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Care in Practice

On Tinkering in Clinics, Homes and Farms

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In what way is »care« a matter of »tinkering«? Rather than presenting care as a (preferably »warm«) relation between human beings, the various contributions to the volume give the »cold« material world a prominent place in their analysis. Thus, this book does not continue to oppose *care* and *technology*, but contributes to rethinking both in such a way that they can be analysed together.

Technology is not cast as a functional tool, easy to control – it is shifting, changing, surprising and adaptable. Knowledge is fluid, too. Rather than a set of general rules, the knowledges (in the plural) relevant to care practices are as adaptable and in need of adaptation as the technologies, the bodies, the people, and the daily lives involved.

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Care: putting practice into theory

Annemarie Mol, Ingunn Moser & Jeannette Pols

Whether we like it or not, human beings need food and shelter, and so do the animals that live with them/us.¹ Someone has to harvest or slaughter; someone has to milk; someone has to cook; someone has to build and do the carpentry. Washing is wise as well, since if they are not being washed pots, pans and bodies start to smell. Failing to dress wounds may lead to infection. And as diseases and impairments also come in other forms, there tend to be sick to look after one way or another – while everyone also needs to look after herself. All in all, care is central to daily life. However, the importance of care has not been reflected in the scholarly attention it receives. The Enlightenment tradition celebrated the mind and its alleged rationality, not the body and its pains and pleasures. To the sciences, bodies were interesting in as far as they could be objectified and explained in the laboratory, but not as they shuffled about, gasped for breath, gobbled up or lingered over food, talked, screamed, or needed to be soothed.² Thus, for a long time care figured in academia as a more or less tedious practical necessity, rather than as an intellectually interesting topic. Or worse: care hardly figured at all. It was relegated to the private realm: there was no need to study it, or talk about it in public settings. Someone or other just needed to get on with it.

Recently this has begun to change. First nursing theory started to talk about care. And then sociology, anthropology, geography, philosophy and ethics followed suit.³ This book is a consequence of that process and seeks in turn to strengthen it. For this is our concern: if care practices are not carefully attended to, there is a risk that they will be eroded. If they are only talked about in terms that are not appropriate to their specificities, they will be submitted to rules and regulations that are alien to them. This threatens to take the heart out of care – and along with this not just its kindness but also its effectiveness, its tenacity and its strength. This is our concern. There is not only a domain to salvage but also, and more importantly, a mode, a style, a way of working. And thus, by describing practices to do with care, all the while wondering what care *is*, we here seek to contribute to the vitality of the *logic* of care.⁴

The chapters of this book emerge from different sites and situations. You will read about phone calls taken by operators in a telecare service for the elderly in Barcelona and about yellow tags inserted in the ears of cows in the north of England. You will be presented with stories that analyse public documents and with treatises drawing upon private experiences. Just at the moment when you have started to sympathise with the users (and the non-users!) of an online record system for pregnant women in Denmark, you will be called upon to care for a syndrome of people in a vegetative state in Austria. Diversity unfolds, even though, globally speaking, what we have gathered here is quite provincial, as all our 'materials' come from rich and Northern countries: one chapter is based in Seattle, while the others originate in villages and towns spread around Western Europe. The kinds of care we talk about are not endlessly varied either: you will find nothing here about the care of craftsmen for their creations, gardeners for their plants, wage earners for their families, dressmakers for their sewing, or parents for their children. We restrict our scope to farming, health care and care for people who are old or who cope with disabilities. At the same time, we do not so much share a set of materials as an array of theoretical resources and ambitions.⁵ As a consequence a few themes recur through the book. These themes will be highlighted in this introduction. Thus, even if we obviously draw on the past, this introduction does not seek to present an overview of 'the field so far'. Rather, we introduce in the chapters that follow thematically. The themes we highlight are not of equal importance to every chapter. What is crucial to one chapter may be mentioned only in passing in the next. But jointly issues to do with 'public and private', 'the good, the bad and the ambivalent' and 'technology and humanness', constitute what as editors we take to be the originality and the force of this collection.

