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## **The Cosmopolitics of Situated Care**

Michael Schillmeier

### **Abstract**

The everyday experiences of illness draw our attention to the importance of the cosmopolitics of care in which 'normal/ized' practices of care can neither be taken for granted nor be expected. Drawing on ethnographies of illness this paper argues that caring relations demand the attentiveness to the emerging requirements of care in concrete situations. Shared policy rules are beneficial if they allow to respond adequately to the unfolding issues, requirements and obligations of care practices. An ethnographic sense of and for caring practices may offer important insights to contribute to health care policy making processes.

### **Introduction**

The everyday experiences of illness draw our attention to the importance of the cosmopolitics of care in which 'normal/ized' practices of care can neither be taken for granted nor be expected.<sup>1</sup> Drawing on ethnographies of illness this paper argues that caring relations demand the attentiveness to the emerging requirements of care in concrete situations. Shared policy rules are beneficial if they allow to respond adequately to the unfolding issues, requirements and obligations of care practices. An ethnographic sense of and for caring practices may offer important insights to

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<sup>1</sup> On the notion of 'cosmopolitics' as explored here, see Schillmeier (2013, 2014) and Stengers (2005, 2010).

contribute to health care policy making processes which aim to avoid the fallacy of mistaking the abstract for the concrete issues of situated care practices.

Caring practices easily unfold the bifurcation of care: those who care and those who need care. The history of the Western Judea-Christian tradition of policing care (as well as the medical gaze) undoubtedly contributed – wittingly or not – to the bifurcation of care, rendering those in need of care as victims of bad fate, as dependent, passive, lacking autonomy, choice and discretion, suffering from an ‘ill’ situation that is beyond what is considered as ‘normal’ and thus ‘healthy’ (Foucault, 2009; Schillmeier, 2014). The history of policing care then is also the history of di/visioning the normal from the pathological, health from illness, ability from disability and configuring thereby the historical multiplicity of the *societal other* and his/her ‘troublesome’ life-worlds (cf. Borsay, 2005).

Care studies critically assess the bifurcation of care by addressing the specificities of caring relations *in situ* (cf. Barnes et al., 2015; Latimer, 2000; Mol, 2008; Mol, Moser and Pols, 2010). These studies highlight that care is not generally divided between carers and those cared for, but distributed between the different actors involved. This includes the person experiencing illness or disability as central agents of care (Schillmeier, 2014). As Mol’s ‘logic of care’ (Mol, 2008)<sup>2</sup> argues, caring practices extend the agencies of care to the non-human. Accordingly, it would appear similarly problematic to bifurcate between care as the emotional warmth of humanness and

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<sup>2</sup> Mol contrasts the *logic of care* with the *logic of choice*. With Mol I share some uneasiness with the current discourse of ‘patient choice’. On patient choice as part of health care policy advocating the idea of ‘personalized medicine’, see Schillmeier (2017).

the cold, rationalizing technology that is prone to endanger and contradict the requirements and practices of care. As ethnographic care studies highlight, technology plays a crucial, but nevertheless ambiguous, role in everyday care practices (cf. Schillmeier, 2014; Mol, Moser and Pols, 2010). As a collective achievement of affective, embodied and material relations between humans as well as humans and non-humans, care refers to practices of attention given to an unfolding relational situation of requirements and obligations that need to be addressed *in situ* to live well with and in it.

Current issues of health care policies in ageing societies pose novel and demanding questions concerning the affordability and the limits of institutionalized forms of care (Harper and Hamblin, 2016; Lloyd, 2012; Milligan, 2009; Schillmeier and Domenèch, 2010; Weicht, 2015). Social change has proven to be a source for controversies by which the different understandings of what counts as 'good care', and what is necessary for it and what can be expected from specific 'matters of care' (Puig de la Bellacasa, 2011), becomes visible. Caring relations about health are exposed to and affected by the demands, possibilities and restrictions of the national or organisational budget, the dependency on different forms of (political) governance and their transformations, the impact of techno-scientific development, juridical questions, issues of management, organisational obstacles and institutionalised procedures, religious views, the outlook of professional training for carers, the effects of cultural differences and so on. Reflecting these changes, the policing of care mirrors wider socio-cultural and political realities, which contribute to the need or dismissal of care, the conditions of possibility of how care is conducted, who is involved in the process

of care, how care is valued and how caring relations are understood and assessed (Barnes et al., 2015).

These multifactorial societal dependencies and changes may not only have improving effects on care practices, but quite often fall foul with or even put at risk the requirements and obligations of the caring relations *in situ* and harm its vulnerable actors – inside and outside of institutionalised forms of health care (Bartlett, 1999; Francis, 2013). Ethnographies of care have shown that neo-liberal economies of care are frequently at odds with attentiveness, flexibility, patience, empathy, skilful engagement, time demanding practices needed to address the specific and changing requirements of everyday practices of care (Heinlein, 2003; Latimer, 2000; Schweiger, 2011). The neo-liberal economy evokes a clash between the demands of situated care practices and (the promises and regulations of) economically driven health care policies.

