Introduction: Placing care, opening up place

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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 common-sense 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.