Public and private: about words

Writing about practices to do with caring started as a way of making public what had previously been hidden in or delegated to the private sphere. As a part of this, words designating other (more obviously public) activities were mobilised to talk about care practices. Rather than representing parental (and specifically motherly) care as a matter of love, beyond all calculation, studies seeking to stress its public importance recast such care as work. The term 'domestic labour' got coined.⁶ Rather than exploring the devotion or the generosity with which doctors engage in caring, medical sociologists wrote about the social power, the status and the salary that accompanied the rise of

the medical profession. Interestingly, calling motherly care ‘work’ was a way of adding value to it, while stressing that medical care is a professional endeavour, was done in a critical tone, as if something bad was being unmasked here.⁷ There was no dialogue between (celebrating) studies of motherly care and (devastating) studies of paternalist doctors. To make things yet more complex, analysts of nursing care, while exploring how this was organised as ‘women’s work’, argued that, for all that, nursing needed to be understood as a real profession. Rather than a criticism, this was a claim – in pursuit of power.⁸ Finally, to complete our short list, the daily activities of farmers were rarely topicalised as ‘care’ at all. If we do so here, it is because we are struck by the similarities between farming and other caring practices. We wonder about the lessons that emerge in moving from one site to the other.

What about those who ‘receive’ care? Academic literatures take them to be in a precarious position. Not enough care, care in excess, the wrong kind of care: time and again the question is how to put right something that is failing. This goes for children receiving parental care, but it also applies to the elderly and people with a handicap or a disease in the context of professional care.⁹ The core point became the lack of power of care-receivers, their alleged passivity, so tellingly condensed in the term ‘patient’. As a result other terms were introduced. Public terms. Instead of ‘patient’, the person who receives care was to be called a ‘customer’. Customers, after all, have purchasing power: on the market they make their own choices. The term ‘citizen’ was introduced as a possibility as well. Addressing people in consultation rooms and care institutions as citizens was meant to emancipate them. As citizens, after all, we are not subjected to decisions, but subjects who can choose. Citizens have no overlords: they are their own rulers.

Using words coined in the public sphere while talking about care practices, drew the latter out of hiding. It sought to make them public, too. However, along the way the *specificities* of care got lost.¹⁰ Framing care as a product for sale on a market makes it difficult to see that a lot of care work is not *bought*, but actually *done* by patients. Far from just ‘receiving’ care, patients actively attend to their symptoms, swallow their pills, follow their diets, and so on. Even when they are being anaesthetised they engage in the job of counting down. Patients also actively visit their doctor – usually not because they freely ‘choose’ to shop for care, but rather because they ‘have no option’. The term ‘citizen’ likewise has its limits. When it comes to it, citizenship depends on faculties that people who are in need of care may (temporarily) lack. The term skips over and denies what it is that makes

people look for care in the first place: their bodies happen to not submit to their wishes, let alone their commands. They are unruly.

Thus, words coined for the public sphere are ill suited for talking about care practices. What to do? There is no easy solution. Words without problematic histories just don't exist. Therefore, the contributors to this book never just take language for granted. Instead they move their words around, play with them, adapt them to what seems to best accord with what is specific to care in the practices they are describing. For example, rather than talking about *collections* of separate individuals added together, the authors tend to talk about *collectives*, variously connected and divided, from which individuals may emerge.¹¹ And if *bodies* are being mentioned, they do not figure as a precondition to the life of the mind, but as themselves actively (eagerly, painfully) alive and living. In the chapters about farms, humans are not necessarily in the centre: animals may care for their farmers just as much as farmers care for their animals.¹² Between humans, too, care may move in complex ways. Finally, while trying to put care practices into words, we do not bracket *failure* and *fragility*, but face up to them. For a long time, attending to public affairs has been a matter of exploring modes of control. But even if it is rendered public, care offers no control. It involves living with the erratic.¹³

