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Afterword: Materialities, Care, 'Ordinary Affects', Power & Politics

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Introduction

> I think we learn to be worldly from grappling with, rather than generalizing from, the
> ordinary. I am a creature of the mud, not the sky. (Haraway 2007, p.3)

In this paper I press some of the themes of this collection for their theoretical and substantive significance.   As this volume helps illuminate, the 'stuff' of social life in medicine, social and health care does not necessarily pertain to 'innovative health technologies' or to 'scientific expertise' – but to, as Haraway is stressing in my epigraph, the *ordinary* and *the mundane*. Specifically, to understand what kinds of worlds are being made (and unmade) in health and social care requires attention to the part that mundane materials play in 'world-making' (Bourdieu 1989), the 'materialities of care'.

This collection helps to flesh out 'materialities of care' by drawing attention to, and opening up understandings of, the spatialities, temporalities and practices of care. As the papers help demonstrate there are several possible conceptual frameworks here. On the one hand there is the perspective of 'material culture' (Buse, Martin and Nettleton, this volume), which stresses how the ordinary and the mundane, the institutional, the private and the personal of how cultural life is materialised can be understood as expressive, and as displays of identity, belonging and relations.   In addition, there are 'material-semiotics' (e.g. Law 2008) approaches which draw together ethnomethodology and post-structural concerns with power and matters of interest, to offer methods for the analysis of how transformation as well as stabilities are accomplished, or not. Here with Latour (1991) sociological knowledge practices make as much room for the 'stuff' of social life – the non-human - as for talk because of how "stability and domination may be accounted for once the non-human are woven into the social fabric." (Pp.103).   And finally, the 'new materialisms' (e.g. Coole & Frost 2010) offer sensibilities for rethinking the materiality of the social in terms of how interaction between humans and non-humans is both political, contested, affective and lively. In what follows I want to distinguish 'care' as illuminated in this volume from health care systems and policy, by designating the latter as 'healthcare'.

In this paper I explore ways of thinking about material practices in terms of hierarchies of value as well as assemblages, in which strategic agendas are made present in everyday practices, with profound affects as well as effects. For example, I suggest how power can work through the association of multiple and heterogeneous materials and social processes to create 'thresholds', as spaces through which people must pass in order to be included *as* patients, and which circulate specific imaginaries over what counts as an appropriate need. I go on to suggest how some material practices are made mundane and *immaterial*, that is inconsequential, so that drawing attention to their importance in how care is done (or not done) helps disrupt the commonplace production and reproduction of the 'neglected things' (Puig de la Bellacasa 2012) of healthcare environments, and by so doing help reimagine what is important for occasions to actually be caring. Specifically, I shift to thinking about a sensibility, one that is highly valued in this collection of articles, that helps illuminate

different imaginaries of care to those that dominate heathcare environments, an approach that I have called elsewhere 'relational extension'. Relational extension is the attachment to and detachment from materials through which specific kinds of relations are done and through which world-making is accomplished, and especially how switches between extensions, or *motility*, re-accomplishes stabilities. While I have shown in my work on medicine and healthcare how this sensibility includes focussing on how entanglement in assemblages and 'motility' helps reproduce stabilities (e.g. Latimer 2004, 2013 a,b), in the example I offer here I show how shifts in extension and motility disrupts stabilities and their reproduction.

Practices & Spatialities: Making Materials Mean and the Constituting of Classes
The collection is partly about focussing on the materiality of locations, whether these be in a home, a hospital, a clinic or even museums and botanic gardens, in terms of how spaces of care are materialised in ways that produce and reproduce particular ideologies and enact strategic programs.

What is being pressed here is how practices and materials in use make up locations of care at the same time as they enable identity-work. Buse and Twigg for example, in their chapter on dressing, clothes and interactions between carers and people with dementia, show that the very ways in which dressing is enacted constitutes occasions for caring. What is being stressed here is that while the materials at stake, clothes, have symbolic currency to help perform and enact identity, and membership of a group or a culture, they are doing much more than this. On the contrary, Buse and Twigg show how meanings have to be continuously evoked, negotiated, performed, enacted, and even resisted and disputed. Moreover, they show that it is how these things are done that constitute not just an aesthetics of care, but care as felt and lived in and through such mundane practices.

