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The Hospital Multiple: Introduction

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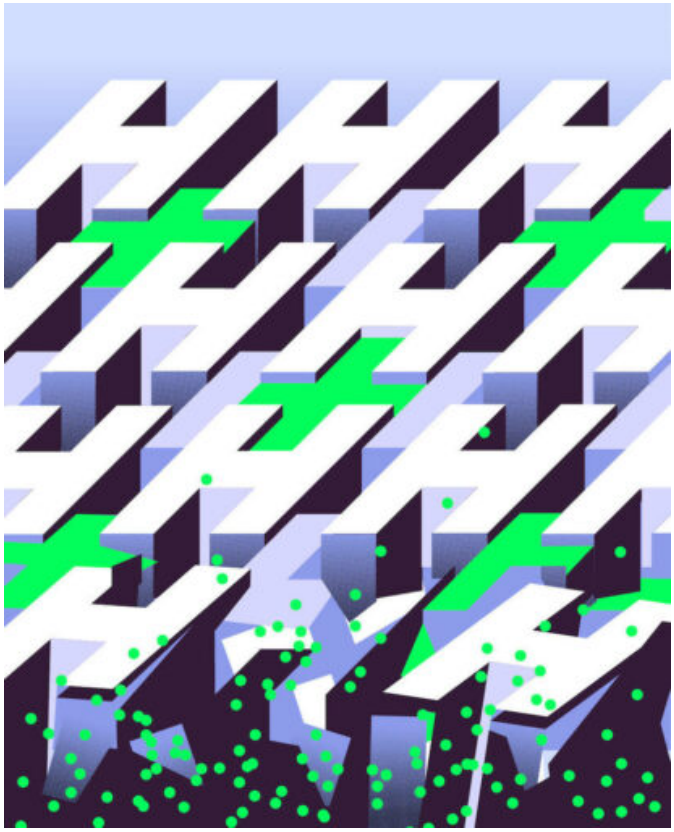

Since COVID-19 has come to haunt the globe, hospitals in all their guises have featured centrally in the pandemic response. As the flagships of health systems, hospitals have rapidly become the primary locus of medical care for COVID-19. They provide staff and beds for acute medical care; they can be rapidly deployed in the form of military field hospitals, mobile tents and impromptu mass-treatment centers; and their level of occupation is used as a measure of pandemic severity. In many respects, COVID-19 has reaffirmed the power and centrality that hospitals hold in health systems worldwide.

Nowhere did this become clearer than in China, when, at the end of January 2020, two makeshift coronavirus hospitals were built in the city of Wuhan in record time (8–10 days).[1] Military health personnel, as well as nurses and doctors from around the country, were sent to these temporary structures, and supplies were airlifted in by the Chinese army. This astonishing deployment of medical power, which responded to an emergent virus within days, impressed the world. Around the same time,

Southern European hospitals began to fill with COVID-19 patients. As hospitals became overwhelmed with large numbers of very sick people, Italy, Spain and France also constructed makeshift infrastructures. These "field hospitals" came in several forms: huge, repurposed buildings, like Madrid's IFEMA "emergency hospital," built in the vast halls of the city's exhibition center; as well as smaller, mobile tents and inflatable clinics like the Mulhouse field hospital in France. Such hospitals provided a highly technologized response to the pandemic through the flexible deployment of temporary staff, as well as ventilators and resuscitation units. In other regions of the world, temporary treatment units were installed in anticipation and for the purposes of triage, even before the first COVID-19 cases were diagnosed.[2]

Irrespective of their form – permanent or temporary, big or small – hospitals provide acute and life-saving treatment for the sick. Hospitals are widely associated with professional labor and engagement in technologized environments; yet, concerns that hospitals would collapse under the unprecedented demands of the pandemic drove the drastic sanitary and security measures that many countries are imposing once again. While governments suddenly made huge amounts of public funds available for saving the economy, hospitals were struggling after decades of austerity and structural adjustment policies had left them drained of personnel, equipment and beds. COVID-19 emerged at a time when, in Southern European countries such as France and Spain, important social movements in defense of public health were under way; the pandemic interrupted mass-mobilization while also fueling continued reflection on the gradual degradation of working conditions and quality of care in public hospitals due to under-staffing and under-financing.[3]

We came up with the idea for this series, "The Hospital Multiple," last spring, in the midst of the emerging coronavirus pandemic. As it became clear that hospitals would be the mainstay of the COVID-19 response, we sought to understand their power, attraction, infrastructure, cost, and significance as medical institutions. But we also wanted to explore the possibilities of grasping hospitals otherwise. In this series, we go beyond a simplistic vision of hospitals as institutions for medical emergencies. Rather, we open a conversation on the multiple and diverse ways that hospitals are positioned in particular contexts all over the world. While hospitals are critical sites for medical treatment and care, they are also public infrastructures drained by austerity where triage takes place; spaces of local ingenuity and improvisation; and places of fear, infection and death, of solitude and uncare; of sickness and healing; of waste and speculation.

