Drawing, Writing, Buildings: An Ethnography of Yangon General Hospital

Nora Wuttke

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Department of Anthropology and Sociology

SOAS, University of London

Content

Abstract

How to write about, represent in text, an institution like a public hospital? As with many anthropological subjects, the hospital is large and complex, and never usually seen or understood as a whole. This thesis takes up this challenge, proposing an ethnography with buildings.

By presenting an ethnographic study of Myanmar's main public tertiary care teaching hospital through drawing and writing buildings, this thesis proposes a holistic engagement with the hospital's daily life; a commitment to "the hospital multiple", a term borrowed from the *Somatosphere* series of the same name (Chabrol & Kehr 2020), while building conceptually on Annemarie Mol's *Body Multiple* (2002).

This thesis is an ethnographic study of the daily life of Yangon General Hospital by way of its buildings, materials, and practices that constitute a hospital. In this, turning my attention to (often unnoticed) "spaces in-between", located between buildings and bailiwicks, the thesis offers original insights into the flows of social interaction these spaces accommodate, and are essential for healthcare.

In this regard, I am re-evaluating how we understand hospitals, large and complex public institutions, by conceptualising buildings/hospitals through drawing and writing.

Experimenting with different lines on paper, drawings and text, I attempt to capture the hospital as a whole and in its parts, making a novel methodological and epistemological contribution to the idea of writing *with*, and alongside, buildings. I situate this task adjacent to discussions on "writing culture," "women writing culture", "writing society", and "writing lives"; questions of how to write anthropologically. How to write ethnography in today's world.

The challenge here is to explore what is gained by looking at a hospital from the point of view of its buildings. This question inhabits the space between architectural practice, ways of seeing, and the anthropological craft of ethnographic narrative that all come together in this dissertation.

Acknowledgements

With all its complexities and complications, I loved to draw and write this thesis with Yangon General Hospital. My utmost gratitude goes to the hospital, its buildings, leaking pipes, unruly nature, walkways, stairs, and especially its inhabitants, present and past. Thank you, to every individual who helped me understand the hospital better; every administrator who took time out of their busy day, every clinician who showed me their department, every worker who allowed this strange foreigner to follow them around with sketchbooks and pens. Thank you, to everyone on and around campus who approached me and my drawings with curiosity and an open mind.

Drawing, to me, is about relationships of bodies in space, between people, and to places. This research was a stimulating experience, an experiment in thinking with my hands through different lines on paper, in drawings and text.

I am thankful to my supervisors, Professor Edward Simpson and Doctor Elizabeth Hull, who gave me their unwavering support in this methodological experiment. I am grateful to Ed for making me SOAS's Anthropology's department's first artist in residence; an appointment that, through teaching and generous conversations with colleagues, ultimately helped me to shape, and sharpen, my thoughts on art, artful-ethnography, and drawing as ethnographic process; a multi-modal avenue I am excited to pursue further.

Thanks go also to Professor Than Pale, my local advisor based, at the time, at Yangon University. Her generous invitation to teach a series of seminars in the Anthropology department were the beginning of my journey as a teacher. Our lunches inspired me, and helped me to unpuzzle many aspects of Myanmar's public institutions. Much gratitude goes to my translator, Maung Day, a contemporary artist and poet. Our conversations were invaluable.

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Towards the end of this journey, SOAS's doctoral school and estates team was instrumental in helping me to realise *Hospital Echoes*, a spatial installation based on my fieldwork sketches, in Bloomsbury. I hope I can develop this artwork further and bring it to Yangon where it belongs.

INTRODUCTION

"WHAT ARE YOU DRAWING?"

A bunch of young monks sprawl over the railing of what seems to be a newly built multi-storey dormitory. The railings glint in the low late afternoon sun. It is a Wednesday in November, Yangon's cold season, with temperatures around 25°C. Equipped with my sketchbooks and pens, I had ventured into the tight alleyways of Thayettaw Monastery complex, a collection of over sixty monasteries immediately West of Yangon General Hospital. Some of the monks spy me, then more and more appear on the verandas. What is this foreigner doing here, drawing of all things? Before anybody can start talking to me, I quickly turn away onto tidy tarmacked paths, bounded by the backs of buildings or high walls. While walking, I sketch the ground plan; open space and streets I shade black, the built area remains white. I stop to draw a roof detail of one of the old teak buildings.

My attention turns towards the allies' vistas; Yangon General Hospital's red roofs and domed turrets are visible in the background, beyond the low 1960s concrete structure that is the A&E. A woman with short black hair wearing a longji[1] and a blouse is heading straight for me. With bright eyes, she eyes the lines on my page and hurls questions at me; where I am from, why I am drawing here, what I am doing? I am uncomfortable, wondering what this stranger wants from me. I cannot hide so I stretch my Burmese skills to its limits. Researching the daily life of Yangon General Hospital piques her interest, she starts talking. Her sister is an ambulatory patient at YGH, they are staying at one of the monasteries, while she receives radiotherapy treatment; every weekday for three weeks, twenty-five in total, the sister spends her days in the hospital's shaded waiting areas for her few minutes of radiation. They come from Bago, approximate 90km north-east of Yangon, where the

[1] Burmese leg dress, worn by all genders.

public hospital does not offer radiotherapy. Aunty Aung and her sister go home every weekend, leaving Friday afternoon, returning Monday at the crack of dawn. They make the two-hour bus journey from the highway bus station, a good hour from downtown Yangon where we are. She begs me along to meet her sister. I get nervous, an unexplainable fear takes hold of me, but I go along. As we stand in front of the two-storey building where her sister is waiting for Aunty Aung to return with rice for dinner, shoes lined up neatly at the door, I bail out. I excuse myself with having to cook dinner, after all it is nearly 6 p.m. Her piercing eyes show her disappointment, she invites me to visit any other time. As I turn away, I immediately regret it. It will take me the rest of the week to muster the courage to return, but I will. I come every day of the following week, sit and chat, one day I bring Kaung Htin, my trusted translator. Aunty Aung is a devoted Buddhist. While her sister waits for her daily dose of radiation at the hospital next door, Aunty Aung spends her days praying, meditating, and reading the Buddha's teachings, between getting breakfast, fetching rice for dinner, and washing clothes in the bathrooms behind the dormitory. It is not Aunty Aung's first time at YGH. She has accompanied more than one family member before. As an unmarried woman she is a good attendant, compassionate company for a distraught outpatient undergoing treatment, a vigilant bedside carer for an inpatient. She knows the hospital's ebbs and flows; a wonderful interlocutor who offered me my first glimpse of the details of daily life between the hospital's buildings, treatments, rhythms, and institutional routines, whom I would never have met had it not been for my drawing practice.

The Vignette of Auntie Aung leads us into the thesis, into Yangon, the hospital, and my engagement and methodology. While visiting Thayettaw for the first time I am no stranger to Yangon. In "Five years of hope" we learn about the country's hopefulness from 2015 to 2020, the research, and my work at YGH; we get a glimpse of the hospital, of Myanmar, my identity as trained architect and social anthropologist, my unique way of seeing the world as an architectural designer that led to

"Writing a Hospital" and my particular questions, which are underpinned by the "Literature Review". Here I set out my intellectual kinships and develop my questions.

"Fieldwork" follows from the literature review as the literature raises the question of methods. I set out what I did, how I got access, and my drawing practice as ethnographic process. "Making sense of the Fieldsite" presents the facts and figures of the hospital and delivers the focus of the thesis (infrastructure and the built environment). With this we are sent into the chapters; the "Chapter Summary" gives a brief overview of what is to come in the following pages.

FIVE YEARS OF HOPE

When I arrived at Yangon General Hospital in 2019 for a year of ethnographic fieldwork where I would meet Aunty Aung, I was no newcomer to the campus. In fact, I was called an "oldie" by interlocutors. In my role as architect for the hospital's Rejuvenation Project since 2015, I had been on campus longer than some of the administrators I was talking to. They would often joke, that I could probably impart more institutional knowledge to them than the other way around.

I first arrived in Yangon in July 2015 from Shanghai, where I had left what some might consider a "dream job" with one of my favourite architectural offices, David Chipperfield Architects, in favour of working on the renovation Yangon General Hospital's main building, a colonial brick structure from the turn of the last century; a past materially converging with present hospital bodies and buildings, and their future aspirations.

"… and whatever I do will become forever what I've done"

It is four months ahead of Myanmar's first "free and fair" elections in which Daw Aung San Suu Kyi's National League for Democracy (NLD) is going to win with a landslide. It is a time of hope for a better future. The above line from poet Winslawa Szymborska's *Life while You Wait* is on my mind.

My diary from that time reads like an ode to Yangon, my new "magical" home, "full of old buildings and relaxed life", "people [who] smile back", a "not loud and pretty clean" city.[2] A perception shaped (maybe skewed) by years of a brutal love-hate-relationship with Shanghai.

In these first few days writing my diary in Myanmar, I knew little of how this perception would evolve over the years to come, become more nuanced and intimate. How my position would shift: from architect for the rejuvenation of the hospital, renovating the main building; to developing a masterplan for the entire hospital site; to ethnographic researcher on campus; to an anthropologist writing about a hospital *with* its buildings, about the hospital's rhythms, moods, atmospheres, people, buildings, spaces, and infrastructure. And how all of it would be swamped by a pandemic and a military coup.[3]

I spent over five years, from July 2015 to August 2020, at Yangon General Hospital, the last year (2019/20) is my ethnographic fieldwork. My work experience as project architect gives me a longer view of the hospital. With this, I can extend our horizon beyond one year of fieldwork, sketching a fuller picture of the hospital's multiplicity and impermanence. We will see buildings and materials, pipes and pathways, services and clinical and non-clinical spaces, its built and natural environment.

During these five years, my journey will have seen the NLD's efforts in national reconciliation, gold-rush vibes amongst international investors coming to Myanmar, continued ethnic conflicts in the borderlands, and the Rohingya genocide of 2016/17. At the point of my departure from Yangon in August 2020, again a month ahead of national elections, it will only be six months until a military coup that highlights the fragility of Myanmar's hybrid government of the past five years (2015-2020); five years of hope and planning, implementation of plans, rejuvenation of buildings, infrastructures,

[2] Quotes taken from my diary, Sunday 5.7.2015 (I arrived in Yangon on Friday the 3rd of July).
[3] In February 2021, in response to elections in November 2020, the Myanmar Military staged a coup. This tumbled the country into economic and social despair. I am not using the much-used term *Tatmadaw* for the military in solidarity with many pro-democracy activists, as it is an honorific name, indicating greatness. Activists supporting pro-democracy movements, ethnic armed groups and armies prefer not to refer to the Myanmar military as "the Tatmadaw" as this attributes "greatness" to a military that terrorises its people (Source: personal conversations).

and processes at the hospital, tied to social and political developments in Myanmar at large. Five years of optimism, even if sceptical at times, coincided with the time I called Yangon my home.

I left Yangon after a year of fieldwork, amidst the Covid-19 pandemic. I am exhausted from lockdowns and uncertainty, the continuous noise, the pollution, the spitting of betel nut (once a nostalgic smell), the leaking pipes, and never quite fixed infrastructure.

As I am writing about the hospital, I am sitting in a basement flat in South-East London; back in Europe full-time and settled for the first time in ten years. Once again infrastructure fails me. Dampness is creeping into my bedroom because nature has encroached on the Victorian structure's gutters and bricks, little roots compromising the masonry; salts blooming from the brickwork in my bathroom, and mould breaking through the paint. Electricity wires with a life of their own fail to supply power.

I left Yangon with eleven sketch books containing drawings of an active, constantly changing place. A place in motion, full of bright colours, soft light, long shadows, ferocious nature, innovation, and wonder. The hospital's only constant is its constant movement; and keeps moving after I have gone.

The Project Architect

When Article 25,[4] a London based architecture charity, offered me the position of project architect for the rejuvenation of Yangon General Hospital, I knew little to nothing about the building I was to "rejuvenate" and had no idea of the extent of the job ahead.

Upon my arrival on campus, due to the political situation around the hospital's rejuvenation project,[5] a reflection of the country's political plight under decades of military rule, I had been advised by my organisation's client to keep a low profile and stick to my remit: the technical support of the renovation of the main building, the project's nucleus.

[4] The name is a nod to article number 25 of the charter for human rights: the right to safe infrastructure.
[5] I have no permission to go into detail from the Rangoon General Hospital Reinvigorate Trust (RGHR), Article 25's client for the project, as this might put individuals at risk.

A century of active neglect and ad-hoc planning had left the hospital campus in a dilapidated state, its services running on a shoestring. However, despite the chaotic, state of the campus I was not allowed to even utter the word “masterplan”. The hospital administration was insistent that they had a masterplan in place; a sheet of A4 paper that consisted of a site plan with proposed buildings and bullet points. Maybe they were fed-up by fleets of international consultants dropping impractical recommendations only to disappear as quickly as they came.

As I was banned from speaking about a masterplan, I embarked on the renovation of the colonial main building inaugurated in 1911. I could build quite literally on the work that the first Article 25 team had done, and which had started work six months prior to my arrival. We were in the privileged position of being a member of the technical committee in charge of the renovation of the historic structure.

During the rainy season of my arrival, the basements of the main building did not flood for the first time in decades. This was thanks to the local contractor’s implementation of our team’s recommendations on improvements to the storm water drains. This lack of flooding, a direct result of our work on site, bestowed me with major trust from YGH’s senior medical superintendent, the Ministry of Health and Sports (MoHS), and our key stakeholders and supporters. Within a couple of months of delivering further practical improvements, uncomplicated assistance to the local contractor on site, and close collaboration with the clinical teams in developing spatial schemes improving healthcare and creating better work environments for doctors and nurses, my team and I were asked to develop a masterplan for the entire campus.

