decreasing (RIVM 2019a). In 2014 the Netherlands had 87 such departments, today there are 75. This is a result of a lack of personnel, but more importantly, of a spatial reorganization policy that sees the concentration of specialized services as a way to provide better care. The pattern follows the merger of hospitals into bigger entities, which then concentrate their services in response to an overall personnel shortage, to save money and to strengthen their market position (Postma and Roos 2016). This concentration logic sees the place of care as an efficiency issue (Pollitt 2011). For instance, the acute obstetrics department in Hoofddorp was closed in 2018 (RIVM 2019b), yet the one in Haarlem was expanded to a 24-hour, luxurious obstetrics center[7]. Instead of having medical specialists, operation rooms, intensive care units and

4 From Dutch: Amsterdam babies.

5 A city less than 20 kilometers north of Amsterdam.

6 From Dutch: National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu)

7 This efficiency logic does not always go unchallenged. For example, when the hospital Sint Franciscus Gasthuis (after a merger with Vlietland) announced the concentration of its obstetrics department in Rotterdam, the municipalities of Schiedam, Vlaardingen, Maassluis and Niesewaard were dead set against the plan, which meant closing the Schiedam obstetrics department. Municipal officials, insurance companies and online petitions sprung up against the hospital. The alderman of Schiedam said: *"We cannot determine what the hospital does, but we do make a final appeal to the board of directors. We agree that the quality of care is paramount, but the distribution of care must have regional support in the region and this is not the case now."* (AD 2016).

labs in two locations, these resources are now concentrated in one place. Next to financial efficiency, hospital groups attempt to consolidate personnel. A national problem, the shortage of medical specialists is felt particularly strongly in the provinces, as doctors are unlikely to apply for positions in regional hospitals (Batenburg et al. 2018, NRC 2018). In this context, an attempt to concentrate care services, especially in a relatively small country as the Netherlands, is not surprising. However, the discussions around this issue are always framed within two points: (financial) efficiency and quality of care. The question goes more or less like this: *Does concentrating care impact its quality – and does it improve efficiency?* For example, closing the obstetrics department in Lelystad means that women from Urk will have to travel further in case of emergencies. An obstetrics specialist quote puts the issue bluntly in the NRC newspaper (2019): "*Sometimes we only have the choice: delivering at home or on the highway*." Stories about delivery complications are considered against geographical distances, in an attempt to calculate if these could have been avoided. Yet, geographical distances are not all that matters – to some parents delivering just a few kilometers north or south of 'their' city is a lifelong struggle. This has to do with the idea of what is the "right place" (Gieryn 2006) for care. The parents do not talk about quality of care, yet they 'care' deeply about *where* their children are born. This is not to say that quality of care does not matter, but rather than more than one nature of care exists simultaneously (Mol 2002). Care and place are linked not only through geography, but through affective emotions, identity and imagination and must therefore be theorized *together*. Stories about passport names, geographical distances, re-placement of care services, and concentration of care are all narratives of care in and for place. These narratives have effects, they do not simply exist, but are based in particular ontologies about the world, about how we (should) do healthcare and about what is good or bad care.

Reorganizing national healthcare services spatially is happening not only in the Netherlands. The United Kingdom's National Health Service has been concentrating services, often working from assumptions about location and care that emphasize efficiency and medical outcomes only. Take for example the centralization of acute stroke care in London in 2010. 30 local hospital units receiving acute stroke cases were downsized to 8 hyper-acute stroke units (HASU) across the British capital. A comparative study of before and after patient outcomes (Hunter et al. 2013) concluded that "a centralized model for acute stroke care across an entire metropolitan city appears to have reduced mortality for a

reduced cost per patient, predominately as a result of reduced hospital length of stay." In a letter to BMJ (2014) emeritus professor of medicine John Yudkin warned against using such studies simplistically, urging scientific rigor in assessing service centralization policies. Evaluating stroke care in the new 8 units tells us little about the quality of neurological care across London. Is the 8 months life extension, achieved by these hyper-acute units 'compensated for' by a decreased quality in other units? Yudkin also asked that we consider the impact on care for stroke patients who "might want to balance benefits of about 8 months longer quality life expectancy against greater distance from their family during admission." The benefits of locating care are more complex than strategically placing specialized personnel and state-of-the-art medical technologies here or there. A stroke patient may want to stay closer to their family; an elderly woman seems to care much more about dying in 'her' town than she cares about the quality of care she receives; and many parents-to-be care greatly about where their child will be born. So *how should we care about the place of care*?

This thesis will show that providing good care requires much more than a geographical calculation or an efficiency score. Understanding both care and place in singular terms is not enough: care should be conceived much more broadly than medical care, just as place should be seen as denoting something richer and more complex than a simple location on the map. As we have seen above, one may care for patients, but also about their home, their city, a label in a passport, living close to a hospital, officially belonging somewhere, and dying in a place of their choice. Care thus conceived is rooted in place; it cannot be extrapolated onto another location, because place *matters* in more ways than one. A place of birth is where mother and child are cared for and provided with all the necessary medical knowledge that they require. Yet it is also a place that one takes with them forever, it is translated into letters in one's passport, becoming a part of their life story. A place of birth may also be a place of interest, a tourist attraction, and a location that has claimed an event, which may mean caring for a town's status and development. The point is: places matter. The town where I was born came into existence, *because* of the river; Donauschingen welcomes many more tourists than Furtwagen, *because* it was officially named the origin place of the Danube; some parents want to give birth in a particular town, *because* of a connection between place and identity; and caring about patient outcomes is not the same as caring for stroke patients. As healthcare services not only in the Netherlands, but in all of Europe are in the midst of spatial reorganization

(Pollitt 2011) the question of place is pertinent and in need of conceptualization. We need a better understanding of how place matters for care.

Where is Place in Healthcare?

The answer to this question is both simple and complex. Place is everywhere in healthcare, every care practice happens *somewhere*, yet the role of place is often taken for granted and rarely problematized (Martin et al. 2015, Oudshoorn 2011, Oldenhof et al. 2016, Lorne et al. 2019, Frederick et al. 2019), both in practice and research. This is important, as "if our researchers place little emphasis on place, then it follows that policy makers will also under-esteem place-related factors" (Frederick et al. 2019). The stories about birthplaces, stroke patients and closing hospitals show that when places are not theorized, we miss out on what others care about, fight about, hope for and imagine. Care is in need of conceptual placing.

Healthcare practices are rarely considered as practices of placemaking for care. We know that places engender and exude affective caring, as is the case with the origins of the Danube or recording a particular place of birth. The former example also shows us that places are not a priori there; they must be made, and much work needs to be done for a place to *become* the "right place" for the job (Gieryn 2006). Finally, we know that centralization (such as cancer care) and de-centralization policies (such as youth and elderly care) in the healthcare field are built upon and rely on dis-placements and re-placements of care services, putting the issue of place squarely into the center of healthcare (Pollitt, 2011). Authors who have drawn attention to the place of care (Milligan 2001) call for further conceptualization and consideration of the consequences for policy (Pollitt 2011, 2012), governance (Oldenhof et al. 2016), and patients (Langstrup 2013). This dissertation builds on the work of these scholars and continues the project of placing care by carefully opening up and utilizing the concept of place.

The necessity to do this is threefold. Firstly, in terms of healthcare policy, healthcare practices must be acted upon with an attention to care spatialities as *places*. Place is a richer notion than the location of care, care cannot be re-placed and dis-placed without consequences. As Oldenhof et al. (2016) have shown, once care is replaced, the process of care also changes, producing different ideas about what 'good care' is and how/who/where should do it. Place of care must become more than a commonsense word that denotes geographical coordinates

and become *a concept*, through which policy makers and professionals understand their work.

Secondly, in terms of theory, there is an urgency to conceptualize care place and give it analytical strength. *How* one formulates an object of study is crucial for the theoretical and empirical claims one makes about that object of study. If we understand place of care as its physical location, research in the healthcare field will be conducted through this assumption, missing out valuable sociological perspectives (Jones et al. 2019). Doreen Massey, the geographer who championed place relentlessly and made large contributions to its development in human geography, demonstrated this point of defining place with a groundbreaking paper on the British spatial division of labor. The paper (1979) attacked dominant policy orthodoxies that framed neoliberal divisions of labor as 'regional' problems. As the title of the article *In what sense a regional problem?* shows, Massey insisted on conceptualizing space and place, arguing that the actions one takes are dependent on our understanding of the problem. Following her call that 'geography matters', the value of the 'remapping' exercise in this dissertation lies with the conceptualization of care and place together. This move reveals a multiplicity of care and place, allowing for a relational approach that illuminates care in place as ecology.

Thirdly, in terms of caring as mundane practice of 'fixing' what needs fixing (Tronto 2013), there is an urgency to connect different care worlds, by which I mean not only in the healthcare field, but rather care as a *practice of relating* to others' concerns (Puig de la Bellacasa 2017). The examples of care places in this introduction, as well as in the chapters, are purposefully divergent – a river's origin and de-centralization of governance practices have little in common at first glance. Yet, these unrelated worlds – of hydrology, policy, politics, etc. come together in the affective place of caring. The following chapters tell stories about healthcare practices and moving care, but also about the 'cares' of migrant women, attempting to connect to their family back home, for instance. They will describe technologies of health innovation, but will also talk about cleaning a dusty floor in a living lab as a way of 'caring' for one's career and connecting a phone to a camera as an act of caring for an empty place, which may or may not be used as a safe haven for abandoned infants. We need to bring these worlds together and talk about caring for, in and through place as an affective practice.

Opening up Place with Care

My goal is to open up the relationship between care and place, in order to explore ways of using place as an analytical tool when studying the spatial in healthcare and beyond. The book charts different ways of conceptualizing places of care, as opposed to devising all-encompassing rules or uncovering 'truths.' These conceptualizations, albeit both empirically and theoretically diverse, are all rooted in a few basic assumptions about the world and the nature of knowledge, which I take from science and technology studies (STS) and human geography. Firstly, I think of places as relational and co-constructed in relationships with human and non-human actors (Country et al. 2015, Hetherington and Law 2002). Secondly, and as a consequence of the first point, I see places are unfixed and "on the move" (Massey 1991), constituting a "spatio-temporal event" (Massey 2005: 131) of an assembled hybridity, while also acknowledging that these are certainly inherently material (Malpas 2012). Thirdly, I take the view that places are multiple and this multiplicity (Mol 2002) is where issues of politics, morality and power can be located and interrogated.

In what follows, I further situate the theoretical underpinnings of my work and chart its influences. The emerging sketch, as well as the following chapters, is an attempt to open up place with care, by which I mean not only delving into the concept of place and mobilizing it in the field of healthcare, but also theorizing place *together with care*. I follow Doreen Massey (1997) in her insistence that the social and the spatial need to be conceptualized together. This is an important point to keep in mind, as this dissertation does not focus on place only, but on places of care in particular. While much attention will be paid to the concept of place, the focus will always be on its productive relationship with care practices. Opening up these two concepts together requires an introduction to each one, as well as an explanation of how I employ them.

The story of place as a concept of analysis begins in the field of human geography. Conceptualizing place has been of interest to geographers for a long time, yet even within its 'home discipline', it took some time before the term was problematized and its meaning deepened, possibly because of the commonsense usage of the word (Cresswell 2004). Place was often equated with space or location, a spot on the map. Yet, propelled by authors like Yi-Fu Tuan (1977), Doreen Massey (1991, 1997, 2005), and philosopher Edward Casey (2001), a place debate emerged. The connection with care was pertinent from the very beginning. One of the first constructivist definitions of place, supplied by Tuan

(1977) offered that place is "a field of care". He began a discussion on place as "lived space", pointing to the connection people develop with their environments. Caring for and experiencing environments meaningfully is what makes space place, what gives a room it's place-ness: a poster, a photograph, the way an old pullover hangs over the back of a chair, the smell of soap or a perfume. When these elements come together, producing meaning through our environments, we are emplaced.

Massey's work in developing the concept further is perhaps the most consequential for this analysis. She argued against limiting the notion of place to simple location and used it as a critical tool in her work on gender (1994), spatial division of labor in the countryside (1984), development and globalization (1991). This work pushed place to work as a relational and open concept at a moment when the idea of place was often associated with nostalgia, inertia, the past, roots[8]. Massey's contribution was crucial for fueling debates on place and opening the concept up for theorizing. She argued that places might be understood as "porous networks of social relations" (1994: 121) and that they are not static, but rather "on the move" (1991) and continuously being assembled. This dynamic view and insistence on relationality put place on the map as a concept for social analysis.

In STS, place has been theorized in relation to science and knowledge making practices (Amsterdamska 2007, Henke and Gieryn 2007). This is hardly surprising, as the field was born and developed through a problematization of the laboratory as a place of 'truth' making (Latour and Woolgar 1986, Knorr-Cetina 1992, Shapin 1994, Livingstone 2003, cf. Bartram 2019). Tom Gieryn has mounted the most thorough investigation of place as a social actor, considering the role, nature and consequences of buildings (2002), and focusing on how certain places become "the right place(s)" for science (but also for care and healing, see Carey 2014). His example of the way the Chicago School used both lab and field strategically, in order to legitimate their sociological findings considered place to be a main actor in social processes. The 'where' of doing science matters for the kind of science (valid, less valid, not science, hard science, etc.) that is being produced; a point further developed by Henke (2000). Henke's research on farm advisers demonstrated that different types of knowledge are always associated with different types of places. Labs produce 'objective' knowledge,

8 This notion is very strong in Heidegger's work (2005).

while farm fields produce 'field knowledge'. The distinction between laboratory and field knowledge produces power dynamics and inequalities, which have real consequences for what is done in practice. Another point of attention has been the metaphorical use of the term laboratory in sociology and STS; Guggenheim (2012) shows how the term laboratory has lost meaning, made to denote any place of scientific work. His critical argument against this "laboratization" has demonstrated the complexity of places as knowledge production sites. Furthermore, STS have explored the historical development of places for science: Shaping (1988) has exemplified the importance of place for an analysis of experiments in 18th century Europe. He showed that for an experiment to be considered successful, it had to be witnessed by particular audiences (of gentlemen); it needed to be seen, communicated, and made visible through demonstration. Nowadays, on the contrary, 'true' knowledge is produced behind locked doors in "the ivory towers" (Calon 2009: 46) of scientifically controlled environments. In order to be believable, research has become extremely secluded. In Callon's words: "This irresistible evolution will be carried to its conclusion by decades of the Cold War, in the course of which the alliance between scientists and the military will transform seclusion into isolation." (ibid.) 'Real' science can only take place within the purity and control of isolated laboratories. These insights reveal that place in STS has been considered overwhelmingly in relation to science, knowledge and truth. In the book "*Truth-Spots: How places make people believe*", Gieryn emphasized the strong link between 'truth' and place (2018), by showing how people believe certain facts as a result of their particular placing (he opens his book with a wonderful reflective vignette on the oracle of Delphi). Truth, Gieryn writes, may be the daughter of time, but it is also the son of place (ibid.)

Recently, debates in the field of the sociology of health and illness have started to make use of this relational concept of place, calling for more attention to its productive relationship with care. Martin et al. (2015) opened up this theme by focusing on the architecture of hospitals, in particular. They argued that an attention to the design of care buildings is fruitful for understanding how care practices are done in place. Another debate in healthcare research that takes place seriously emphasizes the materialities of care (Buse et al. 2018, cf. van Hout et al. 2015) by teasing out and exploring how material culture matters in healthcare contexts. Scholars have done this by focusing, for instance, on beds as prescriptive design for elderly care, showing how beds reflect wider changes in healthcare (Nettleton et al. 2019) or on dressing patients with dementia as a

form of identity work, done through the dress material (Buse and Twigg 2013). Care, in this sense, is located in the act of dressing. The debate has also done valuable work in explicitly relating place to materialities, as in the work of Lovatt (2018), who traced the process of 'becoming at home' at a nursing home through a focus on objects.

These debates bring together an interest in places as social actors on the one hand, and a concern for care as an ecological system on the other. The concept of care is a difficult one to tackle; it has been called "a slippery word" (Martin, Myers and Viseu 2015). In STS debates about care are flourishing, with contributions that deepen and problematize the meanings attached to the term (Mol 2008; Mol et al. 2010; Puig de la Bellacasa 2011, 2017; Murphy 2015). Following the feminist tradition of opening the 'black box' of care and problematizing its nature, Mol et al. (2010) argued for the need to understand care in practice. Care, for them, is not only an abstract sensibility, and idea and a discourse, but also a doing: "Someone has to harvest or slaughter; someone has to milk; someone has to cook; someone has to build and do the carpentry." (p. 7) There is a need to attend to those practices; otherwise they might be overlooked, forgotten, "eroded" (ibid.). Someone has to do "the dirty work" (Andal 2000) of caring for old, soiled, weak bodies; clean messy rooms and scrub filthy pots. Caring is not always pleasant, it often is a job, and it is globally distributed through particular politico-economic structures (Parreñas 2001). Parreñas's ethnographic work on Filipina migrant workers in Italy and the United States revealed their positioning as 'servants of globalization' within the neoliberal global economy; the structural forces that delineated financial streams also delineate and propel care steams, where certain people (women of color; Filipinas) performed caring for other people (white, American, Italian). Care may appear simple – it is about practices like washing bodies, cleaning pots and cooking, but it is also complex, because it is entwined with oppression, inequality, gender and power. Care is done through practices 'on the ground' and yet it is about living together in the same world, where inequalities are materialized in mundane acts.

The work of Puig de la Bellacasa (following Tronto 2013) and Murphy, in particular, were very valuable in structuring my own thinking about care. Puig de la Bellacasa sees care as ecology, which is inclusive of more than the human. This insight resonates with me, especially because of the mode of attention to objects that I worked with during this project. It furthermore extended the notion of care to other actors, questioning the very deeply engraved assumption that care

is human; an assumption that is clear in much theorizing in geography that takes place to denote space, made meaningful by/to humans. Murphy's work took up Puig de la Bellacasa's call for 'matters of care', arguing against a notion of care as a positive, noble feeling and instead, calling for a politics of 'unsettling' care, in order to "stir up and put into motion what is sedimented, while embracing the generativity of discomfort, critique, and non-innocence." (2015: 717) Answering this call for "stirring up", this dissertation's subtitle is a nod to the spirit of Murphy's work – 'unsettling' place in healthcare.

These debates on place and care form the theoretical base and ontological assumptions in this dissertation: place is an open, relationally produced, socially constructed, material concept, which is the product of the forming of assemblages. It is always co-produced with and within a field of social and material relations. Care is a broad concept, which is here employed both as an empirical base (investigations focusing on the field of healthcare) and an analytical sensibility of interconnectedness, especially in an attempt to decenter the human experience as the only valid one. Thinking of care as practice (Mol et al. 2010) is an important caveat as well, as it opens up the concept, making it a matter of concern: it matters who cares and how. And, importantly here, it matters who cares *where*. As the following chapters will show, care practices are done not only *in* place, but also *through* place.

A Methodology for Odd Places

This dissertation is based on an ethnographic methodological approach. As the goal was to understand the role of place in healthcare, the study design was open and explorative from the beginning. The initial pulse for delving into place came from observing a general trend toward re-placements and dis-placements in healthcare (Oldenhof et al. 2016), which meant that the research object – place in care – was much too big to tackle and challenging to delineate. After all, what is *not* a place of care?

Carving a research line through this all-encompassing theme required two types of effort. On the one hand, as an explorative study, the design needed to include a variety of place-cases. On the other hand, the methodology needed a focus, a more specific subtheme to serve as a binding element, bringing a diversity of care places together. This research line, which I dubbed 'odd places', developed naturally about a year into the PhD-project, subsequently guiding the choice of cases. This book presents five such cases: an island nursing home, a

foundling room, a living lab, temporary migrant dwellings in Italy, and a sensory reality cabin. This 'oddity' approach was beneficial in several ways. Following the STS methodological point that studying controversies is useful for understanding otherwise 'hidden' phenomena (Leydesdorff and Hellsten 2006, Collins and Pinch 1998) the focus on 'odd places' allowed me to look at outlier cases; care places, around which actors constructed different, sometimes conflicting, ideas about care. While I do not wish to imply that controversies are the same as odd places, understanding how such multiplicities work together (or not) invites a deeper and layered analysis of place. Chapter 3 is an example of the value of this approach, showing how place is maintained and feeds off of a controversy about care. The chapter discusses a foundling room, where ideas about care clash (care for the mother, care for the child, care for the law, etc.). Yet, the chapter shows how it is precisely the room's unclear status that allows its existence. The foundling room is certainly an 'odd place', not least because it problematizes the notion of care to begin with – is it care to abandon an infant anonymously?

Beyond controversies, I found the oddity approach helpful in other ways as well, since it acted as a magnifying glass for patterning placed care. Odd, out of the box, weird places of care showed how place matters; their idiosyncrasies made the role of place visible in ways that regular, accepted, common sense places could not. This is not to imply that there is something inherently weird or normal about places, since these are always in the making (by the public, by the researcher, by their materialities). However, the starting point for this 'weird' cases approach was that, although a hospital patient room is certainly a place of care, the small island case in chapter 2 is imbued with 'place-ness'. The ways, in which the assemblages of care on the island interacted, helped in presenting a clear argument about placed care. Certainly, this approach may be critiqued for cherry-picking cases where place matters greatly and making an argument about place in general. While this point is well taken, I argue that it is not consequential for my arguments here. Based on the explorative research design, I do not attempt to devise all-encompassing rules about placed care, but rather to examine possible ways of working with place as an analytical tool when studying healthcare practices, and spatial (re-)organizations in particular. This goal is much better served by exceptional, odd cases, where the place is curious, different, puzzling. This peculiarity clarifies the ways, in which space is imbued with place-ness; the characteristics of place becoming visible.

Finally, the oddity approach is a valuable methodological tool in terms of the ability to reflect on how the research object becomes, and is constructed in the course of the research. The oddities here acted as a catalyst, forcing me to *find* the place in these cases (cf. Ivanova 2017). A hospital is obviously a place of care, yet a foundling room is not. This inevitably raised the question *what is a place of care*? Such a question was especially necessary in this research design, because it is very easy – and alluring – to work with obvious assumptions about places of care; these would normally be hospitals, general practitioner practices, nursing homes. Yet, the design of this study requires questioning these basic assumptions and, further, working toward uncovering them. What is and is not a place of care is here teased out on a case-to-case basis, emphasizing the multiplicity of both terms and how we may work with/in this multiplicity. What is more, an oddity case must always be constructed as such by the researcher. For instance, chapter 4 makes an argument about placemaking for care by following the construction of a living lab, meant to test and develop assisted living environments for elderly residents. Choosing this case as an 'out-of-the-box' place of care is an act of making up a particular research object. How odd is the living lab in chapter 4? As a case study for placed care, it helps present an argument and point out the common assumptions we make about place and care. There is nothing inherently odd or strange about it; its status both as a place of care and as an odd place is constructed here for the purpose of showing how placemaking is done collaboratively and co-produced with care within imaginaries of futurism.

Taking this point further, I make use of these 'oddities' or what I have elsewhere called 'oddity contained' (Ivanova 2017) to examine and work with my (in-) ability to relate to the object of analysis. Verran's work and her concept of disconcertment[9] (2001) were very valuable in developing a particular sensibility to the odd, the not quite fitting, and the weird. While this is not explicit in the chapters, it may be traced through the dissertation as I attempt to stay within, and cherish, feelings of discomfort, examining my affective stance toward each case and its normativities.[10] The premise of odd cases works very well with a reflective approach, since, much like the argument that odd cases illuminate patterns of place, the disconcertment one feels when working with odd cases

9 Disconcertment, or epistemic disconcertment (Verran 2013), can be described as "a moment of existential panic – being suddenly caused to doubt what you know" (Verran and Christie 2013).

10 I have made a more explicit argument about working with 'resisting' research objects in a KWALON article (in Dutch), which is based on the foundling room case from chapter 3.

is very palpable, almost inescapable. Working with disconcertment propels an awareness of working with one's research object and allows for challenging easy assumptions about it, a point that will be further discussed in the book's conclusion.

More specifically in terms of methodology, I relied on an ethnographic sensibility and used the following data collection methods: observations, participant observation, semi-structured interviews, informal conversations, document analysis (including websites and emails in some cases) and an emphasis on reflexivity as an opportunity for analysis, which was done through field notes and personal observations. The number of semi-structured interviews varies dramatically between cases, as chapter 5 makes use of data gathered in the space of 9 years (this data was the subject of my bachelor and master theses and was supplemented and reanalyzed with place in mind), while chapter 2, for instance, is based on as few as 8 interviews (and much observations, immersion and document analysis). All interviews were transcribed verbatim and coded, based on a general concepts list, as well as concepts emerging with each data cycle. With the exception of chapter 5, the rest of the cases are all based on data, gathered between February 2015 and July 2019. Chapters 2, 3, and 4 are based on articles written together with my supervisors Iris Wallenburg and Roland Bal. In the research process of these articles we discussed the data frequently and worked on the argument development together. Chapter 5 makes use of data that I started collecting during my bachelors and on which both my bachelor (supervised by Dr. Herman Tak) and master (supervised by Dr. Hans de Kruijf and Prof. Dr. Ton Robben) theses are based.

Coming back to the empirical diversity of cases, each of these required different methodological efforts and strategies. For instance, chapter 2 – a case about the co-production of care and place on a small island – was done in a short period of time, making use of ethnographic immersion into this particular island's life, or its rhythm. Chapter 5, on the other hand, is the product of years of cyclical field engagement with the topic of migrant caregivers in Italy. The rest of the cases were done through frequent short field engagements, temporal snapshots, which I slowly built on. The common denominator for these cases is the effort to find the nature, meanings and implications of placed care. Where is care here? How does its place *matter*? Furthermore, all cases were approached with similar ethnographic sensitivity to detail, to the mundane and 'hidden' dimensions of place and placemaking, be it the normatively suggestive teddy

bear in the foundling room's white crib or the layer of dust in the room where the sensory reality Pod – the empirical subject of chapter 6 – was placed by the health managers, who attempted to incorporate it into everyday care practices. Another characteristic of the methodological strategy was an approach to objects as (social) actors (Latour 2005) that have political agency (Marres 2013). Materiality, more generally, was a point of emphasis in this project from the beginning stages, since an attention to place necessitates spotlighting materiality as a productive force of places (cf. Massey 2005).

A final point of methodological importance is this book's insistence on developing a conceptual, explorative argument, based on intense, well-chosen and revealing moments of engagements with the field. The emphasis here is on the strength of the conceptual arguments, offering a variety of ways to work with and map place in healthcare. In this sense, the following chapters do not attempt to reveal a 'truth' about the empirical nature of each case, but rather to use that nature as a base and a springboard toward conceptualizing placed care. The story of migrant caregivers, a foundling room, a living lab, an island's nursing home and a sensory reality Pod are simply different routes to that same goal.

The Red Thread[11]

These cases represent conceptualizations of place, analytical efforts to work with place and an explorative engagement with the term's multiplicity. The cases are all very different, and apart from being places where care is done, they have little in common empirically. Yet, I ask the reader to bear with me and read on, as she moves from place to place, because it is exactly this multiplicity of the nature of place that I work toward unveiling. The value of this diversity is in putting up five different places of care and asking: how can we understand the nature of their place-ness; how are these places enacted and imagined as actors in the social; what do they show, despite their differences, about place and care?

11 I use the notion of the 'red thread' to mean consistency of a narrative, which is not overtly explicit, but rather requires active following. In Swedish, Dutch and German, for instance, the expression is used similarly to signify that something follows a theme. The origin of the expression – which I hope the reader will keep in mind, as she reads on – is said to be the Greek myth of Theseus and the Minotaur. According to the story, Ariadne, daughter of king Minos, had fallen in love with Theseus, which is why she gave him a ball of red thread to help him find his way back from the labyrinth of the Minotaur. Tying the end of the string as he entered the labyrinth, Theseus managed to kill the monster Minotaur and find his way back. Although the cases presented here are diverse, the research questions chart the theme of place and care that runs through them all. Yet, much like Theseus, the reader may have to keep holding the thread in her journey through this conceptual map.

These analytical efforts were guided by a few research questions, which formed the core of this explorative journey with the goal of unsettling place in care and (re-)drawing a conceptual care map:

How is care produced, configured and enacted in place?
How does placemaking in healthcare matter?
How is care in place productive of new ontologies of caring?

The first question aims to conceptualize how care is done in place (production), as a process (configuration) and in terms of political effects (enactment). The motivation behind this research question was to make the relationship between place and care tangible – how are these concepts connected, how should we work with them? The goal was to begin building a vocabulary that is able to address this connection. Yet, it was clear to me from the beginning that places of care are not simply there, waiting to be conceptualized, but rather are a process that is constantly being configured. The notion that my research object is not static, but *in the making* meant that configuring places of care had to be part of understanding them. Finally, the question of enactment owes much to Annemarie Mol's (2002) work on multiplicity and her suggestion that realities are enacted differently, with particular consequences. Places of care, therefore, are not simply about the 'where' of care practices, but also about what notions of care are being enacted, valued, desired, and imagined and to what consequences.

The second question zooms in on placemaking in healthcare, focusing on placed care as an achievement, resulting from much and diverse, intended and unintended, work. The starting point of this question is the basic insight that places are not a priori there – they must be imagined, constructed and made meaningful. Moreover, care places reflect and produce our ideas about care and caring, structuring care processes in nursing homes and hospitals, but also shaping normativities about care. Should nursing homes have single rooms or not? Is it better that nurses should have more visibility of their patients? How can we make patients feel at home in the nursing home? And should we attempt to make them feel just as home inside a hospital?

The third question talks about ontologies of care: a term that may need a little introduction here. Ontology is a philosophical idea that denotes what is and what exists; it is a branch of metaphysics that tries to understand the nature of being. STS has used the term to make a rather disruptive argument about

the kinds of things that exist and how we should think of them. Mol's (2002) empirical work on atherosclerosis showed how reality is constructed through practices, and how different practices build more than one reality. So, the question of what is and what exists is about the practices, through which it is done. The example of the illness atherosclerosis can be enacted, or performed, as a thickness of veins (in the lab) or pain when walking (in the clinic). This does not mean that there is more than one disease, but that there are multiple realities of that disease, or multiple ontologies. If we follow the argument that reality is multiple, that means that what is and exists is multiple too. The same is then true of care. This dissertation will show that caring in place lets us see different realities, pushes us in new ways of understanding what is place and what is care. This last question reflects this ambition, asking how does it matter that we think of care and place together and what does this new way of seeing makes visible?

The questing of ontology in the social sciences has to do with the question of truth and the ability of having, and working with, multiple truths. In philosophy, ontology is a term that signifies the condition of being, of reality, of what is. The term may be used to make a point about the simultaneous existing of realities, as Viveiros de Castro (1998) did in his analysis of Amerindian cosmology by showing that it is irreducible to Western distinctions of nature and culture. Mol (2002) used the term to think outside of rigid notions of truth, suggesting that different enactments of reality – different practices of *doing* an illness – may result in different realities that are sometimes contradictory.[12] This way of thinking about the world allows a theoretical freedom and an openness that are welcome and needed in an explorative work, such as this. The third research question therefore deals with ontological multiplicity as both a theoretical and methodological tool; it invites an explorative view of care in place by attempting not to locate a truth, but rather 1) to understand how placing care gives rise to new ways of doing care and new ways of imagining what good or bad care might be, and 2) to work with places of care differently, allowing for more than one way of conceptualizing the research object.

12 The danger of ontological politics (Mol 2014) is the idea that there is no truth at all. As Mol and Latour (2017) have acknowledged, issues such as climate change that require action are being complicated by the notion of multiple knowledges. Yet the question of ontologies – or of what is in the world – in the plural form, is a crucial part of the argument, presented here, because the case studies show that there is no one way of caring in place. In understanding the productive relationship between these two concepts, it is necessary to work with different ontologies, or ways of being. This does not mean that we cannot have normative judgments about what good care is; yet, understanding the process, by which care becomes good or bad must be explored as open and multiple.

With these questions in mind, the book will serve as a map[13], charting routes and exploring roots (Cresswell 2019) within placed care as a conceptual world. The map here serves both as a productive metaphor and a practical tool. As healthcare is being re-organized, argued over, criticized and endlessly politicized, scholars, researchers, citizens, and professionals alike will benefit from a care map, which shows the pitfalls, promises and opportunities for a (better) care system. However, a map that claims to represent the care landscape would miss much of what is happening 'on the ground' and how places (are made to) matter to people. In this sense, such a map would not be 'caring' in either practical or scientific way, because it would not manage to take into account the complexity of care in place and problematize its consequences. With this in mind, this dissertation will relentlessly push against traditional, flat maps, attempting to destroy the idea of healthcare landscapes as clear depictions of reality. There is an urgency to rethink the idea that care can be moved seamlessly from one place to another by simply looking at a map. Re-placing births from one place to another, just a few kilometers south perhaps, or organizing stroke services by calculating outcomes 'from above' is not enough. Maps that organize care in this way are misleading and detrimental; theorists and practitioners of care must abandon them and think of mapping as a creative activity of understanding co-productive care. We need to question and unsettle basic ideas about the place of care as location and present an alternative and richer way of understanding and working with care as an inherently placed phenomenon. The care done in place is much more complex – it is about different dimensions of mapping. One such dimension is geography, of course, as it does matter how far one lives from a hospital, for instance. There are more dimensions, however – the politics of care, affective caring landscapes, the infrastructures of places, healing placemaking, scientific landscapes of healthcare knowledge, the physical layer of buildings for caring, the ways, in which objects do care, etc. In order to understand and work with this place-care complexity, it is necessary to make our care map a multi-dimensional one, that takes into account a multitude of scapes: smellscapes, ideascapes, technoscapes, culturescapes (Appadurai 1990) and more.

13 The relationship between place and maps is both obvious and problematic. The old, common-sense idea of place allows maps to capture it onto a flat surface, yet the conceptual notion of place as relational and open insists that maps are just objects-abstractions of places. Non-representational theory (cf. Thrift) shows that reality is not something that can be summarized and offered on a map: maps simplify, embellish, and create certain versions of reality that are political and productive.

I do the work of unsettling place in care by charting a care map – yet one of a different kind; not one representing reality (cf. Thrift 2008), but one producing it. This map outlines a way through place and care, conceived together, by challenging basic assumptions about these concepts; it is a way of thinking through the multiplicity of these terms, instead of clearly delineating them; it is a way of making sense of that multiplicity by smudging contours, instead of presenting a calligraphy of neat definitions. The book's working methodology is thus twofold, where the linked actions of destroying or 'unsettling' (the idea of a healthcare landscape map) and building or 'assembling' (an alternative, conceptual map of care in place) are done concurrently.

An Outline: Five Care Places

The dissertation opens with a case about a dilapidated nursing home, housed in a large building complex on a small Dutch island. This opening chapter shows how care on this small island is inextricably linked to its identity, history and imagined futures. The nursing home was evaluated by the Dutch Healthcare Inspectorate as performing under the national standards of care quality. Yet, despite housing only 8 residents, it remained open. My co-authors and I argue that the home is kept open, because it is a much larger place than a building for the elderly; it is a place, where care for the island is materialized. This chapter introduces the concept carescape, building on notions of care and Arjun Appadurai's 'scapes', in order to signify the co-production of care and place. These concepts, the article shows, cannot be understood on their own and must be considered together.

Chapter three takes us from the salt shores of the Wadden Sea to a suburban neighborhood near Rotterdam and inside a peculiarly refurbished garage. This garage is part of a volunteer's home and has been redecorated as a nursery room, which is known in the Netherlands as a 'founding room'. Created by a donations-based NGO, the room is a place for anonymous abandonment of infants – an act that is illegal according to Dutch law. Yet, despite much national attention and controversy, the foundling room had not yet received an abandoned infant. In examining the various infrastructures, surrounding this room, my co-authors and I argue for the importance of infrastructures in creating and maintaining places. We show that some places only exist by-proxy, through doings elsewhere, and while remaining empty, are able to galvanize and sustain social and political discussions about care for children, mothers and the state. This chapter not only

describes the wonderful proxy abilities of places, but it also demonstrates that the boundaries of place are constantly being drawn and re-negotiated; that places are not a priori there but must be sparked into existence by numerous infrastructural arrangements.

Chapter four takes us from proxy places to collaborative places, in order to examine the process of placemaking in relation to healthcare. The case is about a living lab for the testing and experimentation with solutions for elderly care, such as smart flooring; creating a sense of home; strategic placing of lights; a smart bed, etc. This process of conceiving and constructing the lab was followed from the beginning stages through to its fulfillment. The living lab was an odd place, because it was both a physical and an imaginary place, where the "future of elderly care" was imagined and thus produced through its physical set-up and locus. The lab was therefore productive of new ontologies of caring for the elderly, where care was imagined as high-tech, collaborative and scientifically produced. While it has been established that places' natural state is a process of becoming and they are never finished, the process of actual construction of a care place is a fascinating topic to explore, as it reveals the work, discontinuities and negotiations that go into the decision making process when creating a place for care practices. The chapter argues for a different attention mode to placemaking in healthcare – one that emphasizes the work and logics that go into making a place *for care*.

Chapter five transports the reader to the sunny Tyrrhenian seacoast of Italy, telling the story of migrant 'badante' women, who work as lived-in caregivers for Italian elderly, and introducing the notion of 'folding places'. In this article, taking inspiration from Deleuze (1993) we see care as located in "folds", as both care and place are problematized. The article shows how migrant women care by choosing to be away from their children and how they 'fold' place in an attempt to continue to be a part of their life back home. The traditionally employed, simple distinction between here and there, home and away in studying migrants is deepened and the very notion of place is pushed to include the ways, in which places are not only material, but experiences, co-produced with affective caring.

Chapter six takes the point of pushing place beyond physical contours even further. It questions the imagining of the future of care places through a case of a sensory reality technology, known as the Experience Cabin. The chapter introduces the term *post-place*, as a first step in developing a speculative vocabulary for working with places of care beyond dichotomies, such as material versus immate-

rial, digital versus real or place-full versus place-less. Post-place care, unlike the idea of placeless care, is an inclusive, open, and most importantly, generative notion. Its strength lies in its disruptive potential for challenging existing place-care ontologies and opening up generative space for thinking through the changing landscapes of healthcare.

Finally, *Chapter seven* assembles the different chapters and the concepts they have introduced, considering their analytical potential and interconnections, as well as answering the research questions, presented in this introduction. It then delineates the dissertation's theoretical, methodological and practical contributions and, finally, sets up a research agenda for future research on care places and placed care.

"Regular maps have few surprises: their contour lines reveal where the Andes are, and are reasonably clear. More precious, though, are the unpublished maps we make ourselves, of our city, our place, our daily world, our life; those maps of our private world we use every day; here I was happy, in that place I left my coat behind after a party, that is where I met my love; I cried there once, I was heartsore; but felt better round the corner once I saw the hills of Fife across the Forth, things of that sort, our personal memories, that make the private tapestry of our lives."
Alexander McCall Smith, Love Over Scotland[14] (2006)

14 Published by Anchor Books, Random House, New York.

Chapter 2

Care in Place:
A case study of assembling a carescape

Abstract[15]

In this article we analyse the process of the multiple ways place and care shape each other and are co-produced and co-functioning. The resulting emerging assemblage of this co-constituent process we call a carescape. Focusing on a case study of a nursing home on a Dutch island, we use place as a theoretical construct for analysing how current changes in healthcare governance interact with mundane practices of care. In order to make the patterns of care in our case explicit, we use actor-network theory (ANT) sensibilities and especially the concept of assemblage. Our goal is to show - by zooming in on a particular case - how to study the co-constituent processes of place- and care-shaping, revealing the ontological diversity of place and care. Through this, we contribute a perspective of the heterogeneity and multiplicity of care in its dynamic relationship of co-production with place.

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Introduction

In this article we analyse the meaning of place for how health care is imagined, shaped, and enacted. Specifically, our goal is to capture and make explicit the dynamics of the processes by which care becomes emplaced, as well as the different ontologies that emerge from this emplacement. Place is an increasingly important topic in health care and has recently come to the foreground in, for example, governance practices through policies of concentration and decentralisation, becoming 'a focal point for policy-makers, managers, professionals, and patients' (Oldenhof et al. 2016: 2). The restructuring of the healthcare sector, as well as demo- graphic and technological changes have led to an increased diversity of settings where care is received (Andrews 2002). This has sparked a research interest in the meaning of place for care practices (see Moon 1995). One of the most important research foci within spatial health geography is the home as a place of care (see Dyck et al. 2005, Milligan 2001, 2003, Twigg 1999). Others include the spatiality of nursing (Andrews 2002, Liaschenko 1997, Malone 2003), therapeutic landscapes (Gesler 1992, Williams 2002), rural care (Cutchin 1997, Milligan 2003), chronic illness (Lian and Rapport 2016), women's health (Mahon-Daly and Andrews 2002, Moss and Dyck 1996), wellbeing (Wiles et al. 2009), voluntarism (Milligan 2001, Milligan and Conradson 2006), patient safety (Mesman 2011), and gerontology (Andrews et al. 2007). Recently, a promising new avenue of architecture and design in health- care has been introduced by Martin et al. (2015), advocating the prolificacy of places and the built environment for the sociology of health care.