Writing about care, then, means that we need to juggle with our language and adapt it. However, the most difficult aspect of writing about care is not finding *which* words to use, but dealing with the limits of using *words* at all. Care, after all, is not necessarily verbal. It may involve putting a hand on an arm at just the right moment, or jointly drinking hot chocolate while chatting about nothing in particular. A noisy machine in the corner of the room may give care, and a computer can be good at it, too. And while your cows may respond to the tone of your voice when you talk, they don't much mind what it is that you are saying. Social scientists have often insisted that professionals should listen to their patients and talk with them, rather than just silently using diagnostic techniques and handing over prescriptions. And who would disagree? But stressing the verbal too much misses out on the large non-verbal component of what is specific to care practices.

As authors of this book, we seek to give words to things (events, habits, frictions) that have previously been unspoken. Such articulation work may help to make the specificities of care practices travel. Perhaps, when articulated, when put *in so many words*, care will be easier to defend in the public spaces where it is currently at risk of being

squeezed. Perhaps care practices can be strengthened if we find the right terms for talking about them. A language suitable for (self) reflection may also help those involved in care to improve their practices. However, at the same time one can only say so much. Not everything fits into language. What, then, is it to write, to make a book even? Words may carry information or, like tools, help to get something done. They may be evocative, a move in a game, a request for help, a modality of tinkering. But words only go so far. The question, then, a question that recurs throughout this book, is which words to use, and how, at the same time, to best respect the limits of the verbal. Beyond those limits, for sure, come photos and drawings. These may forcefully convey reality in a different way. But when it comes to it, ‘conveying’ is not the only thing reality calls for.

The good, the bad and the ambivalent

Why did care become an *object of concern* and what is it about care that warrants being studied and attended to in social science writing?¹⁴ This question cannot be answered by pointing to bare facts, but has to do with values. It evokes the *goods* and *bads* that are at stake in care practices. The oppression of women was linked to the (public) invisibility of their (private) care work. Care-givers deserved more credit for their good work, that should also be better organised and more widely shared. Doctors, in their turn, were never taken to be disempowered by the fact that medical care remains largely hidden in consulting rooms. Rather than being too weak, doctors were (for a long time) deemed to be too strong. Their care was not accepted as self-evidently good, but taken to imply their domination over others, their patients. Nursing care, again, escaped both generalities. The nursing literature, seeking to strengthen nursing as a profession, delved into the details of what goes on in care practices. In this book we build on that tradition: we unravel and articulate details to do with care. However, our particular aim is not to strengthen *nurses*, but, slightly more widely, to strengthen *care practices* – and whoever is involved in them. Thus, we talk about nursing homes, wheelchairs and webcams – and explore the feeding and slaughtering of farm animals. Rather than using large brushstrokes to cast the care we come across as either good or bad, we give detailed descriptions in the hope of opening up questions to do with qualities and values in new ways.

That this is needed has to do with developments in the care sector. While social scientists were concerned with the broader social effects of care, inside the care sector questions to do with the quality of care

were asked in an entirely different way.¹⁵ There, the great variety of activities and interactions typical to care settings, was divided up into separate ‘interventions’ plus the ‘relational work’ that facilitates their delivery. This made it possible to use the methods of epidemiology to explore which interventions were ‘effective’ and which were not. To give a simplified (but instructive) example: a patient and a doctor talk in a consulting room, but this is taken for granted; the drug that is finally prescribed is called *the intervention*; the patient may then take the drug (or not, nobody knows) and after a given time, one or two *parameters* are measured (that may range from blood pressure to scores on a depression test) to see if these have *improved*. One hundred people are prescribed the drug under scrutiny, and a hundred others are given a placebo. If there is more improvement among those who received the drug than among those who received the placebo, the intervention is called *effective*. In this way, the *clinical trial* establishes whether or not an intervention equals ‘good care’. Alongside this evaluation technique, and in contrast with it, an entirely different way of investing in *the good* was institutionalised: that of medical ethics. At first, medicine was an attractive field for ethics because (unlike most other people) doctors were supposed to have power over life and death. A great normative moment. However, within a few years medical ethics no longer saw decisive doctors as interesting but as paternalistic. Thus, there was a massive shift in medical ethics to arguing in favour of *patient autonomy* and the right of patients to make their own decisions. It evaluated care practices as either respectful (good) or undermining (bad) of patient autonomy.¹⁶