History, sociology and anthropology have long provided rich insights into hospitals as sites of professional interactions, and as frontiers for clinical

practice, biomedical innovation and pharmaceutical development (Van der Geest & Finkler 2004; Livingston 2012; Fortin & Knotova 2013; Kehr & Chabrol 2018). More recently, studies on the politics of healthcare rationalization, "new public management," and public–private partnerships have shown the intensity of economization and financialization of these highly managed organizations (Lefebvre 2007; Çal??kan & Callon 2009; Belorgey 2010; Hull 2012; Otremba, Berland & Amon 2015; Juven 2016; Hunter & Murray 2019). Nourished by anthropological approaches to hospitals as "affective infrastructures" (Street 2012), "haunted" sites (Varley & Varma 2018) and places "as such" with specific politics, properties and forms of production (Kehr & Chabrol 2018), in this series, we open up a renewed anthropological conversation on hospitals, viewing them not only in their historical thickness and affective materiality, but also in their geopolitical situatedness and mundane everydayness.

The Hospital Multiple

There is much more to hospitals than the practice of medicine. Hospitals have kitchens, laundries and cafeterias. Hospitals are buildings, situated in neighborhoods, where different communities meet. Hospitals have fences and security services, surveillance cameras and guidance schemes, parks and parking spaces. Hospitals are equipped with waste-management systems and logistics departments with well-defined protocols for the entry and exit of people and things. Hospitals are dusty places and sterilized locations. They are warm and cold, labyrinthine and intimate. They have histories that haunt the present. That is, hospitals are *multiple*.

Multiplicity, in Deleuzian terms, means being "in constant flux", though attaining "some consistency for a short or long duration" (Tampio 2010, 912). Multiplicity is characterized by "porous boundaries … defined provisionally by its variations and dimensions" (*ibid*.). Multiplicity, in other words, connotes a fluid assemblage of solid matter and consistent ideas that nevertheless cannot be pinned down to a singular form. Assemblages vary in space and time, and take on different shapes and meanings depending on perspective, interpretative angle and conceptual framing. Seeing a hospital through the eyes of a cleaner will not reveal the same dimensions as seeing it through the eyes of a nurse; following food in the hospital will reveal different aspects of care and uncare than following ventilators; approaching hospitals as places of scientific research will disclose other meanings than investigating them as places of precarious migrant labor or as public buildings in need of constant maintenance, rebuilding and repair or as production sites of medical garbage.

An anthropology of *the hospital multiple*, as we understand it, consciously unwraps all these different, more-than-medical aspects that are folded into

hospital spaces, so as to render our thinking about hospitals more nuanced and open to non-medical dimensions, be these economic, political, architectural, infrastructural, military, metabolic or sensorial. An anthropology of the hospital multiple thereby unfolds hospitals' contradictions without the need to resolve or disambiguate them. Attending to hospitals "as such" – that is, to hospitals as they are diversely built, inhabited, maintained, worked in, transformed, destroyed, closed, imagined, experienced or judged by different people and their realities – demands, in short, a "multiplicity of approaches, theoretical moves and countermoves, an array of interpretive angles" (Biehl & Locke 2010, 347). This is our aim for the forthcoming series. Rather than giving answers to the question of what hospitals *are*, we invite consideration of hospitals as truly multiple places that always already transcend the medical realm.

