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## Conceptualising ‘materialities of care’: making visible mundane material culture in health and social care contexts

Christina Buse, Daryl Martin and Sarah Nettleton

### Introduction

[O]bjects are important not because they are evident and physically constrain or enable, but often precisely because we do not ‘see’ them. The less we are aware of them, the more powerfully they can determine our expectations by setting the scene and ensuring normative behavior, without being open to challenge. (Miller 2005: 5)

There is growing attention to the significance of materialities within the sociology of health and illness, situated within traditions of science and technology studies and new materialist approaches. The theme of this edited collection picks up on this interest, and also reflects our recent work on material culture in healthcare contexts. This research ranges from the significance of dress for supporting identity and personhood in dementia care (Buse and Twigg 2014) to the role of interior design in enacting care and comfort in cancer centres (Martin 2016, 2017), as well as ongoing work on the significance of architecture in health and social care contexts (Nettleton *et al.* 2018). Our interest in materiality is situated within a wider attention to material culture within sociological studies of health and social care. Science and technology studies (STS) approaches have been applied to thinking in the sociology of health and illness, highlighting the active role of technologies in healthcare practices, for instance; the metered dose inhaler (Prout 1996), the Cervical Smear Test (Singleton and Michael 1993), information and communication technologies (Lehoux *et al.* 2008), medical imaging technologies (Burri 2008), and technological innovations in areas such as genetic testing (Webster 2007). Other research within this tradition explored the role of assistive technologies in configuring caring relations (Schillmeier 2014), revealing the involvement of non-human actors or ‘things’ in care practices, including medical technologies, assistive technologies and bodily matter and fluids (Mol *et al.* 2010). More recently ‘new materialist approaches to health’ (Fox 2016), use the concept of ‘assemblage’ to situate the healthy or ill body within a network of material/physical, social and psychological relations and affects. ‘Health assemblages’, ‘ill-health assemblages’ (Fox 2016) or ‘diagnostic assemblages’ (Locock *et al.* 2016) may include a range of diffuse human and non-human elements – for instance, an organ, health technology, the arrangement of a room, a doctor, a letter, relatives and carers – and recognise such assemblages to be processual, relational and dynamic, shifting across time and context.

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This body of work highlights the importance of attending to materiality and the co-constitutive role of technologies in health, yet the literature to date tends to focus on technological innovation. Other aspects of material culture remain unnoticed in the background, and yet they hold potential to shape encounters in health and social care, and the ‘experience and feel’ of care in practice (Abbots *et al.* 2015). Maller (2015) calls for a social practice based approach to thinking about materiality in the sociology of health and illness that can explore moments of ‘doing’ in health-related practices. She emphasises the importance of going beyond ‘obvious health technologies’ in order to explore more mundane aspects of materiality, such as the built environment – including car parks, pathways, roads and buildings – as part of infrastructures in health.

This emphasis points to the interdisciplinary field of material culture studies, which has long drawn attention to the significance of mundane materials as part of social practice. For instance, Miller (1987, 2005, Miller and Woodward 2012) argues for the importance of addressing ordinary objects – blue jeans, furniture, household objects – which can go unnoticed because they are so embedded in the tacit, embodied routines that underpin, but are nevertheless crucial to, everyday life. Research bringing a specifically material culture studies approach to sociology of health and illness therefore highlights the significance of often neglected objects. Scholars have explored the materiality of nursing, examining how mundane artefacts – sluice pans, towels, gloves, washing bowls, clothes, cotton balls – can illuminate nursing cultures (Nelson 2003, Sandelowski 2003). Latimer’s (2003) ethnography of nursing, which she further describes in the afterword of this collection, illustrates hierarchies in classifications of work and patient that are articulated through privileging of technical or clinical materials by nurses over materials connected to washing and dressing. Pink *et al.* (2014: 432) address the importance of ‘taken for granted’ or ‘quiet’ materialities including hand gel, gloves, soap, wipes, carpets and shoes, as part of the ongoing negotiation of safety, contact and touch by health care workers. Historical research also draws attention to the significance of mundane materials to understanding the experiences of service users, social hierarchies and relationships. For instance, Hamlett (2015) explores experiences of Victorian asylums through historical analysis of material life, drawing attention to the importance of ‘small things’ – false teeth, glasses, jewellery, watches – in supporting classed and gendered identities and facilitating wider connections with the outside world (Hamlett and Hoskins 2013). These themes are pertinent for analysis of material cultures in contemporary health and social care institutions, and indeed we bring a focus on relatively neglected and mundane materialities to the fore of current debates in this collection.