Thus, how things are done is a part of how identity-work, membership and belonging are done, how dominant power relations get produced, reproduced and disrupted, and how care is lived and experienced. For example, in my early work on the assessment, diagnosis and care of older people in acute medical units (Latimer 1997a, 1999, 2000, 2004) I suggested that the bedside of care under change agendas was becoming an increasingly '*complex location*' (Robert Cooper in Spoelstra 2005): a site of organization politics, precariousness and identity-work (for patients and nurses alike) and of ordinary practices and processes of inclusion and exclusion (of types of knowledge, work and patients). I pointed to how healthcare contexts are organized by a 'constituting of classes' (Latimer 1997a, 2000; Charles-Jones et al 2003; Hillman 2008; Thomas and Latimer 2015) of not just healthcare work but of patients, and the continuous deployment of hierarchies of work, practices and patients, with mundane care and work, and the staff that give it as well as the patients that need it at the bottom. This means taking a *comparative* view of how different materials are being made to mean, a version of the ethnomethodological concept of 'indexicality' (Garfinkel 1967). That is, what materials are being made to mean and how the practices that engage them are classified partly happens through reference to and in relation to other materials and practices, including talk, and gestures. In medicine and professional healthcare practice, as I have argued elsewhere (e.g. Latimer 2000, 2011), practices such as helping an older person to wash and dress are downgraded and devalued.

By focussing on what is so often made mundane and taken for granted, such as clothes and dressing (Buse & Twigg, this volume), food and dying (Ellis, this volume); personal effects as people move into a residential setting (Lovatt, this volume); use of a home blood pressure device (Weiner &

Will, this volume) and the exchange of implements between scrub nurse and surgeon (Heath et al, this volume) research can lift the 'neglected things' of healthcare organization and practice, and disrupt the ordering that downgrades what is actually underpinning that organization and practice, as well as shaping how care is 'felt and lived' (Buse & Twigg, this volume).

Assemblage and the politics of the Threshold

Attention to the materiality of care and spaces of care can also help show how and when materials and the practices through which they are mobilised, become significant enough or valued enough to not be treated as taken for granted, or mundane. For example, Heath et al (this volume), focus on the exchange of 'commonplace things' (surgical instruments, swabs etc.) during surgery to reveal the extraordinary embodied and interactional competence and complexity involved. Here, by highlighting what is usually made so mundane as to be invisible they are able to problematize possible shifts towards deploying robotic substitutes as autonomous (and potentially cheaper) 'agents' in the delivery of surgical healthcare.

Attending to material practices thus helps to capture the complexity and heterogeneity of the commonplace. Indeed, I think that it is probably the shifting between the taken for granted and the invisibility of some material practices and when those become foregrounded, that is potentially of importance to being able to illuminate not just how power and domination work, but also when what the editors in their introduction refer to as contested imaginaries and the disrupting of relations between bodies, materials and practices can come into view. Here rather than focussing on *an* object or *a* material practice, the focus can be understood rather to be on *assemblage*, where material practices as "…assemblage implies heterogeneous, contingent, unstable, partial, and situated." (Ong & Collier, 2004: 12). A focus on assemblage not only illuminates complexity but helps to make explicit how different materials, technologies, social processes, narratives and discourses are juxtaposed and articulated, and critically what gets accomplished by these assemblages, as juxtapositions, articulations and alignments (see also Latimer 2013 a,b). For example, focussing on healthcare for refugee and migrant populations, Bell's paper (this volume) illuminates how clinical spaces, specifically a waiting area and an examination room in a US hospital, can be thought of as assemblages. The assemblage is made up of associations between architectural and material practices that manifests both discursive as well as cultural relations. Her paper explores how the specificities of the cultural and discursive world that the spatial and material practices enact, have profound power effects when they collide with global flows of people, ideas and identities.