Henceforth, I spent my time explaining the nature of a masterplan to YGH staff, the all-party parliamentary committee chaired by Daw Aung San Suu Kyi, the initiator and patron of the reinvigoration project, and other stakeholders, alongside understanding YGH’s infrastructure as well as healthcare services inside-out.

My team and I followed the bowels of the infrastructure above and below ground. We assembled drawings of the existing campus, and analysed flows of patients, staff, and vehicles. We understood the puzzle of the different medical and surgical services. We spoke with the clinical staff, administration, and maintenance teams to see what works and what does not. We analysed the existing buildings and site. Based on this analysis, we produced a document of almost 200 pages (excluding appendixes) in Burmese and English with plans for heritage conservation of buildings and landscape, sustainable water and energy infrastructure, new construction and health care services-organisation and waste management, traffic planning and public space planning. The masterplan formulated a set of recommendations for healthcare improvements, focusing on the spatial organisation of services and processes alongside recommendations for physical improvements, to YGH's infrastructure in four phases over 20 years.

The approach that healthcare-process improvements have to go hand in hand with infrastructure development is grounded in my experience that processes are only as good as the facilities allow them to be; the best trained nurse can only do so much in an Intensive Care Unit (ICU) without reliable electricity; the best hand hygiene training is in vain if the hospital has no safe water supply, hand-wash-basins, or sustainable stock of alcohol based hand rub solution.

Early on in presentations to YGH and the Ministry of Health and Sports, it became apparent that YGH was lacking what is called a "clinical vision" and Myanmar a "vision for healthcare". At the same time as I was working on a masterplan for its biggest public tertiary teaching hospital, the country was in the process of formulating a clear vision for healthcare provision. The masterplan became a vehicle for discussions around the country's public healthcare system; YGH Campus is a finite site, only a set amount of floor area can be added which translates into set additional bed space, and hence informed discussions about the wider healthcare environment ensued.

Some five years later, after the military coup of 2021, the magnitude to which the political situation was precarious comes into full view, and I can start to gauge my position within it. Through the

rejuvenation project my team and I did not only create new and improved physical spaces. We provided a figurative, and seemingly apolitical, space where discussion and consensus were possible for an interparliamentary committee that had never existed before, to decide on the future of the country's biggest and most prestigious hospital and its buildings.

The Émigré

Similarly to Orkideh Behrouzan in *Prozac Diaries* (2016), I am an émigré who travels between disciplines and identities. For both of us, our professional selves granted us unique access: into spaces, conversations, and mindsets. Her into clinical spaces, me into the in-between: between buildings, walls, infrastructure, official narratives, best-practice, and into the rhythms and atmospheres of daily life on campus, abandoning perspectivism in favour of practice, something I will discuss in detail in Chapter 1 "Writing".

During my time as an architectural engineer at the hospital, understanding its infrastructure and spaces, I was fascinated by the detailed realities of the daily life on campus: its human and non-human agents and their relationships and affective atmospheres intrigued me, but I had no capacity to delve into the complexities. Therefore, I returned to my training as social anthropologist and embarked on research, that I felt, I was missing as an architect working at a hospital. My good relationships afforded me the permission to carry out ethnographic research into the hospital campus' daily life; understanding YGH's physical presence, creaking and leaking in its downtown location, exploring its places, rhythms, and relationships which I was never able to tap into with sufficient satisfaction for my anthropological sensibilities while on the job as architectural engineer.

In my ethnography, buildings always win. I cannot shake my professional training of six years as an architect, the way I learned to see the world. In combing this training with anthropological sentiments, I offer a novel, even refreshing, proposition. I write *with* buildings and through them. This does not mean that the people are secondary. Rather, they are in everything I am writing; every step, wall, and door frame has been designed and made by someone, is used, and affords privacy, or

the lack thereof, to someone. Every betel nut stain has been spat by an individual, someone used every broken pipe and tap. I see people in the buildings and in every construction detail; not letting them off the hook for their actions manifested in the material world.

Drawing, a non-verbal medium, lead me into most of my fieldwork's richest conversations, as the opening vignette showed; I only conducted interviews, accompanied by my translator, several months into fieldwork. Most of the time, these interviews confirmed observations, delivered clarifications and were done to satisfy the performative expectations of fieldwork, such as having to interview certain people on campus. The resulting text is evidence of this, and truthful to the process in which language was decentred.

Most "conversations" I had during my fieldwork were a collage of languages, drawings, and shifting moods; they were fluid in their locations around campus, for example walking with a family member to wash laundry, and fluid in their medium (non-verbal and verbal language). Therefore, the only direct quotes I use are from interviews in English, or with my translator where the translation from Myanmar to English was unambiguous, or where the *translation of an idea*, such as with the proverb "I dig a hole when I need to poop" (in Chapter 5), leads into a discussion of its own. This touches on the problem of translation as discussed by Bourdieu; who translates what, for whom, and how (see chapter 'Understanding' in Bourdieu 1999: 607ff)?

I decided *not* to translate conversations, or snippets thereof, into English, as most of my exchanges evolved in a space between words, languages, gestures (in the air and on paper as sketches), and moods; a sideway look would indicate if a conversation was over or someone agreed, a smile meant I understood but my interlocutor did not want to say more. In a country where much is said between the spoken word, a country with a legacy of violence like Myanmar, these gestures are key, and it took me years to learn to read them. Experience would have been curtailed by an attempt to relay quotes concisely. Instead, all my words on the following pages are stories guided by what I was "told", shown, or convoyed between spoken words. More often than not, my drawings were

bridges; a passing nod in approval of a sketch showed me that my observations were approved of, a question or clarification improved my understanding.

While I mobilise local concepts such as *nalehmu* in Chapter 5 as discussed by Roberts and Rhodes (2022), and Thawnghmung's conceptualisation of "everyday economic survival" in Chapter 8 (2019), I refrained, despite my half-a-decade long engagement with YGH and Myanmar, from conceptualising ephemeral concepts such as "anade" (a, by foreigners, much discussed emotion between "shame", "loosing face", and "maintaining harmony")[6] myself as I feel it would only be poor attempt at "translation". Maybe my long-term engagement with the country and its language made me suspicious of words. This might come across in the present text as a distance between my interlocutors experiences and my written words. I risk losing my interlocutors viewpoint while capturing their experiences beyond language. Here, the drawings left between the lines become relevant; it might help the reader to conceptualise them as non-verbal quotes; a voice beyond text. My interlocutors', and my, experiences are more than words. To tune into the hospital's rhythms, I listened with my entire body with care (Dupuis et al. 2022: 14). Therefore, the anthropology perused and developed in this thesis is one of more-than-words, moving beyond words and language, adjacent to recent feminist methodologies that question what counts as knowledge (Harcourt et al. 2022). Feminist methodologies are counter narratives to dominant models of research that are preferential of the spoken word. In my ethnography, through observations of the environment and interactions, the experiential and embodied nature of research is foregrounded (Dupuis et al. 2022: 4); maybe at times at the expense of the spoken and written word.

This is not a "post-human" anthropology but an intensely human scholarship. This is an unusual approach for an anthropologist, but bear with me as I develop my proposition in Chapter 1.

[6] Very few has been written about anade; one SOAS master dissertation by Jeanna Bauer on the topic explores anade in the context of international development.

While Yangon had evidently shifted out of the paranoid years that scholars before me have written about (see for example: Fink 2009; Skidmore 2004), interlocutors interacted more or less freely with me. The Rohingya genocide falls into these years alongside many other ethnic conflicts and civil war in parts of the country. In Yangon, even though never removed from the past and present violence, I was in a position to carry out some extraordinary research. I met and spoke with extraordinary people and experienced a remarkable hospital campus; a hospital that no anthropologist has conducted research at before. We will come back to the political and historic context in Chapter 4.

Writing a Hospital

My position as architectural engineer developing a masterplan for the campus afforded me with a unique perspective of Yangon General Hospital. I saw the institution as a whole and in its parts. I had a literal bird's eye view through topographical surveys, MEP[7] drawings, conservation schemes, and clinical services mapped onto site plans. As project architect, I was drawing the parts together into a whole. The question emerged for me, how this expert knowledge and distinct perspectives, after all each plan had an author with a specialist lens, turning focus on and off, translate into an understanding of the hospital that I was yearning for, and missing in my work as an architect? How could I bring together my holistic but high-level understanding of the hospital, a collection of perspectives, with an anthropological/ethnographic intimacy of daily life, its events, practices, and rhythms? How to gain this intimacy in the first place without losing overview? How to move between scales? And what might the intersection of my two disciplines bring to either?

I was faced with a puzzle: How to write an ethnography of a hospital? How to represent an institution like a hospital that is so large and complex in text? I propose an ethnography with buildings, with the (built) environment.

[7] Abbreviation in the construction industry for "Mechanical Electrical Plumbing".

Few hospital ethnographies address hospitals in their entirety, they tend to focus on aspects of hospital life and spaces of biomedical purview. For example, a particular space or concern, as Shahaduz Zaman does, presenting an ethnography of an orthopaedic ward in Bangladesh (2005), or Elizabeth Hull with nurses' professionalisation in South Africa (2017). Others circle in on specific diseases, like Julie Livingston on cancer and the care thereof in Africa (2012). Most prominent is the theme of patients' hospital experiences, here, in connection to hospital infrastructure, Fanny Chabrol writes about ruination and coloniality in a Cameroonian hospital (2018). Ethnographies looking at hospitals through their infrastructure, as does Alice Street in Papua New Guinea (2018), are few and far between, but prove to be promising points of reference towards a fuller picture of the institution. Street shows how infrastructure and buildings can be formidable guides in the study of hospitals. My ethnography attunes us to the spaces in-between, often unnoticed by hospital ethnographers, that, as we will see over nine chapters, constitute much of hospital life and are essential of biomedical services.

In this thesis, I am conceptualising buildings/hospitals through drawing and writing. Experimenting with drawings and text, I capture the hospital as a whole and in its parts, making a novel methodological and epistemological contribution to the idea of writing with, and alongside, buildings. I situate the task adjacent to discussions on how to write anthropologically, how to write ethnography in today's world. Questions of anthropological rhetoric have long been present in anthropology (see for example Behar & Gordon 1995; Bourdieu 2008; Clifford & Marcus 1986; Geertz 1973, 1988). I am interested in how anthropological text can layer with other forms of knowing. Here, I understand writing as part of the knowledge process, alongside drawing (in the field), and other forms of sensory ethnography. In this, I integrate representationalist approaches, as developed by the writing (and reading) culture movement, with phenomenological projects.

The immediate problem is: How to represent buildings in text? Text is linear, sequential, and made from blocks of words, sentences, and paragraphs, rather than bricks which in combination are more

than the sum of their parts, turning into walls, storeys, buildings, city blocks, and towns; pathways that are shaped by and shape buildings; zones of activities, functions and uses. All this is multi-dimensional, rather than linear.

LITERATURE REVIEW

Before immersing us in the ethnography of the daily life at Yangon General Hospital, it is necessary for me to provide a brief overview of the academic literature that inspires this thesis and influenced the questions I pose above. The concepts laid out in this selective literature review, are chosen for relevance and suitability to support the overarching ideas outlined in the thesis. They provide the theoretical anchors for the ethnography throughout the chapters. I will expand on them as relevant in the main body of text. Despite writing about a hospital, I am not a medical anthropologist. Hence my academic kinship is rooted in ethnographic scholarship on "Infrastructure", "Buildings", and "Hospital Ethnography", as well as scholarship on "Spaces and Bodies", with an interest in "Atmospheres, More-than-Human Agency and Affect"; the five subsections of the following literature review.

Most authors who are the coordinates of this thesis can be situated within a phenomenological tradition as discussed by Desjarlais and Throop (2011). Furthermore, drawing and writing buildings, as a methodology and way of knowing, favours experience and practice over perspective and functionality. Essentially, an "ethnography with the built environment" (as we will see in Part I, Chapters 1 and 2) is a phenomenological approach marked by a focus on experienced and practices, time, process, and materiality.

Why this insistence on materiality, you might wonder? Materials matter. Slave owners exchanged recommendations on best building techniques for their possessions' dwellings, as some materials are less prone to absorbing pungent smells (Denyer Willis 2018: 332); colonial engineers re-designed hospital buildings for better infection control using brick and driving costs up, as we will see in

following chapters in which the hospital's materiality is coming to life. Anthropologists, such as Ann Stoler with imperial debris (2013), Alice Street with affective infrastructures (2012), and Yael Navaro-Yashin with melancholic objects (2009), know of the importance of materials. I am adding to this canon on affect and materiality with a detailed architectural-engineering understanding of materiality. Here, "affect" and "atmospheres" seem useful anchors in this endeavour to bring together phenomenological approaches, agency, and the preciseness of materials.

Located within a phenomenological tradition, this thesis is rooted in experience and embodiment. As Buchli illustrates in *An Anthropology of Architecture* (2013), much anthropological engagement with buildings has been focused on form and function, and the materiality thereof. I am shifting this focus towards a phenomenological engagement of practices and experience. At the same time, while the phenomenological engagement with buildings and categories is preoccupied with house and home, or the lack thereof (see for example Desjarlais 1997), it has factored-out materiality, form/shape, and function of buildings. I put forward an *experiential* engagement with buildings, shifting from form and function to practice, adding materiality into the discussion. I develop this idea over the course of the thesis, returning to it in the conclusion with reference to design.