### **Defining ‘materialities of care’**

We use ‘materialities of care’ as a heuristic device, where mundane materialities act as a lens for (re)examining care practices in health and social care contexts. Attention to materialities can provide a way to make visible the ‘ordinary’, tacit and non-verbal aspects of care practices. As Sandelowski (2003: 196) advocates, this approach involves ‘paying close attention to objects and other features of the physical landscape of practice’, thus generating ‘new insights and new questions concerning practice’. This entails synergies between methods in museum studies, design and archaeology, and involves strategies of ‘material imagining’ (Woodward 2015) by starting with analysis of a concrete aspect of material culture as a way of exploring embodied practices. While analysis may focus on a particular aspect of material culture (e.g. dress, food) the use of the plural ‘materialities’ draws attention to the intersection of multiple materials within practices (Shove *et al.* 2012).

'Materialities of care' encompasses ideas of 'materialities' and 'care' which are diffuse and hard to define. The concept of materialities is contested and increasingly encompasses the immaterial (Miller 2005; Tilley 2006). Here we focus on materialities as physical 'things', encompassing not only artefacts which are artificially created and embed cultural scripts, but also composite materials – 'everything from a stone, building or bench to the remains of an architectural artefact' (Reichmann and Muller 2015: 14). However, we also recognise the intersections between the immaterial and material, and the materialities of bodies and 'things' so as to encompass more intangible qualities of materialities such as atmosphere and ambiance (Edensor and Sumartojo 2015; Bille *et al.* 2015). Materialities of care prompt consideration of the relationship between these mundane materialities and care practice. Materials are shared between people as part of practices of care, they sometimes 'stand in' for caring relations, and may shape, enable or constrain practices of caring. As argued throughout this collection, materialities are not merely a backdrop for care interactions, but play an active role in constituting relations of care.

Care is also a contested and diverse concept (Abbots *et al.* 2015), encompassing 'caring about' as an emotion or disposition towards someone, 'caring for' as a form of labour or physical work, and care as a social relationship. Here we focus on care as a practice, focusing on particular moments in the 'doing' of care in interaction with materialities (Puig de la Bellacasa 2011), as well as considering how these practices become sedimented or altered over time. This engages with debates about care as a mode of 'bodywork' (Twigg *et al.* 2011), although our definition extends to encompass paid, unpaid and self-care; distinctions which are often blurred in acts of caring. While focusing on practices of doing care, we recognise that the physical and emotional elements of care are difficult to disentangle (Rummery and Fine 2012), and that material practices and architectures of care are generative of, and imbued by, affect and emotion.

Crucially, a focus on mundane or taken for granted materials can unfix understandings of care, thinking beyond conventional care practices, and bringing to light acts of 'caring through things' (Puig de Bellacasa 2011). For us, the 'materialities of care' provide a novel way in to examining 'practices of care' as they unfold in a range of formal and informal settings, and in relational ways, whereby embodied, routine and often unnoticed actions of caring are constituted through and between the relations between bodies, objects and spaces. Such practices are spatially and temporally enfolded and, taken as a whole, the chapters in this collection reveal the importance of these spatiotemporal considerations. We therefore explore these three interlocking themes or strands of materialities of care (spatialities of care, temporalities of care and practices of care), before turning to consider the methodological implications for undertaking research within this conceptual and empirical terrain.

