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The matter of hospitals: an ethnographer investigates

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Madam Pro-Rector,

Esteemed colleagues and students,

Dear family and friends,

There is a distant rumbling in the bowels of the place, but right now it's too far away to hear properly.

It's night but not dark, for hospitals never really are, with their illuminated ward desks and intravenous poles emitting flashes of light.

One of these nights I am eight years old, lying in bed after an operation, the metallic sensation of clotting blood in my mouth. I am listening; not scared, but on high alert, in this very strange place.

More nighttime images from hospitals hurtle along the neural routes of my memory. This time I am a teenager after a long car drive to see my paper-thin grandmother in her final days. Then I am a medical student, in a paediatrics ward, reading *Harry Potter* to a kid who can't sleep;

I can taste the dry Vegemite toast breaks in the middle of my 36-hour shifts as an intern; then the slipperiness of a twilight emergency in the obstetrics theatre, where my principle job as a resident was to hold onto the instruments, tight.

The rumbling gets louder. Now I am in this increasingly familiar place of the hospital as an anthropologist, spending time with migrant physicians - that is, doctors who trained outside of Australia - while I complete fieldwork for my PhD. Some of these doctors work in Melbourne as taxi drivers during the day and study in the hospital libraries and cafeterias at night.

The doctors feel at home in this environment among the anatomy textbooks and awful free coffee. Other doctors work on the wards in whatever jobs they can get. It was waiting with them one night shift, that I first witness the source of

that rumbling, the sound getting louder. Then, in a release of pressured air and with a soft plop on a towel I see what it is: a capsule from the pneumatic tubes.

This is the matter of hospitals. In the sense of the stuff that moves, substances in tubes extracted from bodies for analysis, travelling on trolleys and passed by hand to pathologists to slide and study. Matter in the sense of all the materiality of the operation theatres and wards and waiting rooms, with their walls and their waste. And matter in the sense of what happens there: births and deaths, sickness and loneliness, cleaning and sorting, coding and operating, and so many other vital practices of care.

In these precious 45 minutes together, I want to talk about the matter of hospitals. And through this talk it is my wish, with this lecture and with my chair, to find promising paths into the urgent topic of how to make sense of our material world – together.

Chair in Anthropology and Medicine

I am honoured today to accept this professorship, a Chair in Anthropology and Medicine. In the context of these two academic fields, my more specific focus today is on hospitals and their matter.

For some people, these fields may seem worlds apart – medicine on the one side, a discipline seemingly characterised by rationality and objectivity; and on the other side anthropology – subjective and inductive. The incentives and desire to keep these fields separated is strong. Many in my own field of the social studies of medicine, for example, take great joy in setting up biomedicine as a monolithic and imposing unity that traverses from pole to pole. I, along with collaborators and those writers who inspire me, disagree, recognising the interplay between shared material histories of medicine and the local specificities of how it is practiced today.

Certainly, I could discuss with you differences in approaches to how those in medicine and those in anthropology make sense of the world. I could, for example, take how these fields generate and work with evidence. This might involve comparing what the French philosopher Michel Foucault called medicine's clinical gaze – a way of knowing evident in everything from imagining technologies to how hospitals are built, and I could compare this to anthropological modes of noticing – of being with others during ethnographic fieldwork.

Yet this very comparison highlights a similarity in approaches too. Both the clinical gaze and ethnographic noticing utilise forms of sensory triangulation to generate their evidence. In other words, what the doctor sees, hears and feels and what the ethnographer sees, hears and feels are all very important. Both work through what the Australian-Lebanese anthropologist Ghassan Hage calls 'the comparative act', which constantly exposes the anthropologist and the doctor, to being other than what they are.

By now I hope it is obvious that my own interest is in understanding what these fields share. But rather than working ‘across the river’ (as in the Randwyck and the inner-city campuses of our university) or looking for bridges, I am interested in another river phenomena: the confluence. That is, where we can find points of coming together.

And for me, similarities in approaches of medicine and anthropology can be found in the seemingly simple practices of *observation*, *examination* and *investigation*.