Care relations often become the locus of the enactment of these discrepancies. To name a persistent concern in health care practices: Next to many other issues, the lack of time to engage sensibly with emerging situations in the conduct of everyday care practices names a long-standing, significant and often unsolvable problem for neo-liberal health care systems. As Schweiger has put it: Carers do have patience, but do not have the time for it. She shows that the lack for *caring time* became most apparent when the institutional settings of care practices (of a specific ward in Germany) changed from being governed by a Judea-Christian regime of care committed to the 'grace of charity' towards a more business-oriented model of care. With the latter, the

*patient* turned into a *customer/client* of a profit-oriented health care economy delivering calculated care packages (cf. Tritter et al., 2010). All too often, pre-given formats of how much care should be delivered and how much time can be afforded to do so, limit the time for the emergent requirements of care situations which frequently render generalized economies of quality assessment problematic and in need of re-assessment in the concrete situation (Schweiger, 2011).

For the caring relationship, this conflict – of having patience without the time to realize it in situations that would require so – recurrently creates stress for the carers and those cared for, provokes moral dilemmas and evokes rather uncaring situations. Situated care often requires flexible engagement to the shifting requirements of care that demand patience and time to provide *and* experience good care. The problem of having patience without having time for it enforces the *neglect of hesitation* of what is ‘good’ or ‘bad’ care in practice and often results in highly limited possibilities to engage a good caring relation. If the neglect of hesitation is inscribed e.g. in abstract time measurements of care policies, it provokes the risk to structurally dismiss to care for the emerging cosmopolitics of situated care.<sup>3</sup>

### **Caring for the Situation**

No doubt, to improve care policy it must become more real, i.e. care policy must become more sensitive towards the cosmopolitics of care that allude to the emerging requirements and obligations of situated care. This is not an easy task since the

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<sup>3</sup> On hesitation as a source of public modes of caring about science, technology and medicine, see Schillmeier (2015).

requirements and obligations of care unfold from an emerging situation that frequently disrupts what is considered as taken for granted, routinized and normalized care practices, and consequently leaves open and put into question of how to adequately engage in a caring relation that is considered good. Health care policies of care remain too abstract if they try to offer a framework of care which relies on the assumption that caring situations are primarily repetitive, comparable, hence measurable and standardisable. Having said this, routines and standards are always part of caring practices, but become caring techniques only if they contribute to the situated requirements and obligations of care. Situations of care unpack the conditions of possibility of care in the first place, which need close attention, since they often do not provide clear and fixed solutions, but need time and space to find out what is required to accomplish *good care in practice*.

What becomes apparent in emerging situations of care practices as well as in ongoing attempts to revise care policies, is the power of an occurring problematic situation which can't be solved along mere means of standardised practices. When we care, we are concerned about the possibilities of care, we hesitate, we struggle, we tinker, we pause, we concentrate, we mobilize and aim at skilful action. When we care, we are moved by a *social* problem enacted by the embodied eventfulness of everyday practices. 'Care', as I put it elsewhere, 'as a social matter of concern preserves the possibilities of difference as an on-going collective achievement' (Schillmeier, 2014: 102). When we care, we are affected by a social matter of concern and demands that one becomes attuned to the other as s/he (and it) becomes present in a highly specific and often vulnerable and unforeseeable situation. When we care, we care about the

fragility of embodied, emotional and material social interaction. When we care, we become aware that we live with and for others on speculative terms, which can easily turn into careless practices. With care comes the risk of being/becoming careless.

To be sure, the problem of care - initiated by hesitating about a situation that requires a contrast to given routines - does not mean that previous solutions of similar situations may not work. Rather, they may work, but the same solution in a different situation may appear careless and possibly may do harm. Caring for emerging situations require an openness concerning the very questions of what is cared for, how to care and who cares. To foster caring relations, the policy making process would do good to give space and time to engage with the openness of what a situated caring relation requires and how it could be collectively accomplished. The following sections will provide some insights into the complexities of situated care.

### **Cosmopolitical Events and Precarious Selves**

This is the story of Mr B who has been suffering from two strokes.<sup>4</sup> After the second stroke Mr B decided to move into a caring home whereas his wife remained in their apartment (Schillmeier, 2014). Mr B's decision to move into a nursing home, so he told us<sup>5</sup>, became necessary since he saw himself turning into a burden for his wife who suffered from a slipped disk when helping him out of bed. This was a significant issue

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<sup>4</sup> Mr B played an important role in Schillmeier (2014). In the latter, I was trying to develop a cosmopolitical understanding of experiencing illness. In this chapter, I will briefly re-narrate the story of Mr B by focussing solely on the question of situated care.

