CARE/PLACE
Unsettling place in healthcare

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Zorg/Plaats
Ontregelen plaats in de zorg

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

1 Published by Continuum.

Chapter 1

Introduction:
Placing care, opening up place

A Place of Birth

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

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

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

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

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

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

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

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

4 From Dutch: Amsterdam babies.

5 A city less than 20 kilometers north of Amsterdam.

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

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

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

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

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

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

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

Where is Place in Healthcare?

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

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

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

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

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

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

Opening up Place with Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Methodology for Odd Places

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

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

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

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

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

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

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

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

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

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

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

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

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

The Red Thread[11]

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

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

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

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

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

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

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

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

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

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

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

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

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

An Outline: Five Care Places

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

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

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

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

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

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

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

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

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

22 Written by Emma Donoghue and directed by Lenny Abrahamson.

Chapter 3

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

Abstract[23]

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

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

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

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

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

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

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

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

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

Concepts and method

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

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

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

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

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

25 http://www.beschermdewieg.nl

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

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

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

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

Enter

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

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

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

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

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

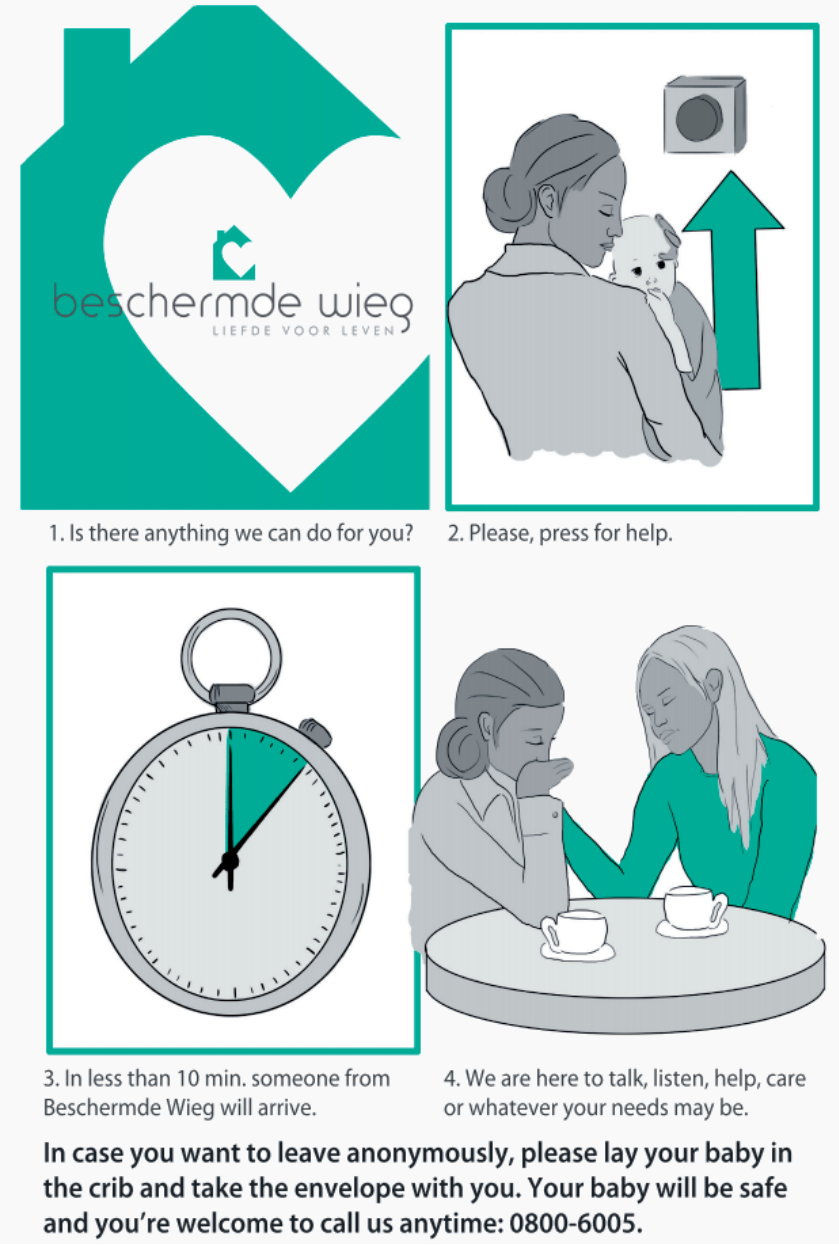

Figure 2. Wall poster. © Beschermde Wieg

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

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

A Room of Possibilities

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

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

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

32 The name is fictitious.

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

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

Aligning Infrastructures

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

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

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

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

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

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

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

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

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

36 The name is fictitious.

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

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

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

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

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

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

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

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

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

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

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

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

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

Place in relation

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

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

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

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

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

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

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

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

Place-by-proxy

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

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

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

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

Exit

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

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

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

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

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

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

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

Chapter 6

Post-Place Care: Disrupting place-care ontologies

Abstract[59]

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

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Introduction

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

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

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

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

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

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

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

61 In Dutch: belevingscabine.

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

Disrupting 'placeless' care

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

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

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

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

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

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

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

Method

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

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

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

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

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

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

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

Place layers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Caring through place