Observation, examination and investigation

Let's look at *observation* first, or what could simply be called paying attention. Observation is often the first step a doctor is taught in order to make a diagnosis: look at how the patient enters the room or is lying in bed. It's a Sherlock Holmes way of tracking and tracing clues. Observation is also at the core of the ethnographic method central to anthropology. This kind of noticing is not innate, that is, something we are born with, but rather a practice that is cultivated within these fields, through education and practice.

Examination is another word which threads across anthropology and medicine, from anthropologists examining a field, a text or a community, to the doctor performing a clinical examination. Again, while it may seem that the fields diverge greatly here, both share an understanding that examination is a sensory and a bodily practice, and a practice that involves materials whether it be a stethoscope or a notebook.

And finally we have, *investigation*. This word is in the title of my talk, and I will return to it again later at the end of my lecture. In universities, we have principle investigators. I am one of these, leading a team research project. There is also the clinical investigator. Ethnography, the anthropologist Amade M'Charek reminds us, has similarities to forensic investigation. It is the private

investigator though who perhaps most of us can picture when we think of the term investigation, wearing a trench coat and leather gloves, holding a magnifying glass or notebook.

So observation, examination and investigation are all terms that sit snuggly in the two fields listed in my chair's title. Why are these terms, and the connections between them, important? For me, these concepts and their relations lie at the heart of the question of how we make sense of our world. In the remainder of this talk I will thread these terms into stories, as I attempt to formulate the investigative style that I wish to develop in the years to come.

In doing so, I will make three invitations: **first, to consider the sensory as empirical; second, to consider materials as incomplete; and third, to explore new ways of making sense in common.**

In the remainder of my lecture, I will reanalyse past work to help build these propositions, always in conversation with selected scholars. My research has traversed many topics, from genetics to sound and from migrant workers to education, however for the sake of clarity, I will home in on clinical matter; in fact, on three specific objects.

These objects are carefully curated, and I will practice comparison and juxtaposition in my talk by moving between them. In doing so I will be sketching out a research agenda for the duration of my chair and beyond. It involves brand new projects, exciting collaborations and creative ways of doing research that have implications for our faculty, our university, academia and beyond.

The Imagining Unit

Let me start with a balloon. I would say that it's cost price is about 10 cents, maybe less. I actually hate balloons, with their sad deflation and that strange sensation of being rubbed in your hair during the electricity experiment. But in the medical school where I did observational fieldwork, our very own Skillslab in Maastricht, I saw balloons in a whole new light as a rather elegant teaching tool. The first balloon I saw in this context was on my collaborator and officemate's desk, blown up and half filled with water. This teacher was using it to educate students on how to examine a person's abdomen, looking for signs that there was too much liquid due to disease.

At first read the balloon could be seen as an overly simplistic representation of a patient. However, there is so much more to it. In a team project I led and conducted with others called Making Clinical Sense, this was one of the many

objects we saw being used to teach students how to examine bodies in medical schools. More than representing bodies, these objects were part of carefully choreographed performances, used to slow down a lesson, to break it up into components or highlight an aspect of the body that the student should pay attention to.

On closer reading of the balloon, I have come to think of it, in collaboration with Christine den Harder, the Skillslab teacher I mentioned, as a sensory analogy. An analogy works when the properties of the two things being compared share similarities. A philosopher of science called Mary Hesse developed the idea of analogy with a focus on the material analogy; one that contains details that are sensory and observational in nature.

If we return to the balloon's analogous properties, we can see how perfectly it works in the clinical lesson to teach something that the students find hard to imagine – liquid inside abdominal spaces. As a sensory analogy the balloon shares many aspects of the sick patient in a hospital bed – moveable fluid inside a cavity for example – yet also adds new elements, like the ability to see the fluid through the opaque skin of the balloon. Some might dismiss such a tool as reductive, reducing a patient to this object, others might consider it crude and unsophisticated. Personally, I find this tool brilliant and exemplary of what good teaching with materials can do, that is, allow a space, a gap, for the learner to

cultivate their own bodily imagination. The balloon works because the student has to do the hard work of making the connection to the patient – such information was not given to them in a slick PowerPoint slide; it was felt and needed to be cultivated in a material-sensory encounter.