Each of the forthcoming ethnographic contributions to our series focuses on a different hospital, its emplacement and tensions, thereby revealing what gives particular hospitals their ambivalent specificity while also reflecting on what that can tell us about hospitals as such. Livia Garofalo beautifully describes "wounded attachments" that afflict public hospitals all over the world; she uses the example of the National Hospital in Buenos Aires, where "idealism and disappointment, precious marble and no soap, clinical histories and histories of torture, desire and what is left to be desired, live side by side". Frances Williams leads us into St. Thomas's Hospital in London, where she describes how political specters of the past encounter the current anti-austerity mobilizations of artists and staff; "Tommies", as it is called by Londoners, thus becomes "a continued project of welfare state deconstruction, disguised as one of national recovery", a statement that resonates far beyond the United Kingdom (Juven, Pierru & Vincent 2019; Kehr 2019; Chabrol 2018b). In her sensory ethnography, Gabriela Elisa Morales movingly captures clinical atmospheres in a windy hospital in the Bolivian highlands, in which cultural politics of warmth and recognition as well as medical "benevolence can sometimes slip into violence"; this makes the Andean hospital a prime site for what Lisa Stevenson[4] has shown to be a foundational ambivalence that plays out in any form of care in the post-colony. Nora Wuttke uses ethnography and drawing to depict issues of everyday maintenance and waste in a tertiary care hospital in Myanmar, vividly showing the extent to which always already outdated clinical infrastructures should not only be seen as "investments (with an eye on short term returns) but as insurances" that need to be laboriously maintained in the everyday. Katharina Rynkiewich takes us into an infectious disease ward of a public hospital in the American Midwest, where new diseases like COVID-19 "get folded in … temporal continuations", making this particular hospital "a troubling picture of the relationship between infectious diseases, medical care, and racism"; her

analysis has far-reaching resonances well beyond the US (Varley & Varma 2018; Kehr 2018; Chabrol 2018b). Laura Burke writes about a “hospital without people” in Timor-Leste. The “calm and quiet” that Burke sketches might provoke longings for pause in times of COVID-19, but Burke reminds us that this calm is also a sign that biomedical “visions” have neither been fully realized nor accessible to everybody; this leads to a situation in which people don’t want to go to the hospital, or simply can’t afford to go. Sugandh Gupta takes us to a mental health hospital in Jammu and Kashmir, where medicine and the military cooperate under conditions of occupation (see also Varma 2020); here, in the context of the clinic, “occupation” is understood as a signifier of political and epidemic processes at the same time. Taking us to Madrid, Janina Kehr writes about an unfinished pandemic hospital that is currently being built in the Spanish capital with tons of concrete at a cost of over 50 million euros; Kehr thereby shows that hospitals are not only places of medical care, but also “spectacular infrastructures” where spectacle and speculation are rendered possible through specific affective, economic and legal regimes. In Niamey (Niger), Fanny Chabrol analyses the new Hôpital Général de Référence, built and funded by China as a geopolitical and social project set up to become a model not only in terms of medicine, but also in terms of what kind of society is imagined and desired by some – ordered, militarized and highly organized.

In the best ethnographic tradition, the contributions each focus on a specific place, giving a dense anthropological picture of hospitals as such: where intimacy and the easing of pain encounter violence and exclusion; where issues of laborious everyday maintenance might be covered up by spectacles of care; where militarization and community investment are met with cooperation as well as resistance; where being cold, or lost, or feeling disgust are as crucial to consider as feelings of comfort and shelter; where shiny investments cannot fully gloss over the crumbling walls and staff weariness caused by decades of austerity and structural adjustment policies. Existing hospitals are haunted by conflicting pasts, as Garofalo, Williams, Morales, Rynkiewich, Burke and Gupta show, while the construction of new hospitals comes with multiple future-oriented aspirations, promises and expectations, as Wuttke, Kehr and Chabrol argue. The latter show how far hospitals and hospital construction projects are “speculative infrastructures”, an idea that to date has been insufficiently addressed in anthropology.

Hospital Speculations

New and planned hospitals are sites of speculation regarding medical futures and markets. For emerging powers like India, China, Turkey or South Arabia, recently built hospitals in the African continent both represent important geopolitical terrains (Chabrol, Albert & Ridde 2019)

and constitute new markets as well as sites of experimentation with medical training or digital medicine (Duclos 2020). As such, hospitals already are and increasingly will be an intrinsic part of economic and geopolitical investments and powerplays in the field of global health. Novel hospital projects are quite literally built on the speculative terrains of medical, technical and infrastructural promises, through tenders and contracts, urban transformation and land adjudication, and large-scale investments in energy-consuming "digital solutions" that pledge to augment quality of care. Hospital architecture strongly evokes such forms of care and hospitality (Street 2012; Geenen & De Nys-Ketels 2018), thereby reflecting visions of health systems and their political-economic forces, which are concretely built into hospitals themselves (Jones 2018). In contrast, the public hospital as loved and hated figure, long criticized for its lack of efficiency, is fading away under the image of clean and technical "hospitals of the future." Such hospitals of the future promise to "embed new technologies into their design and operations to improve the customer experience, as well as outcomes and costs" and their promoters make assurances that "technology and data will be pervasive and transform care delivery models." Big international consulting firms like McKinsey and Deloitte push these "smart hospitals" or "digital hospitals", presenting them as a "solution" for adaptable, individualized and optimized care pathways, centered around the best possible "patient experience." The hospital of the future is presented as intelligent, because digitalization is said to reduce costs and enable organizational rationalization, performance and efficiency.