<sup>5</sup> The research was conducted from 2000 to 2003 in Germany and was part of a wider research project on 'service as interaction' (Anderson & Heinlein 2003; Dunkel & Voß 2004), funded by the German Research Foundation (DFG; No. Vo 775/1-1). Many thanks to Michael Heinlein, see also Heinlein (2003).



for Mr B. Although Mr B has been the focus of daily care, it was of most importance for him to be able to care for his wife, even if it means to leave their beloved home and move into a nursing home. *Relieving* Mrs B from the everyday burden of caring for him remained one possibility of Mr B to show how he cares about the well-being of his wife. By doing so he felt that he was still part of a long-standing caring relation; he felt he still had a saying and could positively contribute to solve a caring situation that became problematic for the carers (his wife and a nurse) involved.

Twenty years earlier. Mr B was 61, working hard and successful in a leading position, when he followed the advice of his doctor to retire. To care more about his body than caring about his work wasn't a voluntary act, he said. Mr B enjoyed and was used to organising things. He cared for his work, his colleagues and the company he was working for. Facing retirement was very difficult. Mr B needed something that would keep him busy working, planning, creating and developing, although in a more private setting. He rediscovered his old love for bees and beekeeping. With much care and effort, he developed his own and successful apiculture. Enjoying the work with bees and the production of his own honey contributed to his wellbeing even though he wasn't the healthiest person any more.

Ten years after his retirement he suffered his first stroke. Mr B's body required intensive rehabilitation to slowly ease the negative effects of the event. Although he recovered well, Mr B had to give up his apiculture, and he and his wife moved into a new flat. Their old flat became problematic since it was in the third floor and without elevator access. After the stroke, Mr B's life had changed dramatically again. Caring about his professional apiculture proved impossible. Caring about his wellbeing

changed as well. His body became the centre of his care: Daily exercises, avoiding hard and intensive work, and additional medical treatments were needed to live as good as possible with his stroked body. To engage with a stroked body was not easy and often required painful work, discipline and endurance. Professional help and the reliability of the companionship of his wife stabilised the process of caring —bodily, mentally and emotionally. Rehabilitative therapy and assistive technologies proved to be helpful allies in Mr B's post-stroke life. Assisted by a walking stick and keeping with his daily exercises, Mr B started to enjoy life more than ever since he began to care about his life without professional work being involved. He and his wife also enjoyed the convenience of their new flat. And with Mr B still being able to drive on his own, they frequently went on holidays. It was the happiest time of his life, he said.

Mr B's shifting caring situations revealed that bodily events like a stroke (or any other serious illness) disrupt, question and alter the practices and routines of caring for oneself and others. Undoubtedly, caring about a stroked body includes the experience of pain, sorrow and suffering, the ambiguities, insecurities and indecisions, and may unleash new situations of care which alter the requirements for the possibilities of good care (Schillmeier, 2014). An event like a stroke unfolds a *cosmopolitical situation*: affected by a stroke bodies experience an unexpected, emerging and disruptive situation for which novel caring practices are required. It requires a process of attentive engagement with a demanding situation that may involve many ups and downs, unexpected everyday life restrictions, disciplining bodies, enrolling others (humans, institutions, technologies), learning to do things anew, to give up (doing) certain things and so on.

Caring rarely is a smooth empirical process. What we have seen so far is that care and its requirements are not only shifting, unpredictable and situational, but care is also biographical and enacts the different modes of caring in highly idiosyncratic ways. Care creates novel interactions and in/dependencies. Caring practices are embodied, material and spatially situated as well as they re-assemble the past, present and its possible futures. Mr B's biography of care – be it self-care and the care for him and others – names a collective accomplishment, a social process of psychological, physical and emotional learning that re-relates bodies, materials and technologies, ideas, affects and feelings.

Shifting situations of care implicate the experience of human beings as *precarious selves*. Precarious selves are no isolated beings; they need others to be/come what they are. Moreover, precarious selves may also experience bodies and minds that act other than expected. Experiencing an event like a stroke, bodies resist complying with what has been taken for granted and limit what contributed to their well-being. With the advent of *cosmopolitical events* like a stroke, the pragmatics of caring relations change significantly — within and/or between bodies and their environments. Bodies and minds become affected by, relate, interact with and become dependent on others in different ways than they are used to be. Stroked bodies often suffer, become less mobile and agile, are in pain, become 'unreliable' or become a concern in the way one cares about them and how one can care for others. Depending of the effects of event, stroked bodies 'seem to be or become [more or less, MS] unknowing' (Latimer 2009: 4).