In research project Making Clinical Sense, we investigated the materiality of medical learning not only in Maastricht but in countries around the world. It lasted almost eight years and included the work of an incredible group of anthropologists, Science and Technology Studies scholars, historians, educators, clinicians, filmmakers, artists, graphic designers and museum specialists.

The materials we studied included chalkboards, lecture theatres, stethoscopes, knitted uteruses, measuring tapes and students' own bodies. Together we investigated how the *way* we learn affects *what* we learn, including the material conditions where bodily imagination is cultivated.

It was working with Bachelor students in my faculty, who take nothing for granted, that we furthered our thinking on how these objects in medicine could be reimagined otherwise. As part of a larger program we called Fringe Editions,

these students questioned how gender and race for example were being enacted in materials. Some of these students made a free catalogue of DIY materials that amplifies the work of a vibrant creative community of educators. I've put some copies in the reception area. With other groups of students, this work got taken into gardens, galleries, cinemas and festivals. With artists we developed workshops making collages of queer anatomies, and with the local bookstore Limestone Books we helped create a community library.

In this first part of my talk, I have described one idea shaping my new research directions – the role of sensory analogy in medicine and education, through which I explored how imagination can be trained, putting forward the important role of materials in cultivating imagination. I hope that throughout I have sufficiently infused the importance and the empirical weight of the sensory. Now I want to discuss a more recent project and fold in a related theme, which is the sensory potential of materials.

The Upcycled Clinic

Here is another object, one that looks very similar to the last one I showed you, this time it’s a pair of latex surgical gloves. Perhaps you saw this image circulating in your social media feeds during the pandemic? The story behind it, so the news reported, is that nurses in a Brazilian hospital took the gloves they

were using and discarding, all that pandemic litter, and filled some with warm tap water. They then tied these bloated gloves to the wrists of patients dying of respiratory failure in the Intensive Care Unit. The nurses used them to raise the patients' temperature for oxygen readings but also described them as holding hands, comfort for individuals whose loved ones remained outside the closed off wards.

These gloves are a haunting reminder of the early days of that virus, of patients alone in hospitals around the world, surrounded by staff sweating and shuffling in layers of PPE, dealing with broken ventilators and limited supplies. I have heard the director of the World Health Organization’s COVID-19 mission describe this image of the gloves as the one she would never forget from this time.

For me, this hospital matter is an example of the kinds of material creativity which happens in hospitals every day. Foregrounded during the pandemic, such practices of repurposing have a long history in the clinic. The first dialysis machine, for example, was created in a hospital backroom in the Netherlands using old washing machine drums and sausage casings. By filling the gloves with warm water, the Brazilian nurses had seen the sensory potential of the materials, of objects that would otherwise be considered clinical waste. I would

suggest that the sensory potential of materials becomes more visible not only when we pay attention or notice such things, but also when we work *with* materials, through forms of making and tinkering, reuse and repurpose. The way we remake objects helps articulate what we think about waste, and what we think about matter. It helps move us further in the direction of a reworking or reimagining of the material conditions we inhabit, rather than take them for granted.

In a new project with a new team, we will investigate such practices of repurpose further in clinics around the world. Taking Ghana, Pakistan, India, the UK, Indonesia, Antarctica and the Netherlands as starting points, we will look at how people create from leftovers, discarded items and objects not normally deemed to have an afterlife in the hospital. We will head into busy urban hospitals, data repositories, maker spaces, polar medical units and other clinical spaces in our investigation to look at what happens under different conditions of constraint.

To understanding what is happening, we need to look beyond doctors and nurses. Only by taking into account the work of cleaners, technicians, repair workers, porters and other hospital staff, can we understand creativity happening in the hospital. This will help us understand, as Dutch Anthropologist

of the Body Annemarie points out, a more nuanced understanding of cleanliness, hygiene and waste, and moreover, to get a better grasp of how sustainability is being enacted on the ground rather than in grand vision statements on hospitals' websites or the slide decks of Green Teams. Perhaps we might get an understanding in the process of how hospital staff are also finding ways, through working creatively with matter, to deal with burn-out, the increasingly digitisation of care, bureaucratic overload and the shortcomings of healthcare systems.