### **Spatialities of care**

There is a close relation between the 'materiality of the artefact' and the 'materiality of space' (Miller 1987: 121), and so we maintain that the influence of space is crucial to considering how care is enacted and experienced (Martin *et al.* 2015). A spatial focus prompts us to consider how care is configured in particular settings, which caring practices are facilitated through different spatial contexts and what the implications are of arranging care and care settings as we do – for carers and those being cared for. The chapters collected here offer studies of care in very different locations, ranging from institutional buildings to informal spaces. The hospital acts as a site for three chapters: these are a micro-scaled ethnomethodological study of the intricacies of embodied action as instruments are exchanged between

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medical professionals in surgical procedures (Heath *et al.*); a meso-level ethnography in the United States that understands hospitals as ‘nodes in transnational networks of immigrant and refugee patients’ (Bell), and a macro-level analysis of a yet-to-be built hospital in the UK, whose planning through the Private Finance Initiative (PFI) illustrates wider politico-economic contexts of care (Jones). Latimer’s afterword also draws on her own ethnographic research on classifications of materials in nursing work in hospitals, as well as Hillman’s (2014) study of ‘thresholds’ in hospital waiting systems. Other contributions present ethnographies of care homes and hospices, and research how everyday material cultures, such as those of clothing (Buse and Twigg), food (Ellis) and furnishings (Lovatt) mediate social interactions and identity work in later life. In these contexts, everyday objects and their in-situ arrangement are integral to building a sense of being at home (Lovatt). In contrast, medical technologies may disrupt a sense of home, and require considerable work to integrate them into domestic spaces and routines, as explored in Weiner and Will’s study of home blood pressure monitoring. Other chapters contribute to our understanding of how care is encountered outside of clinical environments, whether in institutions of a primarily non-medical type, such as the art museum and botanical garden (Mangione), or in the informal and even incidental spaces in Brownlie and Spandler’s study of how neighbours supported each other in Glasgow and Hebden Bridge.

Thinking spatially across such different sites raises questions such as where front-stage and back-stage interactions begin and end; which forms of care are visible in any spatial setting (and, conversely, which are less visible to researchers), and how the dynamics of space intersect with patterns of social ordering. The conflict between front-stage and back-stage underscores Buse and Twigg’s discussion of the ‘aesthetics of care’; in particular, tensions between staff dressing residents so they are publicly ‘presentable’, and residents who chose less ‘tidy’ clothing associated with comfort and being at home. The question of visibility informs Jones’s analysis of the Royal Liverpool University Hospital, where digital images of the planned hospital building present an international corporate design aesthetic that ‘submerges’ and make less visible the local implications of the build; *inter alia*, these include reduced bed numbers, a surrender of clinical space to non-medical agencies and, at root, the hospital’s funding through an opaque PFI model, which loads debt long-term onto the public sector. An understanding of how the dynamics of space intersect with patterns of social ordering is traced through Bell’s careful hospital ethnography, where she notes how even the arrangement of furniture – where the chairs are placed, and who is permitted to use them – in examination rooms convey ‘a set of assumptions about doctor-patient interactions and their contribution to clinical knowledge’. Conversely, the assemblage of furniture and objects in the waiting room of the same hospital proffered ‘a more flexible, less formal space where patients could take more control’. These dynamics of control and social ordering are again picked up in Latimer’s afterword where, citing Hillman (2014), she considers the waiting room as a ‘threshold’ space in which assemblages of ‘uncomfortable plastic chairs’ and complex triage systems create an inhospitable environment.