To look at caring relations as shifting and situated reveals that caring about one's body is to learn to have a body through embodied and material relations in multiple ways. As Latour (2004: 2) reminds us: 'to have a body is to learn to be affected, meaning "effectuated", moved, put into motion by other entities, humans or nonhumans. If you are not engaged in this learning you become insensitive, dumb, you drop dead'. Caring trajectories reveal indeed, as Spinoza suggested, that we don't know what a body is capable of (cf. Deleuze 1992: Ch. 14). It may be good or bad. Good care in practice, though, aims at keeping and strengthening the situated possibilities of well-being, it's health as it were, rather than diminishing or endangering these possibilities.

This is important, since precarious selves express the vulnerability and fragility of caring relations that require a shift towards (often) unacquainted forms of care. Precarious selves should not only be understood as in need of human help and/or medical and technological assistance. Rather, precarious selves become *cosmopolitical actors* as well (Schillmeier, 2014): They demand a changing relation of care, practices and environments (inner and outer) to meet the requirements and to live well with it. As cosmopolitical actors, precarious selves question, disrupt and alter the common, normal and taken-for-granted – be it biographical, physical, mental, institutional as well as their diverse interlinking. As cosmopolitical agents, precarious selves bring to the fore the question of care and address the differences and limits of how care was experienced and practiced so far. Cosmopolitical actors unfold a learning situation for all the actors involved and require the *ars inveniendi of care* that is attentive to the relational demands and obligations.

## **Caring with Precarious Technologies**

Care practices include members of the family and relatives, charities, voluntary carers and care professionals, different expertise of social services, nurses and clinicians, spiritual or religious companionship, medicines, technologies and so on. Situations of care bring to the fore the different perspectives and practices of what counts as care (good and bad) and how caring relations are engaged, by whom and/or through what.

Let me briefly return to Mr B to make this point clearer. According to Mr B, his happiest time lasted for ten years to the moment when his life took another dramatic turn: Mr B suffered from a second stroke. Mr B is now in his early eighties and the second stroke has paralysed half of his body. Caring about his everyday life involved the assistance of a nurse and his wife. As mentioned above, to care about Mr B became too much of a burden for the nurse and especially for his wife. When Mrs B suffered from a slip disc while helping Mr B out of bed, Mr B decided to move into a nursing home. Caring about Mr B at home turned into an involuntarily 'careless' and thus problematic situation for his wife. Mr B was adamant that his wife – also in her eighties – needed to take more care of herself as well. The last thing she should experience are health issues from caring for him!

The nursing home provided not an ideal situation, but a possible alternative to Mr B's flat, since it was equipped with specialized caring facilities, professional assistance, medical care and so on. Moreover, his wife would be able to care for him by visiting him whenever she felt like. Supplying him with good honey, self-made food and a good spirit kept him connected to his former lived home. Occasionally, Mr B also managed

to care about the ward with his singing group and regularly lightened up the everyday ward life with his humorous and lively being (cf. Schillmeier, 2014).

At the same time though Mr B's bodily agility and strength deteriorated and caring became more demanding, troublesome, and increasingly unsatisfying for everybody involved. A body lifter entered the caring routines to ease the everyday bodily care, both for Mr B and the nurses. Using the lifter, the nurses were able to wash and cream and properly look after Mr B's body. Moreover, the nurses could take more care about their own body, which could be easily hurt by lifting heavy bodies like Mr B's: The lifter assisted Mr B to elevate himself from a lying into a sitting or standing position. The lifter was designed that the patient needs to engage with it to do its caring job in a satisfactory manner. In that sense, the lifter contributed to a distributed situation of care in which both the nurses and Mr B could care —although in highly specific and different ways.

After a while though Mr B's body became too frail to contribute to the daily washing routines and the nurses decided to use a differently designed lifter. The second lifter allowed lifting Mr B from a lying position *without* his assistance. Shortly after the second lifter was introduced, Mr B began to dislike the new lifter, he screamed and resisted to be moved by it. The nurses felt that they had no other option than to reintroduce the first lifter, which in turn eased some of Mr B's discomforts. However, it didn't improve the overall caring situation neither for the nurses nor for Mr B. Mr B's body was too weak to contribute to the successful and satisfactory use of the first lifter and the intentions of good care related to it. Consequently, the second lifter was re-introduced.

What becomes apparent from the brief insights into the shifting use of different technologies of care is the importance of companionship – both human and nonhuman. A cosmopolitical perspective as outlined in this chapter reevaluates the importance of nonhumans and technologies as matters of care. It is precisely the specificity of modern everyday human care by and through which technologies play a significant role. To be sure, technologies of care are not neutral objects. They are designed for a highly specific caring relation and thus enrol humans in highly particular practices. These technologies may also contribute to bad care when they do not fit the bodily requirements the caring situation demands. And this is precisely what makes a caring situation like Mr B's so complex, precarious and contingent. It involves caring relations that reflect (and enact) the limits of possibilities of good care in practice. As Mr B's shifting situation intimately tells, caring becomes more demanding the more his body asked for caring practices for which no satisfying solution was available to appraise the situation and learn to be affected by it.