Infrastructure

Infrastructure, and with it the built environment, is a fact of our life today. Anthropologists such as Larkin (2013), Boyer (in interview with Lowrie 2014a, 2014b), Björkman (2015), Anand (2017; 2018), and Simpson (2022) show that infrastructures and social relationships are interwoven, have histories and politics, and embody future aspirations, some bygone. They are an undeniable presence from a past, here to stay.

Infrastructure and its "promise" of a brighter future is the reality we live with (Boyer 2018: 223), some might say our own ruins we endure (Boyer on Gupta in Boyer 2018: 224). While Boyer discusses Gupta's notion of "ruination" in the context of "the global south" I do not see this

geographic specification as productive; as we saw with my Victorian basement earlier, decay is not a geographic condition.

For a while, and maybe still today, some humans have been enchanted with large infrastructural projects that promise structural and lasting change, reflected for example in the erroneous idea that roads bring unequivocal development (Simpson 2022). However, as Boyer (2018) discusses, this is not the entire story. He proposes that anthropologists' interest in infrastructure is linked to structuralist sentiments related to "infra" and "structure"; attempts to understand something deeper about humanity, a sentimentality for "hidden truths" (Boyer 2018: 223). Taking this together with the nature of infrastructures as discussed by Larkin (2013), here I am indebted to Boyer's candid discussion of Larkin's seminal article, the nature of infrastructure are relationships between materials and people; a point we will come back to in Chapter 5 "Beyond Campus Walls" when we see systems and people connecting. Infrastructures facilitate flow, they are always connected and in a relationship. I discuss their connectedness and registers of scale, specifically in relation to buildings, in Chapter 1. Infrastructures are mediators, a point we return to in Chapter 7 when we tune-into "Bodies and Buildings". Infrastructures are processes, mediators, and always "[…] enable something else to happen" (Boyer on Larkin in: Boyer 2018: 227). This to me, begs the question, what do *buildings* enable to happen?

Rather than discussing infrastructure as technopolitical, Destree (2022) discusses infrastructure as an imaginative force. Through shared electricity and prepaid meters, Destree sees community, collective and shared aspirations of a better life, imagined through available infrastructures. The idea of infrastructure as imaginative, generative, and productive leads me to consider the hospital in terms of "rehearsal", rather than the often-invoked narrative of "performance". Infrastructures are popularly seen as spectacles with grant moments when opened, red ribbons, and photo-ops, which eventually will fail, crumble under the weight of time, in step with the material metabolisms at work, if not tended and maintained, or failing right away because of mismanagement, corruption, and

human error. What happens when we think of hospitals as rehearsals? What if we allow space, literal and figurative, for failure and contingency? What happens if we understand that buildings mediate the different rhythms, moods, and relationships, providing a physical place for all of this? Eventually the constant making and re-making of infrastructures/buildings is what creates permanence and ensures continued functioning.

In this thesis I am starting from the premises of infrastructure (the hospital) as a rehearsal, a making and re-making, never finished or perfected, a work in constant progress, rather than a performance, in which the hospital buildings are characters themselves. This reading is inspired by social justice discussions, specifically the interview *Every Day We Must Get Up and Relearn the World*, with Robyn Maynard and Leanne Betasamosake, on the generative ability of failure and mistakes in social justice contexts (2021). What happens when we tolerate "rehearsal", when we try again, and do it better and different the next time?

When we see the hospital as rehearsal, we do not understand broken jet washers as a failed performance, a failure as such, but as a rehearsal in which something needs adjustment. Rather than thinking of failure, infrastructure becomes "improvable", "better next time", with the mission to find a way to make it work. In the case of the jet washers this means seeing what might have caused the malfunctioning, rather than deeming the performance failed, and seeing the factors that might have contributed to it (sedimentation in the water that blocks the fine jet nozzles, hard to replace spare parts, missing water filters to get rid of sedimentation in the water), rather than declaring a building, a tool, or an infrastructure as failed. Rehearsal allows us to see potential, an opening up, and the idea of multiple possible outcomes.

This potentiality of infrastructure appears also in Boyer's Marxist lens on infrastructure; just because infrastructures are, and have been, does not mean they have to stay as they are (Boyer 2018). They embody energy and agency (I will come back to agency a little later). Material research and science grant them existence, alongside, as the anthropologists know, the social relationships that come

with the science. Hence, they carry revolutionary potential (ibid). This lends pertinence to my project, which strives to rethink what a hospital campus is, for an "otherwise" understanding of hospitals. The question emerges: How to think about infrastructure? How to think about hospitals?

Infrastructures never exist in isolation, they are social and relational, they are processes. Many scholars have demonstrated this in recent ethnographies. For example, Simpson by looking at roads in India and their existence which reaches far beyond the continent (Simpson 2022); Björkman in following Mumbai's water pipes to understand and re-evaluate the city's social geography (Björkman 2015); Doherty through Kampala's socially and politically enmeshed *Waste Worlds* (Doherty 2022). These ethnographies lead me to ask: And what about buildings? How can I apply insights into the social and material life of roads, pipes, and waste to buildings?

Investigating infrastructure is clearly a future oriented project. We are at a point of a climate crisis where we cannot ignore the material realities that made and are making our world. Studying infrastructures allows us, in Boyer's words to burrow "[…] beneath the surfaces of institutions, deeply into their walls and floors" (Lowrie 2014a) pointing, already in the 2014 interview, to the revolutionary potential he will candidly identify four years later; in this, hinting at the potentiality of buildings.

Buildings

However, while much has been written about classic infrastructures, or the ones that many think of first when hearing "infrastructure" – electricity, water, waste, roads (transport) – fewer have engaged buildings, and even less public institutions specifically, as scholars in the field of anthropology of architecture have pointed out (Buchli 2013; Yaneva 2017).

Anthropologists who mobilised buildings as vehicles for their ethnography, mostly enlisted residential buildings for their ethnographic endeavours, possibly because of the complications with access to institutions, or anthropologists' tricky positionality within (who is the anthropologist in a

clinical setting? Staff/doctor or “user”/patient?). Issues that hospital ethnographers are familiar with (Van der Geest & Finkler 2004: 1998f).

While literature on architecture in anthropology exists, it is quickly exhausted. Yenave (2017), Buchli (2013) and Carsten and Hugh-Jones (1995a) note that architecture and buildings have been a neglected anthropological subject in their own right. Yaneva shows this in her discussion of relevant literature that focuses on Science and Technology Studies (STS) and sociology, urban and architectural theory, rather than anthropological literature (see Introduction, Yaneva 2017). Buchli discusses the notably thin canon on architecture in anthropology (see Introduction, Buchli 2013). Alongside Yaneva and Carsten and Hugh-Jones, he remarks on anthropologists' dominant focus on houses/the domestic sphere (Buchli 2013: 5f).

My thesis changes this. By focusing on the buildings of a public institution, a hospital, I am adding to the canon with a novel building typology; a type of building not even mentioned by Buchli (ibid). I aim to bring the buildings of a public institution into the discussion and demonstrate what buildings as a methodology and way of writing *with* can add to anthropological narratives.

Yaneva’s work has a focus on design and the *making* of buildings, the processes involved. Buchli criticises a focus on “fixity” in anthropological studies of architecture, showing that buildings and the built-environment are in flow (Postscript, Buchli 2013). Both, at different times in the lifetime of buildings, chime with Carsten and Hugh-Jones who point out that the ethnographies discussed in their edited volume show "(...) container and contained are related as parts of a continuous processes of living"(Carsten & Hugh-Jones 1995a: 46). Here, “house” is a process, and house and people are continuous (Carsten & Hugh-Jones 1995a). This thesis shows how this is equally true for public institutions and their buildings.

Four notable ethnographies use buildings as touchpoints for their ethnography, highlighting the value of what I develop further in this thesis as “writing with buildings”.

In Jansen's ethnography of a Sarajevo apartment complex, buildings admittedly stay in the background, but it is specifically through the buildings and him living in the apartment complex that I see his critique of Scott's "gridding" appear (2015). The apartment complex is the nucleus for an anthropology of the state and its people. He uses small scale and tactile examples, such as light switches and taps, to illustrate the grid and the idea of "gridding" people, bringing people into the state "grid", making them visible. The light switch, the pipes, the electricity, the bus ticket, the waiting for the bus, are based within, and are materially connected to the apartment complex, indicating the importance of the place and specifically the buildings' role in understanding statehood within position. Even though he does not make this connection between buildings and the grid explicit, his location writing from inside the buildings provides a "within" perspective of the grid he discusses; a demonstration of the value of buildings as actors in the ethnographic encounter. What makes this ethnography so precise? It is the individuals' *physical encounters with the building* that illustrate larger arguments around statehood.

Ring uses a building in a similar visceral way for her ethnography in Karachi (2006). More poetic than Jansen, she discusses everyday peace in an apartment building, and in a city where peace is negotiated daily. In her writing, the building mediates sociality (shown especially in her second chapter): open and closed doors, corridors, private and public space, real connections, and permanence, comes from extended family relationships of the women living in the building. The building is part of everyday peace negotiations. Her insightful writing, and close observations with the building where doors become moral problems (Ring 2006: 50), inspired me to ask**:** How can, and what happens when, built structures become moral problems? How do individuals negotiate this? Chapter 8 "Spaces of Responsibilities" presents an ethnographic discussion. Both Jansen and Ring extrapolate wider social and political phenomena from the specificity of their buildings.

Mathews (2011) did not live in the building he studied. Using an infamous Hongkong mixed-use (retail, hotel, food, and beverage) building, he shows the underbelly of globalisation, what he calls

"low-end globalisation", and the material reality of daily life that goes with it. Mathews' ethnography discusses the social connections extending from one locale to explore a certain topic: globalisation and migration. What social connections does the hospital have? Seeing how infrastructure systems connect, I became curious of the social relationships and the knowledge that travels in and out of the hospital; I am picking this theme up in Chapter 5 when I look at the hospital beyond campus walls.

King's *The Bungalow* (1984) takes a historical view of a particular typology. Rather than presenting an ethnography of a specific building, he discusses at the hand of bungalows the mechanics of colonialism, neo-colonialism, and tropical architecture, another form of (neo)colonialism (le Roux 2003). Here, themes around society and the built environment emerge. How are buildings part of the process of social production? How were local architectural forms and building styles adapted by the colonisers and exported? King reads the built environment as a metaphor for various social and intellectual trends, discussing how change in the build environment gives rise to new institutions. *The Bungalow* (King 1984) is a history of a building typology, a particular form of dwelling, once again a home/house, through time and space, from India to America. In this, King illustrates the value of the built environment for social analysis.

According to King, "[…] buildings, and the social meaning attached to them, do have effects on people's behaviour, especially when seen in a long-term historical perspective. They are part of the process of social production." (King 1984: 5) Without becoming architecturally deterministic, I wonder, what does this mean for the hospital? What social processes produced the hospital, and what process of social production is the hospital part off? Questions that inspired Chapter 4 which delves into the history of Yangon General Hospital, and Part II (Chapter 6 and 7) where I ask: How do we live with our buildings and they with us?

However, except for Ring who speaks of sound and touch, and King who is the only one discussing floorplans and sections, authors remain vague on the buildings' plans, designs, and materials. What arose from this body of literature is the quest for preciseness and a commitment to materiality.

My longing for material concreteness extends to criticism of Pierre Bourdieu, another author who closely engaged with buildings, yet again the home. Bourdieu's significance, here, lies in his work on bodies and spaces, his fine-grained observations of practices in space. While he masterfully collapses materiality, social relationships, and activities in his analysis of the Berber house, and includes a discussion of floor plans and materials, he leaves the reader with a distinct emphasis on the symbolic, by seeing "the world reversed" in the houses' construction and spatial organisation (Bourdieu 2000a). While concerned with symbolism, Bourdieu develops an important argument that is useful as a baseline for the hospital, and a reading of buildings: the continuity between people and their houses. It is this continuity I am stressing, taking the observation from residential to public buildings.

Carsten and Hugh-Jones (1995a), Buchli (2013), Bourdieu (2000a), and King (1984) all write about buildings and their place in society, politically and historically, demonstrating that houses/homes are more than the sum of their parts. Their buildings are symbolic, affective, and at times alive, illustrating their inhabitants' world view and shaping their life-worlds. As they are all writing about home and house, showing the importance of buildings within the typology of "house", the question for me arises: What about institutions and their buildings? Many of the important questions raised by King in relation to bungalows as a house form are equally relevant to institutions.

Foucault wrote about prisons and clinics, showing the bio-politics of space, with power as the main undercurrent (1973, 1977). In this thesis, I am wondering if there is more to institutional buildings than power and bio-politics, as the above discussed house and building ethnographies have shown. Can the views of buildings as affective, symbolic, and alive, and bio-political be combined? Both are intimate understandings of what buildings are, both readings stay close to the body. A hospital is a

prime site for this endeavour. How can the different views of buildings be brought together in productive ways, approaching institutions with the nuanced understanding we gain from scholarship on the house? I am proposing an ethnography of buildings that speaks to and about more than "home" and "power".

As Boyer discusses in the context of infrastructure (Lowrie 2014a, 2014b), and Yaneva specifically with regards to buildings, we must think with the material reality to see buildings for what they are: sites of contestation (Yaneva 2017: 4). As well as a symbolic entity, or a conceptual idea, we need to understand their emplaced reality, their existence and continued existence, and our daily life within them.