Moreover, given the focus of this collection, thinking spatially leads us to ask how artefacts and environments inter-relate to encourage specific embodied actions and evoke particular atmospherics of care (Böhme 1993). For Brownlie and Spandler, embodied practices of mundane care are indirectly assisted through the sharing of unremarkable urban space which brought neighbours and strangers into contact with each other: their research observes how the shared spaces of tenement stairwells or a town square bring an ‘incidental awareness’ of the lives of neighbours, giving rise to routine yet meaningful care practices such as carrying shopping or collecting prescriptions. These encounters evoke atmospherics of care and echo narratives of belonging that are often associated with the intangible qualities of home. In her

chapter, Lovatt argues for an understanding of home that subtly subverts notions of home as being spatially fixed and ideas of home-making (especially in later life) as dependent on the incorporation of objects from previous homes. Lovatt argues that the assumptions underpinning such ideas rest on 'passive' conceptualisations of objects and processes of identity management that anchor older individuals in portraits of their former selves. Instead, she argues for an understanding of home that is animated by the interactions between objects, spaces and embodied practices in an ongoing and contingent manner, rather than placing residents in the past tense. In Lovatt's research, we glimpse how the spaces of care-giving are subject to the ongoing relations between people and objects that forge a sense of place 'marked by openness and change rather than boundedness and permanence' (Cresswell 2004: 39).

This conceptual movement from space to place helps us to advance the argument that practices of care are not merely embodied spatially but also emplaced. We agree with Pink (2012) that an understanding of practices of care is only effective when considered in relation to place. Just as materialities imply more than material things, 'place' implies something more than locality; it also enables 'a framework for understanding how different processes and things combine to create the world as it is experienced' (Pink 2012: 23). We benefit from the insights of cultural geographers who argue that practices recursively create social spaces and places (Cresswell 2004). Their figuring of place as a site of encounter and 'event' (respectively, in Cresswell 2004, Massey 2005, Pink 2012) captures the dynamic, fluid and unbounded nature of place. Massey (2005: 140) elegantly writes about the 'throwntogetherness' of place which involves negotiation 'between both human and non-human'. The contingent, negotiated and 'throwntogetherness' of places where material and non-material practices configure care is a recurrent theme of the chapters in this volume. In their chapter on the expressions of care that arise out of the happenstance dynamics of community life and its 'by the by' modes of informal helping between neighbours, Brownlie and Spandler's study reveals how the 'assemblage that is mundane care' is contiguous and often serendipitous, emerging in what might seem like unlikely settings.

Their data also reveals the storied nature of places, echoing Massey's (2005: 130–1) contention that stories of place invariably combine with 'articulations of wider power geometries of space'. Weiner and Will deploy Danholt and Langstrup's (2012) notion of 'infrastructures of care' to reveal how the prosaic use of blood pressure monitors in the home are contingent on wider patterns of consumption and individualised ideologies of self care. Bell's portrait of a hospital clinic providing care for refugees and immigrant populations reveals wider power geometries that permeate and shape it as a transnational node. Jones reminds us that global financial flows shape the architecture of healthcare settings to serve interests of capital as much as, if not more than, those who 'consume' care. And so attention to the minutiae of 'materialities of care' does not mean that we lose sight of politico-economic considerations, but instead allows for nuanced analyses of everyday acts of care.

Weiner and Will, for example, find the blood pressure monitors in the home are used along with shared material practices such as having a cup of tea with family indicating here how place can act as a 'field of care' (Tuan 1974). Such fields of care are, though, latent with tensions arising from the family members sharing that space and negotiating caring routines (Ellis). As Bell describes the activities and architecture of the hospital waiting room, she reveals a layering of practices wherein the 'temporary identity of waiting for medical care' can simultaneously invoke 'solitude and anonymity' and moments of 'community and familiarity for newly arrived and established immigrants'. These moments reflect the porosity of spaces wherein the assemblage of the clinic is continually reconfigured, and the salience of place for shaping practices of care is manifested – but they also indicate the temporal routines such spaces afford, and so we now turn to what we term the temporalities of care.