They form a fascinating pair, clinical trials and medical ethics. In the one, the qualification of care is reduced to measuring a few relatively simple parameters and squeezing these into schemes of accountancy. In the other where patient autonomy is celebrated, what might actually be good to do does not follow from research, but becomes a matter for everyone (given ‘the facts’) to decide about individually. The contributions to this book venture into the enormous space left open between these two alternatives. Mostly, we go there ethnographically. Thus, while observing care practices we ask what is sought, fostered, or hoped for, then and there: what is performed as good. Likewise, we are curious about what, by contrast, is avoided, resolved, or excluded: what is performed as bad. Working in this way, we hope to learn more about ‘good care’ and ‘bad care’. However, while sometimes the locally relevant ‘good’ and ‘bad’ are surprisingly obvious, often they are not. A lot of our stories have to do with complexities and ambivalence.¹⁷ Good and bad may be intertwined; good intentions may

have bad effects; if one looks hard enough any particular 'good' practice may hold something 'bad' inside it (and vice versa); 'good enough' care may be a wiser goal than care that is 'ever better'; while sometimes it is simply unclear whether (for whom, to what extent, in which way) some form of care deserves to be praised or to be criticised.

That our stories carry ambivalence is, or so we take it, not a failure of our analyses. Rather, it is in line with earlier contributions to the *ethics of care*. Unlike *medical ethics*, the *ethics of care* never sought to answer what is good, let alone to do so from the outside. Instead, it suggested that 'caring practices' entail a specific *modality* of handling questions to do with the good. The opposition was to other traditions in ethics, and especially to the ethics of justice. In the ethics of justice, 'ethics' is taken to be a matter of sorting out *principles* by means of argumentation. Suitable ethical principles are general, or, better still, universal. In the ethics of care it was stressed that in practice, principles are rarely productive. Instead, local solutions to specific problems need to be worked out. They may involve 'justice' but other norms (fairness, kindness, compassion, generosity) may be equally or more, important – and not in a foundational way, but as orientations among others.¹⁸ We build on this and seek to develop it. In doing so, we do not separate out ethical from other norms (be they professional, technical, economical or practical). In care practices, after all, it is taken as inevitable that different 'goods', reflecting not only different values but also involving different ways of ordering reality, have to be dealt with together. Raising an argument about which good is best 'in general', makes little sense. Instead, care implies a negotiation about how different goods might coexist in a given, specific, local practice. Though 'negotiation' is not quite the right term, as it calls up verbal argumentation. In practice, however, seeking a compromise between different 'goods' does not necessarily depend on talk, but can also be a matter of practical tinkering, of attentive experimentation. In care, then, 'qualification' does not precede practices, but forms a part of them. The good is not something to pass a judgement on, in general terms and from the outside, but something to *do*, in practice, as care goes on.¹⁹

And what if the doing fails? In traditional ethical repertoires, a failure to do good is a reason for moral blame, a negative verdict. In the ethics of care this is not so obvious. What follows from a failure, remains to be seen. The crucial difference is that in rationalist versions of the world, as in fairy tales, there tend to be happy endings. Order, effectivity, efficiency, health or justice: in one way or another these

may be achieved and if they are not, then someone is to blame. But in care versions of the world, the hope that one might live happily ever after is not endlessly fuelled. You do your best, but you are not going to live 'ever after'. Instead, at some point, sooner or later, you are bound to die. Along the way, there will be unfolding tensions and shifting problems. Care is attentive to such suffering and pain, but it does not dream up a world without lack. Not that it calls for cynicism either: care seeks to lighten what is heavy, and even if it fails it keeps on trying. Such, then, is what failure calls for in an ethics, or should we say an ethos, of care: try again, try something a bit different, be attentive. Thus if we had to summarise how the chapters of this book cast *good care* we would put it like this: persistent tinkering in a world full of complex ambivalence and shifting tensions.

