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.