### Temporalities of care

Materialities and practices of care are not only emplaced, but are also folded within a multiplicity of intersecting temporalities. Practice involves routinised activity (Shove *et al.* 2012), and is embedded within the tacit rhythms and everyday rituals that constitute and support our sense of ontological security (Giddens 1992). The contributions in this collection highlight the entanglement of sharing materials with sharing routines. For instance, the fleeting moments of care – assistance with shopping, collecting prescriptions, sharing food – described by Brownlie and Spandler depend on the intersecting routines of care givers and recipients. Brownlie and Spandler argue that these routines facilitate care, for instance, in spaces such as local shops or tenant stairwells ‘because of the way they allow people to feel looked out for, to feel “known”’. Weiner and Will argue that care infrastructures are ‘created by materials and the routine activities, conventions and “work” required to maintain them’. They explore the location of blood pressure monitors within ‘bundles’ of other objects, and how this helps to create routines, for instance, monitoring while watching television in the evening. Lovatt describes how care home residents ‘cultivated a sense of home in their individual rooms by establishing regular practices, routines and interactions with their material surroundings’, including practices of sorting, rearranging and tidying.

Care is associated with a particular form of temporality, described as ‘process time’ which is unbounded, taking ‘as long as it takes’ (Davies 1994). Care is difficult to locate within fixed time slots, because it is shaped by the unpredictable temporality of bodies and care needs. Therefore, the process time of care can clash with fixed institutional routines. Buse and Twigg describe the careful processes of bodily movements and emotional engagements required during the act of dressing someone with advanced dementia, and how this clashes with time pressure during morning routines. Certain garments or ‘stiff’ fabrics require particularly slow movements as they are manoeuvred onto bodies. The institutional logic of time efficiency is in tension with the time needed to facilitate choice and one-to-one engagement during dressing routines.

The collection also captures continuity and change in materialities of care, as assemblages of care are not static but shift over time (Fox 2016). A material lens can provide a way to capture the small yet pivotal ‘moments’ of change in practices of care. Brownlie and Spandler give the example of ‘the seat’ in a local shop which facilitated a caring environment and place to rest, but also how this was disrupted when this chair was moved. At a broader scale, Jones highlights how changing models of care are captured in the materiality of hospitals, as he locates the brutalist architectural design of the original 1970s Royal Liverpool Hospital within a model of centralised healthcare services, and the contemporary re-design within consumerist approaches to care and increasingly complex financial arrangements. Buildings designed for care therefore act as a ‘way of objectifying a sense of the past’ (Miller 1987: 124), and provide a snapshot of models of care within particular historical periods.

Materials not only mark changing models of care, but are also part of how we narrate care, and temporally order experiences of illness. Brownlie and Spandler argue that storying ‘is part of how materialities are allowed to generate care’. In Ellis’s research, ‘food talk’ is engaged as a way of ‘thinking about, monitoring, and making sense of illness’, situating change in physical health within relationships to food throughout the person’s life history. The stories of people are also entangled with those of the objects that ‘share our lives with us’ (Hoskins 1998: 8), and have their own biographies that alter over time (Miller 1987). Lovatt argues that the meanings of residents’ possessions are not inherent in the type of object, but change over time in relation to particular life events and relationships. She offers the example

of a woman putting her deceased husband's pipe stand on display on her windowsill in the care home. This previously mundane, and perhaps unsightly, object became transformed, imbued with memories of the person (Ash 1996).

Materials are not only used to understand the past but also to anticipate or imagine futures, as people engage in processes of 'material imagining' (Woodward 2015). Buse and Twigg explain that when a person with dementia is unable to tell their story, attentive care-workers try to piece together clues about their lives by examining the clothes they came into care with. Lovatt describes how residents' possessions in care homes were not only located within a sense of the past, but were also part of imagining futures, through the purchase of new objects and furnishings. Similarly, families in Ellis's study used food to imagine futures in the context of end of life care, or anticipate change, such as the woman measuring her anticipated future time with her husband through the remaining liquid in a whisky bottle. Engaging in 'material imagining' can also be used to 'reimagine' possibilities for care (Buse and Twigg), arguing for an approach to care that goes beyond a focus on functional needs, to more personalised ways of 'caring through things' (Puig de la Bellacasa 2011) and more sensitised practises of care.