A focus on assemblage also allows us to see how there are multiple and potentially 'competing agendas' (Latimer 1997, 2000), or 'logics' (Mol 2008), at work in how care is done. The following extract, for example, is taken from an ethnography of emergency medicine by Hillman (2008, 2014, 2015), which, like Bell's work, helps illuminate the assemblage that creates a space, or in this case a threshold:

> Following some difficulty with a mentally ill patient who had refused to leave the A&E
> department, there was a young woman with a cut on her ankle waiting to be seen by a doctor
> who the nurses believed to be a self-harmer. She has been waiting a considerable amount of
> time and had repeatedly knocked on the door to the assessment room, which added to the
> annoyance of the staff who had been ignoring her knocking. After the fourth or fifth time,
> Sister Smith opens the door and said *Look I'm with a patient at the moment. I will open the*

door when I'm ready to and not before. The young woman was clearly frustrated and responded by saying that she had been told to knock on the door by the reception staff. An hour later the patent left. (Hillman 2008, page 152)

In this extract, we see how the woman is attempting to breach and disrupt how she is being positioned by a complex assemblage, an assemblage that constructs her as at a threshold through which only some people can pass (Latimer and Munro 2017). In order to access care, she must pass from being a person in the waiting room to becoming a potential patient (see also Hillman et al 2010; White et al 2012). The assemblage consists of an association (Latour 1986) between the architecture of the waiting room, the plastic chairs in rows, notices stuck to the seat of the chair asking her to classify herself in relation to triage categories (a managerial technology for classifying people into priorities of need), the closed door, and Sister Smith the triage nurse. The woman makes an unsuccessful attempt to redistribute the authority and power of the threshold by repeatedly knocking on the door (see also Latimer 1997b). But on finally opening the door Sister Smith aligns her account - "Look I'm with a patient at the moment" - with the materialities which have already positioned the woman. This alignment allows Sister Smith to close the door on the woman seeking admittance, moving her back into the waiting room – she has not passed the threshold. In this way, social processes (accounts) and materialities (the chairs, the door, the notices) are aligned with technologies of governing (the triage system) to move the woman seeking admittance in particular ways, and defend against her attempt to breach the ways in which she is being constituted. Her attempt contests the meanings and values through which she is being held at the threshold, but it fails, so much so that she is thrown back on just waiting, and eventually walks out.

What the example illustrates is that close attention to the articulation of spatialities, material practices and social processes is how strategic technologies like triage are given presence in the ordering of the everyday life of healthcare settings such as an A&E department. Further, by paying attention to these rather mundane and ordinary events rather than the heroic work perhaps going on in the resuscitation room, Hillman is able to illuminate their 'ordinary affects'. Ordinary affects are as Kathleen Stewart describes:

a story of ..everyday life buoyed and pierced by surging affects. Its obsession is with countless points of intensity that twist and turn with the forces at work in ordinary lives: volatile imaginaries, dense materializations, and the direct excitation of the senses.. . . . . The assemblage of forces at work in the ongoing present was highly abstract and wholly concrete; it was literally constituted in the density and texture of things in their particularity: the affects, the technologies, the bodies, the events. (Stewart cited in Marcus and Saka 2006:105)

Attention to these events in A&E helps illuminate them as sites where 'the forces at work in ordinary lives' create surging affects. Rather than mundane materials we can rethink the triage notices as 'volatile imaginaries', and plastic chairs and the closed door as 'dense materialities', that have profound affects: as Hillman observes one Sister express *'doing this job will drive you mad, you end up hating the patients'* (Hillman 2008, p.148). In this case then the ordinary but profound and permeating affects that attending to the assemblages that institute the threshold in A&E are nurses becoming divided from the people who are seeking their help.

The reproduction of politico-economic ecologies and 'neglected things'

In the introduction, the editors suggest that one of the things that attention to the mundane stuff of social life helps illuminate is how politico-economic ecologies are produced and reproduced in settings involved in care and health, and in ways that 'disrupt relations between bodies and material practices'. The woman in the extract from the study of A&E presented above is being rendered as belonging to a category of patient that is unsuitable – one with a minor injury believed to be caused by herself – she is not good 'medical material' for Emergency Medical work, but is being constituted as what in Jeffrey's (1979) much earlier study of A&E practitioners figure as 'normal rubbish'.

