Post-place care: disrupting place-care ontologies

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Abstract   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.

Keywords: e-health, place, STS, telemedicine, space

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[1] 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 (López and Sánchez-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 place-making 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 referred to as Experience Cabin.[2] 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 place-making 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 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'. (2001:

7) 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 (Ivanova *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[3] 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 Domènech 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.

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 placelessness. 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 production and experience of space, place, nature, landscape, mobility, and environment' (Kingsley 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 place-making. 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[4,5] (N = 4), neuroscientists at TNO[6] 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 conducted. 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 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 place-making; 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 displays 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 surrounding 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 odor, 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,[7] 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, somehow existing separately. The conceptualisation of place layers is done for analytical purposes to illuminate the process of place-making. 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 somewhere; 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 backgrounded, 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[8] that I visited was situated in a building in Amsterdam, in Sensiks's office (Figure 1). It was placed in the open hall, becoming the first thing one sees at arrival. Its location was strategically chosen for impressing clients and it was part of what the Pod *did* in this context. This purpose differs

Figure 1 *The Pod inside Sensiks' offices. Image reproduced with permission from Sensiks [Colour figure can be viewed at wileyonlinelibrary.com]*

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 2). 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:

> 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' – neighbours, family members or residents of other homes. In doing so, the Pod could contribute to another organisational and policy 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 3), 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

Figure 2 *Inside the Pod. Image reproduced with permission from Sensiks [Colour figure can be viewed at wileyonlinelibrary.com]*

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
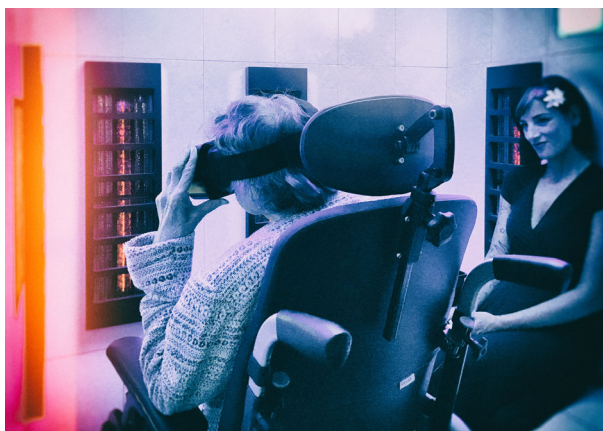

Figure 3 *A patient uses the Pod, accompanied. Image reproduced with permission from Sensiks [Colour figure can be viewed at wileyonlinelibrary.com]*

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.

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 place-making 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 place-making 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 place-making 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 organisation 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 place-making should be followed when manipulating the environment and sense of reality for mentally disabled 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 place-making 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 happens.

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 Domènech 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 qual-ity 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. Further-more, 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. Try-ing 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 concep-tualisation, 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, stat-ing, '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 explo-rative 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 cri-tique 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 oppor-tunity 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 differ-ently 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 (between 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 place-making. 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 (Figure 4). 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

Figure 4 *The Pod as an aesthetic of 'good care'. Image reproduced with permission from Sensiks [Colour figure can be viewed at wileyonlinelibrary.com]*

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 generally), 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.

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Notes

1   I do not mean to imply that there is something radically different happening in terms of technological changes in health care, 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.
2   In Dutch: belevingscabine.
3   Utopia (from ancient Greek): Greek οὐ ('not') and τόπος ('place')
4   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.
5   Sensiks has given consent to being named here and to this article.
6   TNO (Dutch: Nederlandse Organisatie voor Toegepast Natuurwetenschappelijk Onderzoek) is the Netherlands Organisation for Applied Scientific Research.
7   Another version of the Pod is created for wheel-chair access, where the space is wider, and a removable ramp is supplied.
8   There currently at least 3 SRPs owned by Sensiks and more than 60 Pods sold.

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