### Practices of care

'Materialities of care' considers the relationship between materialities and practice. Shove *et al.*'s (2012) definition of practice encompasses relations between materials, meanings and competencies, and so emphasises practice as ongoing, dynamic and processual, where routine activity involves embodied, tacit knowledge. A fine-grained focus on mundane materials provides a window into embodied practices and is attuned to tactile and 'sensory ways of knowing' (Pink *et al.* 2014: 427). As Heath *et al.* argue, we should note the collaborative co-production of material and bodily actions, and through their 'detailed analysis we can begin to discover the competencies, skills, the 'know how', that enables, and is, part and parcel of practice'. Heath *et al.*'s analysis reveals the 'craft knowledge' involved in holding, manipulating and exchanging materials in the operating theatre, as scrub nurses anticipate and respond to the 'emerging shape' of the surgeon's hand and the material properties of the instrument. They provide a detailed account of the sequences of bodily interactions with materials as an 'evolving dynamic of co-ordinated action'. Materials and bodies therefore become embroiled in making and remaking one another during these moments of care. Some materials remake the body in directly physical ways; as Ellis describes, food is incorporated directly into corporeal bodies. Materials such as food or dress are also shared between people and can sometimes 'stand in' for caring relations. These materials also constitute relations of caring, as Brownlie and Spandler argue, materials 'are not just what passes between people – or what people pass through – they are part of how relationships are constituted'.

Material practices of care are also embroiled in the co-constitution of identities, whether of carers or those cared for. Care, as Latimer argues in the afterword of this collection, is an 'emergent property of how materials in association with social processes can help re-assemble subjectivities as well as relations'. Materials such as dress, shape possibilities for the enactment of identity at a direct bodily level, altering the way the wearer moves and sits (Entwistle 2000). As Buse and Twigg discuss, this is related to gendered and classed identities, and a sense of what feels 'right' or comfortable at a sensory level. Ellis examines how practices of preparing and consuming food connote gendered identities; for instance, association of masculinity with being a 'big eater', and the preparation of 'hearty' and 'traditional meals' with generationally and regionally specific femininities. Bell describes how the material

arrangements of the waiting room could facilitate – or inhibit – a sense of communal or collective identity for Somali speaking migrants.

The collection also demonstrates disrupted relations between bodies, materials and identities in the context of health and illness. Routine practices such as eating, dressing, or everyday household activities may no longer be carried out seamlessly, but can become slow, painful and pronounced. The involvement of a paid or unpaid carer in such activities can undermine privacy and a sense of independence. It can necessitate the introduction of materials that conflict with personal identity, for instance, foods like soup which can be ‘materially ambiguous’ or forms of casual dress. Care then becomes about the restorative work involved in managing these disruptions to embodied practice, in ways that support identity and manage ‘threats to the self’. As Brownlie and Spandler argue, sensitive forms of giving and receiving care can support ‘the art of holding one’s own’, and avoid positioning in terms of dependency.

Materials are also entangled in the construction of hierarchies and power relations within care practices. Care is not always benign (Rummary and Fine 2012), and can act as a mechanism of disciplining and regulating bodies (Abbots *et al.* 2015), as well as embedding hierarchical distinctions and divisions (Pedwell 2014). Bell describes how the arrangements of furniture in exam rooms work to restrict and direct the movement of patients’ bodies. Heath *et al.* describe how the successful co-ordination of activity in the operation theatre depends on scrub nurses’ craft knowledge, yet reproduces ‘asymmetries of expertise and influence’ and ‘remarkable deference to the emergent requirements of the task and the surgeon’. Distinctions and hierarchies in tastes and competencies were also embedded in the practices of non-medical professionals. In exploring therapeutic practices in museums, Mangione describes the historical privileging of visual perception and cognitive responses over sensory and emotional engagement. She situates recent therapeutic initiatives within a history of (classed) moral projects, aimed to cultivate ‘good citizens’. These distinctions and hierarchies in competencies and ‘tastes’, therefore, embed classed, gendered, and racialised divisions. For instance, Bell describes a doctor’s insensitivity to non-Western healing practices and approaches to dealing with pain, while Buse and Twigg discuss how the dress of residents becomes read as an indication of care-workers ‘tastes’, in ways that are classed and racialised.