Critically, however what we can see in this example is how strategic agendas are made present in the association of spatialities, materialities and social processes through which some people are excluded, or their needs downgraded and effaced. However, I want to press how the ways in which practitioners and patients are positioned in and by strategic agendas can lead to serious disruptions between material practices and bodies in ways that are deeply *clinically* as well as existentially problematic. In fact, I think that attention to the ordinary can help illuminate how existential and clinical efficacy are actually deeply entwined. Moreover, this is something that the papers in this volume help make explicit.

The extract that follows is from a study of dignity and older people in acute hospitals by Tadd et al (2011a&b). This study helps illuminate how agendas such as patient choice, patient safety and risk assessment are new technologies of governing that run alongside financial controls and targets to help deliver the New Public Management. The extract that follows shows how these agendas are enrolled and translated (see also Latimer 1998) in the day to day to account for and reinforce the accomplishment of particular forms of organization to the detriment of older patient's dignity:

> Annie [in bed] calls out again and Amy (HCA) goes to her.
>> Annie: 'Can I go to the toilet please?'
>> Amy: 'You've got a pad on.'
>> Annie: 'Can I have help to the toilet please?'
>> Amy: 'If you… (she sighs with frustration) you've got low pressure, when you stand up your blood pressure drops and you'll be falling' (Tadd et al 2011b, p. 100).

The authors suggest how in this example, Annie is being figured as at risk of falling, a risk that contravenes a strategic managerial agenda in the hospital regarding patient safety and falls prevention. The nurse, Amy, enrolls this agenda in her account for why Annie should use the pad she has on to go to the toilet. The risk discourse Amy is enrolling alludes to Annie having 'postural hypotension' – a condition where her blood pressure falls if a she gets up too quickly. This condition can be addressed by getting up slowly and in stages, in ways that prevent postural hypotension but which also necessarily takes time. The authors suggest that the patient safety agenda alongside the privileging of the routine of getting the meals out on time is being prioritized over the preservation of Annie's dignity. They stress "the indignity of being told to soil herself and the feelings of degradation that must naturally follow" (Hillman et al 2013: 947).

But what I want to press in this example is how there are more than managerial agendas and contested temporalities at work here. What is usually called basic care in healthcare environments, such as 'toileting patients', by being made mundane and taken for granted demotes these material practices as *immaterial* – making them into an example of Puig de la Bellacasa's "neglected things". Within this framing helping Annie to get up and eliminate in a commode or walking her to the bathroom, rather than exhorting her to use the incontinence pad, need to be reimagined as replete with multiple and complex clinical as well as affective and existential possibilities. In particular, for Annie, helping her to the lavatory or even just to a

commode by the bedside has all numerous 'speculative' (Puig de la Bellacasa 2012) possibilities for nursing. Specifically, helping Annie to go to the toilet rather than pee into the pad could:

- help keep her bladder 'trained' and prevent incontinence, while use of the pad may make her lose her bladder control;
- help to keep her drinking plenty – making her use the pad may mean she drinks less to avoid bothering the nurses or have the indignity of what amounts to a soiled nappy;
- attend to her concern to go to the toilet thereby affirming her identity as having agency and help her maintain her sense of self, even preventing her from becoming confused and disorientated, always a risk for older people in hospital;
- support her vitality by keeping her mobile (moving and getting out of bed);
- help her rehabilitate through helping her practice getting up and out of bed in a way to manage her postural hypotension.

The extract demonstrates not only how organizing and ordering are being done to privilege the temporality of the routine (getting the meals out), and the circulation of patient safety agendas (preventing Annie from falling) but also the production and reproduction of conditions of possibility through which alternative possibilities for caring for Annie seem to have been erased.

Reimagining those material practices associated with health, or dying, or just illness, that are made to seem so mundane and *immaterial* that their possible efficacy becomes invisible, helps illuminate precisely how the existential and the affective as well as the *effective* are actually deeply entangled and situated: so while they may seem commonplace or ordinary, they are not mundane. Many of the papers in this volume are exactly helping to reveal this entanglement of the existential, the affective and the clinical or therapeutic. For example, Ellis (this volume) helps make visible how food practices, that have therapeutic as well as cultural value, are also relational and entangled with family, care and dying. In her study, care emerges as material, contingent, relational, negotiated and situated practices, including the importance of 'food fights'.