### *Dementia and Self-Care*

With her focus on people with diabetes Anne-Marie Mol's *logic of care* offers a rich account of care as a matter of 'tinkering' and 'doctoring' to re-compose caring relations (Mol 2008). Mol highlights that different illnesses afford different forms of care practices. Whereas 'people with diabetes engage in an impressive amount of self-care, [but] people with dementia do not', so Mol (Mol 2008: 104). I fully agree with Mol that care differs concerning what kind of illness is experienced, who practices care, when and where. The notion of *situated care* that I advocate here, fully endorses

such a reading (cf. Schillmeier 2014). Having said this, it seems a bit hasty to suggest that the difference between distinctive illnesses decide whether people engage in self-care or not. Without doubt, there are significant differences of how people with diabetes and dementia participate in care. And it is one of the long-term effects of the *process of dementia* that the possibilities of self-care are shrinking. One of the reasons for lacking self-care is that we know little about dementia. We have also not many ‘techniques of care’ that people with dementia would be able to engage in and care for. To be sure, I am not suggesting that self-care is a fixed capability irrespectively of the illness experienced. What I try to highlight though is that people with dementia may engage quite intimately in self-care. What differs though is how self-care is expressed and practiced.

Let’s meet Mrs M, a woman in her seventies who lives in nursing home and has been diagnosed with Alzheimer’s Disease. Mrs M is the central character in an ethnographic film ‘Der Tag der in der Handtasche verschwand’ [‘The day that got lost in a handbag’] by Marion Kainz, which I have analysed in some detail elsewhere (cf. Schillmeier 2014). What makes the award-winning film so interesting is precisely the careful video-ethnographic engagement with Mrs M that documents her struggles in an often unknown and uncanny world. The intimate portrayal of Mrs M brings us closer what it may mean to dwell in ontological insecurity, but it also sheds light on Mrs M’s attempts to regain a sense of meaningful be/coming (with others). At the same time, it is an intensive documentation of the demanding and shifting relations of dementia and institutionalized forms of care, its rare successes and its dramatic failures.

**Scene 15:** *Mrs M walks along the corridor and talks to Marion Kainz, the filmmaker (19:26).*



Mrs M. Well, these are messy [*schweinige*] things, you know, which I don't like.

Mrs Kainz: What do you mean [Was denn]?

Mrs M: Well, all that, ... the whole... the whole.

Mrs Kainz: The house here? Or what do you mean?

Mrs M: No, generally ... You cannot change that. You must take it, as it not and not... You must take it as they offer it (Pause).

Mrs Kainz: Mmh.

Mrs M: If you would get something like that, would you then feel good?

Mrs Kainz: I don't think so.

**Scene 27:** *Mrs M (with Mrs Kainz) on her way to the working space ['Arbeitshaus'], where Mrs M can help e.g. in the kitchen (35:53).*

Mrs M: Wasn't there, just above, a cry, haven't you heard it?

Mrs Kainz: Sometimes, here, people shout, yes, (Pause) but they do no harm.

Mrs M: Yes, ... now we are trapped. Now we cannot get out downstairs, they won't let us leave. (Mrs M and Mrs Kainz approach an elevator). Did you now push here?

Mrs Kainz: Mmh.

Mrs M: Now we cannot get out of here.

Mrs Kainz: You must pass through the glass door.

Mrs M: How do you know all these things?

Mrs Kainz: Since I have been here already.

Mrs M: It is closed.

Mrs Kainz: You must push, ... or pull, no, like this ... The door is hard to open (Pause) Do you know where you are?

Mrs M            Yes, ... in the workhouse, aren't we?

Mrs Kainz        Somewhere like that, yes. But you know this here? You have already seen it.

Mrs M            seen, yes ... but not so intensely.

Mrs M, who often forgets that she is in nursing home, frequently feels 'out of place' and realizes that the whole situation doesn't feel right. Mrs M is agitated, nervous and 'all over the place' when she is not able to connect with her body and environment in a meaningful way. She feels lost and is concerned about all the messy [*schweinigen*] situations. Mrs M is not only concerned with the nursing home and how they do things. Experiencing these dementing moments, it worries her that the 'whole' situation makes her so uneasy. In the dementing situation, she feels lost in between strange practices, oddly behaving people and uncanny things of an intensively felt everyday life. Affected by these 'demented' others and things her existence is felt as deeply troubled.