The COVID-19 pandemic has reinforced a vision of hospitals as merely medical infrastructures of high-tech care, which culminates in the image of a smart hospital of the future. Conceptual ethnographic accounts that broaden and critically question this image are more necessary than ever in order to bring forth hospitals' multiplicity, historicity, messiness and socio-technical contradictions. While the COVID-19 pandemic has rendered the image of hospitals as solutions for health problems even more powerful and unquestioned, it has also shown the fragility, overwhelmedness and chronic strain of these institutions, aggravated by decades of outsourcing and austerity policies that have left many of them drained of personnel, maintenance and means. COVID-19 has also shown that "hospitals can sometimes be dangerous places, and not a resource to use lightly" (Johansson & Heath 2020), where the meaning of care is constantly redefined, and oftentimes deeply "in trouble" (Duclos & Criado 2020).

More than a decade ago, Naomi Klein demonstrated how disaster recovery coincided with an acceleration of privatization and exclusions in the aftermath of Hurricane Katrina; Klein termed this process "disaster capitalism" (2007). When Charity Hospital in New Orleans, a site

emblematic of public service, closed in 2005, right after the hurricane, it was replaced by a private, “state of the art” hospital to which local inhabitants had limited access (Lovell 2011; Ott 2012; Chabrol 2018a). Will future hospital projects be further instantiations of such disaster capitalism? What is currently happening in Madrid hints in this direction, as the costs of the new “pandemic hospital”, built by global enterprises and paid for by public funds, have doubled during construction. Madrid’s pandemic hospital is on the brink of being opened with no plans for the recruitment of permanent medical staff. As anthropologists, we need to investigate the extent to which the building of new hospitals gestures towards much larger economic and political transformations of health systems, not forgetting that hospitals in particular and medicine in general have been intrinsically linked to speculative (disaster) capitalism for decades (Kehr, Dilger & Eeuwijk 2018).

Anthropological scholarship that deals with capital speculation, be it within medical anthropology (Sunder Rajan 2005; Peterson 2014; Duclos 2020) or beyond (Bear 2020; Humphrey 2020; Leins 2020; Núñez 2017), is thus central to understanding current and future hospitals as multiply economized and increasingly technologized sites. But thinking hospitals in terms of “a speculative ethics” is as important, given the long-standing significance of socio-technological assemblages in the realm of hospitals, of which the “smart hospital” might only be the latest actualization. Thinking hospitals in this way allows for another facet of speculation that, as María Puig de la Bellacasa reminds us, is “a speculative commitment to think about how things could be different if they generated care” (Puig de la Bellacasa 2017, 60). Hospitals have always also been places of care. That the smart hospital of the future is characteristic of speculative capital and its technological manifestations does not preclude that novel assemblages of care will take place within it. Seeing hospitals as sites where multiple forms of speculation occur opens up a vast field of ethnographic investigation beyond medical wards, in which it remains to be seen what the hospital of the future is or could be.

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Notes

[1] According to Chinese sources, construction of Huoshenshan hospital was announced by the Wuhan government on January 23rd, and construction began on January 25th; work was completed on February 2nd; on February 3rd, the installation was tested and on February 4, at 9:30 a.m., the hospital began receiving COVID patients (see https://en.wikipedia.org/wiki/Huoshenshan_Hospital). For Leishenshan hospital, construction was announced by the Wuhan government on January 25th and construction began on January 26th; work was completed on February 6th; on February 8th, the hospital began receiving COVID patients (https://en.wikipedia.org/wiki/Leishenshan_Hospital).

[2] For example, following the 2014 Ebola outbreak, many African countries mastered the rapid deployment of such hospitals in the form of mobile tents.

[3] In spring 2020, while the military or police patrolled the streets at night to enforce severe lockdown measures, people in several European countries applauded hospital staff every evening to show their solidarity with healthcare workers, many of whom were particularly hard hit by the pandemic. Just as hospitals lacked staff and beds, these celebrated health professionals lacked basic protective equipment.

[4] Stevenson, Lisa. *Postcolonial Theory and Psychological Anthropology*, 2015. https://vimeo.com/showcase/3666358/video/145944193

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