At the same time, the boundaries between natural and social worlds are blurring. I am not alone in seeing formerly stable categories such as "nature" and "social" in crisis (see for example Hetherington 2019). Indigenous scholars have long pointed out the fallacy of a nature/culture divide (Todd 2015: 245). Furthermore, I see a collapse of man-made and natural environments, in which distinct categories such as built and natural environments, infrastructure and ecosystems, lose their distinctiveness. Who can say what is "built" and what is "natural" environment in a city? I am thinking here of built parks for examples. Is a water system more man-made than a carefully crafted eco-system? I suggest that all of it is socially constructed in human/non-human/more-than-human collaborations and in need of careful attention. This nature/culture collapse is most apparent when thinking of large-scale infrastructure projects that alter entire geographies, such as mega dams, but similar processes are at play on a smaller scale, at the level of buildings and their components (wall, ceilings, roofs, stairs, eaves, pipes and so on); at the scale of a hospital.

Hospital Ethnography

Hospital ethnography has come a long way since its beginnings in the 1950s and 60s, when (American) hospitals were studied as small societies, bounded and closed (Street & Coleman 2012: 6f). Today, I am in good company when I establish a layered and nuanced reading of the hospital, in

which the hospital is understood as bounded and permeable at the same time (Street & Coleman 2012). The following is a literature review of hospital ethnography as it speaks to the historical nature of hospital spaces and buildings, waste management and by extension the environment, hospital design and infrastructure, biomedical and non-biomedical practices, and waiting. In this we will see that hospital ethnographers produced detailed understandings and readings of hospital spaces, mostly parts of hospital campus (such as one ward, the laboratory, the ICU) and with a focus on spaces as they of a biomedical, or clinical purview. In contrast, my ethnography of Yangon General Hospital turns its attention to the in-between spaces that are often unnoticed, and the flows of social interaction that these spaces accommodate.

The hospital is a collection of buildings where this instability of infrastructures, including buildings, natural, and social categories become visceral and literally embodied. At the hospital, often vulnerable, bodies meet in concrete places with historic roots. Buildings, their materiality, spatial arrangements, and geographic locations, with rich pasts, converge and shape bodies and the lives of those who inhabit them daily and *vice versa*. Alice Street demonstrates this in her ethnography of a hospital in Papua New Guinea where she critically engaged with the historic dimension of infrastructure and personhood (Street 2014). Street's scholarship on hospital campus in Papua New Guinea makes the important point that the condition of infrastructure influences how we understand ourselves in relation to the state; buildings carry affect and neglect (ibid).

While Chabrol does not engage with buildings directly, her discussion of hepatitis and the literal and figurative infrastructures that underly the disease show how not only hospital infrastructure can be rooted in a colonial past, but the very existence of a disease in itself, the practices, hence the buildings designed to contain them, and the physical and social ruination that comes along (Chabrol 2018).

Marissa Mika's historical ethnography *African Oncology* (Mika 2021) is firmly situated within hospital ethnography and anthropology of infrastructure. Concerned with the politics of knowledge

production, she centres African knowledge producers in the history of cancer research and care in Uganda; writing a history of Uganda through the lens of a hospital. Here, hospitals function as social worlds, impacted by political, economic, and scientific events. While not strictly speaking a hospital ethnography, Simonne Horwitz's history of Baragwanath Hospital, built for the black population of Soweto, South Africa, chimes with arguments from *Africanizing Oncology.* Both demonstrate the relevance of space in the production of medical knowledge, patients and citizens (Horwitz 2013: 5; Mika 2021). Horwitz describes and discusses the expansion of the hospital as it aligned with political aims. Furthermore, like YGH in 1988 and 2021, Baragwanath was a centre for political struggles and part of political turning points (Horwitz 2013: 5f). She points out, how at times history is made by space; the available physical space shaped history where records were burned because of a lack of archival space (Horwitz 2013: 18), yet another parallel to Yangon General Hospital where records where lost to flooding where files were inadequately stored, loosing knowledge of patients and buildings.

In Varley and Varma's article on hospital hauntings, hospitals are transgressive spaces (2018). While most recent hospital ethnographers note this, Varma and Varley add a spectral dimension by developing a *jinnealogical* reading of the hospital that challenges rational and future oriented narratives (ibid:631). Here supernatural beliefs and medical practices coexist and shape existential and political purposes (ibid:630). They recognise hospitals as "temporally rhizomatic and spatially multipurpose" (ibid:641), inhabited by interactive ghostly-human and nonhuman-jinn presences. In this, they call for anthropologists to consider how other hospitals might also be tesseracts, emphasizing the significance of understanding how supernatural beliefs and medical practices entwine in hospital spaces (ibid:641); hospitals emerge as multidimensional space that store histories of trauma and violence, where supernatural beliefs and medical practices intersect.

In the context of a new 'scramble for the tropics', connected to colonial pasts, infrastructural dependencies and competition arise (Street 2016: 950). Street shows the dependant (ibid 941f) and

relational dynamics between scientists and their hosts and raises ethical implications of scientific research in resource low settings; tensions created by international networks of funding and local context (ibid:950). She highlights the tenuous process of "setting up" a place for science in resource-poor contexts of global health, pointing to the significance of the material exchanges of infrastructure, bodily tissues, and labour that enable scientists to establish a scientific presence in provincial-level hospitals. Ultimately, Street challenges traditional notions of scientific research and development by emphasizing the importance of context and its colonial heritage, relationships, and ethical considerations in global health science. It prompts a re-evaluation of scientific value production, emphasising the significance of mutual recognition and relational value in scientific endeavours.

In a contemporary reading of hospitals, Sarah Hodges reframes “Hospitals as factories of medical garbage” (2017). In this, she moves beyond medical anthropologists’ and historians’ conventional sites of inquiry such as the clinic, the lab, the doctors’ office. Instead, Hodges’ field sites are dumpsters behind hospitals and other uncanny sites; like me, here her attention is on the spaces in-between clinical services that serve biomedical practice, with focus on specific material. Hodges looks at historical and social implications of the widespread adoption of single-use medical plastics that lodged themselves in discourses of hygiene since the 1990s (Hodges 2017: 324). In this, she demonstrates how single-use plastic products transformed medical hygiene, creating a new infrastructure of disposables, which exponentially increased hospitals' material outputs. This new regime comes with unintended consequences; the high impact on the environment and potential health risks associated with unsafe disposal practices. The article's theoretical contribution lies in its exploration of a material as it relates to medical practice, and its call for a rethinking of the relationship between health, healthcare, and the environment. Here, plastic products for healthcare have become an alternative "infrastructure" (an infrastructure of plastic) *in lieu* of much needed healthcare infrastructure development in low-resource contexts such as India (and I would add

Myanmar and elsewhere); disposable plastic products created a "hygienic" space without developing healthcare spaces (ibid:329). Similar developments take place for example in Sierra Leone, as discussed below, where rapid tests displace laboratory infrastructure development (Vernooij 2021: 8), or as noted by Collier, Cross, Redfield, and Street with “little Development Devices” that become a counterpoint to larger infrastructure developments (Collier et al. 2018). Reading hospitals as "factories of medical garbage" refocuses the role of the environment in health care (Hodges 2017: 329f), and I would add the role of healthcare in climate change and extractives practices; a concern I am not alone with, as many recent discussions in workshops and conference panels are evidence of, alongside policy makers.[8] [9]

In line with the theme of extraction, Morales’ article “There Is No Place Like Home” (2018) crafts a beautiful argument at the intersection of medical and political anthropology. Her central concern is how institutional projects to improve care unfold amid enduring dynamics of colonial and capitalist extraction. She analyses the contradictions of care provision in biomedicine and public health, particularly as harm and help, sickness and cure, become bound up with one another. At hand of cultural adapted birthing units, she demonstrated how this spatial adaptation is a continuation of colonial logics, patronising indigenous women, and extending logics of otherness into biomedical processes.

Similarly, but on a broader scale, Emma Varley provides a nuanced understanding of how healthcare infrastructures both reflect and contribute to broader patterns of exclusion and marginalization. In her article “Exclusionary Infrastructures” (2015), she examines through the lens of medical anthropology and critical social theory how “exclusionary infrastructures” are systems, institutions,

[8] For example, Janina Kehr spoke about extractivist practices and the hospital in her introduction to the workshop “The Hospital in Transit: Past, Present and Future of Hospital Ethnography in a Global Perspective” at the MAYS 2023 conference, on 20th of July 2023. Also, ECASA 2023 panel 15 “Hospitals in South Asia: Historical and Ethnographic Perspective”, especially Caterina Guenzi on gamete banks and Smriti Sharma on heath insurances.

[9] See for example the NHS’ 2022 NetZero Policy (https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/) with regards to environmental impacts.

or physical spaces that actively exclude or marginalise certain groups in society; in the case of this article, Shia and Sunni communities. Varley argues that healthcare infrastructures can function as heterotopic sites (referring here to Street and Coleman's development of the Foucauldian concept in their 2012 article, discussed below) of experience and identity affirmation, reflecting and contributing to broader patterns of social, political, and sectarian dynamics (Varley 2015: 213ff).

Like Morales, Varley offers a political reading of infrastructures, in which its infrastructures are mirrors of a wider conflict; in Gilli, public sector hospitals have been socially, bureaucratically, and politically configured as sectarian medical infrastructures.

A series of three articles, written in the context of an European Research Council funded project, "DiaDev"[10] lead by Alice Street, looking at diagnostic devices (and their infrastructural entanglements) in global health, are particularly interesting for their unique perspective of hospitals' infrastructural instability (Vernooij 2021), responsibility (Vernooij et al. 2022), and care (Bah et al. 2021).

By drawing on medical anthropology, science and technology studies (STS), and health systems research, Eva Vernooij's article "Infrastructural Instability, Value, and Laboratory Work in a Public Hospital in Sierra Leone" (2021) focuses on laboratory work as a site of inquiry. Here she explores the social construction and stabilisation of scientific knowledge, as well as the role of infrastructure and materiality. Infrastructure instability is seen in political and economic instability, supply chains, access, and so on, at the same time as internal instabilities, mistrust, and faulty technology.

Vernooij's argument is interesting for anthropology of infrastructure; how infrastructural instability shapes the generation of different kinds of value, emphasizing the interplay between material conditions, institutional relationships, and the clinical impact, and in turn how infrastructure instability shapes clinical practice; something we will also see in the following chapters at Yangon

[10] Project website: https://www.diadev.eu/

General Hospital. The construction of clinical laboratory infrastructure needs attention to micro and macro-levels (ibid:20); when rapid tests, designed for screening, replace laboratory work, lab-technicians and their infrastructures are devalued, influencing in turn decisions to build laboratories (ibid:8). Vernooij notes, refurbishment of buildings tends to serves global donors' interests, focusing on diseases that pose global security threats, rather than routine lab work (ibid:4f); something I witnessed with Covid 19 at Yangon General Hospital, when the WHO sanctioned the construction of new ICU's across the country (Chapter 3).

In "Patient Pathways and Diagnostic Value in Sierra Leone", Bah, Vernooij and Street show how Vernooij's "infrastructural instability" directly effects patient care across sites within the hospital, and how this instability manifests itself in the waiting hall, the community health officers office, the laboratory, the treatment room, and along the pathway.

Also employing a patient pathway approach, "Responsibility, repair and care in Sierra Leone's health system" (Vernooij et al. 2022) considers the individualisation of responsibility for "making the system work" (ibid:2) in the context of Connaught hospital, a referral hospital in Freetown. The authors show coordination of patient care depended on frequent (small) acts of intervention by individuals, including doctors, managers, nurses, patients, and their relatives. The authors conceptualise these acts of assuming responsibility as temporary repair and care for the health system itself, and the system as depend on these acts (ibid:1); an argument that chimes with my findings, when we meet attendants who create patients' "Infrastructure of Comfort" (Chapter 6) and family members and staff bridging gaps in the system (Chapter 8). At Connaught Hospital, like YGH, individuals/people are the solution, not the problem (as I would say; the many checklists and process guidelines that hospital staff contend with, suggest) (Vernooij et al. 2022: 6).

The authors argue that examining how responsibility for the repair of the system is distributed and valued, both within the hospital and in terms of broader structures of health funding and policy, is essential to developing more sustainable systems for repair; healthcare models must include repair

(Vernooij et al. 2022: 7), raising questions about who is responsible for repair (of the system), and who carries the weight?

In the context of responsibility, Vernooij et.al. (2022) and Bah et al. (2021) mentioned ethical implications of intervening in a patient's journey and impact of a patient's death. Considering Ruth Prince's chapter on "Death, detachment, and moral dilemmas of acre in a Kenyan Hospital" (2018) is interesting as she emphasises the complex and morally fraught forms of engagement and detachment experienced by medical staff in the Kenyan hospital, as well as her own ethical dilemmas as an ethnographer conducting anthropological research (Prince 2018: 456f).

Returning to the theme of repair, Jenna Grant's article "Repair in Translation" (2020) mobilises translation as method to contemplate the promise that repair and care hold for making sense of sociotechnical relationships (ibid:18). She challenges traditional narratives of modernity and progress, particularly in the context of medical care in resource-constrained environments, through the concept of "broken world thinking" with reference to Steven J. Jackson, who proposed taking an unwell world as a starting point rather than one of novelty and progress (ibid:17). Through the experiences of clinical practitioners, radiologists and engineers, who maintain and repair medical imaging technologies, Grant argues that repair and care are not just technical practices but involve social, cultural, and political dimensions. The article highlights the importance of understanding repair as integral components of medical care, as do Vernooij et al. above, particularly in resource-constrained environments; "[…] care and repair for, with and in spite of technologies" (P15) are not, as often portrait, the dark side of modernity, but modernity itself (P17). We will come across questions of repair, and maintenance, throughout the chapters, as repairing YGH's creaking and leaking campus in downtown Yangon is a reality of its daily life; especially in Chapter 7 we will meet some of the engineers responsible for this feat.