Mrs M goes in and out of these dementing moments. Sometimes she is rather happy with herself and her environment, she remembers things, tells stories about her family, she wants to see her old home, she enjoys talking about flowers, which have been her professional passion for many years. In other situations, bodies and things are mixed up and often her relations of knowing and being familiar with are lost. Her anxiety brings to the fore that being with others – human and nonhuman alike – has no subjective meaning for her and she feels that she has no capabilities to do anything to change the uncanny situation. She feels distressed, depressed and lost when the

situation remains messy, full of unknowing people, things and unfamiliar practices. Quite often she feels that the environment turns alien and she feels utterly isolated, trapped and moved around by the environment. Frequently, Mrs M feels left on her own and at the mercy of an oppressive environment. Confronted with a multitude of *faits accomplis* (Schillmeier, 2014: 82pp) Mrs M feels that she has no possibilities to engage with and *to learn* to be affected by her environment in positive ways. Rather, the very stubbornness of these accomplished matters of facts make her feel living in an iron cage, trapped, a puppet of and for others. She can't contribute, can't participate, can't learn from and orient herself along them.

As Mrs M made clear, she has seen similar 'things' before, but 'not so intensely'. Although intensely felt she cannot positively relate to her environment. When she feels anxious, her relations with the world are not only 'massive and vague' (Whitehead 1978), but she is driven by negatively felt affective relations that do not contribute to the concrescence of meaningful bodies and things. And yes: Mrs M feels unable to care for the situation in the way she wishes to.

Throughout the dementing situation, Mrs M's world is uncannily present. The sheer presence of bodies and things is negatively felt and keeps bodies and things apart: Bodies and things remain fully present, but don't protract in time and appear as isolated and rather strange beings: coercive, unknown, scary, uncanny, undisclosed *Gegenstände*. Massive and vague, 'demented' bodies and things *object* to become parts of a caring situation to feel at home with. In such a situation, Mrs M and her environment appear as ripped apart. The relation between a forgetting self and

merely present others tears her apart from them and from herself. Massive and vague, the environment becomes conspicuously present as doubtful, questionable, menacing, oppressive (cf. Schillmeier 2014).

Being lost in these situations drastically limits the possibilities of living well and positively engaging with these situations. The dementing situation unfolds an ontological crisis, a cosmopolitical event by which Mrs M's world, her past, present and future and all the people and things through which Mrs M's temporal being is materializing, gets stuck in a situation of the *no longer and not yet*. Nothing repeats, nothing gains time to achieve meaning. Mrs M asks Mrs Kainz how it comes that she knows all that things. Mrs Kainz answers that she knows since she has already been there. In Mrs Kainz's world, things and situations repeat more often. And by repeating they gain some continuity, they gain time. Repetition enables a *learning* process, which when remembered, offers possibilities of gaining knowledge and accomplishing a caring relation. In dementing situations, what repeats isn't remembered and often remains unknown, vague, meaningless, uncanny, frightening. Enacted by ontological anxiety, the grounding caring relation – that unfolds a be/coming with and for others – is missing.

What is absent is a *referential situation*, an *oikos*, i.e. an *eco-logical process* that enables bodies and things to be/come, to be and change, i.e. to be able to be affected in mutual ways. Mrs M shows her awareness and concern for the missing learning process. Indeed, it would be problematic to argue that Mrs M does not engage in self-care. Quite on the contrary, it is her questioning, her constant tinkering with words

that expresses one of her remaining possibilities to positively assemble with humans (and non-humans). With words, she tries to re-gain a caring situation in which she would be able to *animate* her life and her environment, i.e. to make them part of a living situation through which she and her environment gain meaningful relations.

The expression of her bodily feelings, her anxieties and her constant questioning, her experimenting with words are existential modes of self-care which are enacted by and engage with the specificity of a situation which is 1) *experienced as massive and vague*, and 2) *alludes to the questionability of the general, the whole of the situation*. It is the dementing moment, which affects the *erasure of the specificities* of Mrs M's life and unfolds the *questionability of the general*. Massive and vague, everything – humans, non-humans, practices, perceptions – becomes a source of uncertainty and concern due to their 'stubbornness' to refuse becoming part of a caring situation. Without a caring situation, the very subjectivity of bodies and things miss their *soul*, they appear nameless since they lack their thread of life, their caring biography, their constituting world, their positive subjective feelings, their possibilities. The philosopher A.N. Whitehead writes on the importance of the soul and personal identity:

[I]n conceiving our personal identity we are apt to emphasize rather the soul than the body. The one individual is that coordinated stream of personal experiences, which is my thread of life or your thread of life. It is that succession of self-realization, each occasion with its direct memory of its past and with its anticipation of the future. That claim to enduring self-identity is our self-assertion of personal identity. (...) The 'external world (...)' experienced, is the basic fact within those experiences. All the emotions, and purposes, and enjoyments, proper to the individual existence of the soul are

nothing other than the soul's reactions to this experienced world which lies at the base of the soul's existence. Thus, (...) the experienced world is one complex factor in the composition of many factors constituting the essence of the soul. We can phrase this shortly by saying that in one sense the world is in the soul. (Whitehead, 1968: 161pp)

Thus, through Mrs M's dementing moments and how she engages with them brings to the fore the soul's existence as embodied *matters of care*. The dementing moment make us aware of the *importance* of 1) our bodily existence, 2) our relations with other bodies and things, and 3) our temporal being in the way it gives significance to the mediation of the past, present and future. It makes us aware that *having a soul* refers to a process of mediation, a *social process* that constitutes the ongoing realization of selves and others, of bodies and things. Without the experience of caring relations neither the biographical life (as an ongoing collective achievement), nor novel situations that may become part of Mrs M, gain soulfulness. The constituting worlds fade from the souls of each involved being, and the worlds become souls which are merely perceived as present bodies. The togetherness of world, soul and body is lost.