One of the goals of the Upcycled Clinic project is to contribute to a move from *making more* towards *making do,* resonating with broader movements in degrowth economics that veer away from growth at all costs. When making do is highlighted and repurposing studied and shared globally, I hope that we can work towards reconsidering materials in medicine not as only single-use objects where obsolescence is pre-baked into the design, but rather as things which are incomplete.

The examples of the balloon and now the glove show some of the matter that has concerned me in my past and present work. These objects also help me show you my own matters of concern – those of sensorality, materiality and creativity. To sum up the implications of what I have presented so far, I am suggesting that attending to materials in an ethnographic style opens up and

forwards practices in education, clinical practice and sustainability. To do so I have introduced concepts which I have developed from a reanalysis of my past and present work, such as the sensory analogue and sensory potential. Now I would like to dig deeper into this ethnographic style that I have mentioned and lay out how I plan to push the boundaries of ethnographic practice further, and how this will inform my research agenda for the period ahead.

Methodological devices

And so, I would like to introduce a third object into this talk – not made of latex this time, but rather rubber and metal, with drawers and wheels: it is the hospital trolley.

This piece of hospital equipment is so mundane, so mobile, so ubiquitous that like the other objects I have mentioned so far, it often fades into the clinical background. I have come across trolleys in my fieldwork in medical schools, in operating theatres and in most of the hospital corridors in which I have hung around. Trolleys are used by volunteers to wheel around snacks to patients, by porters to move equipment, by operating theatre staff to access supplies and by cleaners to store buckets and cloths.

Unlike with many of the previous clinical objects I have presented so far, I want to explore now how it might be possible to literally *work with* matter in ethnographic research and explore the possibilities this has for investigation more broadly. In other words, I want to think about how to go about research in material terms. The insights of the STS scholar Noortje Marres and her work on devices is very helpful here.

Noortje Marres is interested in public experiments and different forms of material participation. In her work she puts devices at the centre of this activity. Taking examples such as the home smart meter, she describes these as devices of publicity, where people engage politically through material, sensory and bodily means. She highlights the need for researchers to think about different ways of intervening through devices and materials.

Could an ethnographic device be designed to interfere, to create an investigative space for reconfiguration in and of the hospital? How might it start new conversations? In his groundbreaking work on the affordances of art, the philosopher Erik Rietveld invites researchers to literally craft generative materials in our endeavours. Taking on this challenge in the context of hospitals, I would like to explore how making a trolley might, open up new research practices.

These are some preliminary sketches I have been making of one example of how to repurpose a simple hospital trolley as an ethnographic device.

Could this research-trolley be moved around the hospital, record acts of creative repurpose, to video unique techniques for example? Could it become a meeting point, where people can talk and work with materials simultaneously on its upper surfaces, shaping issues together not only through words but with their hands as well in a shared material task? Could this mundane methodological device also be an archive, containing traces of prior research conversations locally or from other places in its drawers? Could it be rolled onto different floors of the hospital, from the basement to the upper operating theatres? In doing so, could it help make visible hierarchical relations in hospitals; the material conditions of work otherwise invisible and the role of settings, technologies and constraints in the articulation of issues of concern? And at the same time, might it also be able to transgress and reimagine these relations? Might such an ethnographic trolley help mobilise communities of relevance to find their own matters of concern?

Imagination, the designer-scholar Sara Hendren reminds us, can be subtle – just merely the sense of the possible in an object, enacted by paying attention to it. Analogue and digital, adaptable and moveable, multi-modal, incomplete and

mundane; for me, this imagined repurposed trolley device offers an example of the creative possibilities for studying, relations in the hospital and for introducing ways of imagining it otherwise. As a participatory device, the trolley explores more 'diffuse' modes of invention and innovation with distributed actors, where the aim is not always to solve problems but also to ask interesting questions.