Technology and what it is to be human

During the twentieth century it was commonly argued that *care* was other to *technology*. Care had to do with warmth and love while technology, by contrast, was cold and rational. Care was nourishing, technology was instrumental. Care overflowed and was impossible to calculate, technology was effective and efficient. Care was a gift, technology made interventions. Much of the resistance to squeezing care into technological frameworks is informed by this line of thought. It wants to keep care pure: each pole of the dichotomy should be allowed its own domain. Care (and caring relations) at home, technology (and instrumental relations) in the workplace. A life world here, and a system over there. This book sings another song. If we insist on the specificities of caring practices it is on different terms. Rather than furthering purifications, the authors of this book insist on the irreducibility of mixtures. Caring practices, to start there, include technologies: from thermometers and oxygen masks to laboratory tests and video cameras. If they happen to be helpful then they are all welcome. At the same time, engaging in care is not an innate human capacity or something everyone learns early on by imitating their mother. It is infused with experience and expertise and depends on subtle skills that may be adapted and improved along the way when they are attended to and when there is room for experimentation. Technologies, in their turn, are not as shiny, smooth and instrumental as they may be designed to look. Neither are they either straightforwardly effective on the one hand, or abject failures on the other. Instead they tend to have a variety of effects. Some of these are predictable, while others are surprising. Technologies, what is more, do not work or fail in and of themselves. Rather, they depend on care work.

On people willing to adapt their tools to a specific situation while adapting the situation to the tools, on and on, endlessly tinkering.²⁰

In one way or another, then, the chapters in this book talk about both care and technology at the same time. Instead of casting care and technology in contrast with each other, we seek to rethink and reframe them together. This is our concern: to contribute to disturbing and complicating the care-technology distinction. And we interfere with other, similar distinctions, too. Care and control; care and economics; care and killing.

What changes along the way? One answer is: what it is to be human. Care practices move us away from rationalist versions of the human being. For rather than insisting on cognitive operations, they involve embodied practices.²¹ Rather than requiring impartial judgements and firm decisions, they demand attuned attentiveness and adaptive tinkering. Crucially, in care practices what it is to be human has more to do with being fragile than with mastering the world. This does not imply a docile acceptance of fate: care is active, it seeks to improve life. But what it does imply is that in a care context, the 'human' is not in opposition to the 'mere beast'. Instead, the fact that human beings are animals too is calmly taken on board. No need to silence the 'beast inside us' – it is likely to call for care. No need either to silence real beasts: they deserve to be attended to on their own – nonverbal – terms. The point is not to preach equality, but to attend to everybody's specificities and to the relations in which we make each other be. Like other animals, human beings live with pain and enjoy pleasure. But unlike other animals, human beings have farms where they raise other animals and they have slaughterhouses, too. Thus, they mix care for their animals with killing them. Does killing oppose care, or may it be done in caring ways? Such questions keep presenting themselves while the webs of resonance and interdependence are extensive and complex. What in all our daily life dealings (and dealings with daily life) to call 'care' and where does the term no longer make good sense?