In an earlier article, "Friends, Partners, and Orphans" (2018), Grant explored the complex dynamics of medical aid and technology donations in Cambodia through the lens of relational ethics. Drawing

on the works of James Laidlaw and Pierre Bourdieu, she examines the paradox of gift-giving and the role of reciprocity and power dynamics in shaping medical partnerships. Here, seemingly altruistic acts of donation and aid are intertwined with interests and power dynamics, ultimately shaping the medical landscape in Phnom Penh. Particularly her conceptualisation of “orphanhood”, highlighting the potential dangers of donations without necessary infrastructure to support them, is pertinent to developments at Yangon General Hospital, both with regard to the hospital’s colonial buildings as well as donations such as a freshwater system, jet washers, and ambulances that lack the infrastructure to tend them.

A series of articles in a 2012 special issue of *Space and Culture* highlight the complex interplay of hospital spaces and practices. In this, following Foucault, the authors understand hospitals as heterotopias. In the introduction to the special issue of *Space and Culture* on hospital spaces (Street & Coleman 2012), Street and Coleman draw on the work of Michel Foucault (especially a 1967 lecture to architects on heterotopias), to understand the heterotopic qualities of the hospital, expanding their analysis of hospitals beyond the modernist institution of knowledge, governance, and improvement (ibid:8f). They show “alignments between multiple and often incongruous practices of ordering, which might be medical, bureaucratic, religious, economic, or kinship-based (ibid:10). This challenges traditional polarised views of hospitals as isolated "islands" or continuations of everyday social space, instead offering a perspective that recognizes the paradoxical nature of hospitals as both bounded and permeable, and as sites of social control and alternative social orders (ibid).

In providing three thematic frameworks (boundary work, generating scale, and layered space), Street and Coleman move beyond a singular disciplinary focus to consider the diverse and dynamic spatial arrangements that contribute to the complexity of hospitals as institutions. The discussion of the articles in the special issue highlights the spatial differences, and inscribed inequalities, of hospitals (ibid 14). This contributes to understandings of space and power in the context of

healthcare (ibid); an important aspect to acknowledge at Myanmar's biggest tertiary care teaching hospital.

In the same special issue, Noelle Sullivan (2012) uses movement as a concept to unravel the complexities of hospitals as ambiguous heterotopias, where multiple, and sometimes conflicting, ordering processes coexist. The concept of assemblage emphasises the interaction between global forms and specific institutions, and the resilience of local environments in the face of global governance. Sullivan shows that hospital design, types of space that are build, when, where and how, reflect wider policies and global health proprieties. At the same time, while certain equipment is tied up with global logics of health and best practice, it cannot escape local realties such as power cuts, patients' adherence or compliance, and data regimes demonstrating the "recalcitrance" of place, and its analytical importance in healthcare settings (ibid:67); I would add the relevance of buildings and their materiality, as we will see in the discussion of "Building New Rangoon General Hospital" (Chapter 4) and in Chapter 7 "Bodies and Buildings".

Jessica Mesman, as a STS scholar with a focus on medical practice, explores spatial aspects of patient safety in a neonatal ICU (Mesman 2012). She uses text and diagrams of floor plans to demonstrate patient safety is not only about medical procedures, but also about the spatial environment in which care is provided. By following doctors and nurses in their work, Mesman demonstrates the crucial role of the collaborative spatial work of healthcare professionals. Here space emerges as integral to social action. She discusses how germ theory takes architectural form (Mesman 2012: 33), akin to the construction of pavilion hospitals whose architecture embodied the miasma theory (Chang 2010: 126f). We will come back to the spatial aspect of patient safety in Chapter 7 "Bodies and Buildings", looking at the interplay of space, risk and responsibility.

In "Ordering, Enrolling, and Dismissing" (White et al. 2012), the authors conducted ethnographic research in a UK A&E department, genetics clinic, and ICU to explore the different logics played out through moments of access to hospital services. Here, hospital spaces are understood as complex

heterotopias where different logics are accommodated at particular times, which may be incommensurate with the organization of the hospital and the care of patients. The authors emphasise that through processes of ordering, enrolling, and dismissing potential patients (or even logics), divisions accomplish particular social worlds (ibid). The article highlights the interplay between political and economic rationality and clinical rationality, and how these logics impact the access to and exclusion from hospital services.

Alice Street, as editor of the special issue discusses the affective nature of infrastructure, exploring the nuanced relationship between affect and hospital landscapes (2012). In this she integrates recent work on affect in anthropology and cultural geography, along with insights from postcolonial studies, to dissect the emotional experiences and attachments within medical spaces. Street's examination centres on the historically layered postcolonial infrastructure of the hospital, emphasising its influence on emotional connections to the "nation" or the "state," as well as shaping expectations for the future (Street 2012: 49f). Street challenges the notion that affect can be engineered, particularly questioning the assumed connection between hospitals as spaces for care and the elicitation of affective states (Street 2012: 46). Street's scholarship also touches on the role of hospitals as political spaces, sending messages about state development interventions, national values, and power. In this, she provides a rich exploration of the affective dimensions of hospital landscapes, shedding light on the complex interplay between historical infrastructure, emotional experiences, and the enduring impacts of colonial legacies; something we will come across in Chapter 7 “Bodies and Buildings”.

The final article I would like to discuss from the 2012 *Space and Culture* issue, as it pertains to my ethnography, especially with reference to biomedical and non-biomedical practices within the hospital, is Hannah Brown’s “Hospital Domestics” (2012). Brown draws on the concept of heterotopia, as articulated by Foucault (and put forward by Street and Coleman in the issues introduction), to analyse the hospital as a space shaped by extended family support in patient care

within the (biomedical) hospital setting. In this, she highlights the interplay between familial and biomedical care models. While many hospital ethnographers noted the importance of extended family support in patient care (see for example Bhalla et al. 2014; Zaman 2013), Brown conceptualises the ways in which caregivers and hospital staff negotiate boundaries between different models of care. Brown's carful ethnography paints a complicated picture of overlaying care arrangements, familial and biomedical that are also observable at YGH. At YGH, my ethnography extends beyond the ward, understanding familial spaces of care, and associated practices, on a campus-wide scale (and beyond).

A recent edited volume sheds light on *The work of hospitals* (Olsen & Sargent 2022). The editors bring together a wider range of themes, in which the hospital emerges as a "thinking institution" (referring to Mead) emphasising the interconnectedness of hospitals with broader societal structures (Wendland 2022). Two chapters stand out on religion, and the night side of medicine (and in extension waiting).

Anita Hannig explores the intersection of science and religion in the context of healthcare in Ethiopian hospitals. Challenging traditional dichotomies between science and religion she shows how they can complement each other. Her rich ethnographic accounts show how biomedical healing and religious faith intersect, and how patients and healthcare providers navigate their religious convictions in the context of medical interventions (Hannig 2017, 2022). In her 2017 monograph, Hannig is concerned how obstetric fistular is understood, breaking with, but not fully dismissing, structural violence as a framework, offering a deep dive into the experiences of patients and the institutional dynamics at play. In extension to this, in her 2022 chapter "Science and Sanctity" in *The work of hospitals*, she explores how biomedical and religious spaces overlap, for patients, practitioners and funders, showing that religion and biomedicine fulfil complementary roles. This ties in with my observations of religious activity on campus, with icons in eaves and under trees.

In her recent chapter in Olsen and Sargent's volume, Emma Varley, explores "The Nightside of medicine" (2022), focusing on obstetric suffering and ethnographic witnessing in a Pakistani hospital. She delves into the impact of medical neglect, misadventure, and predation. In this, she demonstrates that the concept of "night side medicine" offers a valuable avenue for hospital ethnographers to ethically witness practices that deviate from, even defy medical-bureaucratic norms, and/or constitute outright malpractice (Varley 2022: 213). While I have chosen to not explore the "night side" of YGH, which I am sure exists, but I only had fleeting glimpses of with regard to the infrastructure, never any clinical practices, her ethnographic accounts of a labour ward in Gilli makes an important point about waiting. Waiting here is not a universal condition, but a tool to exert power. Here, birthing mothers are made to wait; for a doctor to be called, to avoid liability or are made to wait for care, asserting power over the individual, to coerce behaviour and offer payments. Varley's nightside ethnography shows the power that lies within waiting; a prevailing mood in hospitals, a mood lingering also in YGH's spaces between its buildings, wards, and consultation rooms.

Waiting in healthcare settings, as in the case of Varley's birthing unit in Pakistan, is often related to power. It is also entangled with strategic boundary creation between the waiting and the waited for, who is eligible for what care and when it comes to triaging patients (Hillman 2014; Mattingly 2022; Wamsiedel 2022: 158f). Through my drawing practice of waiting bodies, bodies suspended in time and space, I literally drew out the physical aspect of waiting, and its entanglements with the built environment. Waiting is in itself an in-between space, as scholars who have written about waiting discussed (Ghassan 2018; Khosravi 2020). In my ethnography, waiting becomes an embodied dimension.

While few hospitals ethnographies discussed waiting specifically or exclusively, most above mentioned ethnographic accounts of hospitals consistently refer to waiting, waiting spaces, or non-movement; Sullivan (2012) discussed above, uses "movement" to conceptualise hospital space,

showing non-movement, waiting, as an intrinsic part of hospital journeys. Similarly, Cheryl Mattingly discusses (perceived) inequalities in the waiting room of “the cosmopolitan hospital” (2022)l. In the description of waiting the focus is on the patient pathway, as it relates to patient care. With my attunement to space in-between buildings, I identify waiting as mood around the hospital (Chapter 6), with its aesthetic implications for bodies (patients’ and others’).

Two decades ago, Van der Geest and Finkler discussed the hospital as culturally contingent and permeable, refuting Goffman’s notion of a “total institution”; for them hospitals bring beliefs and values of a given society into view (Van der Geest & Finkler 2004). Biomedicine is “traditionally” seen as monolithic, bound up with power and hierarchies (similar to Foucault’s reading of clinics and prisons), but hospitals are culturally contingent (ibid), a point I will come back to throughout the thesis, adding a material lens. They further point out how hospitals are not only places of care, but essentially bureaucratic structures, separating the healthy from the ill (Van der Geest & Finkler 2004: 1996). Important points when thinking with hospitals!

The recent *Somatosphere* series “The Hospital Multiple”, expands on Van der Geest and Finkler’s notion of what a hospital is, exploring hospitals as spaces of multitude (Chabrol & Kehr 2020).

Hospitals are place of precarious labour, dirty places, and sterilised spaces. Hospitals are critical sites for healthcare, but they are also a battleground of austerity policies (ibid). “The Hospital Multiple” has kitchens, laundries, cafeterias, hospitals are buildings, situated in neighbourhoods, where different communities meet, they have fences and security services, surveillance cameras, guidance schemes, parks, parking spaces, waste-management systems, logistics departments, protocols for the entry and exit of people and things (ibid). Hospitals are dusty, and sanitised, they are warm and cold, labyrinthine and intimate, they have histories that haunt the present (ibid). Hospitals, seen through different eyes, reveal different "truths", for example seeing a hospital through the eyes of a cleaner, or the eyes of a nurse; following food in the hospital will reveal different aspects of care and un-care than following ventilators; places of scientific research will disclose other meanings than

investigating them as places of precarious migrant labour or as public buildings in need of constant maintenance, rebuilding and repair or as production sites of medical waste; “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" (ibid). Making them tricky (Van der Geest & Finkler 2004: 1998f) but incredibly important fieldsites. In this context, my unique access to Yangon General Hospital almost translates into a moral obligation.

There are many ways to approach hospitals as “The Hospital Multiple” shows. As a contributor to this *Somatosphere* series*,* I used ethnography and drawing to portray issues of maintenance, 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” (Wuttke 2020).

Others in this series show the symbolic character of national hospitals (Garofalo 2020; Williams 2020); clinical and social implications of temperature in hospitals, reaching into a colonial past and present, with a beautifully written sensory hospital ethnography (Morales 2020) that builds on Morales’ above discussed 2018 article; and hospitals in terms of spectacle, teasing out hospitals as one of many capitalist nodes with medical as well as monetary value (Kehr 2021), to just name some of the outstanding contributions in this series as they connect to themes in my work.

Taken together, the series demonstrates the multiplicity of hospitals. Chabrol and Kehr develop the term “hospital multiple” in Deleuzian terms: being in constant flux. While the term inspired me and “flux” and “motion as the only constant” are themes in my writing, I develop, or re-develop “the hospital multiple” with relation to bodies, objects, and ultimately buildings, through Annemarie Mol’s *The Body Multiple* (Mol 2002). Needing to re-conceptualise how we think about (hospital) buildings, Mol’s reading of bodies/objects/buildings as multiple through the *practices* done to bodies/objects/buildings allows me to study the hospital beyond “seeing it through different” eyes, or various perspectives that show the hospital in different plans. At the same time, this approach acknowledges the hospital’s parts, blind spots, and contradictions that all constitute each other.