The analytical conceptualisations of place and care, however, have received less attention. Milligan and Wiles (2010: 740 emphasis in original) conceptualise people-place relationships with the term 'landscapes of care . . . the *complex embodied and organizational spatialities* that emerge from and through the relationships of care'. The landscapes operate analytically on both the macro and micro levels and are both a 'product and productive of social and politico- institutional arrangement for care' (Milligan and Wiles 2010: 740). Focusing on place specifically, as opposed to spatiality of care more generally, Milligan (2003) uses Auge's differentiation between 'anthropological places' – which carry meaning and identity – and 'non-places', to problematise the relocation of care for dementia patients. Bowlby (2012) introduces another relevant concept – 'carescape', along with its counterpart, 'caringscape', in an attempt to link the spatiality of care with a time-space continuum. She calls for developing a carescape framework,

'addressing the interactions between caringscapes and longer-term changes in the discourses, policies, and services affecting care' (Bowlby 2010: 2114). We answer this call, building on Milligan and Bowlby's concepts and focusing on the place of care explicitly, as opposed to the more general spatiality in health care. Sharpening our unit of analysis and using literature on place, as well as an actor-network theory (ANT) sensitivity to materiality and semiotics, we show how places matter for, and are in turn shaped by, how care practices come into being and are (spatially) enacted. By focusing on the role of ontologies of care in place and showing how these are balanced, negotiated, (un)coordinated, and entangled, we contribute a perspective of the heterogeneity and multiplicity of care in its dynamic relationship of co-production with place.

We zoom in on a specific case: a nursing home 't Zilt[16] on a small island in the Netherlands. In the late 2000s the home was threatened with closure as a consequence of an increasingly depleted elderly population and insufficient quality of care. In 2012 only six residents were left, insufficient for the nursing home to legitimate its existence. Yet it managed to survive a series of reforms that not only reconfigured the home, but the process of caring – both for the island and the home's inhabitants. In what follows, we introduce the theoretical underpinnings of the paper, showing how we build on and contribute to debates on place and care. Next, we describe our methodology, followed by a presentation of our results, where we zoom in on three of the ontologies making up the nursing home's carescapes, and a discussion.

Theoretical framework

Place is a term understood and used differently across a number of disciplines. For this reason it is perhaps more productive to delineate what place is not (Oldenhof et al. 2015). Crucially, it is not a synonym for space, which has been theorised as an abstract concept, often in the realm of neoliberal economics and politics (Lefebvre 1991). In contrast, place is imbued with the lived experiences and symbolic interactions of humans; it is 'space invested with meaning in the con- text of power' (Cresswell 2004: 12). Despite the very fruitful 'spatial turn' (Thrift 2006) in social theory, the analytical potential of this dual relationship between place and space is still to be developed. Place is a tool for scrutinising spaces of organisations, images, ideas. It is not merely a backdrop to social

16 All names are fictional.

interaction, but it is 'a force with detectable and independent effects on social life' (Gieryn 2000: 466). Furthermore, place is not static, it does not have 'single, unique identities', but is 'full of internal conflicts' (Massey 1994: 155), always in a process of becoming. In healthcare governance, place can be useful for focusing analysis on the specificities of care practices 'on the ground', without getting lost in universal claims of decontextualised management discourses. Pollitt (2011: 41, emphasis in original) in particular, points to this decontextualisation as a danger of forgetting that public services 'serve very different places.'

The notion of place has taken hold in health and illness scholarship, and for good reason. In a 1993 seminal paper, Kearns suggested that the experience of health and illness could not be detached from the places where care happens, and that medical geographers had been concerned with locations only, paying little attention to places. Macintyre et al. (2002: 131) called this 'the black box of places', 'unspecified' miasma which somehow, but we do not know how, influences some aspects of health' (Macintyre et al. 2002: 129). Milligan and Wiles (2010: 736) present a solid conceptual 'framework for unpacking the complex relationship between people, places, and care' by using the term 'landscapes of care'. They deftly engage the literature in human geography to tease out the interplay between the macro and the micro levels of care practices. Care relationships, they point out, are affected by where they take place. 'Landscape of care' signposts a fruitful and necessary avenue for research, yet the term stays closer to spatiality in general, making less use of place, and it needs more intensity and focus in order to show how the spatial element is constituent of the doing of care.

Another good example of conceptualising places of care is Bowlby's (2012) notion of 'car- escape'. Bowlby makes a distinction between 'caringscape' (the metaphorical terrain one travels while making health decisions in one's lifetime) and 'carescape' (the available resources of care which are linked to macro shifts in the economy and policy).

'Carescape' represents here various infrastructures, which influence health delivery. While the dual framework of caringscape/carescape offers a possibility for understanding place-shaping through resources and power, it is however unable to make sense of the messiness 'on the ground', losing out on complexity and dynamics, inherent to care emplacement. The notion of scapes, moreover, is hardly new and has proven to be useful in analysing complex and unstable phenomena. Describing the 'new global cultural economy', which is in a state of 'fundamental disjunctures', Appadurai (1990) employs 'scapes' to capture

the dynamics of what he calls cultural global flows – ethnoscapes, mediascapes, technoscapes, finances- capes, and ideoscapes. These scapes create imagined worlds similar to Anderson's (1991) 'imagined communities', and following their own trajectory they often destabilise each other (Appadurai 1990). Importantly, the scapes allow for an analysis of highly dynamic and complex interactions, adding value to Bowlby's 'carescape'. A carescape must be able to hold more than resources and health delivery. It must engage with ontological diversity, multiplicity, and imaginations, if it is to offer a deeper understanding of care emplacement. We there- fore define carescape as a fluid concept, which 'signifies and captures the process of care emplacement in a context of ontological multiplicity of care and place'.

Ontological multiplicity is well served by another theoretical construct we employ in our analysis: assemblage. Assemblage was introduced in the work of Deleuze and Guattari (1987), who attempted to transcend the binary between agency and structure. To them, structure was too static to account for dynamism and change in the social world. Assemblage emphasises precisely the emergent, processual character of the social, 'while preserving some concept of the structural' (Marcus and Saka 2006: 102), and thus recognising 'both flow and turbulence, produced in the interaction of open systems' (Venn 2006: 107). Ong and Collier (2005: 4) see assemblages as 'ensembles of heterogeneous elements', and stress the emergent temporality inherent in the concept: '[Assemblage] does not always involve new forms, but forms that are shifting, in formation, or at stake' (Ong and Collier 2005: 12).

In employing these concepts, we stay attuned to ANT (Latour 2005). According to Mol (2010: 265) ANT is not a coherent framework, rather offering 'a set of sensibilities.' With such sensibilities, we search for the complexity of care emplacement and work with, rather than simplify, its ontological diversity. Mol's (2002) work on ontological multiplicity has influenced greatly our analysis. She argues that ontologies are not simply there, but they 'come into being, sustained, or allowed to wither away in common, day-to-day, socio-material practices' (Mol 2010: 6). To look at care practices is to look at ontologies that come into being or wither away in place.

The theoretical underpinnings of this paper are located within the health geography literature, which has productively engaged with human geography and spatiality. We build on Milligan and Wile's (2010), Bowlby's (2012), and Appadurai's (1990) conceptual metaphors, in order to enrich and sharpen the

notion of 'carescape' as an analytical tool. Yet we are aware of the prominent use of '(land)-scape' in these works as a perspectival object of analysis. Wylie (2007) problematises landscapes as objects to be observed by a distant 'other'. There- fore, we believe that place is a better-suited concept for engaging with heterogeneity, as places are more than spaces (Gieryn 2000) and richer (in experiences) than landscapes (Wylie 2007). We employ place in conjuncture with carescape to offer a fuller analysis, avoiding the pitfalls of perspectivism. Building on these diverse literatures, we analyse a case study of care emplacement. Our contribution is in revealing the heterogeneity and fluidity of care emplacement. There are multiple landscapes of care, which exist in multiple entanglements, and as Mol's (2002) atherosclerosis remind us, multiplicity is more than one but less than many. This is true of Windland, our case study 'place', which exists simultaneously on many planes.

Locating the case-study

Windland is a small island located to the northwest of the Netherlands. Travelling to the island and back is organised by means of a boat connecting Windland to the mainland on a strict schedule. There are 1,100 residents on the island, the majority of whom live in the only village.

We became interested in the island when we learned of the problems its only nursing home had been going through. Prior to arriving on site, we conducted broad archival research and interviewed key actors connected to 't Zilt (3 face-to-face, 1 by phone). On Windland, we con- ducted 15 semi-structured in-depth interviews with residents and professionals in 't Zilt and healthcare providers on the island, as well as villagers and policymakers. This choice of participants reflected our dual interest in both organised care and life on the island more generally. We performed extensive observations and took field notes. All interviews were transcribed verbatim and, along with the field notes, were later openly coded and analysed for common themes and patterns.

Our initial assumption that care is located and therefore not a universally performed set of practices required a specific methodology. An ethnographically guided investigation proved the best way to understand the emplacement of care. The first author immersed herself in life on the island for the duration of the field work – 8 days in February 2015 – and used phenomenological tools and practices for understanding our research participants' daily lives (Groenewald 2004). Immersion in the everyday life of such a small locality gave us rich ethno-

graphic material, despite the relatively short period of fieldwork. Combined with preparation work and interviews before arrival, this method proved invaluable in understanding the place under study. Moreover, regularly employed self-reflection provided an interesting out- sider-perspective of life on the island, which was shared and tested in conversations with the locals. Where applicable, the first author participated in and helped with activities in the home, such as serving morning tea for the inhabitants and helping out at events. Numerous informal conversations of different length and depth were conducted, without a recording device. All nursing home inhabitants and their families were informed about the research, as was all staff. Participants were always asked for permission before taping interviews and reminded of our research role before conversations. Following Dutch ethical regulations, ethical permission for this research was deemed exempt.[17] We were careful to make our presence unobtrusive and respectful.

Windland as a research location was both an obvious and a divergent choice. A small island off the north coast is as much a unique place as can be. Admittedly, this was partly a pragmatic choice, because of its struggling nursing home. Yet we chose the island, in a way, exactly for its uniqueness. Where else do patterns shine so clearly and are read as easily as tealeaves, but on a small island? It is in such a place that placemaking processes are most translucent and vivid, as if put under a magnifying glass. As Thomas (2011: 514) says of the subject of study, it can be chosen because it is 'an interesting or unusual or revealing example through which the lineaments of the object can be refracted'. We believe that Windland shows how care emplacement practices emerge and form a carescape. Such processes are not unique to this place. Rather, each place forms its unique carescapes. Our goal is to show the underlying principles of care emplacement and to do this we must dive into the ontological multiplicity of 't Zilt and get to know this place.

Results

> A loud whistle signals our arrival. I feel a sudden shudder under my feet as the boat finally docks. Stepping outside, I look back: all water as far as I can see. Out of the terminal, I climb up on the dike, listening to birds

17 Exempt by The Medical Ethics Committee Erasmus MC.

singing, frogs croaking, and waves sliding over the stones below. It is loud, yet quiet, because I hear no cars, no motor- cycles or trains in the distance. I fill my lungs with fresh air and head toward the village. On my way down, I walk past an elderly man sitting on a bench in front of his house. 'The boat was late' - he says matter-of-factly.

I stop uncomfortably, not sure if he is talking to me. I check my watch: he is right. 'Fifteen minutes' – he continues, peering at me from the veranda, as if I had something to do with it – 'I always take my pills right after it docks, so I know.[18] (Field Notes, Arrival)

A special place

Time on Windland is structured around the boat's schedule. Hotels prepare for incoming guests; shops are ready to welcome customers; villagers come to the terminal to meet family and friends or wave them goodbye. Windland's inhabitants refer to time as 'before the noon boat' or 'after the last boat' and can always tell the time by the loud boat salute as it docks or departs. The boat is an invisible clock, which has become a part of the spatiotemporal ordering of the island. Space here, too, is a curious experience for a newcomer. On a sunny day, one can look over the water far in the distance and feel a sense of openness and freedom. But as darkness envelops the island, a newcomer may feel isolation:

> The first years of living on Windland, I always felt a sense of dread when the last boat left. I imagined myself here, with no way of leaving until the next boat . . . (Windlander, Interview)

Interestingly, the idea of distance from the mainland could also be experienced as positive. Preservation of nature is an important ideal for Windlanders – for environmental, economic, and nostalgic reasons. Within this junction controversies arise.

The island depends on tourism for its survival, yet its charm is in its tranquility and disconnectedness from the outside world. For those engaged in the tourist industry, such as hoteliers, attracting more guests is the raison d'etre of their business, defining Windland as a place of tourism. For inhabitants who are not part of this industry such definitions seem exclusive. They see Wind- land

18 All field notes are provided here in their original language. All interview transcripts are translated from Dutch.

as a place to be protected – a special place. Controversies arise as to the kind of tourist Windland should attract, as well as the kind of island it should be. When hotel owners developed plans to create another golf course on Windland, many inhabitants were against, worrying about the island's nature and authenticity. At a municipavote, it was decided not to build the golf course. Our informants called this decision 'a big relief'. Despite this reluctance to change, inhabitants understand the importance of connecting with the mainland. One Windlander shared how happy she is to have a swimming pool on the island. She goes swimming every morning and feels in her 60s again ('a spring chicken'). She was adamant that such services would not have been possible on such a small island, if it were not a tourist destination. However, as we have seen before, there is a difference in the kinds of services desired (swimming pool) and undesired (golf course) and by whom (hotel owners, 'spring chickens').

Yet, the situation is not as simple as nature versus industry. In today's mobile world, places must define themselves to attract visitors (Salazar 2010). Windland has traditionally defined itself as an island of quiet and serenity. Nature is its most treasured (tourist) attraction, folding nature and economics into one:

> People come here for the quiet, for nature. It is what makes Windland Windland. We shouldn't lose that. (Windlander, Interview)

The island's identity is at stake and this identity is linked to both the economy and ecology of Windland. Many questions arise from this intersection. Who profits from tourism and who does not? What does this mean for the kind of island it (does not) wants to be? In the ontological politics (Woolgar and Neyland 2013) of Windland, multiple visions are constructed and contested at different times for different purposes. These are all part of the diverging and dynamic process of assembling 'the island'.

Care and quality of care are crucial pieces in this assemblage, because the carescapes of Windland draw their breath from the ontological multiplicity on site. What is at stake here is not only the (future) identity of the island, but its very survival. Whether Windland will continue to be a liveable place is tied to its economy, to whether there is a swimming pool, to tourism. And crucially: to whether there is a (good quality) healthcare provision or not, as will be made clear below. Without care, tourism will not flourish, people will not move to Wind- land, and many might leave. This is how the ontological politics of the

island become the ontological politics of 't Zilt. They are one and the same. Carescapes here are not simply about quality and delivery (as Bowlby used the term) but also about this place's present and future (s). The carescapes we analyse are made up of complexity and messiness, which is exactly why we must look at them as assemblages of heterogeneous objects, ideas, and imaginations.

't Zilt as an ontological assemblage

> Walking toward 't Zilt takes you up a slight elevation, as the place used to be a dune. Step- ping through the doors and going to the first floor, one only has to open a small back door to get at the other side of the hill. I came to use this back door to reach my hotel faster. Others seem to use it regularly to reach their home or the ambulance station. 't Zilt appears to be a public place, a way 'through' the island literally and symbolically. (Field notes)

't Zilt is a big compound built in the 1960s to welcome pensioners retiring to a quiet life. Some of them had health conditions requiring medical support, but most were mobile and eager to enjoy retirement. Couples moved in the retirement centre, leaving their houses to their children. This changed with time, as healthcare policies in the Netherlands placed emphasis on people living as long as possible in their homes. Residents and finances dwindled, and the home found itself with six residents in 2012 and failing quality standards. The Health-care Inspectorate threatened it with closure, until in 2014 it was taken over by a mainland health- care provider. At the time of writing, the building shelters eight residents. Their age varies from 78 to 98 years, with some having lived in 't Zilt for years and others having scarcely arrived. In the care of a nurse, the residents have a room with basic amenities and participate in commonly organised activities. The building houses furthermore an ambulance post, physiotherapist office, independent living apartments, and mortuary quarters, while some of its rooms are rented temporarily to people in need of medical attention.

What the building is, what it stands for, and what it means varies depending on the interaction of many elements and how they assemble to make sense of the care it offers. It is within this ontological assemblage that island politics and imaginings are implicated. Care is part of the island, part of the building, and part of the ontologies of both; it is through care that both are enacted. We show this here by tracing three ontologies of 't Zilt. The first one is that of a home. 't

Zilt is home to the eight residents who live in the home and to 20+ who live in the independent apartments in the building's left wing. For most residents, 't Zilt is their last home:

> For them this is their last address. It is the final buoy before open sea. (Nurse, Interview)

Importantly, this last address is on the island. For the majority of residents, who were born and raised on Windland, it is crucial to grow old in their home-place.[19] The alternative would be to move them to a nursing home on the mainland, where most of the population speaks a different language (Frisian)[20] and where they would have fewer visits from friends and family due to the distant commute.

There is furthermore a personal connection people build with the places where they live (Tuan 1977). For such a small piece of land, surrounded by nothing but sea, this connection may even intensify, with strong affective relationships to the materiality of the island. More- over, as some of our informants insisted, a person should have the right to decide where they die. The oldest inhabitant of Windland, at age 98, who has lived at 't Zilt for more than 20 years, told us about her funeral plans:

> I want to lie here in the cemetery. Yes, and I have arranged all of that already. I've said I don't want black sheets over my coffin. That's so sad. No, I will have the Windland flag. Yes, I am a Windlander, can't do anything about that, I love Windland. So, when I die, the Windland flag will hang over my coffin. That's what I want. (Windlander, Interview)

When 't Zilt was in trouble due to low quality of care, people who fought to keep it open – professionals, municipality officials, locals – talked about the 'crime' of moving the residents away. One interviewee suggested that 'these people will figuratively die on that boat', in relocation. 'Being home' is memory, and memories are 'all these people have left now', as a volunteer at the home ruminated. The many photographs we saw in the residents' rooms show their

19 It should be noted that the idea of home has often been romanticised, failing to acknowledge that it may be a dangerous or dreaded place. See Sev'er (2002) for an example of the home as a site for domestic violence.

20 Windland was officially part of the province North Holland until the 1950s when it was subsumed under the province Friesland, where Frisian is predominately spoken. Practically, in most nursing homes in the province Frisian is spoken among its residents.

loved ones, some long gone, while paintings in the corridors depict Windland's dunes. Here we see the material-semiotic production of a carescape through the personal belongings of the residents and their memories, locked in photographs on the walls. The objects that make up 'home' create Windland as a special place of remembering. The building incorporates the whole island within its walls and is the residents' 'social space' (Wiles et al. 2009), meaning their environment incorporating everything from social relationships and physical objects they treasure, to symbolic places they cherish. The island and the building are therefore one in the ontological reality of 'being at home'. 'Home' is a key word in multiple: the house one grew up in, the nursing home, one's personalised room, the island (of one's youth, of today, of tomorrow). These layers produce each other, and assemble the multiple meanings of 'home', which the building symbolises.

Another way to think about 't Zilt is as a place of care. With no hospital on the island, the building serves as a port of call in any health-related situation. When a woman suffered a miscarriage, nurses in the building cared for her. When a boy staying at the camping site broke his rib, he was placed in a room on the third floor. 't Zilt even extends care to the dead. In the building there is an aula, which is being used as a mortuary. In the case of a death on the island, the deceased is brought in the building to be washed and prepared. A woman from Norway suffered an accident and passed away:

> Such a situation . . . it is of course very sad. She had come here on vacation, nobody expects this. You just want to help, make the arrangements in a dignified way. And it is very nice . . . rewarding, to be able to help. So, but yes, they brought her here in 't Zilt because we have the facilities . . . and we can take care of the body. (Nurse, Interview)

Care in the building may not only be medical. Many volunteers come to 't Zilt to spend time with its residents or organise and participate in an activity. Most say that their participation in 't Zilt is not only a service to the community, but a pleasure as well. One of the volunteers who had recently lost family shared that visiting the home gave her purpose again. The building, then, offers a place of care for the dead and the living, the locals and the visitors, the young and the old. Despite this inclusivity, 't Zilt's care has been questioned. The home is not only a place of care, but a place of insufficient-quality care. The question of medical

expertise has become part of the discursive image of 't Zilt. The ontology of care is not only about who is cared for (inclusivity), but how is cared for (quality). Both are without a doubt interdependent and come together in the third ontology we discuss here, that of the island.

Windland's very identity is at stake in the building's foundations – its economy, future, and survival. Having or not having a care facility shapes what kind of place this is. The island has seen families leave in search of better education or job prospects. If 't Zilt's inhabitants are moved to the mainland, Windland would become 'a sort of museum', as one of our interviewees insisted. The island would offer little diversity; becoming an artificial place; less than a harmonious whole, and would eventually become uninhabited and uninhabitable. It is clear from a local governance perspective that, in order to maintain the island, care must be avail- able. The nursing home, despite going through managerial, practical and quality difficulties, has been kept open for this reason:

> We want people to stay here. We try to provide everything. Because if we can offer services, then living on Windland would be the same as living anywhere else, only here there is also beautiful nature and quiet, safe environment.
> (Municipal official, Field notes)

The island also wants to attract new population and visitors. It relies heavily on tourism for its economy, so it must provide medical care in emergencies. As the municipality officials said: 'tourists won't visit here if there is no care facility, people won't buy a house here if they can't get sick or old here.' To both keep and attract a population, Windland must offer care. This is a matter of identity for the island, which, as a result of its size and location, must continuously prove that it is a 'real' place. Here care connects to the ontological politics of Wind- land. All of the discussions about the kind of island Windland should be are related to care, because inhabitants need care, tourists need care, and people who wish to live here need care. Care for 't Zilt is therefore, in this ontological plane, care for the island as well.

The 60-year-old compound has grown in and through the island like a vine. Designed for a different time and purpose, it has entered a dialogue with Windland and become a force in its own right, shaping care practices – think of its mortuary – and representing the island symbolically – the pictures on the

wall, the open hall where events take place, the paint of sea col- ours. The building is yet another agent (Gieryn 2002) in Windland's carescapes. It gives a way 'through' the island, which many people use daily. The building is not only for the residents; parts of it are public. When built, a huge dune had to be dug out to make room for the foundations. It used to welcome retirees to a comfortable life, while now it is referred to people's 'last address' and a place of low-quality care. In this dialogue with the island, the building is agentive and a crucial element of the carescape on Windland.

These ontologies – of home, care, and island – are linked, assembled, and working together, or perhaps not. Sometimes they are coordinated and make sense together, sometimes they are assembled in contradictory ways, but they are all there in the building. They almost 'hang together' in Mol's (2002) terms, and their messiness, coordination, and entanglement are best understood as an assemblage of ontologies. It is these ontologies that are at work in shaping the carescapes on the island. These carescapes are specific to Windland – remoteness, tourism, and small-scale care. We describe them in detail, in order to show their co-production, dependency, and enactment. Yet, other places, deep into the mainland's heart or in a bustling urban centre, are just as surely made up of multiple ontologies and make up emergent carescapes of their own. The processes of co-production are the same, every place is 'assembled' and produced, every carescape complex and heterogeneous. Other places tell different stories, of other ontologies, objects, and imaginings. But all carescapes have this in common: they tell how care comes to be and is done in place.

Doing care in place

In 2012 't Zilt was almost closed by the Healthcare Inspectorate, because the quality of care was below standards. The professionals working at the home were said to be lacking necessary medical skills and knowledge. 't Zilt stayed open despite these reports and in 2014 it was taken over by a mainland organisation. As a result, care in the home was restructured, with different practices taking shape. 't Zilt is now much better connected to knowledge and expertise. The personnel follow regular medical courses on the mainland, where they practise necessary medical skills. In an emergency, the nurses receive advice from a medical specialist. These changes have reorganised the kind of care the building offers, quality is vouched for by an external organisation and consequently the home stayed open.

Yet care on Windland still differs from the mainland in many ways. To begin with, there is strong sense of having to work together:

> I always say you should make do with what you have[21]. We must make the best of things. People here gossip, but if something happens, we help each other. (Windlander, Interview)

If a confused elderly man loses his way in the big city, she continues, he would be in trouble. Here people would simply help him back to his house. The conviction that 'we are all in this together' is likely a result of the size of the island and its population, but also has to do with its location. Materially separated from the mainland, Windland is surrounded by water and people have tended to rely on each other. This attitude creates a sense of informality when it comes to governance affairs, and especially enforced rules on the national level. It has produced an image of the mainland as far removed from what goes on Windland. Care practitioners and municipality officials often emphasised that care here 'is a little different'. This means that quality and 'good care' are understood primarily in practical terms and not necessarily in terms of protocols, which were composed and written in places far away from here and for places different than here (Pollitt 2011). Yet, when the Inspectorate threatened closure due to quality issues, the conversation became about more than quality of care. As we have seen above, 't Zilt offers not only medical care, but also symbolic care in legitimating the island. Keeping the home open is important on different levels. Professionals are therefore caught between the specificities of doing care on a small island and the need to provide quality care for the sake of the island. To cope with this, professionals resort to 'tinkering' (Pols and Willems 2011, Wallenburg et al. 2003), trying to 'fix things' as best they can in each situation. Creativity is needed to find suitable solutions:

> You must find other solutions if you don't have something at hand . . . If you don't have a patient-lift and it arrives with the next boat, you must find another way to get things done. You must be creative. (Nurse, Interview)

21 On the island, many expressions use boating and sea metaphors. In this case 'roeien met de riemen die je hebt' which literally translates as 'rowing with the oars at one's disposal.

Medical expertise has been especially problematic at 't Zilt. This is an important characteristic of care on Windland – the island relies on external expertise and multi-skilling. The size and remoteness of the place make specialised expertise unsustainable. Medical professionals try to gain knowledge in different fields and practice as diversely as possible. Since being taken over by a mainland health provider, all personnel of 't Zilt follow courses on the mainland, preparing for a variety of health conditions. The problem is that even when prepared for everything, they do not perform many procedures, due to a lack of specialized needs patients. This makes the issue of expertise difficult to pinpoint and the notion of 'good care' controversial. Professionals 'tinker' with this issue by connecting, linking, and multi-skilling. For instance, 't Zilt's personnel have a line with a medical specialist in cases they need help unavailable on the island. The GPs have a digital connection with a hospital on the mainland, where photos are analysed, tests are ordered, and patients are referred Windland's care links up with quality standards on the mainland through the Inspectorate's forms and evaluations. These linkages on and outside the island do not 'make up' good care, but they are how care is done, how the carescape comes to be and how it is assembled. Doing care on Windland frames the different ontologies we found in the building through practices. 'Tinkering' is doing care inside cares- capes of ontological multiplicity.

This shows the importance of the concept of assemblage in our analysis. The heterogeneity of the carescapes does not only refer to the island's ontological planes, but to its interconnectedness. Carescapes do not have a beginning and an end and they do more than link networks operating together. They are a 'fluid space' (Mol and Law 1994: 660), where 'it's not possible to determine identities nice and neatly, once and for all' or to discern 'inside from outside, this place from somewhere else', because similarity and difference come 'in varying shades and colors'. Carescapes are fluid spaces because their linkages are unstable and gradient – they do not exist and cease to exist, rather they flow. How does one understand their shape? We argue that the co-shaping of their assembled elements offers a view on how they flow. Carescapes are always an assemblage of fluidities. In the case of Windland these fluidities reach out of the island to grasp at the mainland shores, landing with hospital equipment, health provider and quality forms, but in other cases they will flow into other points, linking – or spilling – into other places.

How does place matter, if places spill into each other? It does precisely because care and place cannot be practically or analytically separated and because places have identities, purpose, and real effects. For instance, in assembling the carescape on Windland, we see that care here is 'a little different': it is small-scale, familiar, sometimes by necessity creative; it happens through connecting, linkages, and associations. 'Doing care' on Windland is about solving problems and 'making do with what you have', about 'tinkering' and linking to external expertise, and multi-skilling. Windland is a place of unique carescapes (as every place is) that flow through and beyond the island in an assemblage of ontologies. Unless we recognise this flow, our understanding of a carescape will always be limited. To look at places is to see what places do. To look at carescapes is to see how carescapes flow.

Conclusions and discussion

Our goal in this paper was to contribute to the growing literature on place and care by enriching the concept of carescape and employing it in the analysis of care emplacement. We traced the processes by which care emplacement emerges and evolves in the carescapes of a particular place, a small island in the Netherlands. During our fieldwork, we came to see the cares- cape on the island as an assembled multiplicity of Windlands and 't Zilts and this ontological diversity allowed us to identify the crucial role of ontology as folded into the processes of care emplacement. Our analysis showed that carescapes are unstable assembled phenomena, where social and material objects interact by forming short-lived equilibriums. An assemblage is a notion that transcends the boundaries of a specific place – becoming fluid and thus ideally sui- ted to trace the 'fluid space' of carescapes. By employing assemblage, we avoid the pitfall so easy to fall into when talking about place: making it a rigid spot on a map. In our analysis place is about specificities, because these are important in shaping care, but we also show that place is multiple and ontologically ambiguous.

The analysis of three ontologies of the building shed light on the diverse nature of a cares- cape. Attuned to ANT, we used what Neyland (2016: 68) calls 'deflationary sensibilities', a way to 'move away from accepting the fixed or agential character' of a phenomenon. We build on Bowlby's (2012) and Milligan and Wiles's (2010) conceptualisations of place and care and take a step further, beyond their fixed definitions. This allows us to rework and enrich the concept of carescape by showing that there are multiplicity and assembling being done,

heterogeneity and messiness to be acknowledged. A carescape, which is fluid and multiple, can achieve a truer and sharper analysis of the relationship between care and place. We problematise this relationship by showing how the carescape in our case study is assembled of ontologies and produced through materialities and practices. Assembling is an important verb, because it shows the work being done to keep care in place. This work is in coordinating the different ontologies of the carescape in a way that they make sense together. These ontologies are not aligned; they have their own, specific trajectories; or may even be contradictory.

In our island case, the ontology of care is about quality, standards, Inspectorate visits, proto- cols, safety, medical professionalisation and good practices. The ontology of home is about one's memories and room with its objects – old couch, picture frames, the afternoon sun through the window, pots with plants, the dunes on the island. The ontology of the island is about a future and sustainability, about the municipality ensuring a standard of living, about being far away and close to the mainland; about Windland as a tourist destination. These ontologies come together within the contours of 't Zilt, where each produces and informs the other: an ontological 'home' is why a care facility exists on Windland, despite all difficulties, while the care facility provides not only medical, but symbolic care for the island, which in turn becomes concrete through practices. The ontologies spill into one another, leading in different trajectories to multiple futures. The care ontology may lead to insufficient quality of care and closure of 't Zilt. Its documents travel to the building of the Inspectorate, on the mainland. The home ontology may lead to heart-breaking decisions of selling one's house. The island ontology may lead to actions by the municipality to re-organise care on the island. The work involved in assembling these diverse ontologies is how, ultimately, we see the emplacement of care in our case study. 'Doing care' on the island is about coordinating, tinkering, adjusting, and making it all somehow fall into place. The assembling of the multiplicity of care on Wind- land shows how the constant (re-)coordination of ontologies is part of the emplacement process; it is at the core of how care is done in place.

We see such tracing of care emplacement processes as a promising avenue for future research. While much has been done on the relationship between care and place in health geography, more work is needed to problematise and shed light on how care becomes emplaced. We have identified the role of ontological multiplicity and heterogeneity in assembling a carescape, but we believe more empirical studies are needed to understand the assembling of ontologies. A

material-semiotic perspective on the production of carescapes could be an entry point in studying care emplacement as a process, while keeping in mind that although places are unique (as this island is), the processes, which emplace them follow a similar logic of assembling.

"There's so much of "place" in the world. There's less time because the time has to be spread extra thin over all the places, like butter."
Room (2015)[22]

22 Written by Emma Donoghue and directed by Lenny Abrahamson.

Chapter 3

Place-by-proxy: Care Infrastructures in a foundling room

Abstract[23]

The concept of place has become fertile ground for sociological investigations, yet it is still undertheorized and in need of further development. Its most advanced employment is to be found within a sociological agenda on materialities of care and health architecture. In this article, we build on this work to conceptualize 'placed care' and to show how ecologies of care are produced and maintained through care infrastructures. The article investigates the case of an illegal baby foundling room in the Netherlands, where one may abandon one's infant anonymously. We conceptualize this place, continuously produced through its care infrastructures, as 'place-by-proxy': a place that allows, by virtue of simply being there, for the animation of infrastructures around it. With this concept, we advance discussions on places as bounded and open, pointing to the work and consequences of 'binding' place and opening up the concept for further application to various sociological concerns, particularly in healthcare.

23 This chapter was published in *The Sociological Review* as
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Introduction

> I step inside. The room is small, the air stifled. When was the last time someone walked in here? I look to my left and I see a painted tree, gracefully traced along the light-blue wall. A birdhouse is perched on the tree's branches, purple and green. Under the tree I see a crib, covered with an olive-green blanket. A teddy bear guards the crib, and in its feet, I see an envelope entitled '*Lieve Mama*' (Dear Mommy). I look around and I see a black button attached to the wall and a pictogram, depicting a woman pressing this 'help' button. Stuffed animals stare at me from the chair in the corner. I turn around and I see a camera, pointed toward the crib. Uneasy, I look around – am I being observed? (Fieldnotes, December 2015)

This paper engages with debates on place, care and infrastructure, in order to understand how ecologies of care are created and maintained. We do this by using a rather exceptional example: a baby foundling room, which we see as a particularly placed care-ecology for foundlings. In this room, created by the non-governmental organization 'Beschermde Wieg'[24] and operated by volunteers, one may abandon their infant anonymously. Despite the lively societal debate, the room's existence has sparked, it has remained empty, with no infants abandoned there, while paradoxically igniting much action, work and discussions around it. This incongruity forced us to think differently about (and learn from) this place: as a point where various care infrastructures (Danholt and Langstrup 2012) temporarily meet. Theorizing the room alone could not explain its emptiness; its relationship to care came into focus only in relation to particular infrastructures (Star and Ruhleder 1996). Therefore, this empirical analysis explores the infrastructural making of place, arguing for an understanding of places working *by proxy* – doing work and igniting action *elsewhere*.

The concept of place has proven to be a fertile ground for sociological investigations in the last decades. While it was first developed as an analytical tool in human geography (Casey 2001, Cresswell 2004, Massey 2005) and anthropology (Ingold 2000), sociological work on place has related to discussions on gender (Ward et al. 2017), class (Paton et al. 2017), nationhood (Pilkington 2012),

24 Beschermde Wieg (literally from Dutch: 'protected cradle') is a non-governmental, volunteer and donation-based Dutch organization, founded in 2014.

and memory (Degnen 2005), as well as to wider conversations on materiality (Watson 2003). The latter, in particular, have insisted on conceptualizing place as "relationally performed" (ibid. 145) and emergent from a mix of human and non-human elements (Country et al. 2016). This exploration of place as an effect of heterogeneous relationships is at the center of Buse et al.'s (2018: 253) call for attention to the "outside of care", or how designers, planners, and architects do placemaking for care.

The relationship between place and care has been theorized as co-produced (Ivanova et al. 2016; Bowlby 2012; Milligan 2003; Milligan and Wiles 2010), with an emphasis on its emergent character and as a relational activity between humans and non-humans (Ivanova et al. 2016; Danholt and Langstrup 2012). Danholt and Langstrup (2012) have shown how care practices are located within infrastructures of care as heterogeneous assemblages. This focus on the infrastructure of care owes much to STS work showing infrastructures to be political (Bowker and Star 2000; Star 1999) and relational (Star and Ruhleder 1996) and has further benefitted from the conceptual development of place within geography. Debates on place have seen a dichotomous conceptualization of anthropological versus non-place (Augé 1995); problematized its boundedaries (Massey 1994, 2005; Malpas 2012), and seen the concept evolve from a simple location to a transient mix of "relational, material and more-than-human" (Country et al. 2016) elements.

It is against this background of place as dynamical and transient, the co-production of place and care, and infrastructures as relational, that this paper is located. Its aim is twofold: to show placed care as an infrastructural achievement, requiring 'binding' work, and to argue that places, as both open and bounded, may be productive through their infrastructural forms. This infrastructural productivity is what we refer to here as *place-by-proxy*. The foundling room in the Netherlands is a peculiar and fascinating case, which allows unpacking the notion of place within care practices, demonstrating this proxy work. The room seems contradictory – both a place of care and intimacy and a non-place, to be entered fleetingly. A room, carefully designed for use (for those, who would abandon an infant), which everyone hopes will never be used (and no infant will be abandoned anonymously). Much more than a place for abandonment, this room is an experiment in caring.

Concepts and method

Infrastructures are seen as "something upon which something else 'runs' or 'operates', such as railroad tracks upon which rail cars run" and are easily delegated into the background, forgotten unless they break down (Star and Ruhleder 1996: 113). They have been analyzed as deeply relational; infrastructures do not work when isolated from their use, only becoming "infrastructure in relation to practices" (ibid.). In the sociology of health and illness, the term was linked to care in an attempt to make sense of care practices in relation to space and materiality. Danholt and Langstrup (2012) use 'care infrastructure' to understand how an individual is always intertwined with people and things in caring. Their focus is on the mundane elements that underpin medication practices, in decentering self-care from the locus of the individual. Weiner and Will (2018) apply the term to the context of home care monitoring, arguing that care infrastructures allows them "to see the socio-technical relations behind care" (ibid.: 272). Similarly, it helps illuminate spaces that are traditionally thought of as 'outside care', as "designers, architects, and planners can orchestrate environments where care may take place with intended and unintended consequences" (Buse et al. 2018: 253). By relating care infrastructures to place we take this concept outside the context of mundane practices and broaden it to help us understand the making and unmaking of placed care.

Firstly, thinking in terms of care infrastructures allows rethinking the notion of place. Malpas (2012) called for clarifying the meaning of the concept after the spatial turn in sociology advanced place as relational and open (Massey 1994, 2005), which he also understood as boundless. In Massey's view place is a "meeting point" of flows and transience – in her famous example even mountains are on the move (within a different temporality) and according to Thrift (2006) "there is no such thing as a boundary". This "neglect of boundedness" in relational place is problematic (Malpas 2012: 238), because relations presuppose boundaries, meaning that boundedness and place must be reconsidered (ibid.: 240). We do this here in empirical terms by conceptualizing the foundling room as both deeply relational and bounded. This case allows for rethinking the boundaries of place, because it shows how place may work beyond its physical contours, through numerous infrastructures aligning.

Secondly, and related to the issue of boundedness, the room's peculiar positioning contributes to furthering discussions on place/non-place (Augé 1995). Augé (1995) has argued that the notion of 'place' comes from a societal system

anchored in living on the land, "in the permanence of an intact soil", while 'non-place' is characteristic of postmodernity, the contemporary world of motorways, shopping malls and airports. The foundling room project currently consists of six rooms, spread throughout the Netherlands. These rooms are identically designed and filled with the same objects; manufactured as places to go 'through', not stay in – in many ways they are non-place. Similarly, Augé (1995) sees non-places as fleeting containers for post-modernist movement, consumerism and disconnect, like airports and shopping malls. Yet, there are important differences, as the room is both anonymous and intimate, a last resort and – as we will show in this analysis – a place for care. We show below that, instead of a contradiction within the dichotomy of place/non-place, the room is rather a place-by-proxy, thus adding a third category to the discussion *placeness*, or how places are. Through the analysis place comes to be understood as an infrastructural alignment that is deeply relational; places that appear to be placeless, or non-places, may produce strong place effects elsewhere.

This focus on infrastructures designed the research both theoretically and methodologically, as the paper drew on ANT and relational ontology, in order to understand the configuration of place as a heterogeneous process, including both human and non-human elements. This paper is, therefore, built on the assumptions that material entities have agency (Bennett 2010) and that places are emergent assemblages (Deleuze and Guattari 1987; Delanda 2006), which stabilize briefly, while constantly changing (Massey 1994). These insights sensitized us to the dynamic nature of place, structuring the method of this study in important ways. Using an ethnographic approach, we studied the organization 'Beschermde Wieg' through archives, observation and participation; conducted archival research, including newspaper articles, documentaries, and Dutch laws concerning foundlings, all of which were analyzed discursively. 23 documents, including positions of the UN, The Dutch Council for Child Protection and documentation of Dutch parliamentary discussions formed the bulk of our archival research; and analyzed the website of the organization[25] discursively. Six in-depth, semi-structured interviews were conducted with a representative of the organization, two volunteers, a hospital physician, representatives of the Council

25 http://www.beschermdewieg.nl

for Child Protection, FIOM[26], and a Ministry of Justice official. We furthermore conducted observations in two foundling rooms and of the working process of 'Beschermde Wieg'. We observed the opening ceremony of a foundling room inside the hospital Isala hospital. We decided to focus on one of the existing six rooms and understand its place-ness. Throughout the paper we speak of 'a room', yet six of them exist in different parts of the Netherlands. These six rooms have been designed identically and there is no considerable difference between their interiors. However, the infrastructural alignment around them may vary, which is why, instead of focusing our analysis on the phenomenon in general, we explore here the room in Papendrecht, a suburb of Rotterdam. The research took place between December 2015 and June 2016. Most of the interviews were conducted in January and February of 2016, while the observations were conducted in April 2016. Follow up conversations and observations were conducted in May and June, while archival research was concentrated in, but not limited to, March 2016. The three researchers discussed emerging patterns throughout the fieldwork period, as the collected data was openly coded.