Such imagined devices also offer a material reconfiguration of how researchers engage with the field during investigations. The trolley is an example of an alternative to the tired devices we have for what is clunkily labelled as science communication. The trolley offers something vastly different from communicating about research in talks often organised on university campuses that are hardly public, and as an alternative to delivering participants' results through difficult to read information pamphlets and badly designed websites. Mediating devices like the imagined ethnographic trolley resists the idea that the issues at stake are objectively given and that communities are already formed; two fundamental mistakes made in scholarly engagement with local settings.

I believe that imagining and making material devices like the trolley could have wider implications for how to go about doing research. I want to explore this

point now in the penultimate part of my talk, to consider not only what materials are involved in research but also who is involved as well.

Public investigators

Twenty years ago, in a museum on the stormy shores of Cornwall, I nervously presented my first conference paper titled ‘The Artist as Surgical Ethnographer’. In this paper, which also became my first journal article, I argued for a broader consideration of who does the work of hospital ethnography, giving examples of artists such as Barbara Hepworth who had spent hours in surgical theatres observing surgical teams at work, making drawings and sculptures from her sketches. Here I want to return to the idea of the ethnographer outside of anthropology and develop it further.

The everyday ethnographer has prior ancestors. In science and technology studies, for example, there is the rethinking of expertise within fields of scientific knowledge production, and the recentring of users in user studies. Within medicine, social movements around patient advocacy for new treatments can be traced to the rise of HIV. In recent decades, the citizen scientist has become prominent.

Other figures close on the family tree to this everyday ethnographer are the amateur and the connoisseur. Amateurism has a bad reputation in academic circles, something to be wary of and separated from in establishing scientific rigor. Yet, what might it mean to consider the amateur a closer relation? Tim Ingold invites us to embrace the amateur, not as a figure to study, but as inspiration for doing research. For Isabelle Stengers it is the connoisseur we need to seek out. The connoisseur is someone who is not an expert in the scientifically trained sense, but who has curiosity and knowledge, who has sought out ways of understanding a topic through practices of appreciation.

I come from a long line of amateurs and connoisseurs. One grandfather was an amateur photographer, a grandmother an amateur seamstress. My upbringing was a celebration of learning new crafts and skills, not to master but always to try and experiment.

The everyday ethnographer, an ancestral relation of the amateur and connoisseur, is engaged in the same kinds of questions as the academically employed researcher, asking how do I make sense of the world, and what skills and tools do I have to do so? Everyday ethnographers have intuitive tools to work with, ways of noticing that they have learned along the way. However, just like the anthropologist and the doctor, these observers can also cultivate their skills of noticing further.

For some time now I have been developing training tools to cultivate this sensory awareness. After PhD, I expanded the sensory possibilities of the interview with Marilys Guillemin. more recently I considered fieldnote workshops in gardens with my longtime collaborator Marres. During the last years, I have been teaching The Crash Course in the Arts of Noticing to medical students and worked with a collective of primary school teachers to develop these ideas for children which we gathered in a book called *Sensory Probes*. These tools have never felt more relevant and timely with the price of our attention at a premium. The training of our arts of noticing should not be solely an individual project though. The question that I believe should underscore this work is how might we make sense of the world together?

I want to consider everyday ethnographers not as audiences for engagement activities nor as novices to be trained by academic experts; but rather, and picking up on the ideas I shared around the trolley, I want to consider everyday ethnographers as what I have come to think of as *public investigators*.

To be clear, I do not refer here to investigators of public affairs, nor to police or government officials. As a cousin of the principle investigator, the clinical

investigator and the private investigator, the public investigator shares an investigative mode but may not have an official status or expert qualifications with ‘investigator’ in their title.

What is an investigative mode? In their book *Investigative Aesthetics*, Matthew Fuller and Eyal Weizman describe the investigative mode as the combining and interpreting of clues that are out in the open. The investigative mode differs from the dominant approach to research long established in the social sciences and humanities: that of critique. Fuller and Weizman point out that a critical scholar peels through layers of representation to expose their formative forces. Investigation on the other hand assembles truth claims from a collage of fragments each holding a clue.