As seen above, scholars have conceptualised hospitals differently; for example as heterotopias, layers of biomedical and social spaces (Brown 2012; Street & Coleman 2012; Varley 2015) or *jinneaological* / multi-temporal understandings (Varley & Varma 2018), or through movement and patient pathways (Bah et al. 2021; Sullivan 2012; Vernooij et al. 2022). All demonstrate that hospitals are not singular. This multiplicity obviously resonates with my conceptualisation of hospitals. However, as an architectural designer, my first degree in architecture took me time and time again back to Foucault, biopolitics, the panopticon, and heterotopias. Thinking inherently spatially and with a perspectival understanding as laid out above, I needed to escape spatial concepts to unlearn and re-learn space. In this, I reach for Mol's "multiple" to develop an understanding of the hospital through *practices* (as located in-between literal and figurative structures); practice allows me to think with buildings without architecture, which ultimately lead me into the spaces between the walls and structures I was so used to.

You might have noticed my complicated relationship with perspective. I urge you to hold this thought. We will come back to it in detail in Chapter 1.

This discussion of hospital ethnography throws-up the issue of method. How to study and write about a public institution, a hospital? One way, I found useful, as insinuated above with reference to *The Body Multiple*, is to make sense of the hospital is through bodies (human and non-human) in space.

Spaces and Bodies

Two big ideas influenced sociologists' understanding of space and bodies, which are worth briefly discussing here. Both are French, both have written in the middle of the 20th century, and both have refuted dichotomous world views. One is Henri Lefebvre; the other is thirty years younger Pierre Bourdieu. With regards to Lefebvre, his rhythms analysis of spatial and temporal rhythms is particularly interesting, while when it comes to Bourdieu, his work is always firmly rooted in place, his concepts embodied, and temporally contextualised. Both together, and developed through

contemporary scholarship on agency, affect, and atmospheres, lead me to an intensely humanistic more-than-human anthropology.

Lefevre

French Marxist Philosopher and Sociologist Henri Lefebvre's work in the field of alienation, rhythms, movement, and a sociology of daily life, is fundamental in how sociologists understand bodies and space. His scholarship is deeply rooted in western thought traditions and must be read within its historic context, and in light of his own political project, the struggle against capitalism. Much of his work, especially *The Production of Space*, has influence beyond the field of sociology, especially with urban planners. As sociologically inclined architect I came across his work early in my career.

Lefebvre discusses the relationship between space, society, and the city, foregrounding the human body, but he remains (for me too) vague on the materiality of spaces, staying in an urban and abstract scale. His work on space and time *Rhythmanalysis* (2017 [1992]) sees bodies and/in space through rhythms. This opened new avenues in the way daily life (in cities) was studied and continues to be studied today. The movement of bodies through space and at particular times, allowed novel ways of understanding the city through a visceral and embodied register.

This scholarship might be an obvious epistemological as well as methodological touchpoint for my ethnography, but as stated above, my interest lies in the collapse of categories such as "social" and "natural". Lefevre's *Rhythmanalysis* (2017 [1992]) starkly distinguishes between natural (cosmic and vital) rhythms and social (educated and cultural) rhythms, and how the latter are linked to market conditions hence to be criticised. In contrast, I am interested in the whole and connectedness of the hospital's rhythms; cosmic, material, bodily, structural, historical, socio-political. Buildings have material metabolism which synchronise with rhythms of day and night, work schedules and bus times, bodily functions, and wider political and social systems embedded in palimpsests of history. I am concerned with the choreography of it all, especially in Part III of the thesis. Nonetheless Lefevre's *Rhythmanalysis*, the visceral attuning to, and observation of, daily life inspired my thinking.

His work is the first proposal on how to study rhythms, allowing space and time into the same frame, illustrating the importance of paying close attention, tuning-into, the temporal and spatial rhythms of daily life; a notion central to my project. Picking this up, I *include* material metabolism, climate, and more-than-human rhythms. Here I find debates around atmospheres, affect, and agency most productive, a discussion I will come back to below.

While Lefebvre continues to inspire some of my thinking, Bourdieu offers more tangible concepts that intertwine and collapse bodies and space. Hence, I see Bourdieu's *fields* and Mol's *practices,* as briefly introduced above, more pertinent to my project. We will return to Mol in Chapter 1 substantially, for now I would like to turn my attention to Bourdieu.

Bourdieu

While Bourdieu also needs to be read in a specific historic context, especially his work in Algeria, it is his scholarship on the Kabyle that extends his work beyond a purely western context. While he is notoriously difficult to read, maybe a reason Lefebvre with his lighter tone, at least in *Rhythmanalysis,* has had a wider audience beyond sociology, echoing Geertz in his observation that the style anthropologists write in determines our reach (Geertz 1988), Bourdieu's "theory of practice" ground his concepts in data from the field, in daily life. Bourdieu's concepts and ethnographic abstractions are always tied back to the precise, to moments in time, as for example in *The Bachelors Ball* (Bourdieu 2008), or an exact place with woven walls and sleeping quarters, as in "The Berber House or the World Reversed" (Bourdieu 2000a). Even in his discussions of interviews and the problems of writing, he is concerned with precision and exactness, as evident in the chapter "Understanding" at the end of *The Weight of the World* (Bourdieu 1999).

Bourdieu intertwines bodies in places in particular ways, collapsing the two with his concepts of habitus, fields, and doxa. These concepts are so visceral that my translator in the field, a poet and artist, literally explained the concept of habitus to me as "embodied and inherited habits grounded

in a troubled past", when we discussed maintenance and construction practices; themes I discuss in Chapter 5. Bourdieu's concepts are so tangible, they almost become common sense.

His analysis of places, for example the afore mentioned Berber house (2000a), goes beyond the straightforward categories sociologists and architects think in; in his analysis actions and objects receive symbolic meaning. At the same time, he remains precise and concrete, demonstrating ideas with hand-drawn floor plans and precise material descriptions.

Bourdieu is a master of a "balance of tensions" constituting of bodies and spaces, individual actions and society; I am thinking of his discussion of the Sun King's court in "Men and Machines" (Bourdieu 1981). Here he describes how different forces in tension with each other constitute stability; the sun king needs the revolutionary energy of subjects in his court to sustain his position. It is useful to think of the hospital in terms of forces and counter forces, a balance of tensions. Not only are its buildings a set of actual forces and counterforces in an engineering sense (the basic principle of how a building works is through a balance of forces and counterforces), natural-, social-, and built-environment, history, present, and future aspirations, are suspended in a tensegrity structure. With this balance of forces and counterforces, Bourdieu manages to successfully reject dichotomies such as "agents" vs "structure", or "objective" vs "subjective"; they are mutually constitutive of each other.[11]

His most prominent concepts (doxa, field, habitus) collapse these dichotomies. In "The Berber House or the World Reversed" he criticises that sociologists did not include actions and objects in their analysis of houses (Bourdieu 2000a: 505; see e.n.2). However, while the relationship between house and individual certainly is dialectic, he does not resolve this relationship fully beyond the symbolic, an example of this is my reading of the Berber house (Bourdieu 2000a) as discussed earlier.

[11] Bourdieu discusses "agents" and "structure" in "Men and Machines" (Bourdieu 1981); while the problem of "objective" and "subjective" is discussed in *In Other Words* (Bourdieu 2007) and in *The Weight of the World* (Bourdieu 1999).

"Tension", specifically the balance of tensions, is an underlying concept that weaves my chapters together. Tension makes things stable as Bourdieu showed us with his discussion of the sun king's court (Bourdieu 1981). But what happens when the bodies that constitute the tension are not stable, have agency (primary or secondary, are human or non-human)? The concept of tension puts in dialogue natural-, social- and built-environments; they enter the same frame. Actions, agents, secondary agents, objects, materials, natural and built environment stand in in tensions; "'ecstatic' intertwinings between things, persons and environmental constellations" (Boehme on Atmospheres in Brown et al. 2019: 9). In this I expand Bourdieu's fields, adding another dimension in forms of atmospheres, extending into the realm of inter-object agency and affect.

Atmospheres, More-than-Human Agency, and Affect

Bourdieu demonstrated a brilliant collapse manoeuvre with his concepts which bring bodies and space into the same plane. But his ideas have been refined since to meet contemporary challenges as laid out at the beginning of this section.

I pick this up by drawing on other concepts since Bourdieu, in particular Gell's definition of secondary agents. Here buildings become agents, without denying humans their agency.

Alfred Gell, much influenced by reading Bourdieu at the London School of Economics in the 1970s and 80s,[12] defines art objects as indexes. "Index" derives from "indicating", as for Gell processes around an object identify it as "art", rather than the object being art in and of itself. Art objects *indicate* art; hence they are indexes. This move "unfixes" objects of art; it renders them agents, indicators, and processes. This underpins my architectural sentiment to understand buildings as processes rather than fixed objects in my anthropological scholarship. The index/art object nexus developed by Gell in *Art and Agency* (1998) is smoothly extended, without rendering buildings (architecture) "art"; both art objects/indexes and buildings, are "pivots" around which social

[12] Alan MacFarlane writes about Gell's influences at the time in his obituary: https://www.therai.org.uk/archives-and-manuscripts/obituaries/alfred-gell

relations evolve in multiple directions (Gell 1998: 37). This brings us to the interesting question of agency, a point Bourdieu did not resolve, but Gell mastered.

For Gell, indexes are rarely *primary agents*, "entities endowed with the capacity to initiate actions/events through will or intention" (Gell 1998: 36). Indexes, or to make the language easier "art objects", are usually *secondary agents*, "entities not endowed with will or intention by themselves but essential to the formation, appearance, or manifestation of intentional actions" (ibid). Secondary agents *mediate* agency.

While buildings are not art, they spring from creative pursuits, they are pivots of social relationships; buildings, like indexes, are secondary agents. Buildings embody complex intentionality that mediate agency.

While Gell's art/agency/relationships nexus, fine art as a category for action, is useful for my thinking with buildings, I am resisting strict categories in favour for less structured readings which stem from contemporary debates. Forgoing Gell's "agents", "patients", "artist", "index", "prototype", and "recipient" matrix, I reach for concepts such as Atmospheres (Brown et al. 2019; Ghertner 2020), Moods (Gammeltoft 2018; Thonhauser 2021), "Colonial Formations" and "Imperial Debris" by Ann Stoler (2008). Here I am interested in the collapse of human and non-human life on the hospital campus.

As developed above, buildings are secondary agents. In my understanding of "Atmospheres", I follow German philosopher of anthropology Boehm, conceptualising them as "ecstatic" constellations of environments (this to me includes historic environments), objects, and people (Brown et al. 2019: 9), which developing this further, I see as a form of social agency. This leads to the idea of "affect". Affect or "affective" is a slippery category, which I understand as an extension to "agency", widening the concept to emotions; affect combines action and emotions. Affect is another way of attributing agency to non-human entities; the space between, the tension or the field as Bourdieu would call it, of objects, bodies, nature, buildings. Boehm's ecstasies of things (ibid).

Atmospheres and affect are another way of talking about more-than-human agency, hence my intellectual fascination with this, at times ephemeral, body of literature despite my preoccupation with preciseness, concreteness, and non-abstract materiality. Affect widens the term of agency: acting *plus* feelings and emotions.

In the following pages buildings appear as affective secondary agents under atmospheric conditions, drawing on Gell's *Art and Agency* (1998), and being indebted to Brown et al.'s discussion of "Affect theory and the concept of atmosphere" (2019) in developing these ideas. Here buildings emerge as processes suspended in a tension of space, time, and their position in the city, rather than fixed objects.

In this, I develop an ethnography *with and through* buildings, looking at a hospital, its infrastructure and places, history and context, its people, rhythms and moods, in Myanmar. This presents a departure from conventional approaches to hospitals that tend to look at examples from resource low contexts as aberrant or peripheral to the more 'normal' healthcare regimes in "wealthy" nations. But the present Myanmar example is a good starting point. Here healthcare is operating within an environment that seems to be much closer to a realistic future than private hospitals in London, Singapore, Bangkok, and the like.

FIELDWORK

Imagine drawing a portrait, noticing all the little lines, flaws, and curvatures, finding beauty in imperfections. It is an intimate process, a process of noticing and seeing. During my fieldwork at Yangon General Hospital, this is just what I did. With sketchbooks and pens I moved through the campus, along its pathways, into places I did not expect to find, drawing the hospital's daily life.

As the project Architect for the hospital's rejuvenation project, I had been drawing the hospital on tracing paper and in notebooks since 2015. In 2019, I returned as artful ethnographer with A3

sketchpads, black ink pens, and colourful studio markers. Drawing is a process of seeing and experiencing the world in different ways, not through a conscious thought process but a visceral field encounter. This methodology allowed me to focus on the hospital as a whole and its connections. As an architectural engineer and a social anthropologist, I am leaning into my multidisciplinary training: drawing and writing with the hospital's buildings; a methodological experiment that I will discuss in detail in Part I, Chapters 1 "Writing" and 2 "Drawing". For now, it suffices to know that instead of linear text, my fieldnotes were sketches, lines and colours on paper. You will find these artefacts from the field throughout the ethnography presented here; left between the lines as metanarratives, not supplementing but complementing the text, thickening the plot.

I only drew at the hospital; in the field. I never did any drawings and sketching in hindsight or after fieldwork. My aim was to experiment with drawing as epistemological project during fieldwork. I could have drawn after, sketched off, for example historic photographs for Chapter 4 "History", I would probably have learned much from this process; as we will see in Chapter 2, drawing is seeing. I can only speculate what I would have seen on the historic photographs had a traced them. However, I wanted to keep the process of drawing in and with the fieldsite; a new engagement for myself with the hospital as well as my drawing practice.