In what follows, we invite the reader to experience the room as a gathering (Latour 2004) through the alignment of infrastructures. The analysis is committed to 'staying with the trouble' (Haraway 2016) of the room and to 'troubling' the concept of place as a particularly located meaning making. The room is first explored as a place of possibility, then as an alignment of infrastructures in relation and finally as a place-by-proxy. This evolution reflects our analytical steps, as well as our story of relating to the room as an object of analysis.

26 FIOM is The Netherlands Organization Specialized in Unwanted Pregnancy and Lineage. The organization was founded in 1930 under the name Federation of Institutions for the Unmarried Mother and her Child (in Dutch: *Federatie van Instellingen voor de Ongehuwde Moeder en haar kind)*. Since then, it has merged several times with other organizations, but decided to keep the acronym in the name FIOM. For more information see www.fiom.nl

Figure 1. The foundling room in Papendrecht, the Netherlands.

Enter

Entering the foundling room, one sees a black button and a pictogram, explaining what one must do to receive help. A woman holding a baby is pictured pressing the button, while the next slide shows her speaking with a volunteer. A notebook is placed on a table by the crib. Its hand-written text begs the visitor to ask for help, promising anonymity. Operating from the assumption that women who find themselves in a situation of panic after an unwanted pregnancy and birth, the room's organizers have created a story, inscribed in every object. Everything is an attempt to communicate: the painted birds and bunnies on the wall and the plush cushions say this is a place of care; the open door implies non-judgment; the button says we want to listen – all attempting to turn the visitor away from abandoning a child anonymously. This balance of anonymity and contact is a delicate one. A person who wishes to leave her baby completely anonymously in this room may do so. Yet, while the promise of anonymity is alluring, the room is, through its set-up, actively engaged in preventing it. The anonymous option is not desirable; it is "the worst-case scenario", according to the creators.

Historically, the anonymous abandonment of infants has been addressed through the strategic employment of liminal spaces, which have existed in one form or another for centuries. In the Middle Ages in Europe it was common for

parents to leave newborns in public spaces, where they might be easily found (Boswell 1988). Infants were customarily left at the steps of a church (ibid.). Another common arrangement was the foundling wheel - a cylinder, attached to an outside wall (usually of a church) - where infants would be placed. Reaching a peak in 19th century Europe, anonymous abandonment had become a secrecy-based system, expressed in the form of the wheel, in order to preserve infant lives, while maintaining the family regime (Tapaninen 2004). A modern version of the wheel is the baby hatch. Popular in Germany, where it is called babyklappe, it is a place inside of a wall (usually of a hospital) with a warm bed and an alarm[27]. In South Africa, such a hatch is called a "door of hope"[28]. In the U.S.A. the legal abandonment of infants is legally permitted in the so-called "safe havens" (fire stations and hospitals). These brief historical notes show that, on the one hand the foundling phenomenon is characterized by a long history and diversity of forms. On the other hand, the paradox of secrecy, produced through liminal spatial arrangements, is analogous with current anonymous abandonment provisions and sensitizes to the multiplicity of foundling configurations both spatially and temporally.

Importantly, 'Beschermde Wieg' is the first *room*, where one can abandon an infant, as the organizers aimed to create a place, which would offer options. The room offers a narrative of different paths: when one enters it, many futures become possible; the person may reconsider, ask for help, leave some information behind or simply place the baby in the crib and never look back. A baby hatch or the steps of an orphanage are places of (legal) abandonment in many countries, but the foundling room in the Netherlands is *a place of possibilities*. It is pregnant with the potential to remake the subjects passing through its doors. According to the creator of the room, Barbara Muller[29], the official channels for child protection fail to offer help in every set of circumstances[30]. The foundling room project has become controversial, because it is a place to anonymously abandon a child, while anonymous child abandonment is illegal in the Netherlands. The goal is to

27 See http://www.economist.com/node/21549984
28 See http://doorofhope.co.za
29 We have kept the name of the room's creator – Barbara Muller – unchanged. Through her work she has become a public figure and her identity is easily discoverable. The name of her co-worker is fictionalized.
30 She argues that in some cases, such as incest or the threat of honor killing, women distrust governmental channels too much, are terrified about their safety or too traumatized to go through the official process of abandonment.

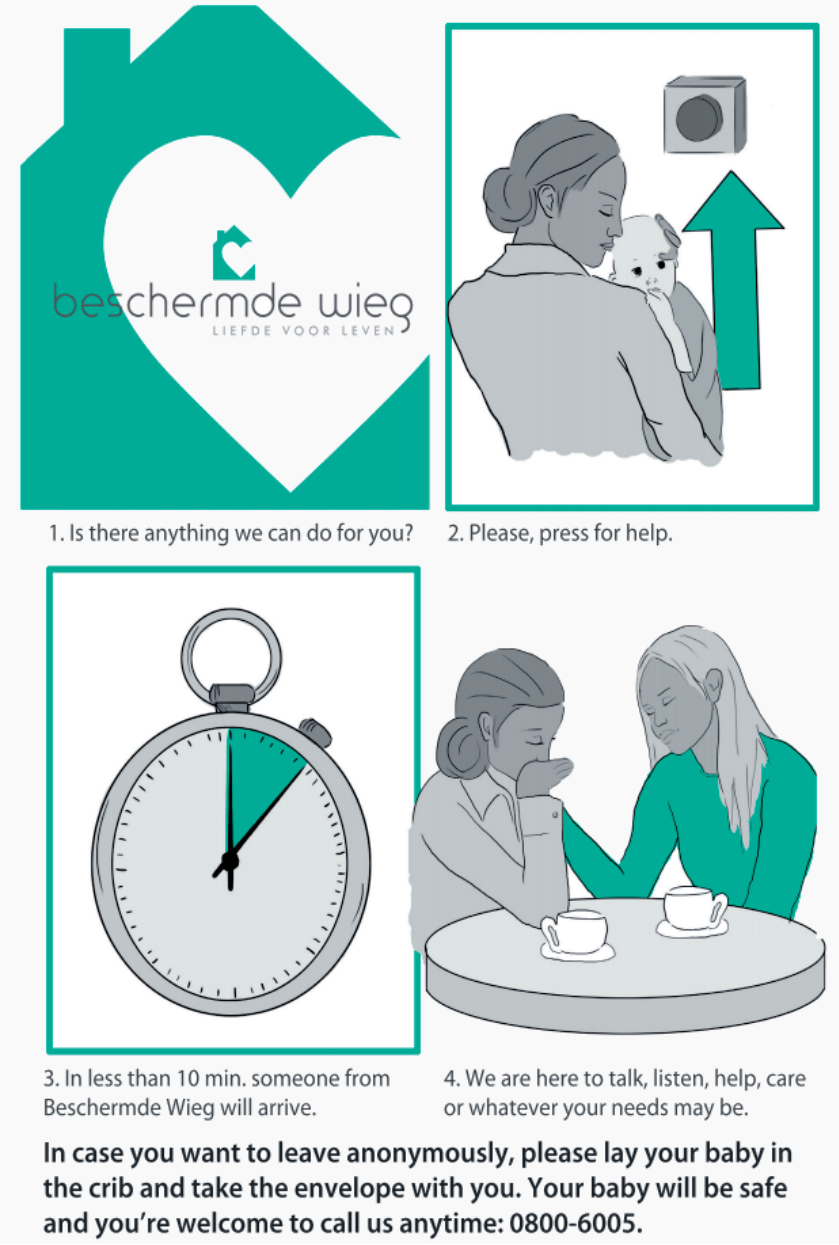

Figure 2. Wall poster. © Beschermde Wieg

prevent unsafe child abandonment of infants – something that happens rarely[31] in the Netherlands. With 6 foundling rooms located throughout the country, a sleek-looking website, a 24/7 phone help line, a media presence and controversy on its heels, 'the foundling room' is more than a room; it is an assemblage of people, objects, organizations, worries and ideals.

The room seems to be, above all, a contradiction – a place (Cresswell 2004) and a non-place (Augé 1995). Much of the room is about its place-ness (the quality of *how* the room is a place; what meanings are produced within it): safety for the baby; danger for the one leaving it behind; possibilities for abandoning or not and for being anonymous or not; care for baby and woman, etc. And yet, there is a decisive lack of place-ness: untouched objects, stifled air, and emptiness; there is no 'affective force' (Duff 2010) within these walls. We unravel these contradictions below.

A Room of Possibilities

Sophie[32] has worked with Barbara Muller before, on a project for temporary foster parents. As she serves tea in the living room, she points to her foster children – each little face framed in a picture on the shelf. Sophie is a volunteer: both as a foster parent and as a foundling room facilitator. 'Beschermde Wieg' operates on the basis of volunteers, who offer a part of their homes to be converted into a foundling room. The volunteers typically have some unused space, as in this case an adjoined garage, and let the organization convert it into a room. The space's makeover is paid for and done by the organization. The volunteer's job is to be at (or near) home at all times. The converted garage is reachable through two doors: one is an outside door, overlooking the street, and the other an inside door, through the laundry room. The inside door is always locked, while the outside door is unlocked. If the help button is pressed or a baby has been placed in the crib, Sophie's phone will ring, and she must be there within 5-10 minutes. Sophie's husband and son are aware of the rules and are always in contact with her. When the family is on vacation, the phone is given to the neighbor.

There is a camera, connected to Sophie's phone, which only points toward the crib, so that whoever places a child inside would remain invisible. The police

31 Statistics are a subject of debate and are often controversial, which we will return to later. On average per year 2 babies are found alive, as recorded by NIDAA - Netherlands Institute for the Documentation of Anonymous Abandonment.

32 The name is fictitious.

are obliged to investigate anonymous abandonments, as it is punishable by law to leave a child under the age of 7 in a helpless situation (Dutch Penal Code, article 256). Five of the identically designed rooms operate from volunteers' homes, spread out throughout the country. The sixth is situated within a hospital – the first such arrangement in a public place. According to the creators of the room, this option affords an alternative. A busy hospital corridor or a quiet suburban street – the foundling room exists between darkness and light and is both visible and invisible.

Inside the room one is transformed into a liminal individual. The woman entering the room may wish to leave her baby behind, yet she may doubt this decision. She may ask for help or not, stay anonymous or not, take a puzzle piece[33] from the envelope inside the crib or not. The child, too, is unfixed. Once becoming an anonymous foundling[34], its life enters a liminality of a permanent character, suspended in anonymity. It may be placed with a loving family or it may struggle to find a strong connection. In a very different liminal situation, Sophie is both at home and not at home in the room. The room is in her house and she maintains it, cleans the windowsills and washes the blanket. But this is not her home anymore; it is a part of a network of identically looking places, which have been created by others with specific goals in mind.

Aligning Infrastructures

The foundling room operates in the Netherlands, where anonymous child abandonment is illegal. It is therefore a curious place, where different rules apply. One is not allowed to leave their baby in a field or on the street, but the action is (currently) tolerated[35] in this room. According to Dutch law, anonymous abandonment is a criminal offense (NIDAA) and in cases of abandonment an investigation follows, with the possibility of sentencing to up to 7 years in prison (Dutch Penal Code, article 257,1). Legally, one may leave a child in the care of the state, a process requiring a woman's full information. Some women may feel

33 The puzzle piece is meant to maintain a relationship with the child. One piece stays with the baby, while the one leaving it behind takes the other. This act is largely symbolic.

34 The word 'foundling' (the same as the Dutch 'vondeling') is productive, because it is loaded with the negativity and shame of being 'thrown away'.

35 From the Dutch word 'gedoogd', which may be translated as tolerated, permitted. This is a standard practice for the Dutch legislator on controversial issues (other examples included drug legalization and euthanasia). We have translated it here as tolerated, as it is neither allowed nor forbidden. The word has a strong temporal component and signifies a liminal period of tolerance. Furthermore, 'gedogen' implies a lot of work that must be done, if this state of being and doing is to be sustained. In this paper we call attention to this work, showing that it is needed, in order to keep the room's liminality.

threatened by this and abandon their child unsafely – every year up to two babies are found dead or alive in parks, containers, even shopping bags, while possibly many more die unfound (Volkskrant 2015). According to 'Beschermde Wieg' the room may prevent this, and the lawmakers have decided to allow, or simply not acknowledge, the room for an unspecified period of time. Proponents of the room argue for regulation, where provisions can be made, so that abandonment inside this place becomes legal. However, the Ministry of Justice is against discussing such possibilities, mainly because of the politically sensitive topic. Their strategy is to stay away from this political 'hot potato' as long as possible:

> It is about such a small number of cases, so why should you make a new law? Just wait and see if it happens, if a baby is abandoned.
> Ministry of Justice official

Numbers are important here, because they are missing. There is no statistic that everyone agrees on, because the problem of unsafe anonymous abandonment of infants is not isolated, but may be linked to other criminal practices, such as molestation, incest, human trafficking, etc. As a result, proponents of higher numbers argue, many babies are never found. In the official statistics only the babies that are found alive are registered as foundlings, while the dead infants do not enter this tally. Therefore, it becomes important who uses which numbers and to what ends. 'Beschermde Wieg' has put together their own statistics and publishes these on their website regularly. Their numbers include the number of women who have contacted their 24/7 helpline for advice. These, they claim, show how many women look for alternative channels:

> Did you see the result of our emergency phone line? We helped already 70 women in the first year of our existence. There were 3 women who wanted to leave their baby in the room, but we changed their minds. (Emma Nieuwstad[36], Beschermde Wieg)

The foundling room expands here and changes; it is not about a wooden crib and stifling air, but about electrical signals, transmitted into radio waves. And these electrical signals are standing guard in front of the foundling room's door; on the

36 The name is fictitious.

phone Emma will try to convince the caller not to use the room (by explaining the alternatives), but to make arrangements, with the help of 'Beschermde Wieg' to go through an official channel.

The room is understood differently in the Ministry of Justice: a thick plastic folder with metal rings, which holds clippings from newspapers and documents about the activities of 'Beschermde Wieg'. The issue of legislation is very sensitive politically, because although the advisory governmental and supra-governmental organizations (The Netherlands Council of the Rights of the Child; the United Nations Convention on the Rights of the Child; FIOM; International Reference Center for the rights of the children deprived of their family; UNICEF) are against the room's existence, the public and the media favor a place, which would afford the possibility of saving infants from assured death:

> There is a lot of political and social pressure. The position that we are taking is a difficult one, because in the debate about this issue it is always – if you are against the room, you like to have dead babies. And this is not such a white/black difference; so that makes it very hard to loudly speak against the foundling room. (Ministry of Justice official)

A change of law seems unlikely, especially in the context of Dutch socio-political culture, where controversial practices are often left unlegislated until time sways public opinion one way or the other (Kater 2002). However, when an infant is found dead and the media explodes with images of dark park alleys or, on one occasion a trash container (NRC 2014), the political conversation gathers speed and proponents and opponents of the room put various arguments forward. The Ministry of Justice must be prepared for such times, when Parliament might request the minister to speak on this issue. An official has been tasked with following the unfolding controversy of the room, gathering all advisory documents (the UN, the Council for Child Protection, UNICEF), clippings from newspapers and other related documents. These are carefully placed inside the plastic folder and arranged by affiliation and importance. The folder swells, as discussion about the room continues and more paper clippings find their way inside yet another plastic pocket.

Part of the legal and political controversy around the room comes from the fact that the Netherlands is a country with relatively few illegal child abandonments, in comparison to other European countries (as we have seen, however, numbers

are controversial). This may be partially explained by historically well-established abortion regulations (van Tiggelen 2016). A system of legal abandonment is well organized, with at least two organizations focusing specifically on helping women make informed decisions about unintended pregnancy. This means that the foundling room began operating within an already established field, where the organizations FIOM and SIRIZ[37] have decades of experience. As the cases of foundlings show, not all women take advantage of these structures and it is suspected that anonymity is a central concern for those who do not. In order to use the official provisions, a woman must disclose her personal information. All personal information of Dutch citizens is stored digitally in a central registry, to which many different governmental agencies have access. Arrangements can be made for secrecy, if social workers decide that a woman's life may be threatened, but bureaucracy cannot always keep a secret:

> FIOM: When a child is born, it is registered in the system and 12 organizations receive this information. The social worker can inform these organizations in time (about this being a secret birth) but she has to talk to each of them before they act. And since there are 12, there is a chance that someone makes a mistake.
> I: Is that a theoretical possibility or does it happen?
> FIOM: It does, it has happened.
> (Interview, FIOM)

Yet anonymity is not the only issue, where the foundling room organization has an advantage over official structures. As a privately funded organization, it is able to provide *more*. In an attempt to get in touch with women before a baby's arrival, they have a 24/7, free telephone-line, where a volunteer will take any questions, listen to someone's story and provide assistance, without requesting the caller's information. Compared to the governmentally sponsored FIOM, this structure is more accessible.

> The government is cutting expenses, and more and more in the social field. FIOM had 14 offices all over the Netherlands 5 years ago. We have

37 SIRIZ is an organization, which offers prevention, support and care for unintended pregnancy. See www.siriz.nl

> now one office, which is this, out of 14. We try to provide the same service as before, but with fewer resources. It is difficult. (FIOM official)

'Beschermde Wieg' is able to afford a free line, where most calls come late at night, while the other organizations are reachable only during office hours. For the foundling room organization, a success story is when the room is *not used*, and the woman in question has made contact with them by phone. In this way their success is made invisible, as essentially not using the room is their goal. The Ministry of Justice hopes for the same, because if the room is frequently used a new law would have to be introduced and much political work would have to be done, on a very emotional and complex subject. For the moment, the foundling room is a folder for the Ministry and a telephone line for the NGO.

This begs the question – how to think of the room? We argue that the room is animated through the alignment of numerous infrastructures around it. The infrastructures of Dutch law, international law and different advisory bodies; the political infrastructure of Parliament and political process; the socio-cultural infrastructure of condoning controversial practices; the infrastructure of media and public opinion; the infrastructure of transmitter and received signals of a free telephone line; the infrastructure of established official channels of child abandonment; the governmental and political practices of 'cutting expenses', etc. These infrastructures are only exposed if the room works in the intended way – the Ministry of Justice waits for the moment they cannot avoid the issue anymore and babies are placed in the crib; political and legal machines will only move forward once there is a necessity to do so. Before this happens, these infrastructures are invisible. Much like the camera's view of the crib, they are not illuminated, yet when exposed, they align in a care infrastructure for the foundling.

Place in relation

Emma is busiest answering calls at night. That is when most women find the time or the courage to call. When asked whether it gets too much, she shrugs and says that she has helped many callers, implying that it is worth it. 'Beschermde Wieg' does not measure success by the number of babies abandoned anonymously in their foundling rooms. Instead, they focus on the number of phone calls they receive and the number of women they help in finding alternatives to anonymous abandonment. These statistics are presented on their website, where they are

linked to a necessity for a foundling room in the Netherlands and a change in the law regarding anonymous abandonment inside the room. 'Beschermde Wieg' is more concerned with the statistics, because their desire is to prevent babies from anonymous abandonment:

> Volunteer: (…) all the times when they wanted to leave a baby, we talked them out of it, or made arrangements.
> Interviewer: Which is the goal?
> Volunteer: Yes, exactly, it is the goal.'
> (Interview, Volunteer)

The room acts as an object of attraction, drawing those who are considering anonymous abandonment or who see no alternatives in their situation. The website and help line that promise the option of being completely anonymous is enticing. Once on the phone, the volunteers can establish trust (again with the promise for anonymity) and inform the caller of possible alternatives or give practical advice. The line essentially prevents the placement of babies and perpetuates the status of the room as experimental. It is beautifully photographed and placed on the organization's website, where it generates interest, spreads awareness and embodies values, such as safety, happy childhood, and care. The room is very easily accessible, yet it seems to be out of reach, pointing out again that the premise of the room's use (in its physical sense) is odd. If one wanted to abandon an infant, would they really travel for hours with a newborn to reach a quiet suburban street in a small town? The room's use in its infrastructural sense, however, is what allows action to happen. The base of the room's existence is liminal (as any experiment is), yet judgment is suspended indefinitely, as the conditions for coming to 'closure' are not set. Importantly, this suspension is not a natural occurrence, but a result of work being done, and efforts put in. The paradox of the place – constructing a room, while hoping that it would never be employed for its purpose, then becoming the actual purpose of it – reveals the ontological uncertainty inherent to the place. Is it a nursery or a crime scene?

Legally, the room is in a curious position – it has not been acknowledged by the legislator as either a legal channel for abandonment or an illegal enterprise. However, anonymous abandonment is illegal and prosecutable, making the room an accessory to a crime. The strategy pursued by the volunteer on the phone and the Ministry official serves very different purposes, yet they converge to sustain

the room's positioning. 'Beschermde Wieg' has a set of goals – to change the law for foundlings; to save the life of babies; to receive public support; to attract donations, etc. These come together in an attempt to keep the room's special status. The same is true of the other actors – the Ministry of Justice official wants to gather information in a folder and prepare for a political situation, involving the room. The goals of both the organization and the Ministry are not aligned. In fact, these are goals *in relation* to their own contexts; the red plastic folder is a political tool, while creating or volunteering at a foundling room may be a very personal goal. If we examine the result of these two infrastructures working toward their goals, we see that they converge, producing the special status of the room. Crucially, this production requires different forms of labor: the telephone line must be maintained, someone must always answer the phone, flyers and an interview must raise awareness, numbers of foundlings must be carefully calculated, information about the room must be gathered and arranged, memos must be written to the minister, etc. These forms of labor – of both human and non-human entities – center the foundling room as a particularly placed care arrangement; they do the work of connecting, similar to what McLeod (2014) has called 'collaborative connective labor'. Numerous other infrastructures are involved – the police, the Public Prosecutor's Office, the UN, UNICEF, the Netherlands Council for Child Protection, various Dutch political parties, newspapers, this article (!). These care infrastructures work in relation to one another, maintaining and prolonging the foundling room's current unclear status.

The unfixed character of the room brings up a puzzling question about place. We show here that the room is a place, which works by igniting action to happen elsewhere (by proxy). Yet, is it a place or a simple location? As theorists on place have argued, looking at places as locations only, might miss the experiential aspect of 'being' in a place (Ingold 2000), but similarly, a focus on perceiving the environment of place might miss the infrastructural work that goes into making places. This is especially true of a place like the foundling room, which is designed as generic, for a specific goal only. Such places lack true connections and are transient, non-places (Augé 1995). Yet non-places are usually burdened with speed and movement; "fleeting, the temporary and ephemeral" (ibid.), while the foundling room is static, dusty, stifled. It is pregnant with meaning(s), which are not contained in its physical contours, but within its relationalities – its infrastructures. Far from a non-place, the room is *place-full*, but this 'place-ness' (the quality of *how* the room is a place) can only be seen in the infrastructural

achievement it is produced by and contingent on. The place-ness of the room is in the way its infrastructures come together – requiring (alignment) work and caring.

Place-by-proxy

In May 2016 the news that the first ever baby has been left in a foundling room in Groningen, flooded Dutch media (NRC 2016). Reports say that the prospective mother used the phone line to contact 'Beschermde Wieg' and spoke with a volunteer, who helped arrange safe labor in a professional setting. The baby was then entrusted to the foundation's volunteers, who brought it to a hospital. 'Beschermde Wieg' convinced the mother to leave her personal information with a notary, where the child will be able to find it, once he or she turns 16 years.

This twist in the foundling room's story – an abandoned baby, just as many, ourselves included, had come to think of the room as an empty place – points to a fascinating manifestation of what we call 'place-by-proxy'. Not only does the room do much work upon other infrastructures by virtue of it being an experiment, but it also has, in a very practical sense, become a proxy for this baby's story, which media announced was 'abandoned in the foundling room'. In fact, the baby did not come close to *being* in the room; the crib is still just as empty as it was before this occurrence. The mother phoned the organization in advance of labor and was given assistance during delivery and with surrendering the infant. The infrastructures around the room – the help line and the volunteers – worked in preventing a child from entering the room. A place-by-proxy is a place, where nothing happens, yet it propels action elsewhere, in the place's infrastructures. The foundling room is a place-by-proxy, because it remains untouched, while its infrastructures are acted upon to perform certain practices: picking up a phone, arranging a midwife, linking up to the official channel institutions and a notary, informing the police, etc. It is telling, however, that after all these things were done, the story in every news outlet talked about the first baby "abandoned" in the foundling room. The room is the propeller and the performer, despite it staying empty. Without it, there would be no action elsewhere.

We understand the room to have been used in its physical sense, where use is a localized interaction within this particular place. Yet, using the room could also be understood in a wider sense, as in using the room's infrastructures fruitfully (a baby has been saved). The latter definition is how a place-by-proxy operates. 'Use' is more than a localized place interaction, yet it is not completely

metaphorical, because it comprises a clearly defined set of practices within the proxy's infrastructures. As a physical place, the room contains a script: a scared, confused, often poor[38] woman who moves through the night to leave her baby. The room as care infrastructure works differently, as it is connected to actors, who want to *prevent* using the room as physical place. A place-by-proxy is a figurehead for infrastructural achievement; its *being* moves infrastructures (NGOs, governmental organizations, legal frameworks, police investigations, political parties, phone lines, hospitals, media, etc.) to enact certain practices and by doing so to come together. Therefore, a place-by-proxy not only operates through its infrastructures, but its place-ness – the quality of being a place – *is* its infrastructures.

Exit

Although not intended as such, the room has become an experiment not only in anonymous abandonment, but also in centering and decentering place: how care infrastructures come together, with very specific consequences. As an example of placed care, or the idea that care is always an ecology, co-produced in/with place (Ivanova et al. 2016), this case demonstrated how to understand place as an infrastructural achievement and in doing so, coined the term place-by-proxy.

Place-by-proxy challenges the idea of places as a priori centered and allows us to see the work required to make/bind place. Buse et al. (2018) called for exploring spaces "outside of care", by which they mean designers, architects, and planners, who are involved in making care (spaces). Place-by-proxy problematizes the very idea of an "outside of care". As the room demonstrates, places require work in binding through infrastructures joining together or falling apart. These infrastructures are heterogeneous: they entail legal, care and architectural work simultaneously, connecting human and non-human elements in producing places in relation. The critique on relational geography's inability to reconcile relationality and boundedness (Malpas 2012) called for alternative ways of conceptualizing place. Massey's (2005) argument that places are open and on the move is reflected in the peculiar temporality of the foundling room – this is a place that may, at any moment, fall apart. Yet, how are we to think of its

38 In interviews it became clear that there was an assumption about the identity and social status of those, leaving their baby behind anonymously: a woman, who has given birth very recently, probably a Muslim woman, scared to go to the authorities. The reason for this assumption is the practice of honor killings among some (second generation) immigrant groups in Dutch society. However, this assumption is not reflected in actual practices and there is no evidence for it.

boundedness? What place-by-proxy does, conceptually, is to problematize the issue of boundaries. Boundaries (and thus places) never exist a priori – they are made, accomplished through work, and the temporary effect of infrastructures coming together. The debate about boundedness, this case shows should consider the *how* of boundedness – how do places work (or not) and what are the effects of (non) -boundedness. What makes the room a place (the event-ing of it, as Massey would say) is predicated on its other, infrastructural doings: it happens elsewhere. Whether anonymous abandonment in the room is legal depends on the make-up of the room in a suburb's garage, the poster on the wall, the telephone line, the folder at the Ministry of Justice, the political landscape, i.e. all of the infrastructures that do care work, in order for this room to exist.

Place can easily become assumed, rather than interrogated in sociological analyses and often be seen as location (where does action happen?) or imaginaries (the politics of place, sense of place). The analysis of the foundling room allows for further conceptualizing place, particularly of/in (health) -care. The need for conceptualizing places for care has been attested to (Oldenhof et al. 2015) and steps have already been taken toward an ecological argument for care as inextricably placed (Ivanova et al. 2016). Work on care infrastructures has decentered self-care from the locus of individual practices (Danhold and Langstrup 2012) by including heterogenious elements in a more holistic approach to illness management. Buse et al.'s (2018) call for attention to spaces "outside of care" sensitizes to the need of exploring placemaking's infrastructural forms. This paper represents an analytical move of linking these developments in the sociology of health with geography and STS debates on relationality and infrastructures. We show that centering (whether it be self-care or a foundling room) is an infrastructural achievement, requiring work, and that attention must be paid to the processes of (de) -centering places of care. An obvious "outside of care" should not be assumed, but rather interrogated, just as place as assembled, relational, heterogenious and emergent should be understood as forms of labor, made to connect. Much more than located spatiality and if seen as a decentered heterogeneous achievement, place can help us trace connections outside of particular locations.

"Map-making had never been a precise art on the Discworld. People tended to start off with good intentions and then get so carried away with the spouting whales, monsters, waves and other twiddly bits of cartographic furniture that they often forgot to put the boring mountains and rivers in at all."
Terry Pratchett, Moving Pictures[39] *(2012[1990])*

39 Published by Transworld Publishers.

Chapter 4

The Co-laborator: constructing a living lab

Abstract[40]

This article seeks to enrich our understanding of places as knowledge production sites. It discusses what the parties involved call a *living lab* for gathering, experimenting with, and creating knowledge for care in assisted-living environments. Although living labs are becoming popular in multiple settings as places of user-centered innovation, we focus not on the lab's output, but on its construction. We call the lab-to-be a co-laborator, in order to highlight the multiplicities of placemaking within and beyond the physical contours of the living lab. The paper reveals how spaces become enfolded in wider strategies for the future of care, as the co-laborator's temporal positioning highlights the important role of future-making practices in the production of care. Building on literature about place, care and laboratization, we argue for a fuller understanding of the spatial in healthcare that is augmented by social, economic and material concerns. We show how these are present in constructing care places and how they have consequences for imagining and doing care.

40 This chapter is submitted to *Space and Culture.*

Introduction

> The space is located on the second floor of a functioning nursing home, at the end of a long, flower-wallpaper-walled corridor, where elderly residents live under the supervision of nurses. To reach it, one must pass through several obstacles and the route is anything but clearly demarcated. As is the case in many nursing homes, there are two sliding doors at the front. To enter, one must pass through the first door and wait for it to close, before the second one opens. Inside, there is in an open space, filled with tables and a bar. More often than not, elderly residents sit around the tables, playing Bingo. Straight ahead, a small and rather inconspicuous door leads to a staircase. Two flights of stairs lead to the second floor, where the flowers on the wall change to orange and a door to the right takes one through a long corridor of apartment doors to yet another, window-paneled portal. Through it, a small corridor preludes a special entrance. The final door – and the one we have been finding our way toward – seems oddly out of place. This is because, in sharp contrast with the soft, pastel hues of the endlessly flowered walls, this door is painted starkly blue. (Fieldnotes)

Behind the blue door is a place-in-the-making, which we analyze in this paper by deconstructing its layers, just as its creators are in the process of constructing its walls, floors and windows. It is called 'Nursing Home of the Future' and it is located in Newstat[41], the Netherlands. It is a collaborative project between a university of applied sciences, a healthcare organization, architects and industry, with a broad mandate to test and showcase the current state of knowledge on assisted living for the elderly. Innovative technologies and simple solutions to spatial and architectural problems should come together here. The parties involved in this experimental project call it a *living lab* – a popular term lately, as living and urban labs are popping up in many difference contexts, including healthcare (Karvonen and van Heur 2014). Living labs are seen as "places and open networks to experiment solutions for problems of customers and communities" (Geenhuizen 2012: 1121). In this paper, instead of analyzing the output

41 The name is fictional.

of a living lab, we focus on its process of construction.[42] This place will be an experimental site, where a user might live for a period of time and interact with technologies under observation, but it will also serve as a showcase for different products and a teaching facility for students and professionals. With these ideas in mind, many parties were engaged in the complex and often difficult process of constructing the lab: scholars, professionals, industry representatives, an architect, as well as the manager of the nursing home, where this project is situated. By 'constructing' we refer not only to the material build of the space, but the network of relationships and ideas, "the patterns of affect and care" (Kerr and Garforth 2016: 17) and the mundane matters of setting up a place for science (Street 2016).

Just as the construction project was taking off, we, the researchers, also joined the living lab,[43] aiming to unravel the ways laboratization practices relate to knowledge production and placemaking (Gieryn 2006, 2018; Guggenheim 2012). Our interest is in the processes which lead to what Gieryn (2006: 5) calls a truth-spot – a place, usually a laboratory, that becomes, for whatever reasons, "the right place for the job" (ibid.; 2018). We began to examine the construction of our lab-to-be with the intention of understanding what goes into making a place "the right place" for the job (of care). Yet, as we became acquainted with the collaborations at hand, we realized that a different question should be posed: what *is* the job?

In answering this question, the paper shines a spotlight on what has so far been missed in discussions of living labs and societal laboratization: the process of placemaking. The scholarly discussions on labs have tended to focus on the lab's knowledge production output. We argue here that a place for science does much work while in the process of becoming a lab and that these doings are underwritten by a market logic, which, in this case, constructs a particular type of future for health. The market logics and temporalities involved in this lab construction reveal how spatiality in healthcare is co-produced within wider social, economic and material concerns and how these matter. In tracing the layers of lab-making, the paper shows how absences – of people living in the lab,

42 Throughout the paper we often refer to the living lab as the lab, the laboratory or the-lab-to-be, yet we should note here that words matter. As we show below, there has been a discussion about the differences between a laboratory, a field and a living lab. Our argument is that the place under construction is neither (it is a co-laborator instead), but it is important that the collaborating parties refer to it as a living lab or the lab.

43 We did not participate in the project. Our involvement was therefore limited to observations and conversations with project participants. See more on this in the method section.

of collaborators actively working on the lab – are revelatory of the hidden and underappreciated doings of societal laboratization. The partners involved in this project did not see it as a priority yet longed to be a part of it. The nursing home, in which the project space was being constructed, tolerated its existence, because they needed to maintain relationships with the lab partners on other projects. Repeatedly referred to as 'collaborative', the living lab construction often seemed to lack collaborative activities.

Building on these paradoxes, we call this construction project a *co-laborator,* in order to emphasize the multiplicities, contradictions and co-productions inherent in placemaking for science. The co-laborator is a connector and a mediator, addressing both collaboration and laboratization as uneven processes of negotiation and frictions, requiring work. The term refers to an assemblage, a thing that *contains and reconfigures*, but is simultaneously fragile and unfinished, following the example of Deville et al.'s 'comparator' (2016). The co-laborator is more than the physical space of the living lab, although this is certainly part of it; it is a real and metaphorical 'thing', where places of science are being constructed *with and through other doings*.

The Future Today

The Nursing Home of the Future is a space inside a functioning nursing home and is fitted to accommodate an elderly resident. It is a small apartment (Photo 1), with a living room and kitchen area, bedroom, private bathroom, laundry space and a closet. Nurses have access to certain parts, yet the place is built around the notion of self-sufficiency and privacy. For example, the entrance area is separated from the living and sleeping areas and a nurse is able to come in for changing towels/picking up laundry without disturbing the resident. A double-entry wardrobe opens from both the bedroom and the corridor, which allows the nurse to perform tasks, without being seen. The apartment's aim is to showcase and test the 'future' of elderly care, incorporating all innovative solutions of technology and research available, such as a smart floor, which would detect a resident's fall; the use of lights in guiding dementia patients' movements to their bathroom (and back again); a memory wall, displaying loved ones and familiar objects; autonomy-allowing design; friendly and adjustable interior, such as the sliding door between the living and sleeping area that opens and folds to allow for both one space and separate bedroom options; adjustable ceiling lighting, as well as an adjustable bed, which detects when the patient's sheets need changing

and many such details. Some of this detailing is not done through high-tech innovative solutions, but through sensitive design. For instance, the furnishing is done in the 1970s style, which is supposed to remind residents of their prime years, as this period is thought to be closer to their perceptions in cases of dementia.

The idea for a laboratory of experimentation and learning came from a scholar (who became project leader), working in a research institution, which had well-established relations with the nursing home in the Dutch city of Newstat. The project had a small institutional budget and it quickly became clear that most of the work had to be done on voluntary basis. The project leader used his network to attract different parties. An architect made the design, a contractor demolished the old apartment to build the new version, while a variety of companies contributed their skills and products, such as lights, bathroom, flooring, etc.

The first time we entered the space of the lab it was a bare shell – no flooring, no windows, and no lights. Just a cement plate, making sharp noises under our feet. As months passed by and we kept returning, the corridor leading up to the lab stayed remarkably unchanged, while the space inside evolved from space to place (Cresswell 2004). Flooring covered the cement plate, numerous small adjustable lights shone from the ceiling, a kitchen unit was fitted in the corner and small objects that the project leader had bought from antique stores found their way on shelves and tables. A magnet plate near the window displayed a bunch of postcards, and glasses were placed in the kitchen drawers. It seemed like the creators were building a home, yet despite the little details it never quite felt like one. A meter-long cardboard sign was perched right by the entrance, displaying the names of the many companies that were involved in the making of the project. These varied greatly – construction, tiles, bathroom, flooring, lights, architecture, technology, etc. – but all aspired to be involved in the healthcare industry. Their participation in this project was on voluntary basis and they advertised it as an investment in innovation. Hence, the space received the name a living lab, where experimentation would facilitate break-through innovation, paving the way to "healthcare of the future".

Laboratization

Laboratory studies have covered numerous and diverse themes in detailed ethnographic studies, such as laboratory practices and procedures (Shapin and Schaffer 1985; Knorr-Cetina 1992), the epistemic politics and identity work of

lab workers (Doing 2004) and the decision-making processes behind constructing a laboratory (Velho and Pessoa 1998), among others. More recently, the laboratory has been analyzed as a participation site for the co-production of publics and futures (Krzywoszynska et al. 2018); a place for interdisciplinary collaboration without consensus (Centellas, Smardon and Fifield 2013) and a dispersed, heterogeneous place in "closer-to-patient" health services (Lehoux et al. 2008). Attention has been paid to the laboratory's history. While once scientific work required an oddity to be displayed in public, it has now reached an extreme form of *seclusion* (Callon et al. 2009), establishing the lab as an inside with strict boundaries to the world as an outside. The idea of a living lab plays with this distinction between inside and outside and between 'lab' and 'field' science. Science studies have "put different kinds of scientific knowledge into categories, based on the kind of place where it happens" (Henke 2000: 483). A lab is where the world is controlled, while a field is where the world is encountered. Labs are tangible places and simultaneously placeless, as the scientists who work inside them try to standardize and obliterate the specificities of place, so that their research is generalized to all places (Kohler 2002a; Shapin and Schaffer 1985; Knorr-Cetina 1992). The field, on the other hand, embodies an idea of "unadulterated reality, just come upon" (Gieryn 2006: 6). A different kind of scientific credibility is constructed here – one of 'being there', as the "inevitable lack of control becomes its own virtue" (ibid.).

Yet, the distinctions between laboratory and field are difficult to discern. Latour (1983: 154) argues that the line between society and laboratory is blurred and "no one can say *where the laboratory is* and *where the society is*". In this sense, taking a wider view of what a laboratory is (Miller and O'Leary 1994) means extending the meaning of place (the laboratory) to the outside ('real' world) with particular goals and consequences. A poignant example is Britain's housing development in mid-twentieth century (Strebel and Jacobs 2014), where design and science were bundled together as buildings became sites of experimentation. Housing construction was structured "in and through laboratory logic" and there was "a conflation and hybridization of the space of the laboratory, the site of the house and the action of the experiment" (ibid.: 450). This suggests that the extension of the laboratory logic to society must be acknowledged as a productive practice and analyzed as such. Complicating matters further, Gross (2016) argues that laboratories are increasingly defined in retrospect and that real experimentation takes place in society first. According to Guggenheim

(2012), who examined laboratization historically, at certain points in time sociology appropriated the metaphor of the laboratory, while at other moments it distanced itself from it (what he calls 'de-laboratization'). For Guggenheim the term laboratory (when used metaphorically) is imprecise, because it does not delineate a laboratory (by this he understands an isolated and controlled space for scientific purposes). Instead, this metaphor "has reduced a diversity of forms to one historical blueprint" (ibid.:113).