It involves gleaning for particles of information and seeks to render the conditions by which these facts become recognisable, engaging with the specificities of the material and opening up spaces for others to also experiment with what is being presented.

It is the capacity to rethink the status quo that I find so generative in the investigative mode. These ideas become alive in the possibilities of co-creating

methodological devices such as the upcycled trolley, for example, and in the possibility of working with public investigators.

As a concrete example of the latter, take an exhibition called *Seeing 'Normal'* that Annie Zeng, a creative public engagement programmer now based now in L.A. and an alumni of our faculty, worked on in the context of the Making Clinical Sense project here in Maastricht. For this exhibition she brought teaching and clinical matter from the medical school into a domestic gallery space, items like an illuminated eye chart and clinical textbooks.

Alongside these objects she also showcased old drafts of manuscripts from our research project with her own markings, revealing the work that goes into research and offering another route into this labour. She invited people to share stories of eyeglasses and sight. Visitors drew each other's eyes, an intimate and revealing act. With this investigation Annie showed the power of exhibition-as-research and putting research-in-progress on display for others to work with too.

In the years ahead I will continue to engage in community experiments in hospitals and other semi-public spaces, including film series, exhibitions, repair

cafes and the co-design of methodological devices with – and in – everyday settings. In doing so, I want to consider what it means to work with amateurs and connoisseurs and everyday ethnographers in our field sites.

We will work more with kids, as in these workshops we ran a few weekends ago.

I would like to do this with the purpose of developing a more prominent role for public investigation that draws from and further cultivates the core medical and anthropological concepts of observation, examination and investigation.

Such an investigative mode pushes the boundaries of ethnography. In past projects, with others, I have developed methods of team ethnography and sensory ethnography.

We made sense together through experiments in sharing fieldwork material, in modes of correspondence, and in how we created materials with those in the field. In the Upcycled Clinic, we are developing ways to bring ethnographic research in closer conversation with Open Science and the FAIR community, as

well as developing methodologies that forefront physical making with materials through hands-on workshops with hospital communities. We hope to develop resources and techniques that can be used across the study of institutions, not only the hospital. At the core of this research agenda is an academic commitment to the ethnographic style and to expanding its current scope.

Now I hope that through three clinical objects, I have shared enough tantalising details with you of what I would like to develop in the future in the context of this chair. I can summarise these ambitions simply as forwarding and cultivating careful attention to the sensory richness of the world we live in. This means attending to materials, to matter, and their capacity to inspire, provoke, disturb and surprise. It means considering our objects of study as incomplete. It means developing our arts of noticing and cultivating our imaginative capabilities. It means thinking through the social and material processes whereby public investigators can instigate and collaboratively engage with matters of concern. And it means developing new ways to share ethnographic material with others and to see where it leads.

It is with such an expanded ethnographic style that I believe we can not only better pay attention to what matters, but also collectively rethink, reconfigure and reshape our material worlds. With balloons, gloves and trolleys, I hope that today I have been able to show how attention to the details of the mundane

matter of hospitals enlivens generative thinking that is inventive and sensorially rich.

And what's that noise? Do you hear it? That faint rumbling again from the bowels of the place where we gather and teach and research; and clean and look after patients and be cared for, too. It's the pneumatic tube. Things do not vanish; they stay with us.

The tube that first appeared in a wall in a hospital in the outer suburbs of Melbourne during my first fieldwork experience has stayed with me. For I too am a public investigator. With curiosity and without academic credentials, I have followed pneumatic tube networks through stinking sewers in Stockholm and Paris, to fish farms in Canada, love hotels in Japan

factories in Germany, science museums the world over and here in Maastricht in the hospital networks in our own local hospital.