I also felt, given that my interlocutors had seen my drawings, for example many of the senior hospital management saw and comment on my drawings during two presentations towards the end of my fieldwork, that drawing outside the field, from memory and not being able to show my drawings to my interlocutors, would not be true to what I wanted to achieve. Hence drawing remained in the field.

While they are field notes, they are also more. They are visceral *in situ* engagements with the hospital's daily life. In the field, they helped me to see the world differently, beyond text. At home, at my desk writing, they are guides and objects of the field encounter. In this sense, for you, they are

an invitation: to a deeper or “otherwise” engagement with the ethnography. This is not an ethnographic novel. The text works without them. You can read the text without the drawings. You can also mobilise the drawings without the text. Each one tells a story of its own if you pay careful attention; the text offers the context to be able to “read” the drawings. At times, you find the storey in the text, told with different lines on paper, with words, grammar, and punctuation. At others, they are left seemingly on their own, remnants from the field. Some sections have more drawings than others; some have no drawings at all as I did not feel they belonged. I included my sketches intuitively, akin to my drawing style. I sketch intuitively, attuned to my environment; at times I move a lot, drawing while walking, adding colour as an afterthought; at others I am stationary, maybe resting in the shade, daily life moving around me, never still, ever in motion; constant oscillation.

In essence, the drawings are an offer, to you, the reader, to see the field differently, or fuller, or further, thickening the ethnography beyond text, beyond the words written on the page. In this sense, the drawings want nothing from you. I suggest approaching them with curiosity and the sensibility of an ethnographer, considering them like visual poetry.

Alongside drawing, I recorded sound. With my recorder I captured humming air-condition units, dripping pipes, rattling beds and many more infrastructural sounds. Some evenings I would go home and compile my loot into soundscapes, immersing myself into a different sensory register of my fieldsite. These auditory vignettes did not find their way into the thesis in an obvious way. However, they informed my writing, as they were important anchors for my experience of the hospital.

When in spring 2020 the Covid-19 pandemic arrived in Myanmar, my sketchbooks and I were not allowed to enter clinical areas anymore. My translator was not able to join me for interviews and generally my movements were restricted. But given my background as architectural engineer on campus, my history with the hospital, and the trust I had built over years paired with the believe that I knew what I was doing, and what I do being potentially useful to the hospital, I was able to continue my observations. I spend my time in the campus’ external spaces during the extended

lockdowns throughout April and May. Now with appropriate PPE, I was permitted to survey key Covid-19-response spaces, a benefit of my role architectural designer. My former team, who had all left YGH at this point, asked me to survey the A&E, PUI (people under investigation) wards, the isolation ward, which was upgraded, and the oxygen infrastructure. This afforded me access to spaces a lay person might not have seen, and entry into conversations with the people who showed me around and were otherwise notoriously difficult to get hold of. I mapped how the hospital changed with the virus: how fewer people frequented the campus, out of fear of infection during lengthy journeys to YGH, or getting Covid-19 at the hospital; the introduction of booking systems to avoid crowds; the A&E's reorganisation for stricter infection control and installation of fever rooms; new handwash basins with soap at every building entrance; the temporary closure and relocation of the outpatient department to the nearby high school and later to a the oncology outpatient ward as the A&E continued to need more space; the reorganisation of pathways to accommodate a new PPE room outside the central ICU. Much changed in the first weeks and for most of it the maintenance teams were called on.

I spent my days drawing in the shade of one of the old trees on campus, joining in the banter, excitement, frustrations, and anxieties of my interlocutors. Most of June I followed goods around campus; from the medical store to the local storage in wards I traced the pathways of syringes, drip bottles, hand sanitiser, medicines, and other clinical equipment. While drawing routes and floorplans, shelves and organisational systems, I learned much more about operations around campus, roles, responsibilities, and relationships, dropping into conversations I would otherwise never have had. When the first Covid-19-wave subsided, in July 2020, I conducted interviews and visited wards, visits my translator could now join.

The pandemic changed the physical and methodological boundaries of my fieldwork. Where I might have spent more times on wards, these became off limits. The pandemic posed an interesting constraint maybe more helpful than hindering, following Candea in the observation that limitations

on the fieldsite can be productive (2007). While my fieldsite had always been bounded, a hospital campus with walls in downtown Yangon, now new boundaries emerged. My focus landed on the semi-public spaces around campus, the spaces in-between building, between wards, between services, all so vital for healthcare. As everything came to a standstill, my fieldsite flourished within its new confines. Through the hot languishing days of lockdowns and social distancing, my drawing practice became an anchor and motor. For days, I would only see my interlocutors on campus who were kind to indulge my limited Burmese language skills, drawing became a key motivation to go to campus; the words of a dear friend and former colleague, a fellow architect, echoing in my ears: "What a privilege to spend a year drawing the hospital!", I was determined to make the most of it.

I left Yangon in late August 2020 as a second, more severe Covid-19 wave was about to hit Myanmar, a couple of months before the country's last democratic elections that led to the brutal military coup of 2021. I am the first social anthropologist to be granted access for research at Yangon General Hospital, and most likely the last for years to come.

Ethics Review Board

I had laid the groundwork for the research during my years working on campus as project architect for the hospital's rejuvenation project. On my drawing sojourns, acquaintances, administrators, doctors, and sisters, would ask my opinion on how to improve aspects of the hospital; when it came to buildings, infrastructure, waste and related issues I was often seen by my interlocutors as an expert rather than as the "apprentice" whom anthropologists have written about (Jenkins 1994).

Since 2015, I had built trust and relationships with individuals at the hospital as well as on ministry level. Despite my familiarity with the fieldsite and key stakeholders, I had to apply for official permission from the Myanmar Ministry of Health and Sports' Department for Medical Research. While I had the support from the hospital administration and personal emails from the Minister for Health and Sport at the time, my digital enquiries from London did not yield any progress. Knowing

of the workings of Myanmar bureaucracy this did not deter me. I embarked on the official permission process as soon as I arrived in Yangon in October 2019.

At first, the chairs of the ethics review board were dismissive of my application, but the printed emails from the Minister and my track record working on campus quickly changed their mind; they had heard of the rejuvenation project, the organisation I had worked for, and in the abstract about me. Still today, when I mention my research well-meaning interlocutors suggest that I should get in touch with my former organisation, or even "the German architect" who was in charge of the renovation of YGH's main buildings.

My application was not only received and supported with useful comments and suggestions for amendments and additions, for example finding a local advisor from Yangon University, it was expedited. I approached a professor from Yangon University's Anthropology Department and submitted my research proposal beginning of November 2019. In January 2020 I was invited to present to the Internal Review Board/Ethics Review Board.

The panel, with some familiar faces from YGH, was very thorough in their questions. I was queried about privacy concerns, if I would be using a camera, or how I would approach suffering or mourning individuals. I was also asked how I would deal with complains or negative information about the hospital; my answer that I am not interested in catching anybody out or writing a sensationalist journalistic article, but an ethnographic account that would question the way we think about hospitals, satisfied the board. They seemed very interested in my ethnographic, qualitative, approach and their questions showed critical benevolence. At every step of the process, I was met with curiosity, open mindedness, helpful advice, and thought-provoking impulses that only improved my project.

Following an ethics review board hearing in early 2020, I was granted official access to the hospital. I could finally embark on my fieldwork *on* campus; prior to this official permission I had been working

around the hospital, circling in on it from its gates, and places like the Thayettaw Monastery complex.

MAKING SENSE OF THE FIELDSITE

Yangon General Hospital is a gigantic campus in downtown Yangon. It is Myanmar's main public tertiary care and teaching hospital. It took me many years of uncountable site visits, innumerable hours of drawing its many shapes, daily rhythms, structural corsets, and infra-structures to grasp its extent.

The main campus occupies an entire block between Bo Gyoke Aung San Road (north), Shwedagon Pagoda Road (east), Anawrahta Road (south) and Lanmadaw road (west), spanning of 32 acers about double the size of St Thomas in London, the size of approximately 18.5 Premier League football pitches. Sixty-three odd buildings, plus covered walkways and bridges constitute the hospital.[13] The campus is a maze grown over a century, through *ad hoc* planning and construction, based on the needs of the time, without an overarching design, resulting in a hodgepodge of structures from different eras. Some of the majestic centenary Banyans survived and are still branching over parts of today's campus. Navigating the maze of buildings can be challenging for newcomers, with some structures towering over others and paths weaving between them. However, for those who have spent time on the campus, the hospital holds a charm and sense of history, with each building telling its own story of the needs and priorities of its time.

An extension site, the size of another six acres, 3.5 Premier League pitches, (main and extension campus are in total 38 acres). Six odd buildings with corresponding departments, are located here, across the road from the main campus, severed by four-lane, one-way, Bo Gyoke Aung San Road, one of Yangon's main east-west arteries.

[13] Areas are based on a site survey from 2016, published in the 2016/17 prepared masterplan (Article 25 2017).

In 2019, the hospital was home to 27 specialty departments, wards, units, and centres, four general medical and three general surgical units, with a total of 2000 (sanctioned[14]) inpatient beds[15], in addition to general specialist outpatient departments and an emergency department (A&E). (YGH 2019)

The hospital's departments are organised by clinical speciality. It is the specialities that dictate space allocation. This spatial organisation is called "by institute". It is the easiest for training doctors, following specialities as they are taught at university; the Cardiac Building is home to the cardiac departments with their cardiac surgeons and medics; one entire floor of the main building is Orthopaedics, the orthopaedic surgeons' "empire"; Haematology has its own cluster of buildings for the in Myanmar rare haematologists; the central ICU is its own self-contained unit run by the Anastasia department; the Modular Operating Theatre Complex is home to, as you might guess, the operating suite and the surgical wards with their surgeons, and so on.

Inpatients per day are c. 1600[16] (YGH 2019). Each inpatient is accompanied by a minimum of one carer, usually around three, also referred to as attendants. Attendants are mostly family members, like Aunty Aung, occasionally a friend or neighbour would be asked to accompany someone. Additionally to inpatients, approximately 2000 outpatients visit the hospital daily (YGH 2019), when there is no pandemic or military coup, plus attendants who are on average up to five individuals, mostly family members, extended family and friends, to keep the patient company while waiting for their clinic times. This means around 9000 patients (in and out-patients) and attendants are patronising the campus daily. This is not including the many staff (clinical and non-clinical), vendors, pharma company reps, charity organisations, contractors, construction teams and so on.

[14] The actual quantity of beds on wards usually exceeds their sanctioned number.
[15] St. Thomas in London for comparison has about 840 beds – in area and bed numbers half the size of YGH.
[16] Sanctioned beds are 2000 in total, each ward has sanctioned beds and usually the wards are over capacity. However, wards rotate admission days; medical wards have admission once a week and empty-out over the week. On the last day before admission-day a ward can be virtually empty.

A total of 2177 staff (clinical and non-clinical; including general workers such as cleaners, and maintenance teams; engineers; administrators) keep the hospital running, with 880 vacancies; a good third of all sanctioned positions the administration planned and budgeted for, were vacant in 2019 (YGH 2019).

In 2019, the engineering staff had 104 sanctioned positions, but only 28 were occupied: a vacancy rate over 70%. The highest in the hospital. The small, under-resourced team tends to the sixty-nine odd buildings and structures on campus, their (leaking) roofs, (broken) doors and windows, continuously encroaching nature, and other ailments, as well as new constructions and routine maintenance. They care for hundreds of meters of water pipes that transport water from eleven tube wells and five ground tanks to ten high level tanks, getting water to patients' bodies and clinicians' hands for vital hand-hygiene; kilometres of electrical wires, transformers, eight generators (in 2016/17) and other electrical equipment, feeding the hospital's prosthetic atmospheres; numerous lifts under the responsibility of the electrical department who have twenty manning the vertical access; oxygen pipes supplying patients with the vital medical gas. In parts ancient, and prone to blockages, drainage and sewage channels are also their charges. The high vacancy rate of the team responsible for the entire campus' infrastructure implies that buildings are undervalued as compared to other aspects of the hospital. Another reading might be, if I am allowed to briefly speculate, that government jobs are not well paid, and educated and trained engineers can make more money in Yangon's booming construction industry, while labourers with only basic to no education, as well as higher educated people, often leave the country.

Over the past century, the hospital has grown from a 500-bedded general hospital for colonial expats and locals, into a large 2000-bedded public, tertiary care, and teaching hospital.

While numbers are important and have their place, they also have a concealing quality. They hide the reality of daily life on campus, the campus as a place, with a history, relationships and a local

context that produces these numbers, rhythms and routines, atmospheres, and individuals behind the numbers whose lives depend on and evolve around YGH.

Hence, this thesis is about how to research and describe a public hospital to better understand the institution, the category "hospital", enmeshed and whole.

CHAPTER SUMMARY

Four broad questions guide the reader through eight chapters in four parts: Part I "Ethnography with the (built) Environment", delivers the methodological and epistemological contribution of the thesis. In two chapters I ask, "How to capture a public institution on paper?". Part II "Place" asks, "What is a building?" Through three chapters we take a high-resolution view of the "The Campus" (Chapter 3), its "History" (Chapter 4), and relationships "Beyond Campus Walls" (Chapter 5). Part III "Rhythms", grapples with an old anthropological question, "How do we live with our buildings and they with us?" In two chapters, I show the hospital's rhythms, moods, and atmospheres. Part IV "Individual Encounters", addresses what some readers might already have asked themselves in the light of parts two and three, "How and why does the hospital function at all?"

In short, Part I develops a hypothesis, a proposition for an experiment, to which Parts II, III, and IV deliver the proof-of-concept.