Method

We became involved with the project at an early stage of construction. Unlike the other participants, our role was not defined and there were no specific expectations attached to our work. We conducted observations, interviewed and interacted with the project leader, the architect and the contributing parties on an ad hoc basis between January 2016 and June 2017. Most of our engagement was with the project leader and the architect, as most of the other parties contributed a well-defined, small part of the construction. For example, the company that supplied the ceiling was involved only to this extent. Our data, therefore, came chiefly from the leader and the architect, who were doing the coordinating work. Since this project was voluntary and contingent to the parties involved, the scheduling was tentative and often extended in time. We kept in touch through email, phone calls and occasional face-to-face meetings.

Our focus throughout the data collection lay on the process of construction, not only materially, but also conceptually and discursively. Referring to ethnographic observation inside laboratories, Woolgar calls this "science *as it happens*" – a description of scientific work that is "relatively unhindered by retrospective reconstruction" (Woolgar 1982: 483, emphasis in original). Our focus is placed earlier – on the construction process through the observation of practices of laboratization 'as they happen'. Following the process of construction allowed us to witness the decisions that were made along the way. We attended general meetings between the stakeholders and were included in email conversations between them. The construction process was long and difficult, with frequent unscheduled delays. The data was coded openly and then discussed between the three authors.

In what follows we analyze the construction process in three steps of placemaking. Social placemaking depicts the work that is done within the co-laborator, in order to keep the project going; material placemaking explores the futurity

that the materiality of the lab projects; and economic placemaking reveals the market logics underpinning the process. These interweaving analytical threads present a holistic understanding of placemaking in the context of laboratization and collaboration in healthcare innovation.

Social placemaking

> Today, the project leader meets the nursing home's manager and the coordinator between the home and the project. The three sit around the table in the center, going through a number of discussion points. Suddenly, an unexpected issue arises when the lab opens its doors to visitors, these would have to offer sanitary access to a bathroom. The bathroom in the apartment is going to be used if and when someone lives here but allowing visitors' use is not what the state-of-the-art bathroom for people with limited mobility was meant for. The home manager remembers that there is a small toilet nearby the lab's front door, in the tiny corridor outside. Coordinator, manager and project leader head toward the toilet for inspection. The three barely fit inside, as they judge the toilet sub sufficient. Someone observes it has not been used for a long time. Options for cleaning are discussed. It becomes clear that the nursing home would have to do the upkeep of the toilet, and negotiations ensue. (Fieldnotes)

This example shows the material, financial and social entanglements between the lab-to-be and the nursing home, in which it is embedded. It was crucial that a living lab was built *inside* a nursing home, but why? According to the project leader, who wanted to elevate his professional status by heading this project, anyone could build a lab in a university. It is extremely difficult, on the other hand, to helm a project such as this, where not only would a real person live, but a myriad of actors would be involved in the building and subsequent usage. The 'living' part of the lab is where real success and status lay and building it meant building a reputation. It was important for this place to have fluid boundaries between *outside* and *inside*, in a liminal space between laboratory and field. To find this liminal sweet spot, one had to laboratize parts of the nursing home. Here we mean laboratization as the extension of the laboratory as a productive metaphor to various spaces of knowledge production. Since a living lab incorporates tensions from both the laboratory as a secluded and controlled

environment and the field as an open place of experiencing life, the strength of the living lab as a place of knowledge production, at least in theory, lies in its ability to be a liminal space. This liminality is often seen as a positive point for living labs, because of their ability to be inclusive, and thus collaborative. In analyzing this project as a co-laborator, we emphasize not only the inherent collaborations between actors or the extension of the lab-as-concept to other places, but the discursive power and consequences of living labs as very particular places of experimentation and innovation.

How does one go about making such a place? For a lab to be 'living' inside a nursing home, much work needs to be done. This work began with agreeing to have a living lab constructed inside the home, which required persuasion and well-established relationships:

> The old director (of the nursing home) was a study mate of mine; we still like each other very much; but she was also a study mate with the director of Heymans[44] and so am I, so that was like a triangle. So we managed to draw him in and he was like okay, let's do it; we like each other…(Project Leader, Interview)

From the beginning this project was semi-formal. The social aspect of this project was central for the building process. As a volunteer-based, non-priority enterprise, the Nursing Home of the Future depended on *knowing* people, *persuading* them to participate and *maintaining* good relationships with them. The project leader acted as the crux of this network, juggling the numerous parties throughout construction. At meetings and events, he was the heart of the company, shaking hands, talking animatedly and introducing himself to newcomers. He then subtly reminded people of the building status, asked questions and inquired over a delivery timeline or implied that something had to be done before next month. There were tensions to be sure, but there was also an overall impression that this was a *social-networking project* and as such, it depended on "the value of relationships, rather than the value of things" (Street 2016: 957). This is true of the relationship between science and place, and especially when it comes to 'setting up'. In an analysis of such a 'setting up' process, Street gives the example of Mark – a young scientist, whose research project was unfunded

44 A big construction company in the Netherlands.

and taking place in Madang hospital in Papua New Guinea – and shows how his lack of status helped him be seen as an equal by the local nurses, who assisted him in gathering data. In making a place 'accommodating for science', social infrastructures are just as important as material ones. In Mark's case this meant knowing the nurses, being perceived in a certain way, making small gifts, and realizing that he is a guest is someone else's home. Thousands of kilometers to the northwest, the project leader in Newstat knew this:

> The nursing home totally forgot that people are doing this for free. And so you can't go: you need to do this now, now, now! Show a little more gratefulness, don't be very pushy, when people are doing this in their free time. (Project Leader, Interview)

Still, the process of construction was tricky to navigate. Demolishing and re-building an apartment inconveniently closely located to residential apartments was a noisy affair, with lots of dust, dirt and general messiness naturally ensuing. During the days of drilling, it was important to keep the nursing home residents away from the noise, which is why "chocolate, music and booze", as one of our informants phrased it, were provided in the main hall. Yet even when communication work is done well, things go wrong:

> We found out that there were duct works for electricity and so on, hidden in the walls where they shouldn't have been. Welcome to construction–it's always the same stuff. When we had to drill a slit in the floor for the sewage pipe, we came across the main electrical wiring of this wing, and we went straight through. And it's really like, in the movies: bZZZZ. All the lights went off and we were like Fuuuuck! And two minutes later my phone rang: Fraaaaank! (Project Leader, Interview)

Another example came from the Internet usage inside the lab. An Internet connection is necessary for the apps and technologies to work and gather data, such as for example how many times a patient has fallen on the floor. Yet, the lab-to-be had to make use of the existing Internet infrastructure and was referred to the current IT support. For a long time, the connection problem persisted, because the IT personnel could not provide a password that the lab technicians needed. The IT personnel would only provide sensitive details to the nursing

home – their client – and refused to divulge passwords to others. In order to build the lab, existing infrastructures needed to be altered, which resulted in many frictions that had to be solved.

These examples show the coordinating and negotiating done – involving an enormous amount of work – just because the living lab was being made inside an already functioning place, whose management, although interested and generally positive toward the project, did not see the construction as their priority. The nursing home had and continues to collaborate with the project leader's institution (e.g. in offering students' internships) and for them the living lab was a valuable investment in a partnership. Yet, they still considered the space theirs and as such, the process of construction required navigation:

> We like the project, yes. But of course, it is happening in our building, so we have to make sure it doesn't cause problems. (Nursing home manager)

An institutional friction formed when the project leader decided to paint the front door of the lab-to-be blue. One day, as the project leader and the nursing home manager walked down the corridor, the manager gasped, pointing at the door. The blue was seen as problematic. The manager reasoned that the color did not fit with the rest of the home and the door was repainted a respectable grey shortly thereafter.

These laboratization doings – the material practices of making this space a place for a lab – were based in collaborations between the parties, but these were not always successful. Most of the collaborations were fraught with difficulties. The parties involved worked together not because they shared the same end goals, but because their *laboratization goals* aligned within the process of building. The collaborations we see here are of various types – some are personal/social and based on old friendships, as in the case of the project leader and the construction company; some are material, as in the case of the Internet connection password that had to be shared; some are economic, as in the case of the nursing home maintaining its investment in a partnership with a knowledge institution. All these collaborations required work, however: coordination work, persuasion work, negotiation work, information work and, importantly, diplomacy work. The project leader would often encourage, thank, motivate, discuss, and remind. Sometimes the collaboration would cost too much work, so he would opt for doing the task himself. One afternoon he told us that he cleaned the apartment,

because a television crew was about to visit, in order to make a short video about the project. He explained that it cost him less time than contacting the right person at the nursing home and making sure that they did not disturb any of the cables, placed the day before. "It was just easier to do it myself", he said.

The doings of laboratizing a space were not limited to work by the actors involved, however. That is, although social place making supplied the work of connecting and making alliances in situating the lab somewhere between laboratory and field, this alone was not enough. The desired liminal positioning of the space as an open laboratory allowed for a particular placemaking goals. Another place – a laboratory or a nursing home apartment would have been bound by practicalities of function, while our lab-to-be was bound by other purposes: those of representing a future of care. Therefore, the materiality inside the apartment formed an assemblage that told a particular narrative of the future of care – to which we turn now.

Material placemaking

To the architect who did the design for the project, the lab is a space for innovation:

> I was interested in what you can do…with what we know so far about evidence-based design. (…) But then, this is more about what can happen, where the developments will go in the future. (Architect)

The architect was interested in creating a platform for knowledge production. Evidence-based design[45] is a young, developing field within architecture and the possibility for experimentation is exciting. When we asked her what kind of testing,she wanted to do, she explained that she is interested in how the objects inside work together and interact (with a user); an actual 'living' place. Testing one product will tell us a lot about that product, but "if we want to innovate, we need to create an environment where something new can happen", she said. "We need to see how it all works together."

Laboratization would open up a space for knowledge production, once the place starts functioning as a living lab. Yet, in the meantime it is already produc-

45 Evidence-based design (EBD) is the process of basing decisions about the built environment on credible research to achieve the best possible outcomes. For a comparative discussion on EBD and evidence-based medicine, see Viets (2009).

tive by virtue of placing certain objects together. This is a place where various innovative objects are assembled – special bed, smart floor, smart design, memory wall, etc. – which link up to narratives of futurity. The process of combining and assembling, choosing and placing objects in this space is a laboratization practice, which is both material and metaphorical. How does future-making work in practice? To answer this question, we must understand the futurity of the space not only as a discursive ideal, but also as materiality, invested with meaning. Marres (2013: 419, emphasis in original), in showing how things have politics, has gone a step further by asking, "how [things] become *invested* with specific normative powers through the deployment of particular settings and devices." The examples of a poster and a thermostat that Marres gives in her analysis of eco show homes are objects that do not simply signify a normative ideal of environmental participation, but articulate engagement in material form. We may say therefore that placemaking is politics-making. The new technological objects inside the co-laborator are invested with particular political capacities of futurity, but, importantly, this happens not because these objects carry the characteristics of a certain normative future per se, but because of *where* they are being placed. We may say that these objects become invested with futurity in the context of the place. Take the smart floor as an example. It is a technologically innovative solution to the problem of visibility and privacy in assisted living conditions. If a patient falls on the floor, the nurse will be notified through an app on his phone. The floor registers weight and pressure, allowing it to detect a patient falling. Without a smart floor, a nurse would have to regularly check on his patients, limiting their privacy. The smart floor solves this problem by providing a certain form of privacy – although this is exchanged for the loss of another – and visibility. Importantly, the smart floor is not an invention, developed for this living lab (Brodersen and Lindegaard 2015). Although still rather expensive, it is a device, which was 'out there' before construction began. Further research on the floor might be needed as there are questions related to how the floor affects the work of nurses (will it alarm so often that nurses start to ignore it?), as well as how it affects the privacy of patients (will they be bothered by nurses checking on false alarms?). Yet the main intervention here is not the floor itself, but the assemblage of innovative technologies. As is the case with the rest of the elements in the space – such as the lighting or the bed – this place is not about inventing, but about *placing* inventions together in an assemblage of future-making, articulated in material forms – the floor delineates a particular

type of privacy (that is not data privacy), visibility (that is indirect, but constant) and care (at a distance). It exemplifies political aspirations of what a care facility should look like and its futurity becomes "an accomplishment of the setting" (Marres 2013: 434).

The figure of the co-laborator helps to emphasize the role of this assemblage of objects within the space's 'make up'. This 'home of the future' comes together through 1) an entanglement of inside and outside, articulated in collaborative, yet messy interactions and 2) a particular objects-assemblage, which is the result of said entanglement. The co-laborator translates ideas for what the future of elderly care will look like into both material and economic terms. The objects inside the living lab do articulation work, framing the future of care both materially and discursively. The place creates a temporality of care innovation – the healthcare world is currently here, while this apartment is situated further ahead in time and development. This is where, again, the liminal positioning of the lab between laboratory and field is key, because the place is built not only to be an innovation hub, but to be a showroom for future care as well. Far from being a place of seclusion (as the laboratory has become), it is a place of demonstration. Yet, this demonstration is bundled up with economic concerns and market logic temporalities. We turn to this type of placemaking next.

Economic placemaking

Let us take a closer look at one of the objects in the room – the bed. It is a specially developed product for the healthcare industry with numerous special features, such as position adjustments, various detection functions and strategically situated lights. It is certainly an expensive product, which was placed in the lab-to-be without charge. When we spoke to the company representative who is involved in the lab project, he explained that he had read about the plans for a living lab in the local newspaper and had immediately contacted the project manager with the intention to join. He wanted to place his company's bed in the lab:

> We are a company that tries to constantly innovate. For us, the product may never be finished. We wanted to be involved in a project where others can evaluate our product. […] So, on the one hand it was a commercial decision [to join], but on the other hand, yes, there's a public relation

> advantage to it. You can say that you are an innovative company, but let it show that you dare to innovate.

According to the project manager, the lab project is a networking place. The companies came together on a voluntary basis, in order to develop scientific knowledge, while also expanding their market:

> They [the companies] all want to expand; most of them already have market share in healthcare, but others are thinking about expanding into healthcare, so for them this is like having a good show place, with new partners, so it's also an opportunity for them to get a new network, through me. So that's the give and take–I take some of their products, but don't forget that when they sell a product for 10.000 euros, they pay 4000, because there is profit to be made. So the 4000 they can actually deduct from their taxes. In the end, it is social entrepreneurship. They can also get tax deduction and write in their yearly report that they've worked with education, with public partners, bla-bla. That is the story they tell to the outside world, but if you talk privately, it's all about expanding their markets, having a showroom, having experience with partners in a non-commercial project. (Project leader, Interview)

Social entrepreneurship meant that the companies viewed this both as a lab project (what will we learn from this living lab?) and a marketing device (what are the advantages–tax-wise, marketing-wise and image-wise of being part of this place?). The cardboard sign inside the room works as a visibility device for the companies, but so do ads, flyers, introduction bundles, etc. As seen on the architecture company's website:

> GWA architects has been involved with various forms of assisted living for forty years. Our experience with design and construction is complemented by a scientifically grounded framework that defines the relation between design and its effect on residents. In addition, a Living Lab is created to investigate the sense of home and to share knowledge.

The companies claim a particular market – for cutting edge, innovative healthcare 'of the future'. This market-making is being done through the process of

laboratization and vise versa, which is a double procedure made possible by the value of this place as a co-laborator. This double act has been theorized by Asdal (2015) as a process of 'co-modification'. For a product to succeed, the object (in Asdal's case the Atlantic codfish) must be modified *simultaneously* with the market. The difference between an object and a commodity is clarified through a co-modification lens. A living lab-as-object can exist in the abstract, but a living lab-as-product must be made together with a market. The two happen simultaneously, because they constitute each other; in practice, a living lab would not exist without the invested parties in the project pursuing their goals in market-making; in this particular case this is true in the literal sense: there would be no bathroom tiles, no smart floor and no curtains. On the other hand, if there were no market for "the home of the future" in nursing homes, the lab would have no future either. A lab, just as an Atlantic codfish, is always placed not only socially and materially, but also economically. Laboratization is done simultaneously with and through marketization and – for both lab and fish – timing is everything.

Yet, simultaneity was not the only temporal element employed as market building in the co-laborator. A narrative of futurity was crucially related to the collaborative goals of the participants. The co-laborator seemed to be a place that provided a peek into the future of healthcare and this is what the companies were very keen on. The contributor who supplied a sound-absorbing ceiling for the lab explained how his company's participation is aimed at gathering future knowledge:

> Doing this project is not for now, it is for the future. I think nursing homes will change in the future, so it is important to know how this will be in 20 years. This is important for me now. This is why I want to be part of the lab. Our company always looks to the future, to new ways of thinking. Once you stop innovating, it's over. […] I believe that when you know what's going on in general in this sector – how people with dementia walk, how they find the bathroom, all these little things…maybe they are not useful for me now, but what is important is being on top of the developments, what's going on and what will happen in healthcare.

To be involved in the lab project is to be on top of current developments, which will form tomorrow's markets. Being a step ahead means not only having knowl-

edge but being involved with others who have knowledge. The market in which the companies want to be involved, is the healthcare market writ large and its temporality makes the project unstable by design; not aiming at stabilization, but at continuous development. The living lab "may not look the same in two years", the contributor of the bed mused. It must look differently, he insisted, because it must evolve, it must serve as a mirror for the future. The future, in terms of knowledge, is vital to the co-laborator, because future knowledge propels it forward, business-wise. The co-modification in the now (the market-making happening on par with the lab-making) is a projection to the future. This means that, unlike the codfish co-modification as a being and a product, the living lab is not characterized by singularity, but by multiplicity of intentions (knowledge, marketing, networking) and temporalities (now, the future of care, the past as therapeutic). The process of co-modification is therefore done today as a projection for future benefits. These temporalities are underwritten by a market logic, which becomes embedded within the lab as place of science and experimentation during its construction process. This means that the living lab is not only a living lab place, but also a marketplace, which is selling the future.

Discussion and Conclusions

The three steps of placemaking analyzed above – social, material and economic, and how they work (or not) together – are essential in understanding placemaking as a holistic process. The lab-to-be can only become a living lab when social networking, objects and market logic come together. It is this process that we have untangled here as the complex makings and doings that happen inside a co-laborator. This term emphasizes that places of science are constituted and constructed simultaneously with and through other doings.

While the relationship between place and knowledge production is a fruitful theme (Gieryn 2006, 2018), more theorizing needs to be taken a step earlier – when places are being constructed. The co-laborator is a term, which serves this purpose by addressing both laboratization and collaboration in their multiplicity. Collaboration is, indeed, working together and sharing ideas in the pursuit of a common goal, but such an understanding is insufficient here. Laboratization as collaboration is a process of negotiation and frictions, requiring work. The co-laborator is a fragile place – it is being done constantly through networking, but the lab is not a finished project: it projects future developments and resists stabilization by default. This is done both by people and objects, as the collabora-

tive efforts of the assembled network come together in a laboratized setting. The co-laborator acts as a connector; it is situated so that it contains the different placemakings, mediating and translating them. It tries (and sometimes fails) to bring together the social, political and economic questions into a workable whole. This requires a lot of effort, as existing infrastructures need to be altered or adjusted. The term, then, also refers to the labor – the work – that must be done, in order for the project to exist. The arrangement of the objects in the room and its temporalities all have to align within the real and metaphorical space of the co-laborator, which *both is and does l*abor, collaboration and laboratization.

These insights continue to conversations on places (Auge 1995; Cresswell 2004) and placemaking for care in particular (Oldenhof et al. 2016). Further, this article takes up Kerr and Garforth's call to shift attention to the mundane, affective practices in laboratories by 'thickening' (Bellacasa 2012) the analysis of science and paying attention to personal relationships (as shown by Street 2016), the "funny stuff", "affect and care, careers and futures" (Kerr and Garforth 2015: 17). The paper also demonstrates the need for critically examining laboratization practices in society and going beyond the metaphor of the laboratory (Guggenheim 2012) in assessing trendy places with scientific allure like living labs (Kavoren and van Heur 2014). Laboratization practices should be examined and understood as heterogeneous processes, where different agendas are at stake. Finally, we built on analyses of the institutional shaping of laboratory work (Kleinman 1998) in exploring how labs are a product of marketization and, importantly, relating this process to process of placemaking explicitly.

Empirically, this paper spotlighted living labs as liminally-positioned, problematic places. As a result of their positioning between laboratory and field, living labs are made through continuously connecting different worlds. The paper reveals the struggles to make a living lab by both showing what happened and what did not happen. Despite lofty goals of collaboration, the participants were only involved in small and concrete parts of the project. As we argue above, this is a natural result of the market logic underpinning the lab construction. It was important for the participants to be involved in the project, while the lab's future output was less of a concern. Another noticeable absence is that of the nursing home inhabitants, who may get to live in the apartment. The definition of a living lab emphasizes the user's role in co-production of knowledge. If this is so, then why is the user not part of the construction process at all? The only times the residents were discussed was when they needed to be removed from

the premises. The construction of the lab is certainly not a participatory project, which suggests that laboratization practices are goal oriented as opposed to participatory and open. This contrasts with the ideal notion of living labs as an innovation spaces for co-production of knowledge. The co-laborator is therefore not a democratic assemblage; it both includes and excludes. Therefore, this paper argued, the spatial must be understood as folded within social, material and economic concerns, as well as within particular temporalities. Making places for care is an effort not only of collaborations, but also of labor and laboratization.

"It is not down on any map; true places never are."
Herman Melville, Moby-Dick[46] *(2014 [1851])*

"I am rooted, but I flow"
Virginia Woolf, The Waves[47] *(1950 [1931])*

46 Published by Black and White Classics, New York
47 Published by Harcourt Brace, New York

Chapter 5

(Un)Folding Places with Care: Migrant caregivers 'dwelling-in-folds'

Abstract[48]

This paper is based on longitudinal ethnographic work among Bulgarian migrant women who work as lived-in caregivers and domestic servants in Italian households and explores the analytical potential of place and place making for transmigration literature by conceptualizing the co-production of place with subjectivities. Such approach sensitizes to mundane practices of care and belonging, which actively create migratory lives of meaning. Drawing on Deleuze's concept of the fold as subjectivity and Clifford's notion of dwelling-in-travelling, I propose the term 'dwelling-in-folds' – and its mechanism 'folding place' – in order to make sense of temporary migrants' experience of place(s) that foregrounds their ability to connect and reconcile fractures and discontinuities. In doing so, the paper folds place empirically – showing how 'dwelling-in-folds' is achieved and unfolds place analytically – demonstrating the potential of this concept for sociology and transmigration studies.

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> I carried to my lips a spoonful of the tea in which I had let soften a piece of madeleine. But at the very instant when the mouthful of tea mixed with cake-crumbs touched my palate, I quivered, attentive to the extraordinary thing that was happening to me.
> *Marcel Proust,* In Search of Lost Time

Introduction: why (un)fold place?

In the famous madeleine scene, Marcel Proust takes a bite of a sponge cake, which triggers a process of remembering that brings his childhood vividly to life. The taste, smell and feel of the madeleine cause a strange sensation, which leads him down the vicissitudes of memory and places him squarely into the past. The celebrated passage provides a description of the evocative power of memory to fold time. This paper takes its point of departure from this 'Proustian moment' in describing a similar folding: that of place, in order to enrich and nuance the narratives of transmigrant gendered lives, argue against the notion of liminality in conceptualizing such 'in-between' lives and add to debates on 'dwelling' as a particular mode of care.

This paper engages with, and contributes to, two distinct academic discussions: sociological debates on placemaking as subjectivity and transmigration studies. These debates have related to place in different ways, often implicitly. Yet, as Casey (2001: 684) argues, there is no self without place; sociality is always emplaced and embodied. To address this, ideas on place as relational, open and unfixed were developed in the 1990s (Massey 1994, 1995; Harvey 1996). These ideas are particularly relevant for studying migration practices and transnational migrants, as within transmigration studies "more may be said about the theme of place" (Rogers 2005: 405). The paper takes up this challenge by zooming in on mundane practices of care and placemaking and contributing ethnographic detail to the topic of gendered temporary labor migration in Europe.

Secondly, I relate to sociological literature on subjectivity as 'dwelling'. I built on Latimer and Munro's (2009) notion of 'relational extension' as a particular way of making home through caring and 'keeping' things. To do this, I sketch the living and dwelling practices of Bulgarian women migrants in Italy (called badanti), who work as lived-in caregivers and domestic servants in Italian households. Describing the intricacies of their transnational lives, I focus on the micro level of this migration pattern, nuancing their subservient positioning in the

international division of care labor by emphasizing practices of placemaking and showing how they actively build their world through a process I call '*folding*'.

My argument draws on two main sources – Deleuze's concept of the 'fold' (1993) as production of subjectivity, and Latimer and Munro's (2009) notion of dwelling as 'relational extension'. Both are pivotal in troubling the notion of place, and home, in the production of subjectivities. Following this blueprint, I focus on the co-production of place and subjectivities among migrant women caregivers, in order to show how they live complexity through placemaking. This paper takes on three tasks: it offers an alternative narrative of the lives of lived-in migrant caregivers that goes beyond the conceptualization of liminal lives; disrupts, expands and enriches place as a concept in migration literature; and proposes 'dwelling-in-folds' as an analytical frame for studying unsettled, de-territorialized, liminal lives. In doing so, the paper folds place empirically – showing how 'dwelling-in-folds' is achieved and unfolds place analytically – demonstrating the potential of this concept for sociology and migration studies.

The 'dwelling' of migrants

For a long time, migrants were considered people who moved from point A to point B, cutting off ties with their country of origin and integrating in the destination country. This traditional approach to migration was increasingly found lacking in the 1990s, as migration studies began to deal with enduring and continuing bonds between people and places. A reconceptualization of migrants coined the terms transmigrants and transnationalism (Glick Schiller et al. 1992; Portes 1996, 1997), contributing to an understanding of migration as an ongoing process, requiring work and the maintenance of relationships (Butcher 2009). Important work has been done on transnational communities (Portes 1996, 1997), transnational networks (Hannerz 1996), and cross-border families (Baldassar et al. 2006). In a further step, Morokvasic (2004) has pointed out that transnationalism often focuses on durable transnational links over time, arguing for a perspective on ephemeral phenomena of short-term mobility, instead; she used the term "settled in mobility" to draw attention to practices of transnational entrepreneurship among women migrants in East Europe. Furthermore, feminist literature on global labor migration has provided an important lens for analyzing gendered practices of the transnational care market (Hondagneur and Avila 1997; Anderson 2000; Ehrenreich and Hochschild 2003; Keough 2006; Lutz 2008; Boris and Parrenas 2010), linking transnational care practices to

neoliberal forms of exploitation and experiences of partial citizenship (Parrenas 2001).

This reconceptualization of transnational bonds coincided with a rethinking of the notion of place in human geography. A *placial* turn in geography (Casey 1993; Massey 1994; Harvey 1996; Soja 1996, Ingold 2000) opened up the notion of place, unfixing it from locality and arguing for places as relational and co-productive of social reality (Massey 1994; 2004; Cresswell 2004). Yet, in transnationalism literature, place is often used as a commonsense word, related to belonging or home (Schuster 2005; Nicholls and Uitermark 2016), but never unpacked or problematized[49] [50].

In sociology, particularly in discussions of the home as a place of care (Latimer and Munro 2009, Langstrup 2013), the relational experience of place was theorized more fruitfully. Latimer and Munro's (2009) notion of 'relational extension' (see also Latimer 2001) considered *dwelling* (Heidegger 1978) an action of affectively relating: "our argument is that dwelling is not only grounded within locales", but also "takes place" as and whenever relations are formed in the here and now" (Latimer and Munro 2009: 318). They argue that to dwell is *to care and to keep*, to give room to relationships. For Latimer and Munro, people perform relational extension in ways that helps them feel at home (p.329), as opposed to the notion of home as a constant locale. They present a different ontology of home, and therefore of place – one that is born through (care) relations. Such an unmoored ontology of place parallels Clifford's call for unraveling travelling cultures and their dwelling practices. He argued for delocalizing cultural practices with the term "dwelling-in-travelling." (1992: 108). Place in anthropological analyses has always had a localizing function – studying the island, the laboratory, the city. 'Dwelling-in-travelling' invites a different type of examination; one that attends to both movement and attachment and is therefore well suited to studying transmigration practices.

Bringing these discussions on place as relational and dwelling as a practice of relating together, I draw on Deleuze's notion of 'the fold' (1993), in making an argument about migrants 'dwelling-in-folds'. Such a view allows for considering place as a multitude of folds in a topology of endless possibilities folding into each other. The value of such an ontological approach is the affordance of theo-

49 An exception is Bosco (2009), who argued for a relational view on place.

50 Recently, Perez Murcia (2018) has taken a promising step in this direction by showing that places can be experienced as fractured and unfixed in his analysis of the liminal positioning of displaced people.

rizing place and subjectivity together. In many ways, the concept of the fold is a critique on traditional readings of subjectivity – those of strictly separate inside and outside. In Deleuze's words: "The outside is not a fixed limit, but a moving matter animated by peristaltic movements, folds and foldings that together make up an inside: they are not something other than the outside, but precisely the inside of the outside" (1993: 96-97). If subjectivities are only outsides folded in, then places (as understood by Massey 1994, Creesswell 2004 and Casey 1993) too are produced through folding and unfolding. This is important, because migrants do not only live in place (as traditional migration literature assumes), nor are they constantly moving (as much transnational literature describes) or locked in a state of liminality (refugees and displaced people). Transnational lives are a messy mixture of places, networks and relationships, which can be explored in depth by analysing the ways, in which places are produced subjectively. I therefore suggest that Deleuze's notion of 'the fold' allows for zooming in on migrants' mundane practices of care and belonging, which I will analyse here as acts of 'folding place'.

Method

This research is based on more than 8 years of interrupted, interval study in Italy and Bulgaria. My engagement with this topic began as an undergraduate project in 2009. Soon, it expanded to 6 months fieldwork in Italy and another 9 months two years later. In the context of my interest in place, I revisited Italy for a two-weeks immersive fieldwork in 2016. Since then, and in-between periods of fieldwork, I have stayed in touch with the majority of my informants through social media and online conversations. The fieldwork periods can be roughly divided into three cycles: early (2009, summer of 2010), main (all of 2013) and late (summer of 2016). These were intense and immersive engagements with the field, while the periods in-between can be characterized as slow and incidental data collection. I have spoken informally and conducted semi-structured interviews with 34 informants (badanti), more than 20 family members, friends and dependents of theirs, as well as 8 Italian employers and 2 Bulgarian embassy officials.

The research has benefitted from a long-lasting engagement with the same group of migrants. This allowed excellent rapport. Most of the data is based on informal interviews and observations, as well as participant observation in both countries. In the first two fieldwork cycles, most of the data was collected

through unrecorded informal conversations, as many of my informants did not wish to be recorded discussing intimate information. In the latter cycle, most of the conversations were recorded, although this altered the dynamics slightly in favor of formalization. It should be noted that my initial focus was not on placemaking, but on migration and gendered work. My analysis on place came only at the last fieldwork cycle, when I adjusted my lens to focus on the experience of living and dwelling within transnational lives.

Certainly, any current research on migrants is in practice multi-sited (Marcus 1995; Hannerz 2003). The fieldwork was focused in a small town, south of Rome, yet I also visited Brescia, Venice, Milan, the Amalfi coast, Napoli and Rome. In Bulgaria I spent time in the southeast and northwest of the country. The decision to do work in both courtiers, or what Anthias and Lazaridis (2010:10) call the *dual perspective* on migration, proved valuable, as I was able to understand how these places come together in making up badanti's lives. The places are sketched below, yet in other ways they are 'folded', in order to fit within this article. The local diversity of Italy folds on itself, as it becomes "Italy" in the text, losing, perhaps, some nuances of place.

In what follows, I first position badanti geographically: where they are, where they come from and what tensions this engenders. Next, I show how folding is done and the efforts this requires. In a third step, the notion of place is re-constructed and an argument is made for badanti 'dwelling-in-folds'. The concluding discussion reflects on this differently understood notion of place, as well as on 'folding' as a mechanism, which opens up space for new research concerns in both sociology and transmigration studies.

Between folds

> The palm tree trunk is uncomfortable, and I move my back up, checking my watch. When will this bus arrive?! People around me are just as impatient and sit on the cool ground, because the heat is palpable despite it being seven pm and the end of October. 'I just spoke to him'- Denis shouts so everyone would hear. 'He's in a traffic jam, but he'll be here soon.'
>
> Like much else in Nettuno, bus services to Bulgaria are family affairs. Two buses cross the 1600 kilometers every Thursday and Saturday, transporting people, luggage, money, Bulgarian cheese and other much-

missed, much-loved delicacies between Nettuno and Bulgaria. The bus drivers are young men from the migrant community, handling informal money transfers between migrants and their families at home. Ivo, the driver of this delayed bus, is Denis's cousin's boyfriend. 'He drinks on the job'- Denis tells me later. 'It's not about any traffic jams...'

As the small, dilapidated bus bearing the Bulgarian, Italian, and EU flags finally arrives, chaos descends. 'Bulgarians have never been much good at forming queues', one woman happily jokes, as people push forward. Ivo starts selling cigarette boxes at half the Italian price. 'Long live Bulgaria!'- he laughs and stuffs another twenty-euro bill in his pocket. Irma, a badante in her seventh year in Nettuno, grabs a suitcase her husband had sent. She tells me excitedly that there must be a present inside, as she had just had her 44th birthday a week ago. Others are asking the price of cheese and peppers. I notice three women descending the bus, looking tired. 'How are the children?'- someone asks them. 'The baby's getting biiig!' says Eva, who is returning from a home visit. She had left Italy on the same bus two weeks ago. 'Time flies when I go home'- she says. 'Now back to that crazy grandma.' She means the Italian signora she cares for. I had heard stories about Eva's difficulties with this job. The lady, who suffers from dementia, cleverly manages to run out of the house and roam the streets in her underwear, as Eva desperately tries to get her back inside. An hour later the parking lot is almost empty. I offer Eva to help carry her bags home. "Home is the other way", she says.

Nettuno is a small coastal town of about 50 thousand inhabitants, where I often overhear Bulgarian speech when walking down the street. According to the Bulgarian embassy, unofficial data suggests that Bulgarians living in the region are in the thousands, swelling during summers and dwindling in winter. Although I met migrant waiters in pizza places, men working hard-to-find construction jobs, and youngsters living with their parents, the overwhelming majority of Bulgarian migrants in Nettuno are women, who work as lived-in domestic workers and caregivers in Italian homes. Italians call them 'badanti'. (Fieldnotes, 2013)

The phenomenon of migrant badanti exploded in Bulgaria at the turn of the century, as more and more women left their homes for temporary care work in Italy (Komandarev 2010). The structural conditions, which allowed for this migration

pattern to develop, were the dismal financial situation in Bulgaria and the strong demand for migrant female labor in Italy. The Communist Party ruled Bulgaria until the end of 1989. In the beginning of the 1990s shock therapy – "the official doctrine of the IMF [which was] the major source of financial support to most CEECs[51]" (Giatzidis 2002:81) – commenced, aiming to reconstruct the economic sector and introduce market economy. Bulgaria "experienced one of the steepest declines in employment in the region: a 25 per cent in jobs, and nearly double the unemployment rate relative to other countries in the region" (Glass 2008:760). This 'transition' period was especially hard on women (Johnson and Robinson 2007) since during socialism the state provided a large amount of administrative jobs to them and those were the first jobs to be lost due to privatization and welfare policy reform (Haney 1997).

The unemployment in post-socialist Bulgaria coincided with Italian families' need for migrant female labor to fill the gap in elderly care left by the entry of Italian women into the labor force (Andall 2000). Care for the elderly in Italy[52] 'is delegated almost entirely to the family' with little participation from the state (Bettio et al. 2006: 272). Exacerbating this issue are the overwhelming demographic changes taking place in the last forty years. As absolute fertility rates have dropped dramatically and life longevity, typical of post-industrial societies increases, Italy's family structures "will come to resemble an inverted pyramid, with an ever-smaller cohort of youth at the bottom and a mass of old people at the top" (Ginsborg 2003: 70). Commodification of care work – a process Lyon (2006:213) calls the "defamilization of care" – was born of necessity, as families could not cope with the burden of their elderly. This led to "a new division of labor" in Italy, where "female migrants [are] gradually replacing unpaid care by native women", constructing a "new, immigration-based care model" (Bettio 2006: 271-272).

Despite the clear logic of these push-pull factors, the decision to leave one's home is taken within different considerations. The majority of my informants left, in search of possibilities for life goals advancement. In fact, as Parrenas (2001) shows, it is not the poorest women, who leave. Migration is a project, requiring both financial and social resources. Parrenas conceptualized the network of women and care migration work among Philippine women as *care*

51 Central and East European Countries.
52 It should be noted here that care arrangements differ substantially within Italy, particularly between north and south.

chains, emphasizing both the connection and the limitations these networks create. Philippine women leave the Philippines, working as lived-in caregivers in Europe, Asia or the U.S., but hire poorer Philippine women to care for their own children. These global gendered care chains point to the most important trade-off many of my informants faced: care by staying or care by leaving.

Care by staying is the preferred, idealized version; it is "warm" care (Pols and Moser 2009) and it is physical, immediate and unambiguous. Staying seemed to be a choice, discursively anchored in love. When Alena's sister came to Nettuno as a substitute for a badante, who had gone home for the summer, she decided to return to Bulgaria as soon as possible:

> 'They [the children] are too young. I cannot abandon them. Maybe when they are older. Then they will need other things…now they need me.'[53]

When making the decision to stay or to go, being a "bad mother"[54] was always given as the main reason. Caregivers working in Italy for years used the "bad mother" trope to refer to themselves or others, as the quality of being there for their children was seen literally: being at home, at the parent-teacher conferences, at the birthday party, on the beach, at the kindergarten celebration, the hospital, the dentist, the school musical. 'Good motherhood' is *done in place* and is a physical, affective confirmation of love. 'Bad motherhood' is being away from place and is seen as cold, disaffected and distanced. The first one is correlated to staying and the latter with leaving in the gendered migratory work world:

> When I board that bus (to go to Italy), I know (…) I'm leaving. It is so final, you know? Even if I change my mind later, time doesn't stand still. They (her two children) will be grown. And they will always know, 'we grew up without a mother'. (Boyana, Interview 2013)

This dilemma sets up a dichotomy of place – stay or leave, here or there, good or bad. If one is here, one cannot be there. The migratory trajectory promises benefits, but it also demands losses. Physical presence is by far perceived as the greatest loss. This loss is palpable on many levels – many caregivers worried about

53 All quotes are translated from Bulgarian by the author.

54 For a valuable analysis of transnational motherhood see Hondagneu-Sotelo and Avila (1997). They explore how "the meanings of motherhood are rearranged to accommodate spatial and temporal separations" (p.548).

how distance is affecting their marriage; others regretted not being able to spend time with an ill or dying parent. Yet, children were the most pronounced subjects of discussion. Often, there were not many family members, who could effectively care for the children in their stead. Fathers, in particular, were considered unable to care well. In Alena's words:

> Naiden [her husband] is doing his best, but he's a man. He doesn't know what to do [with the children]. My oldest [daughter] does most of the cooking and cleaning, but children need their mother. He doesn't know what to say to them… how to [show] love.

Yet, children's age is seen as a qualifying break in the 'being there' discourse. When children are young, they need their mothers to "be there". When they are older, however, they need "things". This is where 'good motherhood' – an otherwise very clear concept – becomes muddled and confusing, often indistinguishable from 'bad motherhood'.