Focussing on 'neglected things' – often designated by healthcare policy as 'basic caring tasks' - can involve either examining the conditions of possibility for why they are neglected, or help reconstitute them as important 'occasions' (Garfinkel and Saks 1986) for caring. This is of critical importance for helping illuminate how and when politico-economic ecologies are being produced and reproduced, as well as how consequent disruption of bodies and materialities can be made invisible. Focusing on practices of care as assemblages in which persons, social processes and things interact, can also reveal how 'neglected things' are as important occasions for care as any of the more heroic aspects of healthcare. A focus on the effects and affects of the assemblages and entanglements that help make up everyday life in healthcare 'work' can even give permission for innovative, unusual and experimental practices as ways of, as Moser (2010) puts it, changing the conditions of possibility through which care can emerge. And it is to this possibility I now turn.

Relational Extension & Motility as Care

As I have begun to show spaces of care are characterised by the association of persons and mundane, managerial and clinical *technologies* in assemblages, including how quite 'ordinary' practices and technologies can shift the world. For example, Lopez and Domenech (2009) in their study of telecare show how an older person has to *attach* to the alarm in order to wear it, and that attaching to the alarm requires them to refigure themselves as at risk, and for this to happen there has to be a shift in

their subjectivity. Thus, focussing on the specificities of how technical objects enter into and even change everyday practices helps illuminate the complex relations at stake, including sense of self. A beautiful case in point is Weiner's and Wills' study (this volume) of a blood pressure device whose clinical objective is the monitoring of blood pressure. By exploring how, when and at what moments the device is used and embedded in the home Weiner and Will demonstrate how the device 'reassembles' (Latour 2005) the family and the home, as at the same time as the meanings and uses of the device are reinscribed as much more than merely functional.

Opening up how technologies and materialities are implicated in the constitution of relations and of care relies then not just on showing how they are expressive, but how they are affective or as I have suggested elsewhere 'moving' (Latimer 2004).   Thus, what we can begin to see is how by moving materials around we do more than make manifest one set of relations rather than another: the specificities of materials and their use help to *constitute* relations of care. This is not just to say that materials act as props for a presentation of self, although as Buse and Twigg as well as Lovatt press, this is a very important aspect of the identity-work and sense of belonging and of personhood that attachment to materialities such as particular things as well as clothes and forms of dress helps accomplish. Rather it is to also press how theirs and others work in this volume reveals how the potency to (re)order relations is accomplished in *extension* with materials*.* Within this view care is an *emergent property* (or not) of how relations are being done as an effect and affect of entanglements with materials of extension.

In extension (Latimer 1997b, 1999, 2001, 2004; 2007a; 2007b; 2013; Latimer and Munro, 2006, 2009; Munro 1996; Strathern 1991), persons are figured as attaching *and* detaching themselves (or others) to and from materials in ways which have potency.   What I have shown in my work is how in everyday life in many different settings there are endless *shifts* in extension that can constitute not just potent moves, but also help balance, stabilise or even disrupt the multiple agendas that make up the ordering of healthcare and which position patients and practitioners alike. I have, with Rolland Munro, called this switching between different cultural materials '*motility'* (e.g. Latimer 2013a; Thomas and Latimer 2015).

What I want to point to now is how motility in healthcare practices can be done as itself a form of care – care that is an affect, or emergent property of interaction and relations (see also Latimer & Puig de la Bellacasa 2013). Within this perspective care is not a thing or a task, as in the construction of healthcare policy and organization, something to be provided or delivered. In addition, it is never only 'things', the prosthetics of extension, that are switched. What are simultaneously moved around are 'attachments' in that other sense of the word of 'attachment', as affective and affecting.

Here I draw on the example that I worked up in a paper on care and the art of dwelling (Latimer 2011) to illustrate how switches in extension with ordinary materials have profound implications for care in the context of easily neglected practices and people, such as Annie discussed above. Here I am drawing on my analysis of the book (Bauby 1997) and the film (Schnabel 2007) *The Diving Bell and the Butterfly* to exemplify motility and how care as an emergent property of shifts in extension is an affect of 'moving the world' (Latour 1993). The subject of the film, Jean-Dominique Bauby (Jean-Do), is a man who is a) young, and b) relatively famous (he was the founding editor of *Elle* magazine). I want to explore what this film helps illustrate about motility, shifts in extension,

technology, neglected things and care. Within this perspective care is an emergent property of how materials in association with social processes can help reassemble subjectivities as well as relations.