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

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

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

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

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

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

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

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

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

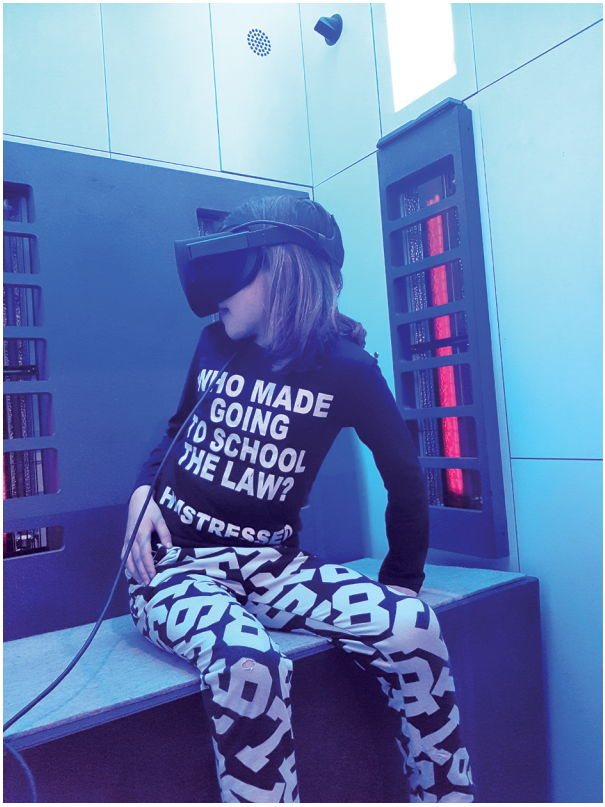

Figure 4 Inside the Pod. Image reproduced with permission from Sensiks

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

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

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

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

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

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

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

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

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

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

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

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

Post-place care

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

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

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

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

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

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

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

Conclusion: disruption as an opening

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

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

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

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

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

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

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

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

Chapter 7

Discussion:
Unsettling place in, and with, care

The Danube Park

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

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

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

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

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

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

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

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

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

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

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

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

An Invitation to Assemble

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

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

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

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

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

The Red Thread

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

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

How is care produced, configured and enacted in place?

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

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

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

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

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

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

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

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

How does placemaking in healthcare matter?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Theoretical Implications I: It's time for place

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

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

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

Theoretical Implications II: Carescapes and power

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

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

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

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

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

Theoretical Implications III: Caring objects

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

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

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

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

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

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

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

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

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

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

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

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

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

Theoretical Implications V: Placing care vocabulary

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

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

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

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

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

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

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

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

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

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

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

Methodological Implications: Oddity and Disconcertment

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

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

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

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

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

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

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

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

Practical Implications I: Caring in nowhere land?

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

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

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

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

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

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

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

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

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

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

Practical Implications III Moving care is like moving a tree

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

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

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

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

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

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

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

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

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

Practical Implications IV: Facilitating (Urban) Belonging

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

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

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

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

Practical Implications V: (We are all) Place makers

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

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

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

Space for Place: A Research Agenda

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Final words

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

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

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

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Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

Samenvatting

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

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

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

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

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

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

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

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

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

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

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

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

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

Acknowledgements
Dankwoord
Благодаря

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Curriculum Vitae

CONFERENCES

2019

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

2018

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

2017 Attendee Stadmakers congress (City Makers conference), Rotterdam

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

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

2017 Presenter EGOS Copenhagen *The Good Organization*

2017 Presenter International Critical Management Studies Conference Liverpool

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

2016 Attendee Stadmakers congress (City Makers conference), Rotterdam

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

2016 Presenter EGOS Naples: Organizing in the Shadow of Power

2016 Attendee Urban Transformations Conference: Vital Cities

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

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

2015 Attendee Safety II and Beyond: Resilience meets Regulation

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

WORKSHOPS

WTMC

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

2017, May: STS and Art

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

ORGANIZATIONAL WORK

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

COURSES

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

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

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

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

OTHER PUBLICATIONS

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

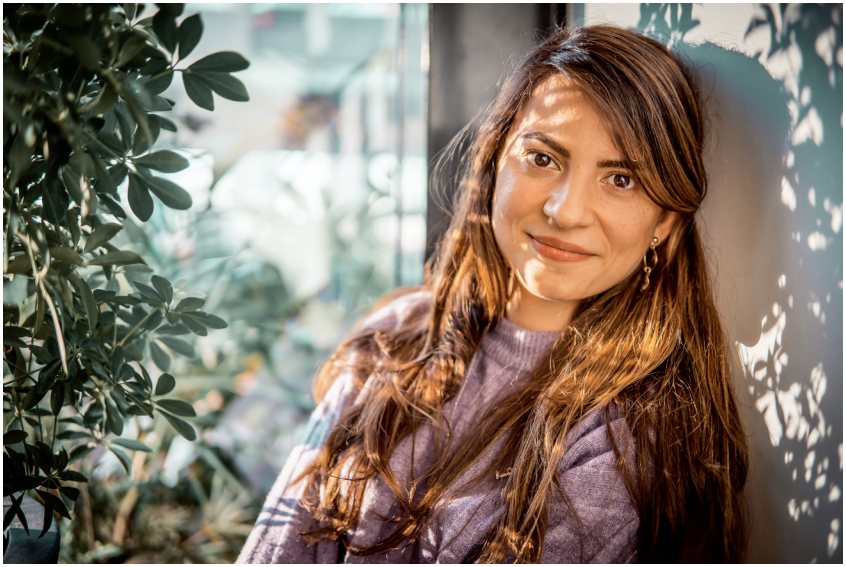
D Ivanova (2017) Losing and Finding: On the Curious Life of Ethnographic Objects In Mewes J and Sørensen E (eds.) *Ethnographies of Objects in Science and Technology Studies*. Bochum 8-17.

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

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

About the Author

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



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

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

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