> Yes, it is good [to be there]. But my children are teenagers now. Do they need me to tuck them in at night? No. They need to be able to study, go to university, and buy clothes. I am a good mother, because I am here. (Irma, Interview 2016)

There was some debate whether this type of reasoning is just "an excuse", but it was often echoed in conversations with dependents in Bulgaria. Irma's two sons referred to her working in Italy as "caring for us" and said that she is "away from home, in order to help my brother and me". Irma's elderly parents lauded her as "a great mother", who "sacrifices her own comfort". The idea of a good life often touched on having "things". A laptop, a phone, books, boots, glasses, and backpacks were continuously mentioned in conversations as things that children need. These things were important tools in the women's placemaking efforts:

> I want my daughter to have a good home. […] to come back from school and have new books on her bookshelf and a good backpack. She knows that she has a good home and […]that she is cared for. (Boyana, Interview 2013)

Being in or away from home qualified this work migration pattern in terms of good and bad motherhood. A rather simplistic idea of 'being there' becomes more complex, when understood in the context of transmigrant – or placeless – care. Migrant women wanted to be with their children, yet they also wanted to provide a good home for them by ensuring that they have the "things" that they need. They were busy with placemaking activities that were happening 1600 km away; they showed care and attention to detail, such as the color of the new bathroom tiles or the new sofa. It is easy to understand this migration pattern in the frame of two places, with transnational workers living 'liminal' lives, caught in-between home and away. Yet, while in formal interviews informants referred to Italy and Bulgaria as separate places, during informal conversations, it became clear that these were not so separate 'in practice'. Women often discussed things happening back home as if they were present in the moment; I often had to clarify the 'where' of stories:

> 'He [her son] is at the shop now, can you take over for me [asking her friend]? I will need an hour or so…'
> 'Which shop?'
> 'He is picking the tiles for the bathroom.'
> 'So he is in Bulgaria?'
> 'Yes, but his father is no good at this. I need my friend to cover for me, so I can advise him (…) on the phone.'
> (Conversation with Alena, 2016)

Lives are messy, and transnational lives even more so. Here and there, in terms of geographical realities, are very much fixed. Distance must be overcome through time; one cannot "be there" and thus cannot always be a "good mother". However, here and there are not so fixed in terms of experience, or what Clifford (1992) and Ingold (2000, 2005), via Heidegger, call 'dwelling'. Despite being here, in Italy, women seemed to also be there, in Bulgaria. This sense of what I call simultaneity of place differs from liminality, which signals an unfinished and uncomfortable incompleteness of being. The analytical strength of liminality, especially in the literature on transnationalism is to point to how migrant lives are partial (Parrenas 2001; for an example on displaced people, see Brun 2015 and Perez Murcia 2018) in a neoliberal global economy of exploitation, which is also gendered and racialized (see Andall 2000, Anthias and Lazaridis

2000, Chang 2000). Such works are very valuable, yet this paper diverges from their discussions and focuses on the flip side of this in-betweenness. My data suggests that despite the geographical gap in their everyday lives, Bulgarian migrant women caregivers in Italy work with place in surprising ways that allow to care for their loved ones in different ways – by 'being there' or by providing 'things'. "Settled in mobility" (Morokvasic 2004), badanti construct place that is simultaneous with both *here* and *there*. Time is the biggest issue that they must negotiate through folding, as it cannot be undone. Distance may be overcome, but time will always be lost. Meanings are made and remade between the folds of time – the meaning of good motherhood or the ideal of being there for young children and providing things for older children. The time that is lost is turned into an asset, as women migrants construct places of dwelling by folding here and there, simultaneously.

Folding work

> Rayna is worried about signore Angelo. He is getting weaker, refuses to eat. When I visit them, he sleeps. Rayna tells me that he looks "like a child". 'Just like Kaloyan [her son]. The other day I went to check on him and I saw Kaloyan, I swear! (…) The body is so small now, he needs me so much. There is a song my son likes. He begs me to sing it over the phone. I sing it to signore Angelo now; it calms him down. Calms us both down.' (Conversation with Rayna, Fieldnotes, 2013)

Rayna's son Kaloyan sang the song for me, when I visited their home in Bulgaria months later. He was 8 years old at the time and said that he missed his mother very much. When asked who sings the song to him now, he said that his mother does; only it has to be over the phone, because "mommy is far away". The question had seemed strange to him.

A month before signore Angelo's passing, Rayna held him in her arms and sang her son's favorite song. At this point, his body was very small, and he disappeared in her embrace. Rayna's emotional state was heavy: she spent her days looking after the dying man. She had worked there for 2 years. Furthermore, she was worried about her job, as it was clear that she would no longer stay employed, once signore Angelo passed away. She had started to look for a new placement by spreading the word to other badanti in Nettuno and by talking

to the local church, which often facilitates badanti jobs. The search had proved unsuccessful and Rayna was worried. Such periods are especially difficult on badanti, who spend money, living in a rented room, and are away from their families, without making any money. The heavy atmosphere in the household was mirrored by signora Nunzia – signore Angelo's eldest daughter – who walked around the house whispering prayers and erupting in sudden, explosive crying spells that could be heard far away. Singing helped:

> I felt so very far away from everything, but then I sang our song [and] I was back home, holding Kaloyan. It was wonderful.

If places are experiences and emerge as assemblages of materialities, emotions, imaginings and ideas, then Rayna experienced 'there', while being 'here'. Feelings of loneliness and anxiety, the notes and words of a favorite song and signore Angelo's withering body merged to make up a space that is neither here, nor there, but provides comfort.

A similar simultaneity of place happened when Nevena was folding t-shirts in the home of signora Carla:

> 'Carmela [daughter of signora Carla] wants me to fold the children's t-shirts like this (she shows me). This is a stupid way of doing it; it is not how I do it. (…) I am a mother for almost 20 years; I know how to fold t-shirts. My daughter has these horrible Metallica t-shirts – I've folded so many of them. You know, I think of my daughter when I do the ironing, do the t-shirts. I called her yesterday and asked 'Are you folding your t-shirts? I know how you are…' I told her, I'm folding t-shirts now, you do the same…' (Conversation with Nevena, Fieldnotes 2016)

Materialities are rightly considered crucial in discussions of place (Thrift 1999). Places are not abstract; they have a particular feel, smell, and touch. The feeling one gets when entering a nursing home has much to do with the characteristic smell of such places. The dunes and wind of an island town are very much part of how this island is a particular place (Ivanova et al. 2016). Yet materialities are not only grounding in the 'here', they can also transport us 'there'. Proust's madeleine is a time-place machine that takes him back to his childhood. The t-shirts Nevena is folding do both: the action of folding grounds her in the 'here'

– the touch of the materials, the warmth of the sun coming through the balcony, the colorful mosaic beneath her feet, the Italian language from the street – but that same action of folding takes her 'there'. Her daughter's fingers folding, as her own hands are busy; the "horrible" Metallica t-shirts; the white window shades in her home; the ironing table with the chipped end. Nevena lives in a place, which is more than in-between Italy and Bulgaria – it is both. She stops folding and goes downstairs to make lunch, but while cooking, she calls her daughter, asking about the neighbor's dog ("Did it stop barking in the evening?"), her daughter's cousin's birthday ("Do you have a nice dress to wear? Do you need more money to buy one?") and, of course, the t-shirts ("Are you folding your laundry? I know how you are!).

Technology helps to connect and experience simultaneity of place by allowing a type of "being there". Yet, it can also fracture place by clarifying and sharpening here vs. there. Boyana uses a tablet to talk to her daughter daily. She has it on now, while cutting onions and carrots. This used to be much harder back in 2011, when I first met Boyana. She called from a phone without a screen and was often upset that she is not able to "see" her children. Her daughter is showing her a dance routine she learned in her ballet class that day. "Beautiful! Bravo, mila[55]!" – she says. The tiny 9-year-old screams with pleasure into the screen, as signora Francesca (whose house this is) changes the TV channels. "More salt"- she says to Boyana in Italian. The argument is an old one. Her sons had instructed Boyana to use less salt, on doctor's orders, much to the annoyance of the burly and glamorous signora Francesca, who had lived a wonderful life of indulgence and was not about to change gears now, at 88. As Boyana tries to reason with her employer, her daughter spins out of the screen and we hear collision sounds, followed by anguished cries. Soon after a tear-faced little girl reappears on the screen, as her mother tries to console her. Boyana leaves the room with the tablet and asks me to make sure signora Francesca does not add salt to the pan. Luckily, only a bruised knee results from this 'radiator-crash' incident and Boyana is soon back to serve dinner. I later ask whether she is upset about it:

> 'No. Children fall all the time. And mine is definitely a crier.'
> 'But you were not there when she fell.'

55 (From Bulgarian) Well done, dear!

'Of course, I was. You were, too! Besides, if I was back home, I couldn't have sent het to ballet classes.'

Were we really there? All three of us had gasped upon hearing the child's screams and Boyana had hurried to console her. Yet, she was not there to kiss the tears away or place a Band-Aid. On the other hand, this 9-year-old can go to ballet, because her mother works abroad. There are different modes of care here, and all of them require choices. These choices are far from ideal, but the ability to choose – to care by staying or by leaving – presents a different view of migrant caregivers; they are able to mold their lives in powerful ways. They make decisions and reason them, acting in and with care every day, both in their work and home life. In fact, the two often become one, folding in on each other. Signora Francesca does not mind the tablet being taken around the house, often speaking to the little child in Italian (to which Boyana's daughter replies in Bulgarian, neither actually understanding the other). Boyana leaving the room has consequences, too – Francesca may put more salt in the dish (I tried my best to prevent that). Being in Italy allows for ballet lessons, which, Boyana tells, make her daughter popular at school in Bulgaria. These links between the two countries are not merely connections: they construct a third space, as both places are folded onto each other, becoming everyday life for badanti. The ability to "be there" enables simultaneity of place.

Importantly, achieving this simultaneity requires a lot of work. Many informants arranged their schedules and the schedules of their children in Bulgaria, so that "mama can be there" or "mama can help". This has a placemaking effect in both countries, in terms of consequences – both places are being rearranged in multiple ways, in order to allow 'folding'. For migrant caregivers this placemaking effect is how they manage a transnational life. Folding requires effort – organizational and emotional, as well as help and perseverance, as it is often unsuccessful. 'Folding place', therefore, is a process of continuing adjustment and adaptation. Folding place(s), in order to construct a place that "feels good", migrant women make choices and create possibilities. It is often forgotten that the famous madeleine moment did not simply happen; Proust had to put much effort into examining his memories. This points to the same necessity, as 'dwelling-in-folds' requires – the ability to create. We may say that Bulgarian migrant women dwell in a state of travel through (thus not between) places and this is not done mindlessly; it is an action of creating – singing a song, in order

to feel connected, consoling your child via Skype or making the decision to go, in order to be a good mother.

Dwelling-in-folds

> 'I know I'm supposed to say that I miss home. Of course, I do. But it's not so simple as going back.'
> 'Is Italy home now?'
> 'No. Italy allows me to be there for my children…home is home.'
> 'You are away from home; you are here.'
> 'Yes, but I am much more present at home, because I am here. Everything my children have, the house, my daughter studying…I am much more home than I was before. They feel this, and I feel it too. This [feeling] is a good place to be.' (Conversation with Alena, Fieldnotes 2016)

For the last 7 years, Alena has been living in a town on the Amalfi coast, in the skirts of Mount Vesuvius, called Torre Annunziata. Almost every morning Alena wakes up and walks down the boulevard, along colorful houses and under hanging laundry lines, to the pastry shop of Alberto, where she buys 2 Napoleon cakes for herself and signora Rosanella. They have breakfast, then they watch the news and Alena prepares lunch. In the summer, she complains of the heat around noon and throws a bucket of water on the tiles in the back yard to allow them to "breathe". In the evening she speaks fast Italian with the neighbor, signora Silvia, whose eldest son is heartbroken over a girl who left him for his best friend. Alena is here, in the south of Italy, just a throw away from Naples. However, every morning, before leaving the house, she calls her husband Naiden, who is at home, in the northwest of Bulgaria, in a small town called Gramada. They talk for an hour; there is much to discuss: her youngest son is allergic to something and they must find out what it is; the roof is leaking and tiles must be replaced; Naiden's elderly mother is recovering from a heart-attack and her medicines are very expensive; the oak tree in the back garden must be cut off; Naiden misses his wife and is lonely. While walking down the street to Alberto's pastries, Alena is on the phone with her sister. When will she arrive? Who will look after the children? After lunch, Alena gives signora Rosanella her medicines – three blue pills and two white ones – but is thinking about her son's allergies. Could it be dust, because Naiden does not clean the house as well as she would? Now she is

doing the ironing and dictating a list to me – I am writing down all the materials that Naiden will need in order to fix the roof himself. We calculate the costs, as she makes piles of clothes – dresses on one side, skirts on the other, and blouses sorted by color. "Signora Rosanella likes her clothes strictly separated" – she says and continues adding numbers in her head.

When Alena says that Italy is not home, she means that it is not a place to stay; it is not a place to belong. However, it is by now, a very familiar structure to her; she feels at ease, she greets the lady at the vegetable stand and the tabaccheria man. She has a favorite spot on the beach; she likes the ice cream stand near the station and avoids the one on the main boulevard. Yet, Torre Annunziata is a place of living, not of dwelling. The village Gramada is where Alena was born, where she grew up and had her family; she knows everyone there, looks forward to every piece of gossip and will one day return. However, when she visits, she is surprised to see a new clothing shop on the main street or to learn that busses are cancelled on Tuesday afternoons. Gramada is an idealized place of being; it is home, but it is not tangible. Dwelling, in Heidegger's sense, is where one is at home, where one has a place, where sense-making practices are located in familiar structures of being (Malpas 2006). An existential spatiality, a place of being is where Dasein is grounded. Where does Alena belong?

Drawing on Deleuze's concept of the fold as subjectivity and Clifford's notion of dwelling-in-travelling, I propose the term 'dwelling-in-folds', in order to make sense of temporary migrants' experience of place(s) that foregrounds their ability to connect and reconcile fractures and discontinuities. As argued earlier, ideas of settlement, integration and temporary migration are in need of advancement and reconceptualization. 'Settled in mobility' (Morokvasic 2004) is a step toward understanding a different kind of migration, where movement becomes a way of being. 'Dwelling-in-folds' takes this idea further by zooming in on migrant micro worlds and describing *how* such temporary lifestyles are experienced and accomplished. The concept, therefore, emphasizes a process, as opposed to a state. Dwelling-in-folds implies effort and work and is an ongoing struggle to connect, to feel connected and to 'be there'. Yet, as Alena says, this feeling is "a good place to be". She does not refer to a specific location, but to an experience of being; to the fold. The fold allows her to care for her children and achieve her goals, which makes her feel good. She is "much more present at home", because she can contribute to it; she is a good mother and is able to express her love. This is where she dwells; this is a place of being, where her identify, love and belonging

are grounded. If belonging is a grounding feeling of acceptance and affect, then Alena feels it in the fold of both Italy and Bulgaria. Neither place is complete for her, yet the existence within both – when they are folded in one experience of being – is where she dwells. Dwelling-in-folds may be partial and incomplete in terms of space (the physical reality of where one is), but this analysis shows that it is much fuller and satisfying in terms of place[56] (the experience of being emplaced). This does not mean that dwelling-in-folds is unproblematic, or even that it is, or should be, desirable. Folding places is an enormous task – taxing, difficult and often unsuccessful. The notion of dwelling-in-folds does not seek to romanticize migrants' lives. What it offers is another way of thinking temporary living arrangements in a global economy of flows and movement, one that takes experience of, and belonging to, place as its unit of analysis.

Discussion: Dwelling in heterogeneity and complexity

This paper presented an ethnographic account on how women transmigrants construct a place of belonging, where they "feel good" by 'being' in both home and host country. This is what I called 'folding place', resulting in an ontological condition of 'dwelling-in-folds', or folding/molding/bending both home and host country into a place of migrant existence. The paper 'folded' place by an empirical analysis of badanti's 'dwelling-in-folds' and 'unfolded' place by a theoretical consideration of place as 'dwelling'.

In 'folding' place empirically, the paper thinks migrant women's positioning in the global care economy differently. Acknowledging their precarious situation and the good work that has been done on this subject, I try to go a different route by attending to how migrants construct meaningful lives of self-acceptance, going beyond analyses of liminality and partiality. The concept of liminality assumes rootedness in two different places and constructs the transmigrant as caught in-between, while the concept 'dwelling-in-folds' overrides the boundedness of places as locale, acknowledging that dwelling is an ontological state of being. An analysis of folding and dwelling-in-folds sheds light on *how women transmigrants live complexity*.

56 The literature makes a distinction between space and place, defining space as an impersonal, physical reality and place as the lived experience of that reality. For more see Creswell (2004). The exception to this is De Certeau (1984), who made the exact same distinction, but flipping the term space; to him space is "composed of intersections of mobile elements" and "a practiced place" (p.117).

In 'unfolding' place, I presented an analysis of place as co-produced with subjectivity, allowing for a deeper examination of unsettled, de-territorialized, liminal, transnational lives. Following Latimer and Munro's analysis of the home as a practice of dwelling, my analysis confirmed their argument that "dwelling is better understood today as that which *takes place* in terms of relations, rather than be defined in terms of a fixed abode." (2009: 328, emphasis in original) Building on this understanding of place as relationally produced through keeping with things, I add a temporal dimension to this process: not only does dwelling take place "as and whenever relations are formed in the here and now" (ibid.: 318), but also as they are formed in the 'then and there'. Migrant women's dwelling is produced through "keeping with" both here and back home, now and back then. Managing the "making room" for these temporalities is a particular mode of dwelling, which I call 'dwelling-in-folds'. This analysis contributes to sociological debates on troubling the notion of home and place further, while also suggesting that 'relational extension' (Latimer 2001, Latimer and Munro 2009) may be achieved as relations "take place" at a distance, through memory and in the imagination, as well as through objects and place.

While this paper made an empirical and conceptual contribution through 'folding' and 'unfolding' place, the analysis has also brought up a number of questions. For instance, how do (new) technologies mediate folding? In many ways, my data suggests that technology has facilitated folding, especially since the process of 'being there' had become much easier as time progressed and badanti acquired tablets and smart phones. While this may read as a technological determinist argument, folding suggests the experience of being present in another place: this may be done through the ability to contribute 'things', through ironing shirts and experiencing another place or through singing a song. Yet, it cannot be denied that technologies play a big role in the intensity of folding, affecting heavily the ways of constructing 'dwelling'. The mediation of technology of the experience of being in relation to place would be a fascinating topic to further explore and migratory projects lend themselves well to such analyses. Other important questions might deal with the normative charge of folding as a mechanism of living migrant lives. Should it be seen as a positive concept? How do dependents experience folding on the other end of migratory chains? What are people's abilities to fold in productive ways? Can folding be harmful?

Finally, this paper attempted to show how rich and multifaceted the concept of place can be, and how it can be fruitfully employed in both sociological discussions of relationality and subjectivity and transmigration studies. Not only are places open, ephemeral, unfixed and emerging; they are also bendable, foldable and moldable. Their multiplicities should be unfolded with care.

Appendix

Badanti women who 'spoke' in this chapter:

Irma
44[57] years old; from Bulgaria's northwestern region; village near the Danube River
3 children in their teenage years – two daughters and a son; divorced

Eva
51 years old; from Bulgaria's northwestern region; comes from Vidin town; married; two grown children; her daughter has recently given birth to a baby girl

Alena
46 years old; from Bulgaria's northwestern region; village; married to husband Naiden for 24 years; three children – daughter (18) and two sons (12 and 14)

Boyana
41 years old; from the northeast of Bulgaria; divorced; two children: a son (18) and a daughter (9)

Rayna
42 years old; from the capital Sofia; married to husband Ivan for 15 years; two children: sons Kaloyan (11) and Kiril (15)

Nevena
52 years old; from Bulgaria's northwestern region; small village near Vidin town; one daughter (25)

57 This biographical information refers to the time I first met with these badanti.

"To fly is the opposite of traveling: you cross a gap in space, you vanish into the void, you accept not being in a place for a duration that is itself a kind of void in time; then you reappear, in a place and in a moment with no relation to the where and when in which you vanished."
Italo Calvino, If on a Winter's Night a Traveler[58] *(1981[1979])*

58 Translated by Willian Weaver and published by Harcourt Brace Jovanovich, New York.

Chapter 6

Post-Place Care: Disrupting place-care ontologies

Abstract[59]

With the advent of telecare and the logic of information technologies in health care, the idea of placeless care has taken root, capturing imaginations and promising placeless caring futures. This 'de-territorialisation of care' has been challenged by studies of care practices 'on the ground', showing that care is always (materially) placed. Yet, while sociological scholarship has taken the role of place seriously, there is little conceptual attention for how we may think through immateriality and the changing nature of place in health care. Based on a case study of the introduction of a sensory reality technology into a care organisation, this paper argues that we need (1) to push the definition of placed care into new (digitally produced) landscapes and (2) a new vocabulary, with which to address and conceptualise this changing nature of care places. The paper introduces the term post-place, as a first step in developing such a vocabulary. Post-place care, unlike the idea of placeless care or emplaced care, is an inclusive, open and generative concept. Its strength lies in its disruptive potential for challenging existing place-care ontologies and opening up productive space for thinking through the changing landscapes of health care.

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Introduction

Place and materiality have been conceptualised in the sociology of health and illness as co- constitutive of care practices (Bell 2018, Ivanova et al. 2016, Martin et al. 2015, Weiner and Will 2018). While the avenue of emplaced care has proven fruitful in healthcare analyses, the continuous advent of digitalised technologies[60] is poised to complicate what we consider 'the place of care' (Dyb and Halford 2009). On the one hand, the so-called 'technologies of place- less care' promise to do away with place (Cairncross 1997, Giddens 1990) as 'technological utopias still abound in the decision makers' minds' (Berg 2002). On the other hand, studies in the field of science and technology studies (STS) and the sociology of health and illness (SHI) have pushed against the notion of placeless care, showing that care is always (materially) emplaced (Lopez and Sanchez-Criado 2009, Oudshoorn 2011, Pols 2012). Yet other literature considering care places has focused on the 'feel' of medical places as assemblages of material, affective and sensory elements (Bille et al. 2015, Duff 2016, Martin et al. 2019), as well as the role of place as pedagogical tool in medicine (Bartram 2019). These debates have emphasised the role of place differently, foregrounding technology, affect, materiality, architecture, 'atmospheres', care processes and simulation.

In this paper, I build on these debates to argue that the changing care landscapes require a reconsideration of the very nature of place and the conceptual vocabulary we use in making sense of it. The paper opens up space for such reconsideration, engaging with debates on placemaking in health care (Ivanova et al. 2016, Oldenhof et al. 2016), materialities of care (Buse et al. 2018, Nettleton et al. 2019) and STS discussions of 'placeless' care (Langstrup 2013, Oudshoorn 2011, Pols 2012), arguing for an extended conceptualisation of place that integrates these discussions. It furthermore answers Bartram's (2019) call for scholars to 'unpack how place works in simulated spaces'. Finally, inspired by Agnew's notion of post-place politics (2016), I suggest the term post-place care as an attempt to 'unsettle' (Murphy 2015) common sense place-care ontologies and open up generative space for thinking through place in care differently.

The empirical case on which this paper is based is a technology that is said to create an immersive experience of place – the sensory reality pod (SRP), also

60 I do not mean to imply that there is something radically different happening in terms of technological changes in healthcare, as I agree that technologies – be they digital or not – have always affected and have been affected by care practices. However, I do believe that current sociological debates on care are often framed in terms of the "decline of place" (Dyb and Halford 2009) or care materialities (Buse et al. 2018). It is this dichotomy that I aim to (carefully) unsettle.

referred to as Experience Cabin[61]. The SRP is a wooden cabin, fitted with panels, which stimulate the senses: sight, smell, hearing, touch and taste. By creating neurobiological stimuli for the five senses simultaneously, the Pod creates sensory alignment – a state in which all senses are said to be working in unison. This produces an immersive environment, where a person can fully experience another place, all the while sitting in the wooden cabin. The technology is being launched and tested in many different fields: interactive gaming, wellness and spa, education and training, holidays and leisure, as well as in warfare training. However, health care is considered one of the most important markets for sensory reality (SR), particularly mental care (dementia, PTSD, autism, brain damage, burn-out), as the technology is claimed to be healing through targeted sense stimulation. Healthcare organizations in the Netherlands, where this technology is being introduced, are interested in testing its potential benefits, not least because of the cabin's high level of customisation: once inside, the user's vitals are recorded and stored, allowing the Pod to predict what type of content would make one feel better or worse.

For the purposes of this paper, the SRP is a fascinating place to think through conceptually, because it is a layered place – a cabin, a gathering data device, a promise, a multiplicity of 'experiences', a potentiality of anywhere. The Pod both questions the concept of place (where is place if we can go anywhere once we step inside the cabin?) and reinserts its importance for caring (where and how patients use the cabin matters), while also revealing the role designers and technicians play in placemaking for care through simulation. It is important to note that the paper does not present results on whether the SRP works as an innovative technology and does not argue for or against its implementation. Instead, I use the Pod as a heuristic for understanding and conceptualising the changing nature of place in health care.

In what follows I locate the paper conceptually by presenting the debates it engages with and contributes to. I then analyse the Pod in three steps: as a layered place, as a caring place and finally, as post-place care. The discussion unravels both the promise of 'placeless technology' and the insistence that care practices are firmly placed, with the help of a new, inclusive and disruptive ontology, which goes beyond – and integrates – thinking of place-less and place-full care. Finally, I suggest a research agenda for studying 'placeless' care places in the

61 In Dutch: belevingscabine.

context of sensory reality care, calling for thinking places for, and materialities of, care differently.

Disrupting 'placeless' care

Citing Agnew's (1987) outline of fundamental characteristics of place, Cresswell introduces place as 'meaningful location' in three steps: '1. Location 2. Locale 3. Sense of place'. Locale here means the material setting of place; its shape and materiality, while sense of place denotes the 'subjective and emotional attachment people have to place' (ibid.). In health care much research has argued for the importance of place (Bell 2018, Hodgetts et al. 2011, Ivanova et al. 2016, Lovatt 2018, Lorne et al. 2019, Martin et al. 2015, Oudshoorn 2011), as place is seen as more than a backdrop to social action, but rather co-produced with care (Iva- nova et al. 2016). These studies use place as much more than simply locality, showing that the concept is always co-produced with care and steeped in meaning – a view in contrast to debates in health innovation literature, where placeless care is hailed as the solution to all ills of the healthcare system, with ICT paving the way to a utopian[62] world (Oldenhof et al. 2016).

Science and technology studies (STS) scholars have challenged this very positive view by detailing how doing eHealth requires networks of social and material actors to do work, in order to configure care in particular settings (cf. Danholt and Langstrup 2012, Milligan et al. 2011, Mort et al. 2009, Pols 2012). Telemedicine, in particular, has promised 'placeless care' in introducing care at a distance (Oudshoorn 2011, Pols 2012, Schillmeier and Domenech 2010). Work on telecare has shown that despite its claims of placelessness, care is firmly situated within material and non-material relations and therefore very much 'placed' (Oldenhof et al. 2016). To capture this dynamic interaction between people and things in care, Oudshoorn (2012) introduced the notion of 'technogeography of care', which allows for considering how telecare technologies distribute care responsibilities and reconfigure who cares and how. The value of this technogeographical approach is in taking place seriously in understanding technological configurations of care. Furthermore, Langstrup (2013) showed that when care becomes 'placeless' it actually becomes re-placed somewhere else – telecare technologies becoming embedded into the home of the patient means that this home sphere becomes a different sort of (medicalised) place.

62 Utopia (from ancient Greek): Greek *οὐ* ('not') and *τόπος* ('place').

Similarly, scholarship focusing on the materialities of care (Buse et al. 2018) and healthcare architecture (Martin et al. 2015, Nettleton et al. 2019) has foregrounded place and the role of the material in health care. These explorations of everyday objects in care practices are very helpful in considering how care is configured – in (Weiner and Will 2018) or outside (Brittain et al. 2010) the home; within a small island community (Ivanova et al. 2016) or care buildings (Nettleton et al. 2019). This line of research has shown how the material conditions of care frame care delivery, prompting an examination of mundane artefacts of care as 'neglected things' (Puig de la Bellacasa 2017). Nettleton et al. (2019), for instance, used beds as a lens through which to understand the changing context of care. They explored how the design of beds for nursing care has shifted, offering valuable insights about care design as prescriptive, thus problematising the role of objects in the process of care (see also Buse and Twigg 2014).

These discussions on care materialities and telecare have illuminated the emplacement of care and argued against the notion of placeless-ness. Yet, the landscapes of care have been moving to new spaces, making the question of the 'where' of care a pertinent one, as places of care today may also be digitally produced and virtually and sensorially experienced. The home discipline of place – geography has been recently framed as a discipline in the midst of a 'digital turn' (Ash et al. 2018; Kinsley 2014). The argument is that the digital has become so pervasive in everyday life that both a recognition of how the digital is 'reshaping the pro- duction and experience of space, place, nature, landscape, mobility, and environment' (Kings- ley 2013: 27) and a turn to the digital as an object of study, result in a 'digital geography'. So how has this development affected care places? And what kind of geography of care is needed, in order to understand these developments?

This paper is a conceptual attempt to build on and extend these discussions. I use the case of the sensory reality Pod (SRP), in order to show that thinking of it as placeless (focusing on its digital layer) or material (focusing on its physical layer) is insufficient. I propose the concept post-place care; inspired by Agnew's (2016) rhetorical question is there a post-place politics? In an argument against the idea that place does not matter for politics in an age, dominated by (social) medias, Agnew asserts that post-place politics is not yet on the horizon, showing how politics is still rooted in particular places. My notion of a post-place care stems from this argument yet takes a different direction: post-place care is

meant to disrupt dominant place-care ontologies; it is a term that imagines how our thinking on placed care might evolve. The Pod is a suitable case to think through these issues, as it does not comprise two distinct places – one digitally created and another one 'real'. Instead, the Pod only becomes a place of care once it integrates and negotiates these layers. This way of thinking about place de-centres the concept, pushing for ontology of placed care that does not frame care as either material or placeless, but as carefully layered through practices of placemaking. In an attempt to stay with the trouble (Haraway 2016) of placing care, I aim to disrupt, or unsettle (Murphy 2015), these ontological assumptions about care in place, suggesting a more inclusive notion of place that can deal with an ambiguity of placed care conceptually.

Method

The paper is based on qualitative interviews, document analysis and observations in the period between September and December 2018. Semi-structured formal interviews with the creator of the SRP and owner of Sensiks[63] [64](N = 4), neuroscientists at TNO[65] involved in the Pod's creation (N = 2), an experience designer and IT support for Sensiks (N = 1), the healthcare entrepreneur responsible for introducing the Pod into the Dutch healthcare market (N = 1) and managers in the healthcare organisation, where the Pod was introduced (N = 3) were con- ducted. More informal conversations with the Pod's creator were held subsequently, which were followed by observations during three events, where he presented the Pod to a wider audience. Sensiks's online presence, press interviews and releases (N = 20), and promo videos (N = 5) were analysed. Furthermore, I was provided with official reports and documents about the pilot testing of the Pod specifically for care. More document materials on the working of the Pod in health and other settings were analysed. My observations were mainly focused on the company's work with clients and day-to-day activities, as my interest was in the production of the cabin and its content. This work was followed by observations of the Pod in a healthcare organisation, where I interviewed three managers about the incorporation of the cabin within their established

63 Sensiks is a Dutch startup company, which introduced the first fully functional sensory reality pod in the fall of 2016. The company is collaborating with numerous partners in different fields, gathering expertise and connections, which makes it a node in a large network of partners, interested in sensory reality.

64 Sensiks has given consent to being named here and to this article.

65 TNO (Dutch: Nederlandse Organisatie voor Toegepast Natuurwetenschappelijk Onderzoek) is the Netherlands Organisation for Applied Scientific Research.

care practices. Furthermore, I was able to experience the cabin myself, producing field notes through observations.

All data – interviews, documents, observation and experiential notes – were coded openly and grouped in themes. From the beginning of the research, the analysis was focused on placemaking; my goal was to make a conceptual step in rethinking place in health care, which led me to collect data on the cabin's material and technical set up and location, as opposed to its healing effects. The paper keeps a careful balance in assessing the Pod positively or negatively. As a controversial technology, various claims about its effects on health will come forward in the paper, yet my intention is to only use those in understanding how the Pod is a place for care, as opposed to if it works.

In presenting the argument below, I first unravel the SRP as a layered place, answering the question where is place in this case? I then focus on how care is done through place, showing that the Pod is far from placeless. Finally, I argue that we need a different place-care vocabulary, with which to address the Pod's new (digital, sensory, imagined) landscape of care. I thereafter introduce the concept post-place as a first step in building such a vocabulary.

Place layers

> The cabin has a glass door and wooden walls. A colourful screen to the right of the seat dis- plays emojis for different stages of wellbeing, as a voice asks, "How are you feeling today?" and requires my name, age and gender. I sit down and touch the black wood sur- rounding me. It feels smooth and even. The cabin does not look or feel 'high tech'. I place a cable clip on my earlobe. The screen lights up, displaying my heart rate. Feeling a little exposed (who else can see this?), I put the goggles on in equal measure apprehension and excitement. Suddenly, I see savanna in front of me. I turn around and the landscape continues; I'm enveloped. I realize I'm warm, I feel sun on my skin and a light breeze. I smell fresh air and grass. There is a buzz, the kind you hear on a warm afternoon, lying in the garden. Insects? But, wait, I smell something else. . .As my brain tries to diagnose the peculiar odour, a loud trumpeting sound pierces the blue sky and my heart rate jumps up. Three large elephants come up behind me and the smell finally makes sense to my brain – it is elephant dung. As the biggest elephant makes a step forward, I close my eyes for a

> moment. It's not real, of course. But I feel the elephant coming closer, the breeze picking up. My eyes now open, I find myself thinking that I have never seen an elephant this close. (Field notes, September 2018)

At first glance, the Pod looks like an unassuming, albeit fancy, cabin. It has three walls made of smooth black wood and a glass door. The space inside is sufficient for one person[66], who may sit on a wooden plank and put VR goggles on. Once inside, with the glass door closed, a number of panels hidden behind the walled planks will start stimulating one's senses. Scent, temperature, airflow and light frequencies are synchronised with audio–visual input. The panel that simulates warmth is fitted with infrared radiators, which work on the same principles that saunas do. They are able to quickly warm up the cabin, simulating sunshine in the African savanna, for instance. Scent panels similarly disperse smells through aroma packs, placed inside the panels. These technologies are not new, but their synchronisation with audio–visual content for the purpose of experiencing (another) place is where the Pod claims a contribution. Sensiks calls this environment 'sensory reality' in an attempt to distinguish it from other types of simulations, such as virtual or mixed reality.

The Pod presents us with a peculiar, dispersed and somewhat ambiguous type of place. Where is the place of care in this case, if the cabin can transport the patient anywhere? To answer this question, I present the Pod as a layered place, untangling its layers. Importantly, I do not mean to imply that places – this or any other – are comprised of distinct layers, some- how existing separately. The conceptualisation of place layers is done for analytical purposes to illuminate the process of placemaking. The notion of layering here is therefore rather an investigative metaphor, as opposed to a descriptive concept.

The first layer of the cabin is its (endless; place-full) digital environment. The argument behind the SRP is that when all senses are stimulated simultaneously, the dispatched neurobiological signals will trick the brain into another experience of place. This is how the Pod has been made interesting for the healthcare market. The cabin is said to do care by creating a connection to place for patients suffering from anxiety, burn-out, dementia or trauma. The cabin's synchronised sensory stimulation is supposed to allow for feeling connected (to some- where;

66 Another version of the Pod is created for wheel-chair access, where the space is wider, and a removable ramp is supplied.

indeed, anywhere). For instance, working with the Canadian army's mental health unit, soldiers suffering from PTSD were placed inside the Pod, simulating the trauma situations:

> I couldn't believe it. This big guy, this soldier went in and we played it [the content]. And he was crying; tears everywhere. It was so immediate. (Fred Galstaun, founder of Sensiks)

The second layer of the cabin is its physical 'envelope', which is always present, despite the variety of digital places it may allow for. The panels behind the walls are instrumental in creating the experience of place and so is the rest of the Pod, which also acts in this material–experiential assemblage:

> When the elephants came closer, I wanted to run or reach up to them, but I didn't know whether I could stand up; the cable may not be sufficiently long. (Field notes, September 2018)

This shows that the materiality of the Pod is not lost during an experience, as it structures the spatiality of that experience. We may say that the cabin's materiality – its stuff – is back- grounded, yet it does not disappear. The Pod is not Utopian as there is a material infrastructure that is identical to all experiences: the wooden plank seat, the black panels and the glass door remain the same. What is more, the senses-simulating panels are material mechanisms that can be reproduced in other places. The cabin's design is open source and can be downloaded, 3D printed and installed in different settings. This means that one may print and place a Pod in a Dutch hospital, while someone does the same in a care home in Australia. Modular and mobile, the cabin promises placelessness; theoretically, it may be placed anywhere.

Yet, materialities are always enmeshed in relationships; they are always situated somewhere. Once patients step outside of the cabin, they are engulfed in a particular care setting. This leads to the third layer of the experience cabin – its care embedding. The first Pod[67] that I visited was situated in a building in Amsterdam, in Sensiks's office (Figure 3). It was placed in the open hall, becoming the first thing one sees at arrival. Its location was strategically chosen

67 There currently at least 3 SRPs owed by Sensiks and more than 60 pieces sold.

for impressing clients and it was part of what the Pod did in this context. This purpose differs from the purpose of the Pod I observed in a care organisation in the Dutch town Voorburg, where the Pod had to be integrated into the care process, in order to care for patients 'efficiently'. I will come back to a detailed discussion of the latter in the following section.

These layers make-up the Pod as a care place: the quality of how it is a place must be found in the interaction of its layers. In its core, the Pod is a simulation of digitally created content. Yet it is also a material place; it has a touch and a feel, 'stuff'. Although this physical layer may look the same regardless of its location, the Pod's placement matters greatly. The interaction between these layers is where we may pinpoint the Pod as a place of care (or not). The Pod presents us with a de-centred, perhaps fractured, ontology of placed care, posing the question – how does this place do care?

Caring through place

This question is explored through interviews and observations of the 'placing' of the SRP inside a care organisation in the Netherlands. Although welcomed with enthusiasm and excitement, the Pod's introduction into the organisation gave rise to issues, which, as I will show below, are very much place related.

To begin with, the matter of where to place the Pod had to be negotiated. The organisation had bought a dozen Pods and distributed them to different buildings, with the expectation that it will improve care quality, save caregivers time and adorn the organisation with a 'futuristic' care aesthetic (Figure 4). Visiting one location, I was surprised to find the Pod placed far from patients, outside of the entrance of the organisation, inside a small, rather dusty storage room. Old newspapers were piled up in one of the corners and the Pod looked decidedly unimpressive. The manager explained:

> We didn't quite know where to put it. . .First we put it in the living area, but people didn't like being seen by the others. [. . .] Also, it made a lot of noise.

She went on to explain that there is a concept for the room, where the Pod will play a starring role:

Figure 3 The Pod inside Sensiks' offices. Image reproduced with permission from Sensiks

> We are planning on making a relaxing ('snoezel') room in the future, with lava lamps and such, where [we can] bring clients who are anxious or overexcited. [. . .] The idea is to make [this room] open to people from outside. This is why it's here.

By 'here' she meant far from the living area. The Pod was situated in such a way that it would be able to accommodate both residents and 'walk-ins' – neigh-

bours, family members or residents of other homes. In doing so, the Pod could contribute to another organisational and pol- icy concern: connect care to the local community/'make it part of everyday life'. The manager tells me that the organisation sees the cabin as a way to battle loneliness among residents. The exciting futuristic aesthetic of the cabin is considered a curious enough object to facilitate much more than medical care, but also community and social care beyond the walls of the building.

Yet, while this plan was not yet implemented, the so-conceived location of the Pod already presented difficulties. As the cabin is placed far from the living area, the nurse must leave the patients he is responsible for, in order to bring someone there. Some users may stay in the cabin alone, while others find this scary and prefer to be accompanied, yet if a caregiver stays in the Pod (Figure 5), he would not be able to look after others in that time. This difficulty has resulted in the Pod being used only occasionally. The action of placing someone inside the cabin is not simple either. The 'Pod care' has a physical component that requires (elderly, handicapped, confused) bodies to be placed in a particular position – and remain there. The VR goggles must be put on faces just right, buttons on the screen must be touched, the sound must be tested; objects and bodies must fit together; restless, confused, difficult bodies must be soothed and composed, in order for this place to do care. This may be difficult and time consuming (possibly harmful), meaning that the Pod as a place of care has yet another layer – it requires a configuration of actors and process (cf. Oudshoorn 2011), as a nurse must accompany patients, a visitors' schedule must be made, supervised, etc.

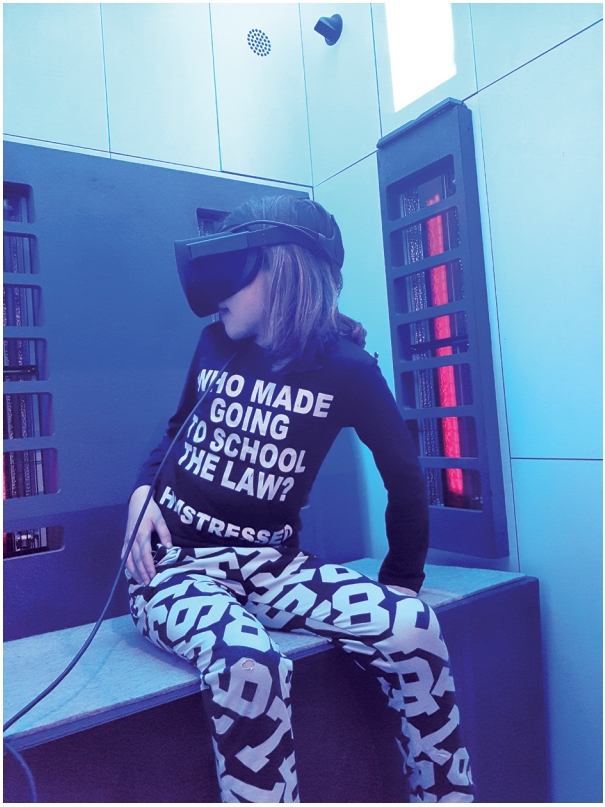

Figure 4 Inside the Pod. Image reproduced with permission from Sensiks

Figure 5 A patient uses the Pod, accompanied. Image reproduced with permission from Sensiks

This 'location layer' of the cabin is yet another part of how the Pod does care. Entering the small room before entering the Pod impacts the experience of the cabin as a place of care, since, importantly, one does not only enter the Pod but also exits it, at which point one is back in a particular (material) reality. We may say that the SRP creates a particular aesthetic of care (Pols 2019) that requires working with and within the layers of place. The care manager has to juggle the layers: the noise and privacy of patients requires it be placed somewhere private, the distance to the storage room means that nurses cannot use it much, yet the room is close to the entrance, so that visitors have access. This fitting together has not worked (yet), resulting in the Pod not being used much, and in it not doing care (while being able to keep this promise alive).