Mrs M's dementing situation brings to the fore the highly problematic ontic as well as ontological status of merely present 'matters of fact' as highly distressing and questionable, all too fixed, fully present but 'time-scanty' entities which indeed appear as soulless. But, to be sure, the point is also that Mrs M's 'self-care' is not fully erased by these soulless matters of fact. Quite on the contrary, they gain importance in the way they turn into matters of concern that trouble Mrs M's world. And these matters of concern are translated into matters of care through the ways Mrs M

engages language to address the *questionability* of these matters. To be *in language* unfolds a very specific mode of existence that achieves togetherness, which may prove to become a way of *re-member-ing* with her body and her environment. As one mode of caring, dwelling in between the meaningfulness of words, the use of language gains foremost importance in Mrs M's life to possibly re-associate with other modes of concern, belonging and caring (e.g. being in soulful relations with humans and things).

### *Repetition, Care and its Failures*

**Scene 25:** *A member of staff (MoS) asks Mrs M (who formerly worked as a florist) to help him to tie a bouquet (32:06)*

MoS: Isn't that a bouquet?  
Mrs M: Yes, (...) They are nicely fresh.  
MoS: Smell them!  
Mrs M: Mmmh.  
MoS: Yes, are they fragrant?  
Mrs M: They are fragrant, yes.  
MoS: I would like to give you pleasure [Ich wollte Ihnen ja`ne Freude bereiten]  
Mrs M: Yes.  
MoS: I know, that you like flowers.  
Mrs M: Mmh...  
MoS: But I am so utterly uncreative, I have absolutely no clue. I don't know how to deal with it. Can you help me tying a bouquet? Can you show me, how it works?  
Mrs M: I am not in favour of it [Ich bin nicht dafür].  
MoS: No? Well, last time though you showed me beautifully how to do it  
Mrs M: Well, you see!  
MoS (He goes to the en suite bath) I am back in a second; I am just getting us a vase.  
Mrs M: (while MoS is in the bath) He drives me up the wall (Pause)  
MoS: (back) I am so very clumsy. Are these roses?  
Mrs M: This is a rose, the one you are holding in your hands.  
MoS: This is a rose. It is a specific rose? Since it is a bit pale at the bottom, or is it normal?  
Mrs M: This is normal.

MoS: This is normal. ... And what kind of flower is this?  
 Mrs M: I don't know. ... A yellow flower.  
 SoS: And it smells nicely!  
 Mrs M: Doesn't smell at all.  
 MoS: So where would you like to start?  
 Mrs M: Nowhere, with, with nothing. I want to know nothing about these flowers. Nothing. Nothing. Leave. I have enough ... I have had it today.  
 MoS: Yes.  
 Mrs M: I am of no use [Bin nicht zu gebrauchen]. No, well go, go, I am sick and tired of the blather. Leave now!

All the attempts of the member of staff to repeat a situation in/through which Mrs M would be able to interact with and re-assemble her past (as a florist) dramatically failed. The idea to engage in a caring relation proved impossible. On one hand, Mrs M, we may say, resisted complying with a sheer repetitive act. She had no concern for the member of staff and his caring attempts. On the other, one may also argue that the member of staff didn't give much attention to Mrs M mood and the sensitive and precarious situation she was in. One may say that he acted rather careless and Mrs M disliked his way of 'superficial' engagement. Having said this, the member of staff may also be acquainted with a situation like this and may have expected that Mrs M may change her mind and will contribute to his caring ambitions. The situation, however, had a quite dramatic ending with Mrs M asking the member of staff to leave the room. Mrs M was not in the mood at all for being mobilized to care for the other's caring efforts. Quite on the contrary, it seems that Mrs M was bugged by the (stubborn) attempt of the member of staff to make her do things she didn't feel like doing. Mrs M didn't feel to engage in a staged situation that is not hers, to make her smell flowers which do not smell, to listen to his idle talk to make her become the florist again, and so forth. It seems that Mrs M feels that she is unable to care about flowers in the way



the member of staff wishes for. She was asked to be creative, to use her florist hands and thus to engage in meaning- and skilful bouquet tying practices. To hand-tie flowers wasn't of her concern, in the situation flowers appear as mere matter of facts, purely 'flower facts', some yellow, some not, some smell and some don't, some have a name and some are just flowers, and many flowers become one flower. All in all, just normal flowers but no mediators of care as suggested by the member of staff. Mrs M was not in the mood to repeat what she apparently did nicely the last time and what she must have done and liked for many years of her life.