Our protagonist, Jean-do, has a massive mid-brain stroke at the age of 43. He seems to be locked-in – like a deep-sea diver at the bottom of the murky ocean in his metal diving suit. While he can think and imagine, his motor neurone system is shut off from his brain, and he is totally paralysed except for being able to blink one eye, breathe and swallow. He seems to be without expectation or hope. He can think and he can replay memories in his mind, but he cannot tell anyone what he wants nor can he interact with them in any of the usual ways, for example his face's expression is fixed. In the film, we often live in his perspective, looking out at the world as he does, including visualising and replaying his memories with him. In a sense we are positioned in his auto-biographical perspective, but this perspective shifts to become distributed.

We join Jean-Do at the moment when he is moved from the acute, high dependency unit that has 'saved his life' to a long-term care and rehabilitation facility, and one would think in terms of the constituting of classes in medicine, from the heroic to the mundane. Through his imagination, his memories and his reactions we learn that he was the antithesis of everything he is now: rich, cool, a playboy, fit, active, at the heart of the Parisian fashion world with its emphasis on looks and aesthetics, a prototype of the *belle monde* in early '90s France. He and his life as it emerges through his reflections and memories is the apotheosis of liquid life politics (Bauman 2003): lifestyle, consumption, choice, mobility, money, style, and the disposability of relationships. How he seems now is its anti-thesis: he is stranded, in the arms and at the mercy of others, monstrous and incapacitated, imprisoned in the routines and repetitions dictated by his needs. He is left to reflect, *all day long*, as an-Other to the image of his past self to which he is still attached.

The film shows him with family and with staff in a painstaking effort to build a life in the wreck. But this life becomes for all involved much more than the provision of mere existence. There are terrifying moments, such as when with him the audience experiences the eyelids of the eye that can no longer blink being sutured together by an insensitive surgeon jovially recounting his marvellous skiing holiday, evoking the glamorous, invigorating world of snow and speed and light that Jean-Do himself has enjoyed in the past but which he is now excluded from. There are also extraordinarily humorous moments, such as when Jean-Do is watching his football team on the TV about to score the winning goal and a care assistant turns the set off – and he cannot protest.

But what the film shows us is how Jean-Do detaches from his past self – and all the materialities through which that self was enacted and performed. This detachment entails a shifting of worlds: a shifting between a world that is rooted through self, choice, and face, and something else, something that stresses how agency as well as world-making are relational. Specifically, people try to give him 'face' and 'agency' by checking what Jean-Do wants, giving him choice and information: blink once for yes, and twice for no; 'Do you want to see your children?' – two blinks – 'No'. And so on and so forth, but this cannot completely work: for him to have a life there has to be more. Then there is a sequence in the film in which we see Jean-Do turned over. Specifically, a shift occurs, a moment of motility, through which he is moved to detach from one form of world-making and to attach to another.

At the beginning of this sequence, the speech therapist (Henriette) arrives with her new technology. Henriette has told Jean-Do previously that this is for her the most important case she has ever had, and that she is determined to make a success of it. Henriette has made a technology

that is an alphabet etched in white letters on a black card and in the order in which letters most commonly appear (in French). So, this is, compared to the machines that have saved Jean-Do's life, quite an ordinary technology. She and Jean-Do try it: Henriette speaks each letter in its turn in this special order and when she reaches the right letter Jean-Do has to blink. In this way, she says, they can build *words* together so that he can communicate. They try it out but it is very hard for him to concentrate and she goes too fast: it all seems unnatural to him – it has none of the slickness, fluidity and speed of his previous life as he remembers it. She tells him he must think ahead before the next session about what it is that he wants to say to her.

After some disastrous interactions with his wife and others, we see Jean-Do in the next session with Henriette when he painfully, letter by letter, blink by blink, spells out the words "I want to die". As he blinks each letter into being it is vocalised by the therapist – i, w, a, n and so on. All the emotion that Henriette feels as she realises with horror what he is trying to express 'cathects' (Goffman 1955) her face – and of course we are seeing her face, and its meaning, as Jean-Do sees it, as a portrait of intense emotion, distress and agitation. He is after all refusing to attach to her extension, an extension which is about building a world in the ruins of his life.