Another important point is the design of the digital 'places' it offers. This, after all, is the essence of the care the SRP offers. Technically, Sensiks is able to offer complete customisation, producing the sensations required by their clients:

> We make the technology and we co-create with our customers. They tell us what to do. Our task is to make it work. (Fred Galstaun, Sensiks founder)

This means that clients (whether those be managers, patients or family of patients is another issue here: who, exactly, is the client?) have control over the content, which presents a couple of difficulties. Firstly, based on the empirical case studied, the care managers do not have the time or the clarity as to what content they want. For the moment Sensiks offers a limited number of 'experiences', which were not created with a specific care angle in mind. The care manager imagines patients creating their own experiences, as well as some 'creative' patients producing content for other patients, which would be beneficial for both groups. If any of these options become actualised in the future, this would only make the question of placemaking more complex, introducing more layers into the place-care equation. Yet, for the moment it is Sensiks experiences that are being used. Not only is this problematic, since Sensiks content creators do not have a background or experience in health care, but it also brings up the issue of top-down production of care. Making content for the Pod is, in this case, decidedly a placemaking activity. Sketching the way in which the cabin supposedly works as a healing environment, one thing is certain – the experiences inside the Pod are not organic but designed. In fact, they are made to order and

can be detailed to one's preferences. It is designers and IT specialists, who make the audio–visual content and create environments to match the needs of clients.

If we understand place to be emergent, contingently co-produced and tightly connected with power (Cresswell 2004, Massey 1997, 2005), then the Pod's experiences are top-down affective manipulations. Content creators imagine and narrate a place, while Sensiks finds technological solutions for simulating it. This is not to imply that 'real' places are completely organic, as every object and physical environment is scripted (Akrich 1992). A care organisation has scripted protocols, just as a building is scripted by architects and designers by creating corridors, placing tables and chairs, a coffee machine or beds (Nettleton et al. 2019). Yet, while scripts are always present, the nature of the Pod takes placemaking to an extreme. This production articulates a particular type of care aesthetic, where 'good care' is about experience (for the patient) and efficiency (making anxious or difficult patients relaxed).

This aesthetic is not least problematic, because as the Pod gets to know a patient, it learns to recognise their moods; it knows you by saving your vitals and analysing your reactions. The technology saves these data and can tailor the experiences to patients. This customisation is an important selling point on the healthcare market and makes visible how power is articulated spatially (Massey 2005), with particular consequences:

> These Pods can really help nurses. [Nurses] spend a lot of time with patients who are moody and aggressive. But the Pod benefits patients. They feel calmer and relaxed. So [this nurse] can use this time for something else. [. . .] Maybe in the future we can have a whole room of simulated experiences, where we can make patients snoezel. Healthcare entrepreneur

Another aspect requiring consideration is the very desirability of the Pod as an actor in the care process. The cabins are currently marketed as experimental, in the sense that the organisaion is learning and assessing the technology through doing. When asked about ethical issues the cabin may bring up, the manager tells me that this has been discussed by the board of the organisation, yet no decisions have been made on this point. What boundaries of placemaking should be followed when manipulating the environment and sense of reality for mentally dis- abled or dementia patients? If a sense of place and its materiality are a basic compass to our being, then can we justify the manipulation of place for

patients who cannot consent to it? Should there be normative considerations of placemaking in relation to the Pod? If some clients request pornographic or violent content, for instance, should they be refused?

These questions are at the heart of caring here – the cabin is a case in point not only of the co-production of care and place, but of caring through place. Despite presenting an aesthetic of care that is immaterial, futuristic and placeless, we cannot think of the Pod as placeless, as it is placed in material, social, affective and organisational networks. However, the way it does care is not only material, but is rather an amalgamation of materiality, imagination, subjectivity, memories and the senses. Therefore, a new vocabulary is needed, with which to address these developments. An analysis of place-less versus place-full will not do the job.

Post-place care

In a 2016 essay John Agnew posed the question is there a post-place politics? Discussing Italy, he argued that there is no such thing as placeless politics. One of the early theorists of place, Agnew's questioning of politics as placeless disputed accounts, which ascribed the success of Italian politicians like Berlusconi and Beppe Grilo to the influence of television and social media. Challenging these assumptions, Agnew showed that place still matters in politics, albeit in different ways than was once the case. The term 'post-place' politics served as an inspiration here for developing of a similar concept in the field of care, which both builds on, and departs from, his iteration of post-place. Post-place care takes its cue from Agnew's insistence that the changing nature of 'where' politics happens has consequences. While he argues against the notion, showing instead how politics is (still) grounded, I will use the term here to open up space for thinking through how to articulate the changing nature of 'where' care hap- pens.

In a context of a relentless discourse on healthcare innovation (Janssen 2016), practices are being displaced in numerous ways. Care no longer happens in the hospital only but has now moved to the home (Langstrup 2013, Schillmeier and Domenech 2010), neighbourhood (Oldenhof et al. 2016), city (Solanas et al. 2014) and finally, the digital realm. Many caring practices are already taking place in the immaterial virtual setting of the Internet, or what many enthusiastically call e-Health. Telecare scholars have acknowledged this technological displacement of care and theorised it as a reordering and redefinition of healthcare practices (Milligan et al. 2011, Mort et al. 2009, Pols 2012). Oudshoorn's

(2011: 121) term 'techno- geography of care' endeavoured to 'further explore this changing spatial configuration', high- lighting that the place of care matters. These valuable works have shown that the introduction of technology within the care process alters relationships and thus affects the process and quality of care. However, as the Pod case demonstrated here, I argue that instead of redefining how space and technology interact, we should redefine the very notion of (care) place. Furthermore, I suggest that we need a different vocabulary, in order to address the changing care landscapes.

Post-place is a term that conceptualises the extension of place into further (digital, affective, troubling, sensory) carescapes. It has three main characteristics: it is made up of heterogeneous place layers, it must be 'found' and assembled, and it is (ethically) ambiguous. Unlike the notion of placeless care, which is not only misleading, but also unproductive (place disappears, and care is abstracted), post-place forces us to analyse interconnections and disconnections of both material and immaterial elements of caring and embrace their power to 'unsettle'. While it is easier to think in dichotomies – place-less or emplaced – Murphy (2015) reminds us that the work of disrupting what is clear and smooth is important for generating new insights. Trying to locate place in care can be frustrating in cases such as the SRP. Instead of trying to fit care inside a wooden cabin or a building, we would do well to problematise its place as locate-able and come to terms with care places as fractured, layered and open. Such a conceptualisation, I propose, is the territory of post-place care.

The introduction of the SRP into a care process 'on the ground' presented a number of issues – organisational, ethical and material – which cannot be understood completely within a traditional place analysis. For starters, following Agnew's definition of place, where would place be located by such analyses? Agnew argued that face-to-face politics still matters, stating, 'post-place politics is not yet on the horizon' (Agnew 2016). In contrast, my argument here is that post-place care is very much on the horizon, which is why developing an explorative vocabulary is pertinent. I take the notion that caring has moved to different (in this case digital) spaces seriously, yet not to the extent that care becomes placeless. Instead, the concept of placed care is stretched to include various layers of place, which together do care.

This begs the question whether care is really moving into new landscapes? Part of the critique on innovation technologies is their claim that they are new (Janssen 2016). I do not argue that the Pod technology is (or is not) new, but

rather that incorporating it into the care process makes up a differently imagined, structured and experienced carescape (Ivanova et al. 2016). The move is therefore a conceptual one; showing how the idea of places of care is being disturbed by sensory reality technology and suggesting that this disturbance is an opportunity for a generative theorising of place.

Conclusion: disruption as an opening

In an attempt to open up space for generative thinking about placed care and based on the insights from the Pod case study, I have argued that: (1) care is being extended within differently imagined (digital, sensory, experiential) landscapes, pushing the notion of place into new conceptual grounds and (2) a new vocabulary is needed to address and analyse this extension. Unsettling (Murphy 2015) place means here disrupting existing place-care ontologies and embracing a more inclusive idea of what and how places do care. Below I address some possible implications of this conceptual move.

Firstly, how and why is this concept pertinent to medical sociological work? The work in telecare has produced great insights about how technology mediates care relationships (be- tween both human and non-human actors). Oudshoorn (2012) notion of 'technogeographies of care' in particular has allowed for conceptualising the effects technology has on care landscapes. However, these studies (1) rely on a definition of place that insists on materiality and (2) argue that place matters for how technology is experienced. In this way, the concepts of place and technology are conceived separately, with place somehow 'grounding' and materialising telecare. Yet, as the 'digital turn' in geography has shown (Ash et al. 2018), these categories cannot be conceived separately, even for analytical purposes. We need a new vocabulary of/for care. This is not to say that all care places are post-place places or that all places should be analysed as such, but rather that a speculative approach to engaging with this enfolding care geography is needed.

Secondly, what kind of conceptualisation of care place does the term post-place offer? The nature of place in the SRP's landscape is in how it is able to negotiate its layers (or not) – material, digital, caring. The sensory reality Pod only becomes a place of care when it is at once material, sensorial and digital; it is a care ecology, as opposed to different places – one digitalised/simulated and one 'real'/material. A patient experiencing the Pod begins her journey in the corridor, aided by a nurse; enters the stuffy small room and then the black wooden cabin; her body has to fit the cabin's affordances, she must place the

goggles on her head. Then she is transported into a sensory place of virtual cues, only to find herself back on the wooden bench some time later. She then still has to exit the Pod and walk back through the corridor. The place of care in this story should be conceptualised wholly, as opposed to only a cabin or only a digital environment, emplaced in care practices. Any emphasis on a singular element in this care assemblage would not capture its nature.

Thirdly, the notion of unsettling through post-place is not only an analytical move towards a different ontology of place-care, but also a way of problematising (1) how 'good care' is imagined through place and (2) how power relations in health care are stabilised through placemaking. The Pod as a place of care is wrought with problematic assumptions about what 'good care' is, about dealing with 'difficult' patients, about privacy, consent and manipulation. Place and power are tightly connected (cf. Massey 1997, 2005) and power is materialised into a particular aesthetic of care (Pols 2019), which is beautified and exciting. There is a danger, similar to Latimer's argument (2018) about mundane care materialities being 'neglected' in discussions of power, that post-place care may similarly 'hide' (paradoxically, through its heightened visibility) power dynamics. Post-places may be too vibrant and promising, thus (all the more successfully) structuring hierarchies of value. Therefore, what is at stake here is not only a shift in the place ontology of care but also a shift in the politics of care. Post-place, as a disruptive concept, is an attempt to rethink the politics of care; it makes visible how care places are sites of power struggles, having been designed within productive atmospherics (Martin et al. 2019) of 'good care'.

Analysing the Pod through the lens of post-place allows one a deeper understanding of the case, as the term considers all care layers, and their interaction with/in power struggles. We see beyond the limitless possibilities of the cabin, observing instead how it structures hierarchies of care. The Pod becomes a spatial solution to a number of practical problems – patients who are emotional, depressed, difficult or bored can be placed inside, showing that the politics of care are just as much in need of unsettling as the concept of place. Nettleton et al.'s (2019) account of a top-down approach to personalisation, which they call prescriptive personalisation, parallels what the Pod exemplified: personalisation in health care is not only freedom of choice, but rather a particular way of structuring that freedom. The ideology of autonomy is articulated through the idea that everything is possible (in the Pod, in post-place more gener- ally), which reveals an urgency to make post-place care a matter of concern (Latour 2004).

Finally, the concept of post-place may be helpful when dealing with 'the sociological concern with the decline of place' (Dyb and Halford 2009: 232). Post-place allows for working with the idea that places of care are changing without arguing that they are disappearing. Disrupting place-care may lead to conceptualisations of care places as experience, for instance, for patients with limited mobility or struggling with dementia. The dichotomy of place-full versus place-less is doing us a disservice. The place of care, understood as more than its location, will reveal itself to be a chameleon, requiring a speculative and open approach to its (future) ontologies.

"The only interesting answers are those which destroy the questions."
Susan Sontag, in Esquire

Chapter 7

Discussion:
Unsettling place in, and with, care

The Danube Park

The Roman fort-turned-town on the banks of the Danube River, which opened this book, is today home to about 23,000 residents. The municipal province of North-West Bulgaria, to which the town belongs, is the most economically depressed area of the country and has seen negative demographic growth for the past 20 years, as well as exceptionally high emigration rates. The emigrants are predominantly young people, who leave the province for jobs in the capital or abroad, but the area has long struggled with high rates of migrating women, who work as temporary caregivers in Italy or Spain. Some emigrants return briefly, others stay away for good. The once booming harbor, which had been the main exporting connection of Bulgaria to Austria in the 19th century and to the U.S.S.R. markets in the 20th century, is much smaller and quieter today.

The city park nearby, in contrast, is filled with music. A large group of elderly women are singing in perfect musical unison under the shade of the large oak trees, sitting comfortably on the park benches. They are officially a performance group, called *The Pensioners*. In the warm months they rehearse here, in the Danube Park three times a week. Their repertoire consists of old folklore songs and as one of them shared, the group has a preference for "the ones about doomed love". The oldest member of the group is 96 years old; the youngest is 68. They travel at least twice every season to perform in other towns' *chitalishtes*[68], where "elderly activities" take place. They all enjoy travelling, yet long distances on the bus can be problematic for those dealing with diseases. Many of their children have left the town, working and living abroad or in the capital. They tend to worry about their parents' care. The overwhelming opinion in town is that the healthcare system is not very good and that the "good" doctors and nurses have long left for jobs abroad. Many of the younger women in *The Pensioners* are in contact with the children of the older members, helping out with small things and, importantly, coming along to doctor visits.

The worry among emigrants about their elderly parents is not surprising. According to Eurostat[69], Bulgaria is the EU country with the highest proportion of elderly people at risk of poverty and social exclusion: 45,1%. Furthermore, Bulgaria is one of the EU countries with lowest life expectancy – 71 for men and

68 From Bulgarian: a public institution that fulfills several functions at once, such as community center, library, a theater and other cultural activities. This chitalishte has the honor of being the first one in the country, having been established in 1856, during the Ottoman Empire occupation of Bulgarian territory.

69 https://ec.europa.eu/eurostat/tgm/table.do?tab=table&plugin=1&language=en&pcode=tespm090

78 for women (WHO 2017), while it is ranked 4th in the world for its rate of population aging (Velkovska 2010). Care services for the elderly in particular, are insufficient, national reports calling healthcare "wrought by challenges" (Pitheckoff 2017). In this context, living in another country can become a constant emotional burden. The emigrated children do their best to keep in touch with the care of their parents; yet stories about the low-quality national care services is a topic of emotional discussions among migrants. Curiously, the folklore singing group members had different ideas. Stoyana, 71 years old: "*My daughter wants to take me to live in Germany, as [it was] better there. [But] I don't want to leave the singing group or my home*. […] *Besides, I have no intention of dying in Germany of all places. [Give me] the blue Danube and these beautiful songs, that's all I want."*

This vignette demonstrates the layered nature of caring and the manifold ways, in which place inevitably underpins it. Children care for parents, both materially and affectively; the organisation of care on the national level is insufficient, showing, perhaps a lack of care; the elderly care about the lives they have built and the relationships they cherish, they care for the folklore group; there is also care about choices, one's prerogative to choose where they die. Further, they care about the "blue Danube" and the "songs". On yet another level, the demographic reports cited earlier are a type of caring for the country and for data. Me writing this is an attempt to care for informants I met and interviewed in the Danube Park and always felt guilt for taking from them – information, time, and effort – without giving back. Perhaps it is care for my own family, who still live in a place, where "insufficient", "wrought by challenges" healthcare system seems (to me) to lurk in the background, waiting. Yet, most importantly, for the purposes of this dissertation, at every level and moment of analysing these types of care, place is inevitably present and productive. The impossible migrant dilemma of staying or leaving as a form of care is a result of the (globally determined) availability of jobs in Italian and Spanish cities, away from the Danube Park and parents (and spouses and children). The demographic decline in Bulgaria is intimately entwined with recent politico-economic history, as the often-destitute socio-economic positioning of pensioners is produced through particular 'shock-economy' and decentralization practices, dictated largely by the IMF in the beginning of the 1990s. A place of death – much like a place of birth – may be determined by a woman's care and affection for her home, despite the fact that care elsewhere may be better. Caring for a folklore group is also caring for a community, friends, and a town on the banks of a river. *Care for place* and

a *lack of care for place* are part and parcel of this moment, under the oak trees, in the Danube Park.

The Danube park vignette and the five case studies in this dissertation demonstrate that **place can do conceptual work for care**. It is a concept that can be pushed to do analytical work in multiple directions. Its ability to focus on both meaning and materiality can ground care analyses to everyday practices. A place such as the Danube Park in a small Bulgarian town is where collective meaning becomes practice through singing; care practices in the park take place here, as younger group members help older ones. The benches are where care is actualized – phone calls are made, songs are sung, advice is given, discussion about health and the healthcare system take place. The park is moreover a place with a productive affective force. The emigrant children refer to the park when they talk about the lives of their parents; it is "a good place, because they take care of each other [there]." It acts as a counterweight to their worry and perhaps guilt; it is an imagined place that connects a geographically separated community. The park is certainly interconnected with care and caring, but it is more than their context/container; rather, it is *co-producing* care. A world of care, characterized in the West by overwhelming expenditures, personnel shortages and spatial reorganizations, needs such a sharper conceptual consideration; one that will go beyond describing complexity and push for new insights. Perhaps caring is the same as leaving (as many migrant women do) or staying (as many of their elderly parents do); perhaps it is done through singing and not through medicine and it may be about inhabiting "a good place". These are ontologies that become visible through a lens of place in care.

This type of analytical attention for caring as firmly placed within social and material networks offers much more possibility than a cost-benefit analysis of a migration pattern or a description of the ills of the Bulgarian healthcare system, because it not only describes the interconnectedness of various political, organizational and symbolic elements, but it opens up ontological and political questions about care, such as what is 'good care' and can ' good care' be done from afar? An analysis of the above vignette would be analysed by place-sensitive researchers as 'care emplacement'. Although I believe 'emplacement' is a useful and important avenue for understanding care in practice, my argument here is that such a concept, while very useful for describing the landscape of a phenomenon, is *insufficient for opening up* ontological assumptions, such as what is 'good care', who should be caring and why, and how care should be improved.

Often these assumptions remain unearthed; we tend to assume that we are not good children, if we 'leave' our ill parents thousand kilometres away (as I and many of my informants often do) or that they receive bad care, because the country's healthcare system is broken. 'Good' caring, as seen through the lens of place, may mean choosing to (physically) leave the Danube Park, in order to take work abroad and provide for one's loved ones. The park is a material and affective infrastructure for doing care, because it structures everyday practices for well-being, involving multiple actors, far and away. Moreover, it co-produces a process of caring that is communal and self-governed. By focusing on how care is done with/in this particular place, a care in place analysis will not only describe the landscape of care (the healthcare system, the volunteers, the family members, the neighbours, the Danube), but also attend to how different types of care converge – that for health, well-being, community, personal life narratives and histories, the elusive affect that characterizes being-in-place.

Dismantling simple assumptions about care and place (as in: care can be inserted in any place) is an important step before a new, richer map of care can be assembled. Sedimented notions of doing care 'efficiently', through high-tech innovations and in the 'right' place had to be problematized and dismissed. From the river's origin, to the park and *The Pensioners*, through a foundling room and a living lab, to a sensory reality cabin and down an Italian boulevard and inside a Bulgarian home, how then should we work with this urgently necessary sensibility of *care in place*? The following section invites the reader to assemble the chapters' concepts into one toolbox – the goal and contribution of this dissertation.

An Invitation to Assemble

The dissertation tackled mapping this co-productive relationship between caring and place from different angles. Throughout this cartographic process, the relationship between the two concepts in this book – place and care – was examined in different empirical and theoretical contexts, producing a few conceptual 'keys' to serve as a starting point of theorizing the place-ness of care. Chapter 2 set the stage of this discussion with the argument that care and place are co-produced and cannot be fully understood when considered separately, which was made

linguistically visible in the term **carescape,** i.e. the co-produced care in place.[70] Chapter 3 considered place from an extraneous perspective, analysing the workings of place outside of its physical boundaries and through its infrastructures. This analysis used the term **place-by-proxy** to denote the de-centering of place by emphasizing the work done within its infrastructures. Chapter 4 focused on placemaking as a harbinger of place-ness; a temporal negotiation of place as a collaborative *becoming*. It introduced the term **co-laborator**, which acts as an inclusive analytical matrix, in which the physical environment, technical objects and political inspirations are assembled in the guise of a collaborative project to build a living lab. Here place (making) is a diversion tactic; the co-laboration, rather than the living lab itself, is the goal, *as well as* the method for producing different kinds of knowledge – scientific, market, future, etc. Placemaking is thus not only productive of a physical environment, but also productive of markets, futurity, collaborations, and normativities – a point often forgotten in practice. Chapter 5 offered yet another approach to place analysis, continuing the trend in the book to unsettle, move, de-center the idea of the term as a delineated physical environment, where care is done. The story of migrant women working as lived-in caregivers, while longing for, and participating in, life 'back home' mapped place as an intimate *phenomenon of being* and introduced the idea of '**folding places'** as a strategy for meaning making. 'Folding' is a strategy for overcoming spatial constraints and living in place through experience; it is a way of creating place in different spaces. Chapter 6 took this point further through the case of the sensory reality 'experience' cabin, putting the question of placeless (health) care squarely in the center of the discussion of placed care. This final chapter represents the boldest attempt to demolish traditional and simplistic notions of the nature of care places, de-center the assumptions of singular places as interchangeable care locations and put forward a re-definition of place with the help of the concept **post-place**, which goes beyond placeless and place-full care to conceptualize care place as a layered phenomenon that must be 'found'.

70 The insistence that care and place are co-produced is a big part of the argument in this dissertation. To some, especially those in the policy/governance world, this idea may seem rather tired. Within policy, whether it be urban governance of healthcare, the call for co-production has become ubiquitous as a solution to all issues. Co-producing with citizens and patients promises to democratize governance, yet in practice this is rarely the case (cf. Oldenhof and Wehrens 2018). It is important to emphasize that my argument, and usage of the notion of co-production is decisively different. I do not argue for the need of more co-production, because the assumption underpinning this work is that the co-production of care with place is already a fact – it is not a matter of creating or controlling it, but rather to become aware of its effects. Co-production as a policy is therefore inapplicable to the argument here and it must be understood as a conceptual move with the goal of uncovering different ontologies of caring through place.

This final case study hopefully served as an opening of broader discussions on how we may think of virtual care settings as healing and caring, as well as active agents in care delivery, especially in the context of an endless string of technological innovations. Resolved to open up space for more questions, as opposed to providing answers, chapter 6 asked the reader to speculate and imagine both wonderful and terrible futures of places, not of, but rather *as* care, and the moral ambiguity these futures may engender – is satisfying someone's desires good care? Is it morally justifiable to save nurses' time by 'calming down' difficult patients inside the cabin? Would the answer to this question change if we knew that nurses would have more time for patients, who need them? How about if it means that healthcare would become cheaper?

Carescape, place-by-proxy, co-laborator, folding places and post place are *concepts-invitation* to begin assembling a different map of care. This map is made up of folds, tracing carescapes through hybrid connections, containing places within places as it digs into new ontological grounds. Importantly, it is a map that requires assembling; it is not there for us to simply read; it guides us into more productive routes, uncovering new ontologies of caring. Assembling this care map is an analytical effort of opening up, instead of closing; and problematizing, instead of simplifying care in place. In the following section I return to the research questions that guided this research project, providing answers, based on the findings of the five case studies. These answers, while connecting the dots in this argument about placed care, are not exhaustive. Instead, they have unsettled the traditional care map and assembled a conceptual one. The double work of unsettling and assembling was done simultaneously, as unsettling the usual assumptions about care in place – care must fit in the right place, places of care are where care happens, care can be re-placed efficiently – has cleared the way for assembling a multidimensional map of caring. My hope is that this map will be disruptive, serving as fertile ground for more/different/new/critical insights.

The Red Thread

Once again, the research questions guiding this project, this time answered:

> How is care produced, configured and enacted in place?
> How does placemaking in healthcare matter?
> How is care in place productive of new ontologies of caring?

How is care produced, configured and enacted in place?

The first question is made up of three equally important and related elements – production, configuration and enactment. All five cases show that *care is co-produced with place, or that care is placed*. Insights on the emergent nature of place, put forward by Massey (1991, 1994) and others, combined with a broader understanding of care, help illuminate this point. Understanding care as *em*placed is a useful notion, yet it is not strong or sharp enough. Emplacement conjures a conceptual image of care practices being surrounded, or contained within, place. This idea of place as a container of social action has sustained heavy critique in human geography, especially non-representational geography (Thrift 2008) as creating a non-existing distinction between care (as social practices) and place (as their surrounding materiality). Based on the empirical studies in this book, I propose to take emplacement a step further and understand it as co-production. Discussions on care emplacement will benefit from this ontological re-focus, where the term carescape captures the nature of the relationship between care and place as inherently intertwined. Furthermore, this conceptual move sidesteps two problematic implications of emplacement: that of emplaced care as context for social, and, specifically, for *human* action. If we take the idea of places as actors seriously, the notion of the emplacement of care practices does not hold water. An ontological and epistemological commitment to co-production instead not only avoids these problematic assumptions, but it refuses a conceptual separation of the terms.

Such a move has consequences for how we imagine care and for how care is governed. The care done on the small island from chapter 2 will not be assumed to be comparable to care in Rotterdam, London or the Italian coast town in chapter 5. Local issues in the production of care will not be separated from care issues in governance practices. 'Care' will cease to be a reified object to be inserted (or emplaced) within different locations. Instead, 'carescapes' will denote assemblages of being-in-place that must be understood and governed

with and through their particular idiosyncrasies. In chapter 2 we saw this clearly – caring for the elderly is caring for the island; the two cannot be separated. Doing care becomes more than washing their bodies, helping them dress or serving breakfast. On Windland the 8 elderly residents of 't Zilt do care for the island, just as the island cares for them. Such an ontological re-definition will necessitate a different approach to healthcare governance as well. Governance practices working from the notion of emplacement may focus on making care 'fit' local contexts, while governing carescapes may mean governing through place-specific interventions, such as keeping the nursing home open, despite its lacking quality indicators and even adjusting quality indicators to place specific care. The different care needs of cities and countryside, for example, necessitate not only a different approach to how care is done in place, but an understanding of the existence of multiple care ontologies – care might mean keeping a big, inefficient building open on a small island, because this is important for the survival of the island as a 'real' place, where people live and die. The shrinking countryside in the Netherlands does not need an abstract notion of care to be inserted in it, but rather a reconceptualization of what care might mean in a community, a small town or a tiny village without a train station. When politicians call for regionalization (Schuurmans et al. 2020 forthcoming) as an answer to the shortage problems plaguing the countryside in the Netherlands, they call for working together within governmentally assigned areas. Yet, these geographically bound areas on a flat map, hanging on some wall, are not the places of lived experience of collaborations and grudges on the ground, where a traditionally Protestant community has difficulty working together with their Catholic neighbors. A governmental ontology of regions may, and often does, clash with place-produced, caring ontologies of place.

Configuring of careplaces traces the process of co-production by asking *how it is done*. The ontological premise in discussing the configuring of care in place is that carescapes may be configured in multiple ways; configuring draws attention to *the process of becoming a place* and attunes to the multiplicities and contingencies of placing care. For instance, the foundling room is an example of configuring care place through infrastructures. The place only becomes possible through a continuous configuring, or alignment, of different infrastructures – Boards, NGO, political parties, laws and normativities – coming together. This configuration may happen differently, resulting in a different kind of place; yet its existence as a care place requires much work of trying to align, or tinkering,

or fitting together (or not). This is the work that must be studied, in order to understand how care is configured in place. Another example is the migrant case, where care is configured in folds, as opposed to physical spaces. Folding and configuring are close in meaning, as they both denote the process of making care work/fit/feel good (or not), although folding sensitizes to an agentive action and a strategy, while configuring is a neutral term that signifies the contingent nature of placing care. The folding place case shows that care in place does not always work out; often there are disruptions, difficulties and frustrations, like when a woman may not 'be there' for her daughter's graduation. The foundling room case, on the other hand, shows how configuring works within a particular temporality. As long as no baby is abandoned inside the room, it can continue to exist in-between rules.

The 'enactment' portion of this answer is most decidedly related to politics and its purpose is to trace the political processes and consequences, by which places of care are being enacted. The turn to enactment in STS (Mol 2002, Woolgar and Lezaun 2013) has shown that naturecultures may be enacted differently (Law 2004). Places of care, too, are being enacted (differently), with consequences for those who give care and those who receive care. The foundling room enacted abandonment through differently framed notions of place. When enacted as a place, where one may press the button and receive help, the room is where babies are rescued. However, when enacted as a crime scene, the room becomes a place where one commits a crime. Enactment of care (or lack of care) here has political consequences, which are actualized through framing of the room as a place of care or abandonment. When a baby is abandoned anonymously through the organization Beschermde Wieg, without ever having been in the room, the room becomes a rescuing mechanism. Yet, if an infant is abandoned inside the room, the place may be enacted as an unsafe abandonment technology. In the example of the migrant case, we see differently enacted placed care in terms of "good care". A good mother would stay with her child, yet to many of the migrant women who had chosen to leave, the essence of good motherhood meant financially providing for their children and caring from a distance. In their conversations with family and friends, they often used this argument to justify their leaving. Similarly, the distance in caring, or the displacement of mother care, can be enacted as a weapon and an example of "bad motherhood". The migrant women often used such enactments in different

contexts: if a woman's child was very young, she was considered a "bad mother"; yet older children were 'left' in an attempt to care for them.

These examples of enacting place are a reminder that places of care are not only configured differently and contingently, but are also enacted differently, with political and normative consequences. Going back to the research question, 1) care is always co-produced with place; 2) this co-production is configured in an open-ended process of becoming; and 3) it has political, normative and stigmatizing effects.

How does placemaking in healthcare matter?

The second question focuses on placemaking specifically, because the process of making places for care is productive of particular ontologies and values about healthcare, which then become normalized in existing places. Think of hospitals, for example, where ideas about cure are visibly inscribed in the environment, becoming common sense. To tackle this issue, chapter 4 followed the construction process of a living lab for the elderly. Drawing inspiration from Alice Street's analysis on the work that goes into making a place suitable for scientific research (2016), the chapter showed that places are not a priori there and must be constructed – both physically and discursively – as care places. This construction process revealed itself as a complex mechanism, within which multiple motivations were being enacted. Much like the Danube's origin – a place one would say is easily identified with some authority – the living lab, but also the foundling room and the Pod, had to be designated and plugged into different types of networks, in order to become care places. The SR Pod may just as well be a place for fun, for experiencing music or playing video games. To become a place for the healthcare context, it must be incorporated within care practices.

Chapter 5 showed the work – and difficulties – that followed this attempt. The Pod is not a place on its own, but must be incorporated into the carescape of the care organization by placing it appropriately, scheduling nurses time for inside the cabin, making sure it does not disturb patients with noise, etc. To use the cabin, nurses have to bring the patients to it, time must be allowed for this to happen; the Pod does not start working by simply being placed in the organization. The foundling room, too, must become a place of care, as opposed to a crime scene. The work that goes into making it such a care place is visible within the public discourse Beschermed Wieg enacts, but also in the physical design of the room – the crib and the teddy bear, the blanket and wall

painting. Furthermore, the infrastructural workings that the chapter reveals, act to couch the room as a place, where infants are rescued or abandoned. Various actors engage in this work, the result of which is a room enacted as a place of care.[71] Shedding more light on this process of becoming offers another angle of analyzing the place-ness of care. While chapter 2, the Windland nursing home, showed how care is inextricably entwined with place, the foundling room and the living lab cases drew attention to the origins of this process. The living lab in particular, revealed that this process might be much less organic than one may assume; the process of becoming a care place does not just happen, but requires much work, like negotiating with volunteering companies, organizing dinners for collaborative discussions, cleaning the dust off because it is more difficult to figure out who is responsible for the cleaning, making sure that the residents will not be disturbed by the renovations, maintaining good relationship with the nursing home, where the lab is situated, etc..

Placing care is thus not only about healthcare practices and developing affective relationships with place, but also about negotiating and collaborating within a care market, i.e. working within a market logic. This logic is caring in different ways: it cares about knowledge, about cutting-edge innovation, about marketable projects, about tax returns, about careers. Care placemaking may also be care market making and this matters for the kind of care places that come into being: the living lab is about 'innovation' and 'the future', it is fancy and it is informed by science. It introduces and champions a particular (futuristic) ontology of care, where innovation, the market, collaboration and cutting-edge technology are the ingredients that make care 'good'.

How is care in place productive of new ontologies of caring?

The third question considers the analytical potential that the concept of placed care allows for and opens up. Chapter 3, the foundling room case, showed how new subjects – abandoning mothers, abandoned children, laws – are being produced through the room: it is the room that 'makes' mothers into criminals (according to the law) or not (according to the room creators); it is also by being left in the room that children become foundlings. Ideas about abandonment and motherhood ('what is a good mother?' or 'what is good care?') are also reframed

71 Note that the inclusion of the case within this dissertation is yet another way of enacting it as a place of care. Although the chapter questions this framing as well, its inclusion in a book about placed care frames the case as one of caring.

in the context of the room as a place of (politico-) ontological shift, where the room is both good and bad: a mother may be good by leaving her child inside the room, or desperate, as she has had no other choice; the NGO insists that the room makes an abandonment 'safe', while the Council for the Protection of the Child argues the opposite; both caring (leaving your child safely) and uncaring (anonymous abandonment) are accomplished simultaneously through the usage of this place. A similar argument is made in chapter 5 about the migrant women who leave, in order to give their children "good care". This is another challenge of the concept of care, as geographical distance is productive of an alternative ontology of caring for one's children, i.e. physically caring is replaced by financial care that promises future opportunities. The caring is done not in place, but out of place, through a displacement of care in a very literal way. Yet, as the chapter showed, it is then reframed by folding it within different places and temporalities, allowing one to live as well as they could. Placing care in this case means living in folds, while "good care" is redefined.

Yet another example of the ontological productivity of placed care is chapter 6's recounting of the sensory reality cabin as a placeless place. The chapter questioned the conceptualization of care as placeless, introducing a re-definition of placed care as *layered,* in this case as physical/sensory, digital/imaginary and caring/organizational layers. Here we see an ontological shift to the definition of placed care, producing a new ontology of place as an experience driven and manipulative process', where place is produced top-down and prescribed, casting place in a rather negative light. Furthermore, by challenging a place of care, the chapter points out a different, perhaps morally dubious, ontology of care, where the Pod is seen as a technological fix for snoozing "difficult" elderly patients through the use of artificial, manipulative environments. Finally, chapter 2 presented the case of the island as an inextricably linked caring for place, which put forward the idea that care in place must be seen as a carescape. Such an ontological shift results in taking place seriously in any discussion of care on the island.

The central point in this dissertation – place and care are co-produced – is a basic one and not particularly revolutionary, subversive or provocative. To those who have worked within STS and human geography, as well as in care research, it may seem rather underwhelming. However, (the consequences of) *taking this point seriously and working with it analytically*, is where this book attempts to make a contribution. The problem with care in place, much like the problem

with place as a concept, is that it is such a common sense, everyday, mundane idea:

> *Of course, caring always happens in some place or other.*
> *Obviously, it matters where it happens.*
> *Care, just as any practice, is always local.*

While most would agree with these statements, they are rarely, if ever, actualized. Taking place in care seriously means more than acknowledging the fact of co-production but tracing the consequences of this ontological view. Now that the research questions have been answered, the co-productive nature of placed care stated, the placemaking process examined and the ontological multiplicity of place sketched on the care map, it is time to address the million-dollar question within this argument: *so what?*

In what follows, I identify the theoretical, methodological and practical implications of this dissertation, fleshing out the value of this conceptual work and charting directions for research by drafting an agenda for placed care.

Theoretical Implications I: It's time for place

The reason place was largely missing from social science analysis for quite a long time may be traced to an association of place with old, collectivist community (Agnew 2011), where place came to be understood as a nostalgic ontology for the past (Cresswell 2001). In contrary, the modernist idea of a linear evolution of society has moved on to a lack of place – a globalized, placeless world, based upon individualism. Agnew argues that this development in the social sciences mirrors the modernist rise of power of the nation state, which can be seen in the language of geography that changed to studying 'states' and 'territories'. Another reason why place was not particularly popular may be the legacy of philosopher Martin Heidegger. His work on 'dwelling' put forth an ontologically strong concept of place, particularly in developing a phenomenological sense of place (Malpas 2017), yet his involvement with the Nazi regime painted this view in a negative light, delegating place to a nationalist project of belonging (and not belonging) in place.

Yet, currently we are seeing a revival of place thinking, which has gone beyond geography and entered other fields. In health sociology, the examination of place, of which this dissertation is a part, has offered a fruitful way of

conceptualizing changing care landscapes. This is not accidental, as the welfare state retreats (Peeters 2013), while simultaneously moving governance practices to other places – the municipality, the neighborhood, and the home – thus enacting a more complex (spatial) care governance (Bredewold et al. 2018, Knibbe and Horstman 2019). Moreover, the modern placeless world that called for the eradication of place has been experienced as lonely, too individualistic, without roots or what Bauman calls "liquid modernity" (2000); there is a need for experiencing places as rooted and in relation to belonging (Bennett 2014). In this context of retreating state structures and a yearning for community, it is time for place-focused analysis (again). Initiatives in healthcare policy, such as *Aging in place* and *Neighborhood Care* (in the Netherlands) are clear examples of policy using the language of place to put forward normative ideas about togetherness (caring for each other in the neighborhood) and individualism and dignity (aging in place). Such policy actions are important to understand and problematize through a place perspective, which would analyze how places become governance tools (Pollitt 2011, 2012) and how they are employed normatively and politically. As the care world both pushes for place, emphasizing the role of the local and a lack of place, centralizing certain care services on the basis on a neoliberal model for efficiency and profit, it is time for place in care.

Theoretical Implications II: Carescapes and power

The relationship between places and power has been theorized in geography, particularly in terms of people, objects and practices being in or out of place (Cresswell 2001). Within healthcare sociology, the discussion on materialities of care (Buse et al. 2018) has opened the door to theorizing places of care as productive of power relations (Latimer 2018). The cases examined in this dissertation continue this thinking, identifying the contribution of a place-specific lens toward the workings of power in care practices.

Latimer's focus on the material, spatial and temporal is particularly useful for understanding the workings of place. For instance, places of care are productive of ideologies of caring through their material constitution: the example of the living lab produced an ideology of caring as high-tech, futuristic and scientific; the foundling room's materiality produces an ideology of warm care for both mother and child, as opposed to abandonment; the sensory reality Pod produces an ideology of caring as experiential and sensorial, where patients may be 'calmed down' and relaxed (also for the sake of efficiency). Furthermore, the association

(Latour 2005) of objects, actions, and ideas makes caring possible – the Pod's sound system must work, the patient needs to be brought to the cabin, the schedule has to allow this, etc. These assemblages of caring are imbued with power – the association of technologies, objects and practices is such that allows certain patients to use the Pod (they need to be placed there at just the right time), yet also casts some patients as those that take too much time and must be 'calmed down' inside the cabin, or as those who cannot be 'calmed down' enough to be placed inside the cabin in the first place. Latimer argues that we can observe the workings of power within such associations of assembling elements – abandoning a child outside the foundling room is a punishable criminal offence, yet it is condoned inside the room, where one may press a button or take home a puzzle piece. Such assemblages are produced and productive of particular power relations.