What follows

So these are some of the moves in which this book is caught up. At the same time, each chapter has its own specific argument to make, its own story to tell. Here's a short overview of what you may expect. We start with a chapter by Janelle Taylor who talks about recognition. 'Does she recognise you?' friends and acquaintances almost invariably ask her when they learn that her mother has dementia. The question

presumes a narrowly cognitive take on what it is to be human. Mobilising auto-ethnographic stories of daily life in Seattle, Taylor turns this question round to ask instead ‘Do we recognise her? How might we grant her recognition?’ The recognition that a person like her mother calls for is tied up with care. Care of the mother for her children, whom she cared about. And care as a present practice, making human life worthwhile.

With a large jump we then move to a farm in the south of England in 2001. At that time, an epidemic of foot and mouth disease raged through the country and according to policies intended to halt its spread, veterinarians found themselves killing animals that they would under other circumstances have tried to keep alive. John Law tells stories about ways in which, then and there, tenderness and clinical coolness went together, and in doing so suggests what we may learn about ‘care’ from this particular setting. One thing is sure: veterinary care has little to do with being soft.

In the setting researched by Daniel López, Blanca Callén, Francisco Tirado and Miquel Domènech, safety is the goal of the care provided. The authors talk about a ‘guardian angel’: a home telecare service in Catalonia that keeps an eye – or rather a telephone-mediated ear – on elderly people living independently in their own homes. The safety granted to people, or so the authors show, does not follow from total control, but neither from trust in fate. It rather depends on a mixture of faithfully working with procedures and creatively adapting to local circumstances and specific situations.

Myriam Winance explores, in France, the tinkering character of care in a different setting, that of testing out a wheelchair and seeking how to adapt it to the specific needs of the collective in which it is to be used. Caring, she argues, is not a matter of giving something to others who may then passively receive it. To care, in this setting, is rather to meticulously explore, test, touch, adapt, adjust, pay attention to details and change them, until a suitable arrangement (material, emotional, relational) is achieved. Along the way, not only the wheelchair is adapted, but so, too, are the different people involved in using it.

Even in a clinic that was never meant to provide care, but that sought to contribute to finding a cure – a cure for Alzheimer’s Disease to be precise – it is possible to catch care at work between the other regimes that order practices. Tiago Moreira shows this by telling us about an anonymised memory clinic somewhere in Britain. What is specific

about care in this context, he argues, is that it is not staged as a fight against inevitable cognitive decline and does not promise the relief of a therapeutic solution. Instead it is a matter of handling daily life, of making things work from one day to the next, of tinkering. And the problems such care deals with are not localised in an individual's brain, but in the life of a collective.

With Hans Harbers we move back in time, to a Dutch farm in the nineteen fifties and sixties, the farm where he grew up. The animals on the farm got different forms of care – some were individualised and given a name, others not; some were slaughtered, others not; some were invited into the house, others not. But no universal declarations of animal rights were needed for the human-animal relations to be richer, more complex and layered, than a functionalist gloss on farming might have it. Yes, the family depended economically on their animals. But this (at that historical time?) did not exclude care, but called for it.

Still in the Netherlands, Jeannette Pols tells about present day telecare devices for people with heart failure or lung disease. Different telecare devices, or so we learn, each tackle a different problem: one a disease hidden inside a body; the next an unhealthy life style; and the third isolation and loneliness. Accordingly, the devices provide different care. The first device informs professionals about the disease so that they may tell patients what to do; the next helps patients to hold on to daily life routines that professionals have designed for them; while the third encourages patients to talk to each other so as to learn about more interesting ways of handling their daily lives with a disease. But what is it to unravel such differences, Pols asks, and where to go from here?

In Denmark Brit Ross Winthereik and Henriette Langstrup followed a project that sought to introduce a web-based record for maternity care. It came with the idea of turning the pregnant women involved into 'active patients'. However, rather than taking better care of themselves at home, the women involved were inclined to take on responsibility for the way their health care professionals used their electronic record. Thus the record helped to reconfigure the relations between pregnant women and health care professionals, but in quite unexpected ways. This, or so the authors argue, may well have to do with the inappropriate understanding of 'care' that was built into the record to begin with.