Henriette then tells him that what he is saying is 'obscene'. She says she has only known him a short time but that she already loves him, and that none of it (the situation?) is just about him. Hastily she gets up and leaves the room, shutting the door. We sit with him looking at the closed door in silence. We and Jean-Do and Henriette are at another threshold.

Henriette then walks back through the door, walks back over to stand in front of him and apologises. The next shot cuts to the two of them huddled together working with the alphabet: we are seeing them from our own perspective – not Jean-Do's. From this moment on in the film Bauby, his friends, his family and colleagues, are all seen working with Henriette's alphabet card - through attaching themselves to the alphabet technology they make relations and build not just words but a world together, one in which Jean-Do himself is a vital and lively participant.

At first Jean-Do will not attach himself to the speech therapist's technology. In refusing the extension that the technology offers, he seems at first to be making a choice and asserting his self, refusing the world and the refiguring of his identity that the technology brings with it. When he attaches to the technology and expresses all that he feels there is a moment in which he and Henriette are at first in division, on opposite sides like the nurse and patient in Hillman's study discussed above. It is a shocking moment because it reveals that he and his care is as much about Henriette's life as his. Jean-Do is shocked – it is as if he has never been in a world like this before. Henriette is also deeply shocked and for a moment ashamed. They are at a threshold. Both Jean-Do and Henriette are not just turned around, they are turned over (Munro and Belova 2009). This is a moment of motility – a shift in extension that shifts the world. Even Jean-Do's memories change, he no longer keeps remembering himself as as a playboy of the Western world, but in mundane and ordinary moments of connection and relationality, such as when he helps shave his old and lonely father. What gets revealed in taking this shift in extension seriously is not healthcare as a world of provision and delivery, but of care as an emergent property of complex interactions between bodies, persons and things, of affect and relationality. They of course go on to perfect the technology, and Jean-Do goes on to blink his book (Bauby 1997) into being before he dies, the book upon which the film is based, a book that is actually co-produced in ways that disrupt the very figure of the author as an individual.

The moment of movement in the film in which a different world comes into play is when there are switches in extension, a moment of motility that switches from healthcare as about mere existence to the possibility of care as an emergent property of interactions between persons, technologies and social processes that put them in alignment. How different then from the assemblages which position Annie and Amy, or the Sister in A&E and her patients in the waiting room, as on different sides.

Concluding Remarks

'Materialities of Care' helps illuminate how spaces, temporalities and material practices associated with health and care can be thought of as political, affective and world-making. Here a focus on mundane and often invisible materialities and practices help illuminate ordinary affects, as well as potent effects, that counter and disrupt the dominant modes of ordering that position some practices as valuable and others as *immaterial*.

Here I explored how the effects of these practices can be illuminated to show their profound if ordinary affects, such as the ways in which they position patients and staff alike in competing agendas and in ways that can divide them from each other. I focussed on political-ecologies as assemblages, both those assemblages that produce and reproduce dominant relations of power, as well as those assemblages that help disrupt these dominant relations.

I have suggested that a focus on what is (being made) mundane can illuminate materialities of care for what they help accomplish. Here care emerges as situated and emergent, 'in between' the gathering of persons and multiple accounts, the assemblage of materials and processes of negotiation. Materialities of care associate people as embodied persons and *things* in ways that hold practitioners, patients and their families in 'the fold of the human' (Latimer 2013a) as agentic subjects (Moser 2010). Like Winance (2010) many authors in this volume have helped show how a different 'conception of care' can also begin to emerge in terms of "shared work, dispersed in 'a collective of humans and non-humans' (Callon & Law, 1995)" (Winance, 2010).

Materials can be thought of as relational extension, and in terms of attachment and detachment. One way of exploring this is through the notion that shifts in extension represent motility, a perspective in which such shifts can move the world, and create the conditions of possibility through which practitioners and patients alike are participant in world making, and through which care becomes an emergent property of their alignment not their division.

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