I relate here to the materialities of care debate's aim of "drawing attention to, and opening up understandings of, the spatialities, temporalities and practices of care" (Latimer 2018: 380) as a political project. I believe that a place-perspective can contribute to this project by fleshing out an emphasis on the process of placemaking for care. As Buse et al. (2018), Nettleton et al. (2019) and others have pointed out, care places produce ideologies of caring with political consequences for patients, professionals, buildings, processes of care, etc.. This observation may be supplemented by attention to how and by whom places for care are conceived and implemented. Nettleton et al.'s (2019) analysis of the architectural design of nursing homes is a good example of this type of analysis, examining not only how power relations work within assemblages of care, but also *the process* by which settings of care become inculcated with these relations. The case of the living lab construction reveals the politics of placemaking for care, as companies vie for the ability to participate in this collaborative project, structuring a particular market ideology of caring, where privacy, individualism and technology are situated as solutions to healthcare problems: the elderly resident of the lab must have privacy by a design allowing the nurse to change towels without entering the room, the resident would live alone and be monitored by an app and a smart floor, etc.. The foundling room is a political ecology of a different type, as materialities of care are static inside the room, but the infrastructures around it are in movement: the room becomes a ideology of caring once it is in the media, a baby is abandoned, etc.

These examples show the value of a place analysis, where power relations are unearthed through a careful consideration of the elements that make up a carescape. The process of placemaking may be thought of as a process of power negotiation and composition; an analysis of this process will 'unsettle' what is 'sedimented' (Murphy 2015) by attending to material, spatial and social practices of placemaking. 'Unsettling' is a useful term for addressing questions of power relations and their (historical) constitution, following a sensibility that illuminates "different imaginaries of care to those that dominate healthcare environments" (Latimer 2018: 380).

Theoretical Implications III: Caring objects

Objects act caringly throughout the chapters in this book. The role of objects as actors in the social production of place is addressed most explicitly in chapter 4 with the analysis of the living lab as an authoritative futuristic place, because of the objects – like smart floors, old radios, design from the 1970's and a pattern of bed lights – acting together as an "accomplishment of the setting" (Marres 2013). This meant that the mere placing of these objects together, the smart floor, the app that goes with it and the old radio from the second-hand store – inside this place with a special status produce meaning about the living lab as an authority on assisted living in the future. In this living lab, then, objects *act out the place* – they produce its place-ness; the smart floor tells a story about innovative technology, created to aid the elderly, but also one that is superior in the healthcare market; the kitchen design from another era tells a story about scientific knowledge and the market's collaborative work with such 'knowledge institutes'; the lights, showing the way to the bathroom at night tell a story about caring for human dignity, helping those who are confused to find their way, but also about efficiency, as the nurse will not have to spend time on every confused patient late at night. These objects do care, but importantly in this case, they act it out – they demonstrate, show, convince that this living lab (and these companies) know best what is 'good care'.

Objects 'act out' in the other chapters as well. In the foundling room objects, like the teddy bear, are carefully selected to construct a particular narrative, producing the essence the room projects – a warm, safe place for infants. What is more, the objects go even further by structuring action routes: the abandoner is being communicated to through the button (which they are implored to press), the letter (which asks them to reconsider), the puzzle piece (which is a

symbolic object of connection to the child), and the baby toys and paintings all around. Objects here do the work of communicating to the abandoner, but also to the wider public. The room as a place of hope and rescue is being projected in the public debate through numerous photos of objects – the cradle, the tree wall painting, the puzzle piece, the letter, the button, but also, importantly, the camera. It is the objects that tell the story and therefore construct the place-ness of the room. Further, in the context of folding places, presented in chapter 5, objects act as junctures that connect folds. It may be the tablet that connects 'here' to 'there' or it may be a folded shirt that wakes a memory of another place. The stories these objects tell are a way of bridging gaps in time and space, and opening doors to another 'home', to one's loved ones, to 'good' motherhood. Inside the SR Pod it may seem that objects matter little, as one is quickly transformed into another place, yet the objects that the Pod does use – the goggles, the bench, the touchscreen – are always there, underpinning any experience. Caregivers must also negotiate these objects when a patient enters the Pod and may be unable to use the interface menu or place the goggles on their head.

The role of objects in the care process has been examined within discussions of telecare; the work of Jeanette Pols (2010a, 2010b, 2012; also Pols and Moser 2009; van Hout, Pols and Willems 2015), for instance, has shown how technologies of care placed inside the home reshape the process of caring and how devices reconfigure care practices. Her attention to objects as caring (or not) has revealed how care changes place and vice versa. Lovatt (2018) has worked on this theme with a particular focus on temporality as a crucial element of home making practices in a nursing home. Her work pushed the analysis of "becoming at home" in residential home to include not only (the strategic placement of) objects, but also their relationships with time, showing that objects do not act on their own, but are enmeshed in temporal arrangements and practices. These accounts demonstrate that widely care is distributed between different (human and non-human) actors; caring does not happen exclusively between caregiver and care received but is rather a distributed phenomenon (Schillmeier 2017: 56).

Inspired by these insights, this dissertation's case studies contribute an attention to the place of care as constituted through a variety of objects that 'act together' (with other objects, with time, memories, imaginaries, design). The objects in the foundling room act together with the consequences of convincing a mother to ask for help (or not); the objects in the living lab work together to project a care imaginary of future care; objects far and near (in both time

and space) act together in 'folding' place in the case of the migrants in chapter 5. A place analysis therefore contributes specificity to the place of care as 'an accomplishment of the setting' (Marres 2013) and of objects *acting together*. This distributed agency of the setting (or of place) is in line with other accounts of places making in healthcare: Martin et al.'s (2019) study of how places of care became 'enabling' through the creation of architecture atmospheres argue that their analysis led them: "to make a move from thinking of architecture less in terms of designed objects per se, and more of a practice of designing *situations* instead."

Theoretical Implications IV: De-centering place, de-centering care

Another theoretical consequence of this dissertation is a reframing, and in particular an extension, of the concept of place, which as a consequence, extends the concept of care as well. I will first address the former, engaging with a debate within human geography, after which I will address care by engaging with a debate in STS and health sociology.

In the field of human geography, the boundaries of place and its definition have been a matter of debate for a long time. For constructivist place theorists like Massey (1994, 1997; see also Thrift 2008), place is an "eventing", an assemblage of elements coming together in particular, politically consequential, assemblages. Its boundaries are therefore randomly drawn by a confluence of actants and must be understood as such. Although this view has become mainstream in human geography, helped no doubt, by the ontological turn (Stengers 2010, Latour 2005, Viveiros de Castro 1998) in many disciplines, there are scholars who think Massey's definition of place is too open, arguing that if the concept becomes too inclusive, it will come to signify nothing at all (Malpas 2012). Malpas further criticizes this "suspicion of the idea of boundaries" (ibid.: 229) in the work of Thrift (2006: 139), who insists that "there are no such things as boundaries". Arguing in favor of boundaries as the ontological state of places, Malpas (2012) sees places as emerging through boundaries, i.e. place *becomes place* in the emergence of its boundaries.

My empirical cases show that places are both open and bounded at the same time and that the more pertinent questions are those that explore how this open/bounded mode of existence is configured and enacted, or what Malpas would call their 'emergence'. A commitment to understanding the process of this emer-

gence already decenters placed care and frames it as a phenomenon of becoming. The five studies in this dissertation contribute to this project of placemaking process by demonstrating the elasticity of place. Anchored by care, the places I explored here all represented a different degree of de-centering and reframing the concept of place. The foundling room pushed place to include infrastructural arrangements, far and away from the physical location of the room. The living lab problematized the process of placemaking by showing how the production of place includes a variety of interests and motivations, outside of the boundaries of the lab-to-be. The boundedness of place was also addressed in the island case, showing how place is assembled and co-produced with care as an imaginary of a community and a way of life. The last two chapters – the migrants and the Pod – are the clearest arguments of reframing place, albeit taking different routes toward this goal. The migrant story showed that place is both an achievement and a strategy, by which the nature of place is pushed beyond physical boundaries. The sensory reality cabin not only pushes the concept to include different types of realities, but it also problematizes the idea of place-ful and place-less. While this chapter may bring up the question whether places exist at all, I think that it contains a far more interesting question about the *how* of places. What are the mechanisms and the processes, by which places come to be and exist? How are the boundaries of place drawn? In asking these questions, the de-centering of place as a concept becomes concrete; the Pod shows that there is nothing 'natural' about place as an analytical tool, it is created. Importantly, this insight does not mean that places are not material or that this materiality is unimportant. On the contrary, both cases demonstrated that the material elements of place matter for the way place is anchored in and with care: the Pod's 'outer', material layer is crucial for how it is to be used; the distance between Bulgaria and Italy matters a great deal, triggering strategies of placemaking in-between 'folds'.

Within STS, the argument of de-centering the human experience through the lens of care has become a mode of thinking, a critique and (the possibility for) an intervention. The intervention here is in charting a different route to de-centering care: through the re-thinking of its place. Developing the idea of care in place required two conceptual moves – de-centering and assembling of the relationship between the two terms. Care as de-centered and in need of assembling was inspired by, and evolved next to, the work of Maria Puig de la Bellacasa (2017), who beautifully reframed the concept of care in building an alternative, critical care ethics. In the book *Matters of care: speculative ethics*

in more than human worlds, she problematizes the idea that care is something only humans do, thus extending and broadening the concept to include agencies 'beyond the human'. This dissertation owes much to *Matters of care*, as it demonstrated that opening up a concept does not have to mean that it loses its power; on the contrary, place can, and I argue that it must, become a concept of analysis tackling spatial (re-) organizations critically. The de-centering (place is not only a human perception of material elements) and extension (to more realities, actors and technologies) of places of care will lead to a reframing that will open up space for critical explorations in STS and health sociology. STS scholars may find empirical material and conceptual application of Puig de la Bellacasa's de-centering of care, while health sociologists may find place a valuable lens, through which to understand changes in healthcare (cf. Jones et al. 2019), as these are always intertwined with matters 'on the ground', such as the corridor leading up to the fancy sensory reality cabin or the island that yearns to stay 'real' by keeping its inhabitants from being shipped away. By de-centering the notion of place, we welcome a de-centered notion of care – one that takes into account more than one type of logic, experience or ethics.

Theoretical Implications V: Placing care vocabulary

This dissertation has put forward five concepts, which trace different ways of working with the concept of place and leading to different theoretical insights. I will reflect here on how these relate to current debates, identifying and proposing fruitful connections and avenues for cooperation.

The concept *carescape*, or the inextricably linked nature of care with place allows us to think of care places in a holistic manner, allowing engagements with the field of medical sociology and healthcare policy. The concept contributes an important point about the ontological multiplicity of care in place, which is crucial in understanding the context of care practices. Healthcare policy research in particular, may engage with the term as a way of capturing and working with the complexity of care on the ground.

The concept *place-by-proxy*, or the ability of places to ignite and project action through their infrastructures allows engagements in the field of human geography and sociology. This case problematized the notion of place as a locatable phenomenon and demonstrated how places can be thought of as multiple. In the sociology of health and illness, such an understanding of place may prompt engagements with infrastructures of care places and actors that have been tra-

ditionally thought to be "on the outside of care" (Buse et al. 2018: 253). Such work can delineate how infrastructures define what a care place is; extending and enriching discussions on infrastructures as well (in STS in particular, cf. Wyatt et al. 2016, Karasti et al. 2016).

The concept *co-laborator*, or the mediator of placemaking activities for care allows engagements with the sociology of healthcare architecture and care materialities. It may be considered within these fields as a term-connector; it is situated (between lab and field) so that it contains the different placemakings, mediating and translating them. It tries (and sometimes fails) to bring together the social, political and economic issues into a workable whole. The term also refers to the labor – the work – that must be done, in order for the project to exist. The concept may also be useful in discussions on placemaking for science (such as Street 2016) and care (such as Buse et al. 2018). These studies may find it a valuable matrix, through which to consider placemaking as a complex activity of negotiating multiple science/care registers.

The concept *folding place*, or the strategic choice of people to construct place beyond physical boundaries and through time allows a different engagement with place in the fields of migration and mobility studies, as well as in care. Both fields may consider folding as a technique of creating a sense of place that fits in someone's life. It would be fruitful to test the limits of this concepts, as it is certainly not a carte blanche for displacing place: one cannot simply imagine oneself to be somewhere else, but one is rather subject to particular spatial and temporal assemblages. Yet, the concept of folding clears ground for a better understanding of liminal lives on the move and their ability to exist, or *dwell in folds* of their own making. This concept moreover serves to underline the interaction between place and care, as it shows the importance of care for understanding placemaking; folding place is impossible without care – in its core folding is a way of caring. Yet, the concept of folds and folding also opens up considerations of existing in places beyond a strategic choice; it may prove useful for analyses of telecare (Pols 2010a, 2012), where the patient and care professional are made to exist in folds of time and place as part of the (tele)care process. The concept of the fold can conceptualize the experience of telecare, as well as help illuminate the doing of care within and through place 'fragments', which may lead to insights about working between and within folds.

The concept *post-place*, or the extension of caring places to new (digital, sensory, imagined) designed landscapes allows an exploration of what care places

might be and might become. Just as places are on the move and can be thought of as "spatio-temporal events" (Massey 2005: 131), so should care places be seen as transient and in a process of becoming. What is a place of care should not become a fixed notion, but one that is constantly evolving. Today, the idea of environments as healing and attempts to stimulate the senses as a way of doing care are examples of this evolution. This is why healthcare sociology should not only take place seriously, as I argued in the introduction, but also engage with a constant reconsideration of the concept. Post-place is one attempt to denote this urgency and open up possibilities for more theorizing into 'placeless' care, technology and the sensory.

These five concepts are not meant to be exclusive and should be seen as building blocks for a richer theorizing of care and place. They relate in numerous ways – post-place and folding place are both concepts that try to come to terms with a place beyond materiality – yet have different emphasis and connotations, as well as different theoretical underpinnings and targeted contributions. For instance, post-place emphasizes the designing of place as a potentially manipulative and ethically ambiguous activity and seeks to engage with debates in placeless care and technological innovation. Folding place, on the other hand, is a concept that emphasizes the ability to construct a place one may 'feel good' in. This process, revealed in chapter 6, is wrought with difficulties, as 'folding' is not always successful, nor satisfying; yet the process, by which it is being sought and carefully constructed lets us see place as a safe haven of one's own making.

The concepts place-by-proxy and carescape also have much in common, as they both emphasize the connections between different elements of place, while also problematizing the boundaries of place. While Windland's nursing home was the object of analysis in chapter 2, it soon became clear that the nursing home does not stand on its own; it is a part of larger care assemblages, or carescapes, from the island's dunes to its proud inhabitants. The nursing home's quality of care issue therefore became extrapolated to the island and its bid for survival as a 'real place'. The foundling room of chapter 3 proved to be another example of a place that is bigger than its physical contours. The infrastructures around the room were being animated, while the room itself stayed empty. This case showed that the power of places to do care may be displaced and that infrastructures of place are a rich field of investigation for care. Both place-by-proxy and carescape, therefore argue for a de-centering of place as a neatly bound physical space – a notion, which is mirrored by folding place and post-place, as the latter two con-

cepts explicitly go beyond the physical, exploring how care places are constructed in 'other' spaces (sensory, digital, imagined, experiential, etc.).

Methodological Implications: Oddity and Disconcertment

Inspired by Verran's (2001) notion of disconcertment, I picked odd places of care as research objects. I argue here for the productivity of *oddity as a catalyst for reflexive analysis*. My point is simple: an odd case will lead to disconcertment, which can be used in the research process as "composting" – a term, introduced by Martha Kenney (2015).

Composting can be best described as a reflexive analytical layering, where a researcher's disconcertment is looped into a new analysis. Kenney (2015) built on the notion of disconcertment (cf. Verran 2001), utilizing an affective force toward one's research; and composting as a way of cherishing and curating this process. Kenney conceptualized the value and contribution of this process as allowing for the possibility of "generative transformation" (Kenney 2015: 768), where new insights are born out of reconsidering the discomforts throughout the research process and problematizing one's own relating to the analysis. This process is also a way of keeping one's work honest and open; it is a way of 'accounting' and crafting "accountable stories" (ibid.).

How does this theoretical discussion relate to oddity? Using oddities, out-of-the-box stories, weird places allow for such a generative 'composting' to grow. Looping my affect toward the odd cases presented here, decomposing their oddity (how is a foundling room odd?) and strangeness (how is 't Zilt still open?) is a way of continuously searching for the focus of the case and going back to a way of accounting that 'feels' better – how is my work in studying the construction of a living lab giving a certain weight to the project? How is not taking a stance on the normative question of the foundling room influencing my research? How is the research on migrants I conducted taking advantage of their positioning vis-à-vis mine? These questions develop naturally and easily once the disconcertment they cause is embraced as a methodological tool.

Another advantage of using oddity as a methodological-analytical lens is the term's relation to a particular temporality. Verran's work reached the rich, "composting" stage through a time span of many years and reconsiderations of her research. While I'm not arguing that a similar level of analytical reflexivity can be achieved in much shorter time, I believe that a methodological selection of odd cases may serve as a trigger of encouraging and guiding a particular

"composting" (Kenney 2015: 757) sensibility. The selection of odd cases in this dissertation allowed for a different mode of attention to develop, because it placed the oddness center-stage, magnifying the problematic underpinnings of the case. Importantly, it was me who framed the cases as odd; there is nothing inherently odd about these places. Yet, in relation to healthcare, these were places that presented care and care giving in alternative ways; the care in place needed to be 'found'; it was not obvious. Furthermore, the idiosyncrasies of the selected places let their place-ness shine through the analysis, which was incredibly helpful in a research about place. The teddy bear in the foundling room, the stifled air, the fact that the space used to be a garage; the painting of Windland's dunes in 't Zilt; the colorful wallpaper leading up to the entrance of the living lab; the smooth material of the wooden bench inside the Pod in comparison with the savannah soundscape – these are all elements that make the place odd, but also bring sharply into focus the role of place in understanding care. Dwelling on these elements, on one's affect toward them is an opportunity and an encouragement for "generative transformations" (Kenney 2015: 768), for framing, re-framing and for accounting.

Methodologically, an awareness of time is crucial. Coming back to Verran's disconcertment, developed in the course of time, the question of temporality is a pertinent one to address within a discussion on the place of care. Place and time are interconnected concepts not only in physics, but also in debates on place in social sciences more generally. An important methodological implication of this dissertation has to do with the timing of research on placing care. The time element is crucial in chapter 4, where the process of construction is a temporal possibility for collaborative work. The timing of the living lab construction is infinite, which allows it to be an "experimental space". Similarly, chapter 3 argues that the foundling room is only made possible through infrastructural arrangements that keep it temporally 'special'. If it were to become fixed, the room would fall apart. The controversy it engenders is framed in temporal terms – once a decision is made as to what kind of place it is, the place would change/collapse. Further, the temporal element of place is particularly pertinent in chapter 5, as finding care within folds must always be a temporal accomplishment. Folding places, in this sense, is necessarily about folding time. For the migrant women, time is the most valuable commodity of care – one cannot recreate it without missing out. Unable to control the capriciousness of time, badanti women work toward folding place through mundane practices of 'being there' – both here

and there, as an alternative that may be successful or not. Folding place is, in chapter 5, the clearest argument why the temporal aspect of care in place cannot be overlooked and must always be considered.

The five case studies were chosen not only in terms of oddity, but also in terms of temporality. Focusing on the beginning stages of a place (the living lab); a place 'in the air' in terms of status (the foundling room); an established, loved, cherished place (the island); a 'future' place (the Pod); and an imagined construction of an ideal place (migrants) was a strategic choice of allowing temporality a way *in* this dissertation. The attention to temporality was inspired and sensitized by the work of Gieryn (2006, 2018) on the process of placemaking for scientific knowledge, or what he calls "truth-spots". For instance, the town Donauschingen became a truth-spot for the origin of the river Danube through a long process of negotiating between two different towns, but also between two different ways of knowing (Pickstone 2001) – geological/scientific and symbolic/political. Uncovering this process as a construction, which could have been otherwise (Star 1988) reveals, much like a Foucauldian archaeology of knowledge (1972) would, how places are being made to matter in particular ways. An awareness of the 'when' of places of care is crucial for understanding the 'how' of these places. The living lab case brought insights about the types of knowledge and work that is required for a place to become suitable for care, drawing attention to all that is possible at that stage of placemaking. The foundling room was being studied as a controversial case, where temporality was the most consequential characteristic of the controversy. The island case used a temporal lens to explain the affective force and communal need for continuity (of life on the island, of care, of being-in-place), while the migrant story revealed temporalities of place as doors, through which one might construct a better life. The role temporality played in each of these cases was different, yet it was always, inevitably, co-produced within the process of placing care. A sharpened attention to the temporal aspect of carescapes is methodologically necessary, analytically fruitful and promising.

Practical Implications I: Caring in nowhere land?

Marc Augé described 20th century's world of capitalist production as fast, and transient, where we pass through spaces such as airports and shopping malls without experiencing an affective connection to them: we are there to pass through and continue on. He referred to this experience as being in non-place

or living in nowhere land (Augé 1995; Agnew 2011). Airports are efficient, organized and anticipating our practical needs. Yet, are they caring? Taking the example of non-places to heart, we may learn about places of care and consider whether they are caring 'enough' to be place-full. The question policy makers and professionals should ask is not how to provide "the right care in the right place" (Rapport Taskforce 2019), but rather, first, what *the right place is*? If we do not answer this question, we may soon care in *nowhere land*.

To prevent this, and reflecting a zeitgeist of personalization, individualism and choice, policies are aimed at the home as "the right place for the job" (Gieryn 2006) of caring. In the Netherlands, as elsewhere in Europe, the welfare state is retreating, which means that elderly people are expected to live in their own homes for as long as possible, supported by relatives, neighbors and volunteers. This program is called *Aging in Place* and it is considered, in alignment with neo-liberal values and the idea of individual choice, as the preferable and desired way of growing old. And yet, many elderly people feel loneliness as they 'age in place' and prefer some kind of collectivity (Rusinovic et al. 2019, Kemperman et al. 2019). Aging in place programs facilitate care at home, neighborhood care and proper infrastructure (can I cross the street safely? Is the supermarket too far?), yet these valuable interventions solve practical problems of surroundings, not issues of place/of being. They make life easier, yet not necessarily enjoyable. We know from the literature that the home may be experienced as vulnerable (Dyck et al. 2005), ambivalent (Exley and Allen 2007), less home-like, once it becomes medicalized through technologies (Pols 2010a, 2012; López and Sánches-Criado 2009), and even dangerous (Langstrup 2013), and that being at home may lead to extreme social isolation for the elderly (Bookman 2008, Milligan et al. 2011). We also know that places are more than the sum of their parts, so that crossing the street and having the supermarket close by does not make one less lonely. In the small Bulgarian town I sketched earlier, no aging in place interventions are being done. Not only that, but the quality of care is much worse that it is in the Netherlands. And yet the women I spoke to in the park did not want to leave it; they felt *safe in place*, because they were singing songs with their friends near the river, under the oak trees, in the town of their youth. This is the nature of caring in place: it is not just about the healthcare supplied, but about how one relates to place, or what scholars call the affective experience of place (Duff 2010, cf. Martin et al. 2019); does one 'care' to be there?

The policy aging in place should therefore consider place as an idiosyncratic and open concept that may engender different feelings among the population it targets. Some may love being able to stay at home, while others may need more company; aging in place as such should not be a value, but an outcome of a diverse and strategically targeted policy. Thinking in oppositions, such as impersonal nursing homes (non-place) versus cozy personal homes (place), will be more often misleading than not. Choosing for the home as a value has consequences: the home becomes a place of care, a place of loneliness, a place of (governmental, scientific) interventions.

Practical Implications II: Where is place? And how does this matter?

One of the difficulties of working with place is that it is everywhere and nowhere. There are hospitals and nursing homes, where care is understood to be the rationale underpinning the place; there are the neighborhoods, where people are responsibilized to care for each other; and then there are policy makers talking of the region as a place of care, while politicians praise a 'caring state'. Place can be approached on different levels; examining how these approaches are done is important, because policy makers use the language of place strategically.

In a 2014 report Jos van der Lans (van der Lans 2014) writes eloquently about the neighborhood: "*Little is certain; everything seems to be up for discussion. Yet there is something we can hold on to. Somehow these words must find a solid foundation. They have to land somewhere. That is what this note is about. About the playing field of a rapidly changing welfare state. About neighborhoods and neighborhood-oriented work*." The neighborhood, according to van de Lans, is the foundation, of caring policies; a neighborhood-approach weaves together a plethora of professionals, citizens, and bussinesses, as the neighborhood becomes a political statement about democratic and welfare change (as well as a togetherness in caring, caring for each other). The policy *Neighborhood Care* (Wijkgerichte Zorg) uses place strategically to effect changes; the policy language that presents these changes focuses on care place as a small scale, familiar trope. The policy is widely accepted and applied by a multitude of important actors in the Netherlands public policy, such as the Association of Dutch Municipalities (VNG) and the Ministry of Health (VWS).

However, there are two important caveats to this type of thinking: the neighborhood is understood as per definition good and very fixed. In policy, the

idea of the neighborhood as a care place is that it is a safe place, where everyone knows everyone and is there for each other, which is a strongly romanticized notion and is not necessarily true. Moreover, a neighborhood is not an entity that is out there and it is far from well defined; more often it is a messy concoction of diverse elements, coming together. Defining an area may be even detrimental, by cutting off important relationships, for instance. Neighborhoods, as places of care, are in fact multiple: there exist different ways, in which neighborhoods may be experienced or may serve as a "foundation" for delivering care. Therefore, policy makers should avoid romanticizing the neighborhood and understand it is not per definition either safe or fixed. They can then build policies that emphasize and foster care through different layers – neighborhood, city, region and state. Spotlighting the neighborhood as caring is often a political move that hankers back to an idealized notion of living together in place (back to Heidegger's 'dwelling'), especially in cities.

The same is true for regions. The Dutch political landscape has recently taken note of regions as opportune spaces for 'fixing' healthcare problems (Schuurmans et al. 2019). In 2019 the Dutch Health Minister announced a "regional approach" to dealing with personnel shortages in elderly care (Buitenhof 2019). Regions, goes the rationale, would stimulate working together between care providers, building on existing collaborative practices and establishing new relationships within a geographic area. Yet, the definition of this area matters, as well as who defines it and for what purpose. For this reason, regionalization of care as a policy is not specific enough to take into consideration that regions are not 'out there' to be identified and made to collaborate, but rather they come into being through collaborative practices, just as any place does. The work of regionalization would therefore be served by an understanding of places as open "spatio-temporal events" (Massey 2005: 131) or assemblages (Lorne et al. 2019), where mundane actions, such as calling a friend at another care organization (even if it fall outside the official 'care region') for help with a patient or organizing collaborations within a small part of a region, because the distances are otherwise too big, is how carescapes are constituted. Such a lens would understand healthcare regions as a process of assembling "heterogeneous and often ill-fitting elements into a provisional socio-spatial formation" (Lorne et al. 2019: 1237), thus pushing forward a focus on (the negotiation of) relationships on the ground as constitutive of healthcare spatialities, as opposed to the other way around.

Practical Implications III Moving care is like moving a tree

Consider this excerpt about a care in place initiative, placed on the ZonMw[72] website under 'Program Goal': "*Prevent, move and replace care. That is the essence of the ZonMw program 'Right care on the right place' ('Juiste Zorg Op de Juiste Plek'). Together we really change healthcare. Preventing unnecessary expensive or unnecessary care and moving care – closer to people's homes in their own familiar living environment. Replace care with new and different forms of care – such as e-health, home automation or social work*."

It sounds rather easy – although, certainly nobly conceived – "moving care". Based on the insights in this dissertation demonstrating the inextricable link between care and place, it has become clear that moving care has multiple complex and often unexpected consequences. The idea of moving care is not new and has been employed in healthcare policies for a long time, in an attempt to solve issues of inefficiency and finance, but it is time to break with the notion that we can easily get away with doing it. In fact, moving care is like moving a tree – there are roots involved, they get tangled; dragging dirt with them, and it all becomes rather messy.

This simple insight – hopefully helped by the metaphor – is perhaps the most important message for practice in this work. When re-organizing caring landscapes, one must be mindful of how these are experienced and what consequences their reorganization might bring. Importantly, there is no "right" place for care; the categories of care and place do not exist independently, so that we may move them around like chess pieces. The 'right' place for care becomes the place that has weaved its branches through care practices and become one with it. This is exactly why when moving care – to the level of the municipality or the neighborhood care, these branches are disturbed, they need time to adjust and start growing again, perhaps in different directions, completely changing the form of the tree. Take this example for instance: as the government aims to stimulate market competition in the public sector, municipalities often times change public tenders, who may offer better priced care. Importantly, this tender may even be an organization outside of the particular care region, lacking local knowledge and relationships, which leads to enormous discontinuity of care and organizational fragmentation. This leads to a lot of pressure for care professionals

72 From Dutch: The Netherlands organization for healthcare research and care innovation. (Netherlands organisatie voor gezondheidsonderzoek en zorginnovatie)

working in the neighborhood, who must adopt yet another 'new' way of working. To avoid this fragmentation, policy makers should take another value in their assessment of public tenders: local knowledge and continuity, which should be taken together with quality and price in deciding on public care contracts. Financial efficiency alone must not be the decisive factor here.

Furthermore, moving care should always be justified; to begin with, we should ask whether and how moving care might be a good idea. '*The right care on the right place*' approach to caring is an example of policy attempting to solve problems spatially. This can be understood within the frames of what Cribb (2018a) has called a 'technicist approach' to healthcare – an instrumentalist impulse that identifies problems, which can then be solved with technical solutions. The impulse is often employed, because such solutions to practical problems tend to be tangible and visible – when care is centralized or de-centralized, the function of this reads as action: "something is being done" (Coid and Davis 2008). However, a technicist approach to healthcare would surely miss important elements of place, such as local meanings and affective relationships that have taken root *in place*. If we define the problem as a shortage of specialist elderly care personnel within a region, for instance, we assume that a medicalized version of care is the goal and ideal of elderly care, without examining why or how that may be true (or not). The type of care we may want to enact – in Windland or in a Rotterdam neighborhood – can and perhaps should reflect different values and mechanisms. A technicist approach will not be able to appreciate those differences, working on a larger scale with all too abstract ideas of solving care problems, while care issues must be tackled as *carescape issues* instead.

A case in point is the attachment to buildings as manifestations of care. Local communities are often attached to 'their' hospital, as they not only provide case services, but also symbolize an ethos of communal care and togetherness; hospitals are also a source of local employment and politics (Pollitt 2011, Kearns and Joseph 1997, Brown 2003). Buildings are not simply made up of bricks, tiles and window frames, but also 'matter' because they represent values (cf. Brown 2003) and structure and stabilize social life, while also being "forever objects of (re) interpretation, narration and representation" (Gieryn 2002: 35). Care buildings in particular are very rich ground for narration and interpretation, because they are material manifestations of caring, showing that a community 'cares' and is being 'cared for' (Hanlon 2014). The case of Windland for instance showed the affective power of the building 't Zilt. This building represented care on Wind-

land and although inefficient, the building does much more than provide shelter. The 8 remaining residents on the island may be cared for in a smaller building, yet such a move would symbolize an abandonment of the ideology of caring on the island. What is more, we know that buildings are obdurate (Hommels 2000) and when care is encoded in them, they become even more stubborn, as affect is imbued in them; people remember the hospital they gave birth in, for instance.

Moving care is therefore a political act that is rife with resistance, power and ideological consequences (of caring and of not caring). For these reasons, when care must be re-placed, a thorough understanding of the ways in which it is rooted in place will help 'the movers' accomplish their task, while being respectful of the local meanings, attached to care places. This means a broader understanding of public values that take 'place' seriously.

Practical Implications IV: Facilitating (Urban) Belonging

Places have the power to facilitate feelings of belonging (Bennett 2014), self-identification and connection, because they serve as tangible representation of abstract ideals and identities. Iconic places such as Tiananmen Square, the Colosseum, de Plaza de Mayo and the Statue of Liberty have all come to mean much more than their materiality alone. The focus of this dissertation has been on making this characteristic of place visible in the context of healthcare, yet the cases presented here allow for further lessons for practice to be drawn.

As pointed our earlier, feelings of uprootedness and fluidity – or what Bauman (2000) has called "liquid modernity" and Augé (1995) has referred to as non-place – have consequences for one's ability to feel connected to place, and thus one's sense of belonging. This is mainly true in highly urbanized landscapes, and especially in the context of global migration. An inability to connect to place is not typically seen as a health issue, but I would argue here that it is: of health, conceived more broadly. While the notion of urban health often conjures images of pollution and not enough greenery, I believe that a *social urban health angle* – understanding people's ability to feel belonging to place in the city, and thus to their fellow citizens and neighbors – is of great importance for building healthy cities. Facilitating belonging in cities – especially in metropoles – is a difficult task, which is why understanding placemaking as a process of affective and caring relating to landscapes can be helpful to city makers, designers, municipalities and urban initiatives.

The philosopher Edward Casey conceptualized the difference between how one experiences and relates to place by introducing the idea of 'thin' and 'thick' places (Casey 2001). The latter are places of affect and meaning, where one experiences a deep connection to place, while the former lack "substance" (ibid.: 684). Building on this distinction and on discussions about affect as an embodied pre-cursor of emotions (Anderson 2009, Massumi 2002), Duff (2010) has done an ethnographic study of young people's placemaking practices and their sense of belonging in Vancouver, Canada. The study suggested "a direct link between the study of affect and the analysis of place and its role in the maintenance of health and development" (ibid.: 893), having focused on analyzing 'thick places' and how these served as vehicles "establishing a sense of community, belonging and meaning." (ibid.: 894). Creating and maintaining 'thick places' in the city will therefore facilitate the building of community (cf. Knibbe and Hostman 2019 and the concept of 'micropublic places'). Based on these insights, a few practical lessons for healthy cities may be drawn here:

1) Places of care are not, and should not be, confined to hospitals, clinics and nursing homes, but the definition should rather be extrapolated to living spaces more generally – the workplace, the neighborhood, the playing ground, the schoolhouse and the city.
2) Urban design may facilitate feelings of belonging by incorporating citizens in the design process of places and taking into account, as well as building on, local histories and meanings.
3) City makers should understand the city as a map of 'thick places', connected in multiple networks of belonging. Investing in the 'thickening' of places can prove beneficial for how people experience their homes, neighborhoods and cities, thus battling "liquid modernity" problems, such as loneliness, deterritorialization, fluid identity and ubiquity of choice.

Practical Implications V: (We are all) Place makers

Who makes places caring? We may start with the architect of the living lab in chapter 4, who did her best to find scientifically backed solutions for allowing people to feel at home inside a nursing home. Then there are the people of Windland, who collectively, through insisting, pushing and pulling, managed not only to keep their nursing home open, but also to keep Windland "a real place" where one "may grow old". There are the NGO volunteers who supported the foundling room project, remaining connected to the room through their

phones at all times; and the lawmakers, who condoned the existence of the room, between right and wrong. We should not forget Sensiks, the company that conceived and produced an oasis of place-ness by developing technical solutions for simulating place with the senses. Then there are the nurses who fold someone's clothes, making a room tidier and the volunteers, who bring flowers when they come for a chat. The flowers do their bit, too – they open up the following day and bloom the day after that, making the resident smile. The bed that can be adjusted according to one's needs and the lights that bring the resident to the bathroom at night are familiar, making the place feel safe. The dune an elderly resident of 't Zilt sees through the window makes her feel at home. But also, you, the reader, have the power to make place: organizing your books on the shelf, reading the newspaper every Saturday morning; or remembering how a child – now all grown-up – used to play under the table in the living room. This is how the migrant women in chapter 5 'folded' place, as well as time, to go beyond what is there – the physical, geographical space, and enter a place of being, of 'dwelling' that feels good.

All of these actants – professionals, loved ones, friends, volunteers, objects, buildings, dunes – are place makers. They come together in unique ways and this process is how places become tangible and relatable. Hospital managers, start-up companies, health entrepreneurs, ceiling experts and architects are all place makers for care, who are actively trying to make place. Yet, we should not leave that work entirely to them, because citizens, just as researchers, may also make places for care. Placemaking should be understood as a democratic activity. The 'nursing home of the future' does not need to be designed by experts only or include the latest technology; it can be designed by you and me, making decisions about the kind of care we want to have. In fact, this is exactly the reason why the living lab became possible – it claimed to be 'living', thus placing a user in the center of the experiment; the room needed the input of non-experts. Should it be clean and efficient like an airport? Or perhaps a little messier? Being a place maker means accepting a responsibility of *living together with care* and demanding transparency about what values underpin the process of placemaking.

Space for Place: A Research Agenda

The opening up of space for placed care offers, and even insists on, the pursuit of numerous and distinct, research lines. Since this dissertation served as an explorative opening of such space, there are many loose ends that were not taken

up here, but require further attention, providing a rich ground for theoretical and empirical work. I present them here in the frame of a research agenda for *placing healthcare*.

Firstly, a theme that comes through the cases, but is not explicitly addressed is that of the governance of placed care. Governing through spatial arrangements was one of the rationales for starting this project, as it is certainly based in an urgent societal need for governing care differently. Governing through place and placemaking is therefore both a necessity and an opportunity, where more empirical and theoretical attention can be paid to concrete ways of governing. Examples would be the centralization of cancer services and the decentralization of elderly and youth care in the Netherlands and elsewhere. Taking the above-presented insights as a starting point, more empirical work on concrete de- and centralization policies can prove fruitful for a different understanding of governance practices. This means a change in how we look at governance: instead of defining care governance as structures, we would define it as activities/process. Such a way of looking at care will allow researchers to examine empirically what works is done, in order to accomplish re-placements of care. These, as well pointed out by Oldenhof et al. (2016), are already being done through place, yet without an explicit awareness of what such actions may mean.

Secondly, the promise of placeless, or digital care, especially within the innovation literature (ref. Marcello will know) should be further taken up and addressed from the perspective of place and placemaking. The image of technology as a panacea for healthcare problems has been extensively addressed (Pols 2010a, 2012), also in relation to place (Oudshoorn 2011, again Oldenhof et al. 2016), yet much more work is needed to provide an antidote to the placeless care trope. The term 'placeless' must be thoroughly questioned, just as its ability to produce future imageries can be fruitfully analyzed through the concept of place. The Pod case showed that post place care is both placed and not, as care is always a practice, but more questions about the power of the placeless as an image are needed, in order to understand this persisted discursive trope and its consequences for the organization of healthcare.

Thirdly, an attention to the digitalization of healthcare practices opens up space for examining the role of new actors "on the outside of care" (Buse et al. 2018: 253), who are exercising influence in the healthcare domain, yet rarely considered as players in this field. The Pod case touched upon designers as place makers for care and IT specialists as 'fixers' of digital-place problems

and glitches. The role of these new actors should be further scrutinized, because their input in care practices is becoming substantial. Examining the process of translating knowledge back and forth (between designers and digital environment maintainers, care professionals, patients and their families) may prove fruitful for developing further work within the sociology of health architecture (Martin et al. 2015) with a focus on how "outside" actors work within different epistemologies and practices of caring. The politics of the various normativities (what is "good care", what is "efficient care") embedded in these epistemologies are currently a black box. A serious attempt to democratize placemaking in care must unravel and illuminate the values and assumptions beneath the process of making a (digital, good, efficient, attractive, safe) place for care. Furthermore, theorizing (the politics of) care aesthetics (Pols 2013, 2019) may benefit from a research angle examining the (manipulative power of) practices of 'digitalizing' actors. The aesthetic of caring is not only being altered by the introduction of technologies into the care process, but also by the scripting of these new technological/digital/imagined carescapes by care "outsiders".

Following from the above, the relationship between places of care and knowledge production, as developed in the chapter 4 and to some degree chapter 6, offers a fascinating ground for research. Gieryn's work (2006, 2018) on truth-spots and the distinction between lab and field, as well as Guggenheim's (2012) insistence on clarifying the category of a laboratory have sketched a growing research field on how place is epistemologically productive. A place of care is a place of a particular way of knowing (Pickstone 2001): for example, in a nursing home one needs to know how to act with elderly patients, but also how to use certain care amenities. Much knowledge is produced spatially, through touch, for example (Sennett 2008), yet this type of knowledge may remain unarticulated. A place perspective can serve as grounding for such investigations, building on discussions on care materialities (cf. Buse et al. 2018) and opening up new investigative terrain of how places (are made to) become the "right place" (Gieryn 2018) for care. Furthermore, such a perspective can make visible the various epistemologies and 'rhythms' of places that are part of patients' care networks, further problematizing policies such as the above mentioned "*right care in the right place*", which does not take into account these place rhythms and the consequences of changing them. A critical analytical lens is much needed in the evaluation of such policies, and a research focus on place-specific epistemological production can prove very fruitful, both theoretically and practically.

Continuing this line of thought, a focus on the production of knowledge within care places can be especially useful for research on the architecture of healthcare. Care buildings are built within knowledge frames that are currently in flux. As chapter 4 touched upon, evidence-based design (EBD) is a fast-developing area of expertise in the architecture field. The promise of healing environments (Viets 2009) and therapeutic landscapes (Gelsler 1992, Williams 2007, Butterfield and Martin 2016) to supplement health are not only a fascinating theme for research, but also an important addition to the understanding of how epistemological objects are produced with and through particular discourses, in this case of evidence. Particularly in relation to STS work on places as knowledge sites that define or 'color' the acceptability of the knowledge produced (cf. Gieryn 2018), an examination of places as knowledge 'makers' of different types of care – holistic, embodied, affective – will provide insights into *design(ing) as 'doing' care*.