Annemarie Mol then wonders about 'good' care and she does so by telling stories to do with food and eating in Dutch nursing homes. The

different *goods* at stake in this context have complex relations between them. Nutritional value and the cosiness of a pleasant meal, for instance, sometimes appear to reinforce each other whilst at other moments they clash. Taste, yet another good to do with food, shifts between food itself and the person tasting it. And seeking to assess the quality of care by measuring individual parameters, frustrates compromises between different locally relevant goods. It thus risks undermining the quality of care rather than improving it.

Seeking to assure quality by introducing systems of control, does not prove to be an unequivocal blessing either. Not in farming practice at least. Vicky Singleton lays this out with the example of the yellow tags that have to be inserted in the ears of every cow in Europe. In daily practice these tags and the bookkeeping linked up with them, are a lot more messy and bothersome than they appear from the outside. Farming practice, after all, is not a matter of individualised control, but involves living together adaptively. Singleton shows that even the relation between inspectors and farmers is put under pressure. As a disappointed informant put it: the care is going out of it.

Dick Willems writes about caring machines. With material from home care in the Netherlands, he unravels how ventilators and oxygen tanks help to constitute the lives of people with severe lung disease. What it is to breath is not a simple given in these stories, but something that changes along the way. What a body is and where it begins and ends also appears to be fluidly adaptable. And finally there is, inevitably, death. But this is not staged as the ultimate bad. Instead, the question is raised as to how the various machines involved may (or may not) help to frame a good death.

The question as to how care may be good is also central to Ingunn Moser's chapter. Seeking to assess the quality of care from the outside by counting, says Moser, does not work. Rather than spending a lot of energy on trying to do this, we would do better to invest in improving care. Detailed stories from a nursing home in Norway where the *Marte Meo* method is deployed provide an example of how this may be done. In this nursing home, videos of care practices are analysed in supervision settings so as to jointly establish what it might be good to do, and to avoid, in specific situations. The knowledge generated is not necessarily easily transportable, but it made immediate improvements to care locally.

The final word is for the research-artists of XPERIMENT! They have been involved in representing a syndrome that textbooks call ‘persistent vegetative state’. While observing the intricate details of the care for the comatose patients concerned, the XPERIMENT! participants sought to describe, but especially to draw, what might, in this context, be good care. But along the way they began to wonder what it is to do such work. How to align the versions of the syndrome *represented* to the versions of the syndrome *in the field*? And is it possible for practices of research to be ‘care practices’ too, in their own, specific ways? Seeking to put these issues into words, the authors are at the same time caringly apprehensive of what it is to use words.

As may be clear from these short introductions, there is no iron logic in the order of our chapters. We have reasons for this particular order so we suggest that you follow it, but if you prefer to take another route then you are unlikely to encounter problems. One way or another, we hope that the texts assembled here inspire you. That you are moved by them, encouraged, sharpened. And that you feel, as you read, that you, as *the reader*, are being cared for.