It is not Mrs M, the former florist, who is able to be mobilized by the member of staff's care attempts. His well-intended (but clumsy and pushy) efforts to care about Mrs M turned out to be a source of dismissing care. Having said this, the video doesn't reveal much about Mrs M's day, what has been on her mind before, what has been bothering her, what made her feel like she felt. What we know though is that she felt utterly useless, 'Bin nicht zu gebrauchen' and like Melville's Bartleby she preferred not to be mobilized by caring others and their practices. *Bin nicht zu gebrauchen* literally translates as 'I am of no use'. It offers a double meaning. On the one hand, it seems to express that Mrs M lacked power to enrol in that situation and on the other it stated the firm proposition that others must not enrol her into that situation. *She is nicht zu gebrauchen* and nothing and nobody could enrich the situation. No giving, no taking. Her *Befindlichkeit* [mood, affectivity] didn't allow that flowers (or the member of staff) become part of an enjoyable interaction. The caring situation that was intended to give Mrs M a treat, i.e. *the repetition of something that has been experienced as good in the past*, dramatically failed. The member of staff also failed to give more attention

to the intense situation to which he undoubtedly contributed. It is precisely the *caring relation* that could not be established and it is the situation that asked for a dramatic change of how to care about it. The staged caring situation *made no sense*, since neither the good past, nor the actual or the expected meanings of care could be established. Neither Mrs M nor the member of staff did 'benefit' from the situation. None of the modes of temporal engagement, the remembering of the (good) past, the composition of the present, or the proposition [*Vorhaben*] of the intended caring project have worked out. One may say that the process of shifting the process of a matter of fact of everyday caring towards a matter of concern for the situation and subsequently towards a matter of situated care has failed. The emerging situation didn't allow Mrs M or the member of staff to *gain* a sense of care: none of the two *has viz.* is partaking in a caring relation that would enact hesitation and the possibilities of doing things differently. My reading of the video footage sustains Mol's argument that 'in the logic of care the good, better, worse does not precede practice but is part of it' (Mol 2008: 87) and that 'the good' cannot be taken for granted. If the caring situation becomes better or worse throughout the process of caring remains an open empirical question that unfold the situated care practices from which the requirements of and for *good care in practice* emerge.

### **Situated Care and Policy Making**

Following from the brief discussion of Mr B's and Mrs M's shifting situations of care one can argue that to care means to re-compose caring relations between bodies and things. Caring is an open process and often means to engage in new ways of caring

that are attentive to emerging situations of care which possibly unfold changing requirements and obligations of good care in practice. I have also argued that situations of care are the locus of wider societal changes which are very much part of related health care policies. It remains a significant feature of public debates about health care and health care policies that matters of care are constantly changing. As we have seen most recently, health care policies are not exempt from contributing to issues of careless health practices and failures which violate the requirements of emerging health care situations (Francis 2013).

It is precisely the emerging complexities of situated care that names the prime and often unsolved concern of care policy-making. We have seen how current neo-liberal policing of care contribute to careless practices if situated care is regulated by an economy of care that favors standardizing, measuring, normalizing and economizing embodied care practices. The brief insights into the caring life of Mr B and Mrs M revealed that recommendations for care policy are prone to fail if they maintain to deliver fixed packages of care.

Health care policies need a careful design that is sensitive to the shifting demands and obligations of situated care. This means that the 'facticity' of the emerging situation of care itself should be the starting point for good care policy. Health care policies need to pay careful attention to the ways the involved actors do care. It requires a mapping of the different concerns and care practices already in place. Good care demands a careful, i.e. attentive, cautious, gentle, vigilant and meticulous tracing how the practices of self-care and the caring and concerns for others fold the situation in place and provide *evidence of and for care*. What has been proved as good care so far,

which entities have been involved and how have they been contributing and what makes the shifting situation in need of care? This is a demanding process since it requires a learning process of getting affected by a situation that questions, disrupts and alters what has been taken for granted as *caring relations*.

To care well means to look after the process of differing and only through being with others – human non-human alike – differences gain a hold, i.e. make a difference. It is precisely the unruly and often unacquainted processes of how differences occur which unfold the time-spaces of care, time-spaces of learning to get affected by the process of embodied differentiation. It is the cosmopolitics of situated care and its requirements that address the *questionability* of normalized and normalizing embodied and material relations. Paraphrasing A.N. Whitehead (1968) and M. Heidegger (1962), it is the shifting *worlding* [*das Welten*] that characterise the souls of situations of care. And it is precisely the attentiveness to the *worlding* souls of caring relations that are crucial in providing good care in practice. An understanding of care as *situated worlds in the making* may have an impact in rethinking (health) care policy processes and may offer new collaborations between researching, policing and improving health care practices.

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