I wrote a blog about this marvellous matter when that was a thing. I was invited to join a group of retired engineers who shared articles by email; public

investigators with a common interest. One member of the group died recently, and his widow travelled thousands of kilometres to bring me some of the treasures he had collected. This means that, thanks to the help of the Philosopher of Technology Darryl Cressman, my office is now stuffed to the rafters with gold and brass pneumatic tube system parts.

Which finally brings me to reiterate the take-home message of my lecture today, more of an invitation really – which is to dare to listen to the rumblings of the world trying to make itself heard, to take time to notice its minutiae and the smallest of gestures, to engage your senses, attune with things, take the risk of being affected and to follow this all with curiosity and discernment. It's a call to carefully consider what it means to cultivate skills of noticing and not take them for granted. It's a reminder to broaden the collective with whom you are trying to understand the world, to embrace public investigators, to find more, with others.

My aim in this lecture has been to stir a good dose of purpose and possibility into my new chair and plant seeds for new conversations with my fellow academics, with hospital staff, with my neighbours and friends, and to enlist other public investigators too.

These conversations started already a year ago in the making a book of which this lecture forms a part; its essays engaging with and pushing the development of the talk. Over 30 writers have engaged with this lecture text over the last year, and the book includes so many beautiful essays which I encourage all of you to read. The book is now open access via our excellent local press, Maastricht University Press, and we are delighted to have a book launch at Tribune on 7th November with our university president and some authors saying a few words. Check out the posters around the reception for more details, and please take a look too at the book table at some of the other publications which have come out of the projects I shared with you today.

Dankwoord/acknowledgements

Which brings me to my final words of further thanks. There isn't time today to do justice to the incredible support, trust, leadership, collaboration and collegiality that has led to me standing here today. I have tried to do justice to this in the acknowledgements of the edited book with this lecture, so please take a look there at the communities with which this research agenda has arisen. Today I just want to acknowledge a few people that have helped make this event we are part of this afternoon possible.

Starting with the front row...

To my parents, John and Loraine, who I still can't believe travelled over 17 thousand kilometers from Tasmania to be here today. Your illustrations and paper-crafting are just glimpses into your humble remarkable achievements as makers of buildings, gardens, art, food, families and more.

To my husband Thomas who, within months of us knowing each other joined me in a nightime photoshoot in the hospitals where I was doing fieldwork, some of his beautiful photos in my slideshow today. And the adventures never stopped, nor the support, and the inspiration.

And to my son Bastian, almost 9 years old now, who teaches me the true art of investigation every day. Thank you for this drawing, which I still remember you doing one day when you were home sick, while I was working on my grant application and you asked what the project was about. I love your interpretation.

To my structure committee behind the chair, led by Christine Neuhold, for your guidance and support, especially Anique Hommels, an outstanding Head of Department, Peter Peters, who I have learned so much from co-teaching with, Sophie Van Hoonacker, for your belief in me and my project early on, Pim

Teunissen, for your critical engagement and insights about this chair. Thanks Jacqueline for helping think through venues, Cindy for managing the RSVPs, and Peggy at Janfre Uniforms for collaborating on this gown.

To all the co-authors of The Matter of Hospitals, especially those who have travelled to be here today - Annie, Jasmin, Nini, Tessa - and to my local colleagues, Myrthe Eussen, speaking at the book launch, Flora Lysen, for also being involved in the collaging, and Jessica Messman for the blurb. I admire you all greatly - thank you, and any other authors listening online, for helping to create something special together out of this inaugural event. And to Michel and Ruben, and your teams at Maastricht University Press and Reuring Studio, thank you for help make this beautiful book.

To the incredible researchers in the Making Clinical Sense and Upcycled Clinic projects, it is through reading and writing and doing research together that has helped me developed the ideas in this talk. I owe a great deal to you, and also the truly awesome Ethnography Group for pushing the boundaries of ethnography every month for over 10 years now. Thanks too, to all of my colleagues at FASoS, FHML and across the university - thank you for being genuinely excited about this talk and for making this one of the friendliest places in the world to work. Finally to my neighbours and knitting group and

other friends who are attending, thank you for being here, and to those watching online, in Australia, Canada and other countries, thank you for being there.

Ik heb gezegd.