Notes

- 1 This text has footnotes, that, beware, do not give an overview of 'the literature'. There is a lot more that is interesting to read! The main aim of these notes is to point the reader to literature that is directly relevant background of this volume. Accordingly, the proportion of titles written by 'our' authors, is very high. We seek to thus bring out how the lines of thought that we follow here, stem from a network-collective. The first 'thank you', too, is to the authors of this volume, for their generous collaborative efforts. Next, we would like to warmly thank Martin Döring and Jörg Niewöhner for being such skillfull and caring series-editors!
- 2 For the complexities involved in the disentangling of bodily felt passions and publicly organised politics, see the contributions to: Kahn, Saccamo & Coli 2006. For a great history of the way that scientists *in practice* were far more concerned with their bodies than they theories acknowledged, see Lawrence & Shapin 1998.
- 3 For philosophy see Foucault 1990; for the social sciences Robinson 1998.
- 4 We have been trying to do this for a while. For an elaboration of the term *logic of care*, see Mol 2008; for the argument that 'care' is as creative and generative as 'science' Moser 2008; and for the contrast between 'rights' and 'care', Pols 2003.
- 5 Most of us have a background in the *Social Studies of Science and Technologies* and from there have moved out to the study of other practices, all the while keeping an open eye for the ways science and technology inform and interfere with these practices. For this background see e.g. Callon & Law 1997; M'charek 2005; Latour 2002; Thompson 2005; Barry 2001.
- 6 This gave raise to heated debates in the seventies; and the topic is still important, not only because the domestic labour still is far from equally shared, but also because currently it is substantially shifted round the globe by being 'outsourced' to poor regions, see e.g. Anderson 2000.
- 7 The classic author to quote here is Freidson. More recently, however, Freidson has shifted his way of writing about the medical profession from generalised criticism to a more layered approach, open to internal differentiation. See therefore now: Freidson 2001.
- 8 This is still going on- for nurses professionalism continues to be a promise at the horizon. See for a recent example Cohen 2008.
- 9 For literatures that take up the question of the person potentially 'receiving' care (and/or engaging in self-care), see: Epstein 1996; Shakespeare 2006; Moser 2000 & 2005; Callon & Rabeharisoa 2003; Barbot & Dodier 2002; Barbot 2006.
- 10 For various aspects of the argument that 'customer' and/or 'citizen' might not be suitable terms in this context, see: Mol 2008; Callon & Rabeharisoa 2004; Winance 2007; Pols 2005; Pols 2006b; Moser 2006; Singleton 2007; Langstrup & Ross Winthereik 2008; López & Domènech 2009.
- 11 The typical reference point here is the work of Callon & Rabeharisoa, but for a good example see also Moreira 2004.
- 12 Here a crucial reference is the recent work on animal as it revises earlier thoughts on human-animal relations. See for instance Despret 2004.
- 13 For earlier work on the issue of fragility, see: Struhkamp 2005; Varela 2001; Diedrich 2005.

- 14 For the notion of 'concern' and its contrast with 'critique', see Latour 2004.
- 15 For some of the analyses of such (self) surveillance, see: Ashmore, Mulkay & Pinch 1989; Pols 2006a; May, Rapley, Moreira, Finch & Heaven 2006; Struhkamp, Mol & Swierstra 2009.
- 16 Obviously there is a lot more to say about this that complicates these catchy phrases. See for the approachments of ethics and ethnography: Parker 2007; Pols 2008.
- 17 For the issue of ambivalence *within* technoscience see: Singleton & Michael 1993; and Singleton 1998.
- 18 The classic reference is: Tronto 1993; for a more recent publication in this line of work, see: Hamilton & Miller 2006. For a sociological approach, concentrating on the value generosity, see Frank 2004; and for the value dignity, see Nordenfelt 2009.
- 19 For an example of this, see Winance 2006.
- 20 For the argument that *technology* is far more messy than most analysts have it, and depends on care, see: Law and Singleton 2000; Law 2002; Latour 2002; Oudshoorn & Pinch 2005; Harbers 2005. For the argument that *care* always already includes technology, see: Hendriks 1998; Akrich & Pasveer 2000; Willems 2002; Harbers, Mol & Stolmeijer, 2002; Moser & Law 2003; López & Domènech 2008. For an explicit discussion of the 'warmth' involved, see Pols & Moser 2009.
- 21 This comes with a re-thought 'body', too – the body is no longer taken to be given and waiting for the medical gaze to discover it, but is studied as it interacts with medical technologies, while thus being performed in quite particular, varying ways. See for this: Mol 2002; Taylor 2005; Mol & Law 2004; Pickstone 2000; Moreira 2006; Taylor 2008. An imaginative exploration of the body in care practice was presented by Xperiment! in the exposition *Making Things Public* in 2005. For a trace of that, see XPERIMENT! 2005.

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