Identifying who has the ability to purchase, display and manage materials within a particular institutional context is fundamental to understanding these hierarchical relations. Jones traces these dynamics on a wider scale by exploring PFI funding models for hospital design, exposing the tension between the tailoring of the globalised architectural design of the Royal Liverpool Hospital to its localised, specific site. Returning to more familiar social care settings Lovatt’s research demonstrates residents’ ongoing freedom to display and purchase objects. However, their engagements with the material environment is constrained in other ways, for instance, their ability to adjust the heating controls or open windows. Service users nevertheless may subvert divisions in the control of materials. For instance, in response to the doctors’ refusal to give her a pill, Bell describes how a patient produces one from her purse, transforming it into an ‘alternative to the physician’s (metaphorical) black bag’.

### **Methods for studying ‘materialities of care’**

The chapters in this collection also bring to light different methodological approaches for examining materialities of care. Although routinely used by social historians to trace material cultures in care contexts over time, attending to archival sources such as, letters, case

book notes, management minutes, stock lists, and photographs (Hamlett and Hoskins 2013, Nelson 2003) also offers much scope for sociologists (Prior 2003). Studies of medical records, case notes (Berg 1996) and architectural plans (Nettleton *et al.* 2018, Prior 1988), for example, reveal how materials entwine, enable and enact practices of care. In this collection, Jones uses documentary research to trace the development of the Royal Liverpool Hospital over time, examining newspaper reports and architectural plans to explore the wider political and economic context surrounding the building.

Visual methods can also help to grasp embodied practices with materials as they unfold, and explore the enactment of tacit, practical know-how (Büscher 2005). Drawing on ethnomethodological and conversational analysis, Heath *et al.* rise to the challenge of representing bodily, non-verbal action textually by using video recordings and transcriptions to explore the 'sequential, procedural and emergent character of the participants' action'. Efforts to preserve this temporal dimension are important to enriching understanding of 'objects-in-action' (Mondada 2012). The importance of an ethnomethodological approach to understanding how materialities in healthcare contexts are 'made to mean' and their role in the operation of power and interests is further explored by Latimer in the afterword of this collection.

'Materialities of care' as a heuristic can offer novel ways of working with conventional sociological methods to sensitise us to the ways in which materials are woven through practices of care. Contributions in this edited collection use familiar ethnographic approaches, but attend to and explore 'what people do with objects', in order to understand how things create a 'world of practice' (Miller 1997: 19). Pink (2007: 22) argues that ethnography 'should account not only for the observable, recordable realities that may be translated into written notes and texts, but also for objects, visual images, the immaterial, and the sensory nature of human experience and knowledge'. She advocates sensory ethnography as a way of exploring multi-sensory relationships to materialities and environments, drawing out everyday experiences, and understandings of social identities and hierarchies. In this collection, Bell's ethnography of a clinic brings these into sharp relief by 'attending to gestures, nonverbal interactions and interactions with varied objects' where such minutiae reveals much about the everyday interplay of culture, ideologies and engagements constituted within a context of global mobilities and migration.

Chapters within this collection prompt us to be attuned to sensory aspects of care embedded in spatial environments and temporal patterns. Questions of how the spaces of hospices smell and the tastes of the food they provide – and when this food is available – have a bearing on the experience of residents, and how families negotiate the last stages of their loved ones' lives (Ellis). The clothes that residents with dementia in a care home can touch, and the comfort these allow, can impact on their mode of dwelling in that place (Buse and Twigg). Mangione's focus on how visitors demonstrated 'tactile engagements with museum artefacts' persuasively demonstrates art making to be a 'sensory modality', but moreover prompts researchers to respond in kind, and deploy methods that can represent the more-than-representational (Vannini 2015).