Staying close to practice, as opposed to simply evaluating healing environments, will open up space for understanding how healing architecture *mediates and affects* care. Examples of such an analytical focus can be found in the work of Simonsen and Duff (2019), who studied how a healing architectural design in a Danish hospital is transforming psychiatric work, and in Martin et al.'s (2019) study of Maggie's Centre's buildings, where the "orchestration" of architectural atmospheres shapes "the ways in which care is staged, practiced and experienced in everyday ways". Using Böhme's (2017) notion of atmospheres in architecture, Martin et al. deploy it in the context of care to understand how atmospheres of caring are generated and experienced through the architectural design of buildings. Such a focus on *the feel* of medical places has the disruptive potential to bring up different questions about caring, as for instance creating caring atmospheres may prove to be more beneficial to (the experience of) care than focusing solely on the question of scale of healthcare facilities (Martin et al. 2019).

Next, theorizing the relationship between place and infrastructure may prove useful for studies, concerned with the boundedness of place. The development of an infrastructural angle in place studies can provide both a structure for studying the process of binding places of care, as well as enrich our understanding of the concept of infrastructures. The recent move from studying large technical infrastructures (Hughes 1989, Star 1999) to a focus on knowledge infrastructures (Karasti 2016, Wyatt 2016) opens up possibilities for developing the notion of place-infrastructures, where diverse infrastructures *assemble care through place*. Place-infrastructures (as developed in chapter 3 with the concept place-by-proxy)

can be an avenue for overcoming the perceived common sense nature of places, because when infrastructures break down (and thus become visible, as pointed out by Star and Ruhleder 1996 and Star 1999), places of care (and the care process) do as well. The above described transient core of place as a concept can become tangible through an in-depth analysis of place-infrastructures, clarifying not only how places of care must be assembled, but also that this assembling requires much, and different kinds of work: infrastructures must be made to align, in order to produce (and sustain) places. As exemplified in the foundling room case, actors in different (institutional, but not only) infrastructures do not operate by the same normative or political motivations, making the room a rather dispersed, and only temporary, phenomenon. An attention mode emphasizing the work of assembling these multiple structures (and their alignment or misalignment) may reveal a deeper layer of complexity within placemaking, as well as make visible how infrastructures interact to produce particular consequences (of place or care).

Another promising direction is articulated in chapter 5 within the discussion on folding places. Deleuze's notion of the fold (1993) can be especially useful in opening up a discussion on living between multiple places. Much as Bauman's argument about liquid modernity[73] (2000), the fold presents us with opportunities (to fold is to have agency), but also with insecurity, far removed from the grounding notion of place as described by Heidegger (2005), for instance. To Heidegger place is an embodied being, or what he calls a state of 'dwelling'. Dwelling is a form of being, where one remains in place; it is "staying with things" (Heidegger ibid: 151). He theorizes place as a rooting force, a sense of home and a particular mode of thinking. A discussion on the limits of folding place and the care necessary for the act of (un-)folding may be useful for uncovering insights on the relationship between place (as belonging) and movement (be it migration or some other form of not belonging). This may prove particularly valuable for discussions in mobilities studies (Aday 2017, Sheller and Urry 2006, Sheller and Urry 2016, Urry 2007, Cresswell 2010). We may say that the migrant women in chapter 5 negotiate the

73 'Liquid modernity' is a term introduced by Zygmund Bauman to describe late modernity within a tradition of theorists, who position themselves against postmodernism, arguing instead that modernization processes continue into the current era. In Bauman's conceptualization this era is 'liquid', because it is characterized by fragmentation, ambiguity and a multiplicity of identities. The individual within a liquid modernity exists within a fluid, (existentially) uncertain world, where they can be thought of as nomads or tourists, free to change their spouses, workplace, values and sexuality, which then results in normativity of shifting identities and freedom, as opposed to settlement and rootedness.

liquid modernity through an attempt of "staying with things" (Heidegger 2005: 151) or staying in place(s), while at the same time being able to work abroad and offer their families the support they need. They conjure a powerful sense of place, so they may 'dwell'; stay rooted while being (physically) away.

Finally, taking the power of place seriously, a promising research line is the ability of places to act as future makers. The living lab in chapter 4 was called *nursing home of the future* for a reason, and thus producing particular imaginaries of the future of care. The affective power of places to connect to both past and future (in the case of the living lab this was done literally – the lab presented design from the 1970s as innovative care for dementia patients in the future) are especially productive for studying futurity imaginaries within the health field. This research line may relate to the promise of technology, mentioned earlier (as in 'technologies will solve all healthcare problems and make the process of caring cheaper and more efficient'), yet may use future-place imaginaries to delve deeper into their underlying values and their incorporation into caring processes of today. As I show in chapter 5, the future of care is imagined to be placeless and digital, which is why a sensory reality Pod is currently standing (most probably not often used) at a healthcare organization close to The Hague. The powerful productive power of imagining (technology-driven) futures in care should be grounded by a tangible place-focus, which would examine how imaginaries are being translated into 'placeless' places for care. A speculative approach may be especially fruitful here (see Puig de la Bellacasa 2017) in producing work on how places of care reflect and create care expectations for the future (care must be done in healing environments; it must be technologically-driven; it will focus on well-being in the home, etc.). The role of the smart floor in chapter 4's living lab case is not only to signal when a patient has fallen, but also to project a future of caring both incredibly close and at a comfortable distance. Yet, in line with my earlier call for the democratization of placemaking in healthcare, this 'imagineering'[74] (van den Berg 2015) of care should not be left to the healthcare market alone: scholars have the luxury, and perhaps even the duty, to imagine and speculate *alternative futures for care*.

74 The term combines 'imagination' and 'engineering', implying the implementation of creative ideas in practice.

Final words

The choice to begin the introduction and conclusion of this book with a story about a river and a park was a conscious one, as it attempted to unsettle easy associations of care and place.

The basic question of what *a place of care* is, guided this project throughout numerous decisions about which cases to include (and thus exclude), how to structure the chapters and how to use literature and theory. This question is at the heart of the thesis, and it is the one question that, crucially, remains open to a multiplicity of answers. Five such answers are presented in this book through the case studies of odd places, yet these are answers I myself constructed (as both places of care and as odd). This goes to show that a place of care may be manifold – one of the reasons why places of care are a fascinating topic of research. The main task of this book was to shake up, question and redefine the common assumptions about place and care, thus opening up and stretching these concepts toward more inclusivity, more depth and more (ontological) multiplicity. The decision to begin and end the dissertation with a story about a river, a town and a park is a conscious choice in presenting such an extended notion of care place. Thinking of care as an ambivalent, open concept (Tronto 2013) and an ethics (Puig de la Bellacasa 2017) have allowed me to think of care places just as broadly (and boldly). The place-ness of the river town is to be found in its strong affective relationship to the river – the place (and reason) of its birth and, to this day, the cord that sustains its life. The story of the river's origin is one that shows not only that places (of fact, of science, of truth) are contingent, and often time whimsical historical constructions, but also how care is the central agent of placemaking. Caring for one's town is what claimed the Danube's origin and labeled it as a place on a map.

Finally, and perhaps inevitably, the choice is also a personal one, as the river park is a *place to me* that signifies a community that I lost by moving through space and abandoning my own place of birth. It is an attempt at folding and going forward by going back to a place I know, a place I can write about, and a place I care for.

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Summary

This book considers the relationship between care and place, arguing that understanding these in singular terms is not enough: care should be conceived much more broadly than medical care, just as place should be seen as denoting something richer and more complex than a simple location on the map. It furthermore argues that care and place are co-produced and cannot, and should not, be understood separately.

The theoretical argument contributes to debates on care materialities, architecture and healthcare, place (making), belonging ('dwelling'), place and temporality, place and healthcare technologies, the politics of care, and infrastructures, engaging with the fields of health sociology, human geography and science and technology studies. The overall research goal is to delve into the relationship between care and place and conceptualize it by developing a terminology for working with care in place analytically. The book therefore introduces five concepts – carescape, place-by-proxy, co-laborator, folding place and post-place – which may push forward and continue conversations on place and care.

Empirically, the book presents five 'odd places' of care, which are leveraged as an opening into placed care and which offer a variety of ways to work with place. The cases – a remote island, a baby foundling room, a living laboratory, somewhere between home and away for migrant women and a sensory reality Pod – serve as outlier cases; care places, around which actors construct different, sometimes conflicting, ideas about care. These odd, out of the box, unconventional places of care are explored with an ethnographic approach and anthropological sensibility, triangulating semi-structured interviews, observations and document analysis with an emphasis on reflexivity as an opportunity for deepening analysis. The result is a conceptual 'unsettling' of place in healthcare, built around intense, well-chosen and revealing moments of engagements with the field.

Chapter 2 introduces the reader to the phenomenon of *care in place* with a case about a dilapidated nursing home, housed in a large building complex on a small Dutch island. The chapter shows how care on this small island is inextricably linked to its identity, history and imagined futures. The nursing home was evaluated by the Dutch Healthcare Inspectorate as performing under the national standards of care quality. Yet, despite housing only 8 residents, it

remained open. My co-authors and I argue that the home is kept open, because it is a much larger place than a building for the elderly; it is a place, where care for the island is materialized. This chapter introduces the concept carescape, building on notions of care and Arjun Appadurai's 'scapes', in order to signify the co-production of care and place. These concepts, the chapter shows, cannot be understood on their own and must be considered together.

Chapter 3 takes us from the salt shores of the Wadden Sea to a suburban neighborhood near Rotterdam and inside a peculiarly refurbished garage. This garage is part of a volunteer's home and has been redecorated as a nursery room, which is known in the Netherlands as a 'foundling room'. Created by a donations-based NGO, the room is a place for anonymous abandonment of infants – an act that is illegal according to Dutch law. Yet, despite much national attention and controversy, the foundling room had not yet received an abandoned infant. In examining the various infrastructures surrounding this room, my co-authors and I argue for the importance of infrastructures in creating and maintaining places. We show that some places only exist *by-proxy*, through doings elsewhere, and while remaining empty, are able to galvanize and sustain social and political discussions about care for children, mothers and the state. This chapter not only describes the proxy abilities of places, but it also demonstrates that the boundaries of place are constantly being drawn and re-negotiated; that places of care are not a priori there but must be sparked into existence by numerous infrastructural arrangements.

Chapter 4 considers collaborative places, in order to examine the process of placemaking in relation to healthcare. The case of a living lab for the testing and experimentation with solutions for elderly care, such as smart flooring; creating a sense of home; strategic placing of lights; a smart bed, etc. follows the process of conceiving and constructing a care place from its beginning stages through to its fulfilment. The living lab is an odd place, because it is both a physical and an imaginary place, where the "future of elderly care" was imagined and thus produced through its physical set-up and locus. The lab was therefore productive of new ontologies of caring for the elderly, where care was imagined as high-tech, collaborative and scientifically produced. While it has been established that places' natural state is a process of becoming and they are never finished, the process of actual construction of a care place is a fascinating topic to explore, as it reveals the work, discontinuities and negotiations that go into the decision making process when creating a place for care practices. The chapter argues for a

different attention mode to placemaking in healthcare – one that emphasizes the work and logics that go into making a place, fit for caring.

Chapter 5 transports the reader to the sunny Tyrrhenian sea coastline of Italy, telling the story of migrant 'badante' women, who work as lived-in caregivers for Italian elderly, and introducing the notion of 'folding places'. In this article, taking inspiration from Deleuze (1993) I understand care as located in and between "folds", whereby both care and place are problematized. The article shows how migrant women care by choosing to be away from their children and how they 'fold' place in an attempt to continue to be a part of their life back home. The traditionally employed, simple distinction between here and there, home and away in studying migrants is deepened and the very notion of place is pushed to include the ways, in which places are not only material, but experiential, imagined and co-produced with affective caring.

Chapter 6 continues to push the concept of place further, beyond its physical contours. The chapter focuses on the future of care places by an analysis of a sensory reality technology, known as the Pod. The chapter introduces the term *post-place*, as a first step in developing a speculative vocabulary for working with places of care beyond dichotomies, such as material versus immaterial, digital versus real or *place-full* versus *place-less*. Post-place care, unlike the idea of placeless care, is an inclusive, open, and most importantly, generative notion. Its strength lies in its disruptive potential for challenging existing place-care ontologies and opening up generative space for thinking through the changing landscapes of healthcare.

Chapter 7 does the work of assembling the concepts introduced in the previous chapters, considering their analytical potential and interconnections, and offers answers to the research questions guiding this work. Importantly, these answers, while connecting the dots in the argument about placed care, are not exhaustive. Instead, they unsettle the traditional care map and begin assembling a conceptual one. This double work of unsettling and assembling is done simultaneously, as unsettling the usual assumptions about care in place – care must fit in the right place, places of care are where care happens, care can be re-placed efficiently – clears the way for assembling a multidimensional map of caring. The case studies show that 1) care is always co-produced with place and the two concepts should be understood as intertwined, 2) this co-production is configured in an open-ended process of becoming; 3) it has political, normative and stigmatizing effects, 4) places of care must be made suitable for care and this

process requires work, done by a multitude of actors, 5) placed care is productive of new ontologies of caring. Based on these insights, the chapter concludes that place can do conceptual work for care; it is a term that can be pushed to do analytical work in multiple directions; its ability to denote both meaning and materiality simultaneously can ground care analyses to everyday practices.

This concluding chapter goes on to delineate its methodological and practical contributions. Methodologically, the focus on 'oddity' and disconcertment has served as a catalyst for reflexive analysis, allowing and encouraging a different mode of attention to develop throughout the research process – one of sharpened attention to temporalities, normativities and self-reflection. Practically, this work formulates recommendations to policy makers, healthcare professionals and citizens to consider the numerous ways, in which care is placed. Policies, such as *Aging in Place*, *Right Care on the Right Place* and *Regionalization* must take place seriously, avoid romanticizing 'the region' or 'the neighborhood' and develop attention for the affective relations between place and care. Moving healthcare services must be done carefully, with an awareness on the underlying values at stake in such decisions. Finally, the book argues for the democratization of placemaking in and with care, urging citizens to accept the responsibility of making places caring as an act of *living together* with care.

Samenvatting

Dit boek gaat over de relatie tussen zorg en plaats. Het stelt dat het niet volstaat om zorg en plaats in enkelvoudige termen te begrijpen: zorg moet veel breder worden opgevat dan medische zorg alleen, en plaats behelst veel meer dan een locatie op de kaart. Daarnaast betoogt het dat zorg en plaats samen tot stand komen, en dat ze niet los van elkaar kunnen worden begrepen.

Het theoretische argument draagt bij aan debatten over de materialiteit van zorg, architectuur en gezondheidszorg, plaats(maken), thuishoren ('dwelling'), plaats en temporaliteit, plaats- en gezondheidstechnologieën, de politiek van zorg, en infrastructuren. Het raakt aan gezondheidssociologie, sociale geografie, en wetenschaps- en techniekstudies. Het doel van het onderzoek is om de relatie tussen zorg en plaats te verkennen, en om deze relatie te conceptualiseren aan de hand van nieuwe terminologie voor het analytisch werken met zorg-in-plaats. Het boek introduceert vijf concepten – carescape, place-by-proxy, co-laborator, folding place en post-place – die debatten over plaats en zorg kunnen ondersteunen en bevorderen.

Empirisch presenteert het boek vijf 'vreemde plekken' van zorg die een op-maat bieden naar geplaatste zorg, en die verschillende manieren aanreiken om met plaats te werken. De casussen – een afgelegen eiland, een vondelingenkamer, een levend lab, ergens tussen thuis en wegzijn voor migrantenvrouwen, en een sensory reality Pod – zijn bijzondere gevallen; zorgplekken waar actoren verschillende en soms tegenstrijdige ideeën over zorg construeren. Deze vreemde, onconventionele plaatsen van zorg worden op etnografische en antropologische wijze verkend aan de hand van semigestructureerde interviews, observaties en documentanalyse; ter verdieping van de analyse is veel aandacht geschonken aan reflexiviteit. Het resultaat is een conceptuele 'ontregeling' van plaats in de gezondheidszorg, gebaseerd op intense, zorgvuldig gekozen en onthullende momenten van betrokkenheid in het veld.

Hoofdstuk 2 laat de lezer kennismaken met het verschijnsel *care in place.* De casus draait om een vervallen verpleeghuis, gehuisvest in een groot gebouwencomplex op een klein eiland in Nederland. Het hoofdstuk laat zien hoe zorg op dit eiland onlosmakelijk verbonden is met identiteit, geschiedenis en de ingebeelde toekomst. De kwaliteit van het verpleeghuis voldeed volgens de

Inspectie voor de Gezondheidszorg niet aan de landelijke kwaliteitsnormen; bovendien telde het slechts acht bewoners. Toch bleef het open. Mijn coauteurs en ik betogen dat het verpleeghuis openblijft omdat het meer is dan een gebouw voor ouderen; het is een plek waar de zorg voor het eiland is gematerialiseerd. Om de coproductie van zorg en plaats te duiden introduceert dit hoofdstuk het concept carescape, dat voortbouwt op ideeën van zorg en de 'scapes' van Arjun Appadurai. Het hoofdstuk laat zien dat deze twee concepten niet los van elkaar kunnen worden begrepen, en dat ze gezamenlijk moeten worden beschouwd.

Hoofdstuk 3 brengt de lezer van de zilte kust van de Waddenzee naar een buitenwijk van Rotterdam, in een merkwaardig opgeknapte garage. De garage hoort bij het huis van een vrijwilliger en is opnieuw ingericht als kinderkamer; in Nederland noemt men het een 'vondelingenkamer'. De kamer is tot stand gekomen dankzij een op donaties gebaseerde NGO; het is een plek voor het anoniem achterlaten van baby's – een praktijk die in Nederland bij wet is verboden. Ondanks alle landelijke aandacht en controverse was er nog geen baby te vondeling gelegd in de vondelingenkamer. In onze verkenning van verschillende infrastructuren voor deze ruimte benadrukken mijn coauteurs en ik het belang van infrastructuren bij het creëren en onderhouden van plaatsen. We laten zien dat sommige plaatsen slechts *by-proxy* bestaan door handelingen die elders worden verricht; hoewel ze leeg blijven, kunnen ze sociale en politieke discussies in gang zetten over de zorg voor kinderen, moeders en de overheid. Dit hoofdstuk toont niet alleen de proxy-capaciteiten van plaatsen, maar laat ook zien dat de grenzen van plaatsen voortdurend opnieuw worden getrokken en onderhandeld; dat zorglocaties er niet a priori zijn, maar dat ze actief in het leven moeten worden geroepen door tal van infrastructurele arrangementen.

Hoofdstuk 4 richt zich op samenwerkingsplekken, met als doel om het proces van plaatsmaken in relatie tot zorg nader te onderzoeken. In de casus van een living lab voor het testen van en experimenteren met oplossingen voor de ouderenzorg – zoals slimme vloeren; een gevoel van thuis creëren; strategische plaatsing van lichten; een slim bed, etc. – volgen we het ontwerp- en ontwikkelproces van een zorgplek van de beginfase tot aan de uiteindelijke realisatie. Het living lab is een vreemde plek omdat het zowel fysiek als imaginair is; een plek waar de 'toekomst van de ouderenzorg' wordt verbeeld en geproduceerd door de fysieke opzet en locus. Het lab produceerde nieuwe ontologieën voor ouderenzorg, waar de zorg werd voorgesteld als hightech, collaboratief en wetenschappelijk gefundeerd. Zoals bekend is de natuurlijke staat van een plaats

altijd in wording en daarmee nooit af; niettemin is de daadwerkelijke bouw van een zorgplaats een fascinerend onderwerp om te verkennen. In dat proces worden namelijk het werk, de discontinuïteiten en de onderhandelingen van het besluitvormingsproces bij het creëren van een plek voor zorgpraktijken zichtbaar. Het hoofdstuk bepleit een andere manier van denken over plaatsmaken in de gezondheidszorg, waarbij de nadruk wordt gelegd op het werk en de logica die nodig zijn om een geschikte plek te creëren voor zorg.

Hoofdstuk 5 brengt de lezer naar de zonnige Tyrreense kust van Italië en vertelt het verhaal van migrerende 'badante' vrouwen, die als inwonende verzorgsters werken voor Italiaanse ouderen. Het hoofdstuk introduceert het idee van 'folding places', geïnspireerd door Deleuze (1993). In dit hoofdstuk beschouw ik zorg als gelegen binnen en tussen 'plooien'; daarbij worden zowel zorg als plaats geproblematiseerd. Ik laat zien hoe vrouwelijke migranten voor hun kinderen zorgen door ervoor te kiezen om van ze weg te zijn, en hoe ze plaats 'opvouwen' in een poging om tegelijk ook deel uit te maken van hun leven thuis. Het traditionele, simplistische onderscheid tussen hier en daar, thuis en daarbuiten dat men vaak hanteert bij het bestuderen van migranten wordt verdiept, en het idee van plaats wordt verder uitgewerkt om ook die manieren te omvatten waarbij plaatsen niet alleen materieel zijn, maar ook ervaren, ingebeeld en gecoproduceerd door affectieve zorg.

Hoofdstuk 6 stuwt het concept van plaats voorbij aan zijn fysieke grenzen. Het hoofdstuk richt zich op de toekomst van zorgplaatsen; als empirische casus staat de Pod centraal, een sensory reality technologie. Het hoofdstuk introduceert de term 'post-place' als een eerste stap in het ontwikkelen van een speculatieve woordenschat voor het werken met zorgplekken; een woordenschat die voorbijgaat aan dichotomieën zoals materieel versus immaterieel, digitaal versus echt, of 'plaats-vol' versus 'plaats-loos'. In tegenstelling tot het idee van plaatsloze zorg is 'post-place' zorg een inclusief, open en vooral generatief begrip. De kracht ervan ligt in het disruptieve potentieel om bestaande plaats-zorg ontologieën te bevragen, en ruimte te creëren om na te denken over de veranderende landschappen van de gezondheidszorg.

Hoofdstuk 7 brengt de concepten uit de voorgaande hoofdstukken samen; het geeft inzicht in hun analytisch potentieel en onderlinge relaties; en het beantwoordt de onderzoeksvragen die ten grondslag liggen aan dit boek. Deze antwoorden maken verbanden zichtbaar tussen de verschillende punten in het argument over geplaatste zorg, maar zijn geenszins sluitend of uitputtend. In plaats daarvan

ontregelen ze de traditionele zorgkaart en vormen ze het begin van de assemblage van een conceptuele zorgkaart. Dit dubbele werk van ontregelen en assembleren vindt tegelijkertijd plaats: het ontregelen van gebruikelijke aannames over zorg-in-plaats – zorg moet op de juiste plaats passen; zorgplekken zijn daar waar zorg plaatsvindt; zorg kan efficiënt worden verplaatst – maakt de weg vrij voor de assemblage van een multidimensionale kaart van zorg. De casestudy's tonen aan dat 1) zorg altijd wordt gecoproduceerd met plaats en dat de twee concepten moeten worden begrepen als met elkaar verweven; 2) deze coproductie is een proces in wording met een open einde; 3) het heeft politieke, normatieve en stigmatiserende effecten; 4) zorgplaatsen moeten geschikt worden gemaakt voor zorg, en dit proces vereist werk van een veelheid aan actoren; 5) geplaatste zorg produceert nieuwe ontologieën van zorg. Vanuit deze inzichten concludeert het hoofdstuk dat plaats conceptueel werk kan verrichten voor zorg. Het is een term die analytisch werk kan doen in meerdere richtingen: doordat het tegelijk betrekking heeft op betekenis en materialiteit kan het zorganalyses verankeren in dagelijkse praktijken.

Het laatste hoofdstuk schetst de methodologische en praktische bijdragen van het boek. Methodologisch leidden 'oddity' en 'disconcertment' tot een meer reflexieve analyse en tot een andere vorm van aandacht tijdens het onderzoeksproces; een aandacht gericht op temporaliteiten, normativiteiten en zelfreflectie. Voorts heeft dit boek ook praktische implicaties. Het geeft aanbevelingen voor beleidsmakers, zorgprofessionals en burgers om na te denken over de vele manieren waarop zorg wordt geplaatst. Beleid zoals *Aging in Place*, *De juiste zorg op de juiste plek* en *Regionalisering* moet plaats serieus nemen; het zou zich verre moeten houden van een romantisering van 'de regio' of 'de buurt', en juist meer aandacht schenken aan affectieve relaties tussen plaats en zorg. Het verplaatsen van gezondheidsdiensten moet zorgvuldig gebeuren, met oog voor de onderliggende waarden die bij dergelijke beslissingen op het spel staan. Tot slot pleit dit boek voor de democratisering van plaatsmaken in en met zorg; het spoort burgers aan om het zorgzaam maken van plaatsen te omarmen als een gezamenlijke verantwoordelijkheid, en als een vorm van *samenleven* met zorg.

Acknowledgements
Dankwoord
Благодаря

I'm often told that this is the part everyone *does* read, so to those who've skipped ahead, go back to the intro! ☺

After years of structuring themes, thoughts and paragraphs, I'm refusing to do it here. I owe a lot to many people, places and ideas, and I will not decide who/what goes first, second, etc. With this one exception: I am most grateful to whoever is reading this book. Thank you, dear reader, for picking it up and leafing through (I know we are encouraged to read 'diagonally' these days; I appreciate it all the same). It has taken up much of my time, and brain, and courage, and perseverance to write it.

The cumbersome and mysterious process of writing relied on the happy coincidence of many things coming together: the right 'headspace', a quiet place, a comfortable chair, my laptop working, no distractions, rain. The writing 'worked' mostly in (vegan) cafés; with the help of large quantities of almond-milk cappuccinos and turmeric lattes; in Rotterdam, Delft and Amsterdam; on wooden tables in *Bagels and Beans, SharpSharp* and the *Lantaren Venster*. Thank you, Renate and Frank for making *SharpSharp* feel like home. And thank you, Ingrid for the great coffee and kind encouragement. Often times during writing periods, it was *Spirit's* food that kept me alive and in good health. The beautiful, imposing space of the *Erasmus Medical Center's* Atrium reminded me why I'm writing about architecture and care, and the view of the Erasmus bridge brought me down to the tangible now at the odd times I'd look up from my laptop at the *Stieltjesstraat*.

The thinking – an essential ingredient to have covered before sitting down with a cup – has taken me to many places; from Sydney to Athens, from Barcelona to New Orleans and London, from Copenhagen and Helsinki to Zürich, Boston,

Lancaster and Vienna. I am still in wonder at the privilege this has been. I had never even been on a plane until my 20th birthday and the travels that this dissertation has afforded me have brought me much confidence, adventure and appreciation.

To my old home: a country of sun, snow, mountains, valleys, of nostalgia and childhood memories. I'll never know the world in the same way I did when I was with you: impossibly big and full of promise. Now that it has become more knowable, and therefore smaller, some of that magic is gone. Yet thinking back to that place of wonder is how I get that feeling back – remembering what it was like to drag my finger along a map and imagine. That childhood wonder is forever entwined with you, my old home; thank you for teaching me to daydream.

To my current home: this small, green, windy, flat land, populated with tall, strange, cycling people (in raincoats). I am very appreciative of the opportunities you've given me and of the ways you've shaped me. I don't always feel like I belong here, but I also know that I hardly belong anywhere else. *Bedankt voor je vriendelijkheid, je zonnige dagen (en mij leren die te waarderen), je bereidheid Engels to spreken, je mooie groene natuur en je openheid! Ik zal nooit een kaasliefhebber worden, maar ik vind uitwaaien op het strand nu echt heel leuk!*

To my friend Maria, who sat next to me eight years ago, at the first day of school. Writing our masters theses together was a treat, and I've been missing you next to me every step of writing this book. Thank you for being my friend, my partner in (questionable) intellectual discussions, and a fellow dreamer. You are so much braver than me (*she's making a face now*) and never fail to inspire me.

To Iris and Roland, my formidable duo thinking-facilitators, system-rebels and fun-loving explorers. You see, they are both *walkers*. We wouldn't stay in the conference hotels, but somewhere in the city, in the middle of things. Then we would walk, looking around and *noticing things*. Everything was important: books, people around us, dancing, being part of things, being in place. I concluded pretty early on that my supervisors are *cool*, in a kind of an alternative way (it wasn't exactly a surprise to me when they wrote an article about rebels). This basically meant that rules were generally only followed when absolutely necessary, traveling was great fun and we spent quite a bit of our meetings talking

about films and music. Some moments are stuck in my mind: Iris and I skipping a conference banquet and ending up in a protest rally in a metro station in Athens, holding hands as the lights go out to the chanting "oxi, oxi". Next: The both of us pushing through a tiny space between the rocks on an underground tour of Naples, only to end up in a skull collection cave in a bad part of town. Next: Roland, Iris and I sitting in a taxi, headed to the emergency room in a Sydney suburb. My knee – the size and consistency of a juicy melon, my heart racing and my mascara smudged.

Thank you both for the midnight email conversations, for watching the endless slew of TED talks I sent you, for the encouragement, for the freedom to think and find my way, for the commas and streepjes (Roland), and for all the life advice. I might have been quite unbearable at times, so thanks so much for sticking with it!

To Dr. Herman Tak, who inspired me to be a researcher: thank you for encouraging me to write! You are an amazing teacher. I remember that a whole world opened up to me when, having read an essay of mine discussing the 'Bulgarian' bacteria in yogurt, you calmly asked to see this bacteria's passport. My head was buzzing with excitement; there were never enough anthropology classes!

To all my WTMC colleagues, particularly Claudia and Marith: it was such a pleasure to think and talk and laugh with you! And to Bernike and Govert, thank you for the support you gave so willingly. I loved my time at WTMC (want to do it again…)

To my wonderful, funny, hard-working, generous HCG colleagues. Thank you for reading my work, for thinking along, for the encouragement and support and for making these 5 years fun! The best thing about our group are the people in it, and I am so very grateful and appreciative of every single one of you. Jacqueline, thank you for the kind support, it meant so much! Thank you Marthe, Robert and Marjolijn for being such great friends to me. And thank you Tessa for being the best *kamergenootje*! Marianne, I love how we work together; thank you so much for making it fun! And thank you Hester for being absolutely awesome (seriously!) Annemiek, I remember I was slightly afraid of you in my first year (your looks are always very *knowing*), yet you became such an important source of support, and humor, and lightness; thank you. Rik's comments of my work

(the guy's a genius) contrasted quite a bit with our otherwise light conversations about dogs and music; you are such pleasure to be around. Nienke came along much later in the process of writing this, but I can hardly imagine this now; it's like you were always there (and *are* always there for me). And with Sabrina's arrival at HCG, I finally found a match for my critical view of pretty much everything; something just clicked (and is still clicking).

Josje, Martijn and Tineke (David joined a bit later) stumbled through this PhD-thing together with me (although Josje did it gracefully, like a forest fairy), making it less scary and a lot more fun. I'm grateful to you, and for you.

To my friends, and especially Iris (Bakx) and Nanina, whose travel itineraries I'd love to steal and who keep inspiring me to go places! To Yulia, a truly grounding force in my life: thank you for your wisdom, and beauty and patience. Thank you, Henriette for being my Dutch mom and friend, for your advice and support all these years. And to Myrthe, a little engine that always can! I'm in awe of your energy and passion for a better (plant-based) world. Thank you, Marieke and Johanna, Marinika and Jason!

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To the scholars who inspired and generously helped me find my words and formulate my thoughts. I am grateful to Daryl Martin, who has been incredibly kind and helpful to me and whose work keeps motivating my own. Joanna Latimer and the members of the Materialities of Care group have greatly influenced my thinking and continue to inspire me. My thanks go to Michael Guggenheim, who hosted me at Goldsmiths University and whose way of thinking (differently) was a constant and welcome source of inspiration. I was lucky enough to be part of the course *Ethnographies of Objects* in Bochum, where I developed my work, thanks to Helen Verran, Jeannette Pols, Estrid Sorensen and the friends I met there. A special thank you goes to Vicky Singleton, Sarah de Rijcke, Miquel Domenech, Attila Bruni, Sara Sariola and Ulrike Felt, who served in the EASST Council with me, and who I learned so much from. Finally, I am grateful to Willem Schinkel and the members of the COMPOSITIONS group, whose way of thinking and discussions pushed me to think further and differently.

Dear Marcello, thank you for your friendship. Thank you for your kindness and patience, for always knowing what to say to make things better, for the perfume-*uitjes*, for sharing your wisdom and knowledge, for all the dinners and discussions and ballets. Thank you for listening to me and for offering calm in bad storms.

And Lieke! It's hard to come up with words when it comes to you. Your words are always much, much better. Being around you feels like home. There are too many things to thank you for (my Elena Ferrante-obsession being the least of them). You are a brilliant scholar, but you are most of all a *brilliant friend* and super funny to boot. I haven't been able to detect any faults in you, but I hope to keep trying for a long time to come.

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To Rotterdam, *my place* and my partner through long aimless walks in rain and sunshine (but mostly wind). I fell in love with you slowly, but it brewed to a passion that has now become a sense of home. Rotterdam is the first place I *made mine* by walking it, finding its rhythm, listening to the trams and the sirens, waiting as the bridges went down.

Finally, a thank you goes to my mother, who stood at the airport steps, behind the customs line, patiently waiting to wave me goodbye more than twelve years ago, on my way to the Netherlands. I didn't turn around then – even though I knew I should – because I was crying and determined to hide it. This dissertation is just as much a result of your efforts, as it is of mine. More, probably. *Мила мамо, благодаря ти от сърце за всичко и те обичам много!*

Curriculum Vitae

CONFERENCES

2019

Panel convener, presenter 4S Annual Meeting New Orleans *Innovations, Interruptions, Regenerations*

2018

Organizer, presenter EASST Lancaster *Meetings: Making Science, Technology and Society Together*

2017 Attendee Stadmakers congress (City Makers conference), Rotterdam

2017 Organizer *Architecture and Health: Intersections of Care*, Erasmus University Rotterdam

2017 Panel convener, presenter 4S Annual Meeting Boston *STS (In)Sensibilities*

2017 Presenter EGOS Copenhagen *The Good Organization*

2017 Presenter International Critical Management Studies Conference Liverpool

2017 Presenter Annual Symposium of Science and Technology Studies: Experimentation and Evidence, Helsinki

2016 Attendee Stadmakers congress (City Makers conference), Rotterdam

2016 Presenter 4S/EASST Annual Meeting Barcelona *Science & technology by other means: Exploring collectives, spaces and futures*

2016 Presenter EGOS Naples: Organizing in the Shadow of Power

2016 Attendee Urban Transformations Conference: Vital Cities

2015 Presenter APROS/EGOS Sydney: Spaces, Constraints, Creativities: Organization and Disorganization

2015 Attendee EGOS Athens: Organizations and the Examined Life: Reason, Reflexivity and Responsibility

2015 Attendee Safety II and Beyond: Resilience meets Regulation

2015 Presenter Assembling Cities: STS Theories and Methodologies in Planning Studies

WORKSHOPS

WTMC

2017, December: (Re-)inventing Responsibility and Innovation

2017, May: STS and Art

2016, August: Time and STS (summer school)
2016, April: Foucault's Legacy
2015, August: Politics of Science, Technology and STS (summer school)
2015, May: Robots! Work, Care, Performance
OTHER
2018 Atlas-ti, skills training, EUR course
2018 'Are you ready to become a number: Author Identities' TOP, EUR course
2017 Annemarie Mol and Rivke Jaffe 'Spaces and Bodies', Spui 25
2017 Bruno Latour 'An Evening with Bruno Latour: The New Climatic Regime', Spui 25
2017 Noortje Marres 'What is digital sociology for?', EUR workshop
2017 Group Dynamics, EUR course
2016, June (summer school)
Ethnographies of Objects: Descriptive and Analytical Approaches to STS. PhD Workshop Bochum, Germany
2015 ISS The Dean's Master Class: Re-think
2015 Arjun Appadurai public lecture and PhD workshop 'Ecologies of Failure', Erasmus University, Rotterdam
2015 Ready in Four Years, ESHPM, EUR
2014 Steve Woolgar lecture and debate 'What is scientific quality?' KNAW, De Jonge Akademie, Amsterdam
2014 Tutor Skills for Problem-based Education (PGO), ESHPM, EUR

ORGANIZATIONAL WORK

2016 – present
European Association for the Studies of Science and Technology (EASST) Council
PhD Representative
2014 – 2017
JBMG (currently JESHPM) Young ESHPM; Erasmus University

COURSES

Tutor:
History and Philosophy of Science (Bachelor; in Dutch)
Methods and Techniques of Qualitative Research (Bachelor; in Dutch)
Governing Healthy Cities (Master; in English)

Health Care Governance (Master; in English)
Comparative Health Policy (Master; in English)
Advanced Research Methods (Master; in English)

Lecturer:
Governance and Strategy (Master; in English)
Governing Healthy Cities (Master; in English)
Advanced Research Methods (Master; in English)
Health Care Governance (Master; in English)
Methods and Techniques of Qualitative Research (Bachelor; in Dutch)
Master Thesis supervision (in English and Dutch)

Coordinator:
Governing Healthy Cities (Master; in English)
Blok 8 Zorg en Welzijn: Kwalitatief Onderzoek (Bachelor in Dutch)

OTHER PUBLICATIONS

I Wallenburg and D Ivanova (2015) Griekenland heeft een andere politieke cultuur nodig, niet meer geld. De Volkskrant

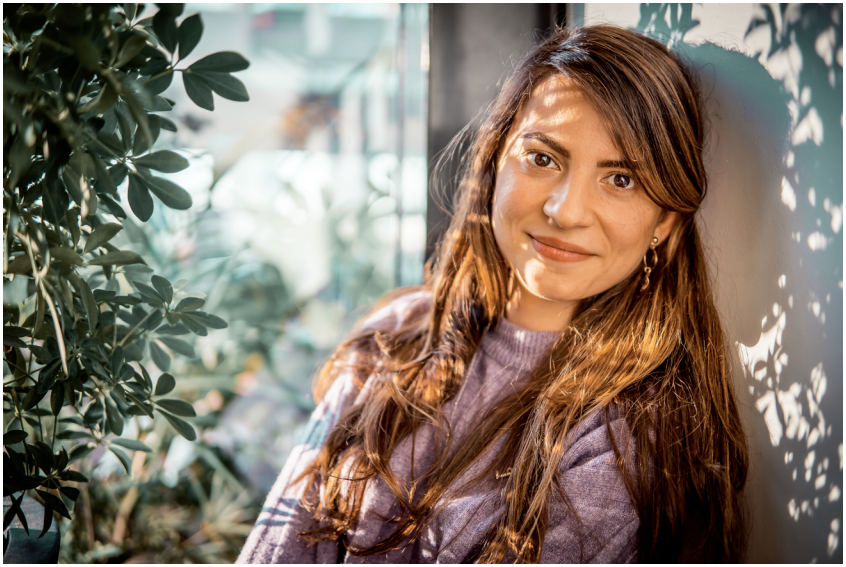
D Ivanova (2017) Losing and Finding: On the Curious Life of Ethnographic Objects In Mewes J and Sørensen E (eds.) *Ethnographies of Objects in Science and Technology Studies*. Bochum 8-17.

D Ivanova (2019) De Pod. Wijsgerig Perspectief (3): 46-47

D Ivanova (2019) Object van weerstand: werken met betwiste onderzoeksobjecten. *KWALON* 3(72).

About the Author

"I haven't been everywhere, but it's on my list."
Susan Sontag



Dara Ivanova was born on September 23th, 1987 in Bulgaria and migrated to the Netherlands at age 20. She completed a bachelor's degree in social sciences at the University College Roosevelt in Middelburg (summa cum laude) and received a Christiaan Huygens NUFFIC scholarship to continue her education with a two-year research master program at Utrecht University. During this time Dara did extensive fieldwork in Italy and Bulgaria, graduating cum laude from the program Cultural Anthropology: Sociocultural Transformations in 2013. The following year she began a PhD project on the relationship between place and care at Erasmus University. There, she also taught, designed and coordinated various courses on both bachelor and master level, including philosophy of science, advanced qualitative research methods, governing healthy cities and comparative health policy, and supervised 15 master theses students.

During her PhD trajectory Dara served as the student representative member of the European Association for the Study of Science and Technology and is a member of the Netherlands Graduate Research School of Science, Technology and Modern Culture. She is currently working as an assistant professor at the Erasmus School of Health Policy and Management. Her research interests include the politics of science and care, the architecture of health, urban health and development, (the ethics of) healthcare technologies, migration and gender, as well research methodology and ethnographic methods in particular.

Dara is a traveler, dog-admirer, amateur photographer, self-appointed film critic and an avocado-addict. She describes herself as a plant-powered, intercultural, creative creature who likes to observe the world, think, walk, discuss and write.