The majority of contributions in this collection use in-depth qualitative interviews alongside observations and/or more creative methods. Pink (2009) reminds us that the interview is itself a material, emplaced and multi-sensory encounter, in which interviewees communicate their sensorial experiences through gesture and bodily practice, as well as through talk. The material and sensory can emerge spontaneously in traditional sit down interviews through retaining a 'material sensitivity' or can be prompted through object elicitation (Woodward 2015). Weiner and Will use material prompts to 'anchor reflections in concrete ways', asking respondents to demonstrate their blood pressure monitor use and talk through

the data generated from the devices. More active interviews provide means to capture issues otherwise hard to access. Buse and Twigg use wardrobe interviews, alongside more conventional interviews and observations, to explore experiences of dress, utilising the material properties of clothing to provide a springboard for discussion. Brownlie and Spandler use walking interviews in combination with observations to illuminate embodied experiences of particular spaces, using the material environment as a prompt for discussion (Kusenbach 2003). However, the potential to follow and observe materials can be limited by boundaries of public and private space and concerns about ethical practice, as described by Buse and Twigg in relation to ethics committee restrictions on the contexts in which dress practice can be observed.

### Conclusion

This collection aims to widen the scope of materialities attended to in the context of health and social care, highlighting the ‘relevance of the slight’ (Brownlie and Spandler). The contributions draw attention to the aspects of material culture that can go unnoticed because of their ordinariness – dress, food, cups of tea, shopping bags and furniture. Where medical technologies are included, they are explored in dialogue with more mundane materialities, for instance, home blood pressure monitors are used alongside daily routines of tea making (Weiner and Will), and an exploration of instrumentation in the operating theatre encompasses more mundane objects of swabs, tweezers and scissors (Heath *et al.*). Brownlie and Spandler challenge ‘thinking of materialities as conduits or merely the “backdrop” to care which ‘assumes that relationships already have to be established for materialities to be shared’. Building on contributions from STS we see materialities as active and co-constitutive of care. Materialities as opposed to materials is important here; material ‘things’ never act in isolation but are interactive and fluid and they work with other human and non-human things to assemble care. Materialities permeate practices of care in relational and emergent ways, and care permeates materialities in relational and emergent ways too.

The concept of ‘materialities of care’ presented in this collection aims to act as an analytic to prompt new questions and novel lines of enquiry to be explored in future research in the sociology of health and illness. What does a materialised sociology of health and illness look like? What does a materialised sociology of care look like? What material aspects of care go unnoticed – when, where, by whom and with what consequences? How might we attend to the mundane, often overlooked or even ‘invisible’ aspects of care? How do materialities and immaterialities of care mesh? How are materials imagined? How do the material properties of artefacts and spaces shape how care feels at a sensory level, to the carer and those being cared for? How are the materialities of care linked with their politico-economic contexts? Future research might further explore how dimensions of class, sexuality and race shape material practices of care. Although referred to in some of the examples in this collection (for instance, Bell’s discussion of migration and hospitals) such issues warrant further enquiry and exploration. Further research might explore questions of whose tastes are seen as appropriate and in what context, and which aspects of, and assumptions about, identity (racialised, sexualised, and classed) are made visible or concealed through material things.

A focus on mundane materials can be used to bring to light not only neglected things but also neglected issues in care. For example, the ancillary labour of laundry workers or cleaners is often positioned ‘outside of care’, and yet this work constitutes an important part of the care team or care assemblage (Armstrong *et al.* 2008, Armstrong and Day 2017). If we cast our net wider we also see that spaces of care are materialised by others thought of

as 'outside of care'; for example, those who shape care at a distance, designers, architects, and planners can orchestrate the texture of environments where care may take place with intended and unintended consequences. This collection has drawn attention to aspects of material culture which are positioned beyond the boundaries of the sociological study of health and illness (such as such as Mangione's discussion of museum objects). Yet as Mangoine and others (e.g. Camic and Chatterjee 2013) have highlighted, these materials are increasingly in dialogue with healthcare practices, spaces and discourses of health, and thus deserving of our attention as medical sociologists interested in questions of care.

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