Part I ETHNOGRAPHY WITH BUILDINGS, consists of two chapters. Chapter 1 "Writing with Buildings" develops the idea of what it means to write with buildings, situating the notion of "writing buildings" within anthropology and discussing the potential of this novel anthropological contribution to the disciplines. Writing with buildings means keeping the environment and the vessel of the social relationships (buildings) in focus. Writing with buildings is a way of knowing the world through a material register. It is specific and emplaced; the qualitative approach is anthropology's bread and

butter; architecture contributes an understanding of the ephemeral quality of place and buildings that goes beyond words. Here we will (re-) conceptualise buildings as processes, rather than fixed objects, understanding them (anew) through practices done with and to them, rather than different perfectives which are necessarily always limited.

Chapter 2 “Drawing” evolves around drawing as a methodology for ethnographic fieldwork. How can we experience a building in order to write about it? Drawing emerges as way of seeing and experiencing the world, knowing it otherwise. Drawing in the field harnesses the power of drawing (the process) to *see*, to *be* and to *engage* with the fieldsite. This chapter provides the basis for artful ethnographies.

Part II PLACE, is an introduction to Yangon General Hospital while also delivering important arguments. In Chapter 3 “The Campus”, I introduce you to the hospital campus and show that a building is more than the sum of its parts. It is as a lived space, a fleshy and disgusting place, where bodies sweat and materials decay, abstract and alienating, a maze and my(th)stery where one easily gets lost; where pathways cross and overlap, and their materiality can translates into a painful reality for patients’ bodies.

In Chapter 4 “History” past and future converge. The hospital’s materiality and past ideologies stand in tension with future aspirations. Its past renders buildings symbolic and anchors them deeply in Yangon’s build heritage and Myanmar’s history, while reflecting social and clinical change over time.

Chapter 5 “Beyond Campus walls” tells of the relationships and partnerships the hospital weaves beyond its boundary. We see people connect where systems connect and contingent reciprocal relationships between hospital and city, in the context of Myanmar. “Lack” becomes a business opportunity and the wares on offer at stalls around campus offer an ethnography of patients’ daily needs. We see the campus in constant motion like our lives are in constant motion; the hospital as never “finished”.

In Part III RHYTHMS, I address how buildings shape our lives and we shape our buildings without falling in a structuralist trap. Chapter 6 “Tuning-in” attunes us to the multiple rhythms on campus and shows how we live with our buildings and how they with us. Life at the hospital is continuous. As seen in previous chapters, YGH preservers in the face of displacement and war; even when the main sewage outlet is crushed the hospital does not stop the merry-go-around, and neither does a pandemic grind everything to a halt.

Chapter 7 “Bodies and Buildings” takes us on a sensory journey across time and space into the daily life of Yangon General Hospital. I show how “bodies and buildings” are rhythmed by colonial and other airs, and how infrastructures relate and rupture healthcare. The ethnography animates the horizontal and vertical, past and present, entanglements of the hospital buildings and bodies of patients, staff, attendants and visitors, all striving for life on the hospital campus. On this journey, I rethink the hospital through its daily practices and materialities.

Finally, in Part IV INDIVIDUAL ENCOUNTERS we meet individuals in their “Spaces of Responsibility” (Chapter 8). The argument put forward here, looks at people and what I call their “spaces of responsibility”; the responsibilities they assume *vis-a-vis* their values and beliefs what a hospital should, or could, be. These individuals ensure the continued functioning of the hospital amongst vegetative reproach, material decay, and infrastructural neglect. It is the interfaces, the change, where we need to shine light on and focus our attention, in order to understand what makes a hospital work. The making never ends; a hospital is constantly made and re-made.

This thesis is an ethnography of Yangon General Hospital, as well as proof of concept of a novel methodological and epistemological approach: drawing for ethnographic fieldwork and writing with buildings. The hypothesis is that researching a hospital, a complex public institution, by way of its buildings yields a holistic picture; buildings keep the whole in focus while moving between and across scales. Understanding the hospital as a whole, we can make proposals to think about

hospitals differently, beyond functions, with practices. In this, the hospital is both object and method.

I ETHNOGRAPHY WITH THE (BUILT) ENVIRONMENT

How to capture a public institution on paper?

"Science aspires to know everything… art pursues exactly the opposite: the subjectivity, the single phenomenon, the analysis of particularities, the facts in their context, personal experiences. Art is un-learning process."

– Damiàn Ortega

CHAPTER 1: WRITING

THE STAIR

The treads of the central stair in the main building are new. Noses are missing for feet to glide under easily in ascent. Renovations just a few years ago replaced the worn stone with white marble. I remember the time when this main vertical circulation was wound around a creaking lift; I never saw the lift in operation. Sickly green walls and corners were stained red from careless betel nut spitting; the space murky and airless; the ventilation blocked by the mechanical intervention; sticky humidity trapped in the space by a corrugated metal roof that did not allow the rising hot air to escape. Today, the lift is gone, the roof transparent with vents; the space is light and airy, its original atmosphere reinstated.

The wooden handrail, likely the original ones that guided English matrons' hands through the vertical space, is smooth. While cleaned-up during the renovations, red betel juice collecting in corners is evidence of the only partial effect of the signs fixed to the marble walls that instruct not to chew betel nor spit it. Spider webs and dust collect in the intricate ironwork of the railings and balustrades.

A pink robed nun climbs the stairs slowly, one hand on the old wood. A hospital worker in a purple longji, flip flops slapping the marble, rushes past, carrying a cooling box with blood transfusions from the blood issue room at the bottom of the stairs. A patient on the upper floor might be waiting for the plasma. Two doctors come down the stairs on their way from morning rounds: chatting, laughing, looking tired. They respectfully greet the nun. Visitors, workers, doctors pass each other in this central circulation space, acknowledging each other's presence with their respective rhythms and moods. The diversity of rhythms contributing to the stairwell's atmosphere. Back and front of house pathways, distinguished by different speeds, vibrating in the same place while occupying different spaces. The staircase holds them all.

Pharma reps and attendants wait bored in the breeze the building catches in the open passageways that connect the central block with the main staircase to the ward-wings, East, West, South.

Three female workers lunch on a plastic blanket by a balustrade on the first floor, chatting over tiffin containers. Conversations resound on the stair's stone surfaces, a laugh rings through the well.

As night falls, the atmosphere changes. In door openings to teaching rooms, and between arches where the workers chattered over lunch, attendants sleep on the upper floors. The cool caustic tiles soothe the sleeping bodies. The air is still as the night is quiet. From time-to-time faint snoring disturbs the silence. The slightly sour smell of sleeping bodies that had nowhere to wash, fills the staircase; a rancid but comforting smell of sleeping air. The hospital worker still rushes up and down the stairs with cooling boxes from the blood issue room, the flip flop of his footwear more pronounced than during the day; a fire alarm about to run out of battery chimes in with its desperate beeps for attention. The night's sleepy atmosphere contrasts the persistent mechanical beep from the material metabolism of the fire alarm's fading power and the purposeful movement of the worker delivering blood in a rhythm set by patients' bodies.

Within this short vignette about the hospital's main building's central staircase, daily overlapping practices of the hospital come into focus; varied events with their materiality, done to and with the hospital; its quality as a place, its rhythms and atmospheres, and encounters between bodies and building.

Towards the end of writing my PhD, I found a short text I wrote about Wittgenstein and the house he built for his sister in Vienna, for the seminar series *Architecture and Philosophy* at my alma mater in Munich. Here, I discuss the house in terms of what the layout, style, material choices, spatial decisions, and detailed design tell us about Wittgenstein's personality and by extension about his philosophy. This is contrary to other discussions that try to understand the house as "built philosophy". I think, it was here where my interest for "the continuity of container and contained" began. What happens when we think the social *with* buildings? How does our knowing of the world change?

Despite this thesis preoccupation with buildings, it is not a thesis about hospital architecture or design of hospitals. It is an ethnographic study of the hospital multiple, the daily life of Yangon General Hospital with its buildings, the materials, and the practices that constitute a hospital. In this I am re-evaluating how we understand hospitals, large and complex public institutions, and buildings in a wider sense. In the process I develop two novel propositions, one epistemological, the other methodological: *Writing* with buildings (Chapter 1) and *Drawing* as ethnographic methodology (Chapter 2). In this sense the thesis itself occupies an in-between space, between drawing and writing; gestures and words.

Text and Drawings

When I started my fieldwork, the first month I would draw façade elevations, with some figures in front. As my own position shifted from architect to ethnographer, through my drawing practice in the field, I challenged myself to draw between the buildings, not remain in the familiar terrain of architectural elevations and details, my drawings changed. They started to show the in-between; in-between buildings and walls where life takes place. In the relationships of bodies in space the buildings are invisible yet present, as bodies would make different shapes and engaged in different relationships in different spaces. I became more interested in the thickness of life between the walls I designed. My more architectural drawings, plans, sections, elevations and details, became

annotations to what I considered important. My drawings are often hybrid; a note of a colour I did not have the correct shade, notes on timing (while drawing encompasses time, as with any visual medium, incorporating time is difficult), or notes on details “Mats; Samosa; Almond Tree”. However, most of these notations speak more to an anxiety of not “recording” enough” rather than actual information. Interesting amongst the scribbles between sketches are questions I noted down which led me into analytical considerations; “where do people pee?”.

At the same time, my drawing style speaks of my two disciplines; the architect’s eye for (depth of) space, plans and elevations, a feeling for inside and outside on one hand, the anthropologist’s sensibility for relationships on the other. Both come together in my drawings and tex.

As an architect, drawings and words do not preclude each other; every drawing has words, some more, some less. Words and sketches are both lines on paper that go hand in hand. They tell the same story in different ways, and one could not exist without the other. This understanding of drawing and text as one translated seamlessly into my ethnographic drawing and writing.

Part I of the thesis sets out the epistemological and methodological baseline for an ethnography with buildings. This first chapter “Writing” addresses what it means to write with buildings. With “The Hospital Multiple” we see the commitment to materials and practices this project entails; where the notion of “writing with buildings” is situated within anthropology in “Writing Culture Debate”, and what this approach contributes to the discipline in terms of “Writing with Buildings as Craft” and “Writing with buildings as Epistemological Project”, before concluding with a discussion on writing with the buildings/the built environment as an intensely humanistic way of writing in a more-than-human world.

THE HOSPITAL MULTIPLE

If a doctor in Yangon says she works at Yangon General Hospital, their interlocutor will most likely say: "Oh I know! It's the big red building on Bogyoke Aung San Road." This speaks to so much more than the building's looks and location. The building is iconic and historic; between its walls people work, care, and heal, tending to bodies and buildings. Most Myanmar people, regardless of where in the world, have a story about YGH; in fact, I have yet to find someone who does not have a YGH story to share.

The question emerges, how to write about this complex public institution that is so many things in one? First, I would suggest, finding a way of thinking and conceptualising the hospital through its buildings. In the introductory chapter we established buildings as secondary agents (following Gell 1998) and processes (Buchli 2013; following Carsten & Hugh-Jones 1995b; Yaneva 2017). Now we need to find a position from which we can think *with* buildings to be able to write *with* them.

The notion of *looking* at a building, the idea of perspective, is not helpful in conceptualising the hospital. I am not alone in noting this. Yaneva points out, how perspectivism only ever renders a partial understanding of a building (Yaneva 2017: 122). Instead of looking at a project from the perspective of, for example, the financier, the users, or the designers, Yaneva proposes to understand architectural projects by witnessing "what a building does with those who interact with it on a daily basis in a multiplicity of events" (Yaneva 2017: 122). I find a similar approach, developed with more theoretical depth, in Annemarie Mol's conceptualisation of the body through what she calls a "specific" philosophy (Mol 2002: viii); a philosophy explicit in origins, derived from a particular disease at a point in time, in a geographic location. What Mol understands as specific philosophy (I would attribute the semantics to her training in both medicine and philosophy) I see akin to Bourdieu's ethnographic abstraction and theory of practice. In a decided departure from *perspective* Mol conceptualises the "body multiple", multiple bodies in one, through *practice.*

Borrowing from Annemarie Mol, I have found it useful to reconceptualise the way *buildings* are understood by drawing on her conceptualisation of the body manipulated in practice (Mol 2002: 4f). Here, buildings are no more singular objects that everyone has a different perspective on, they are rendered multiples through what we do with, around, and in them. It is in practices, events, and materiality, that the hospital multiple appears.

Annamarie Mol challenges the idea of countless perspectives on to the same body, her aim is to get away from the concept that different people have different perspectives onto the *same* body. For her, practices with the body make different bodies. A good example to illustrate this is the boundary of the body. To a dermatologist the skin might be the boundary, the practice of examining the skin for melanoma creates this boundary; for someone who has problems with swallowing, the mouth is the boundary, and the practice of swallowing defines this boundary; if you swallow medicine the stomach lining is the boundary of the body; if you take insulin the blood cells is where the boundary happens. Every time the boundary appears somewhere else, the body becomes something different defined by the practice, while it is still the same body. Hence Mol coins the term "body *multiple*"; a singular noun (body) with multiple, plural.

I extend this thinking to buildings, as a way to understand the hospital. While the idea of the boundary does not translate neatly onto the hospital, reaping a less impactful imagery, after all buildings are not bodies, even though they are both equally porous, let me give you three simple examples. The hospital is inhabited with different practices that render the hospital multiple. For an oxygen worker the hospital is workplace, a place with jovial, at times complicated, but lasting relationships, defined by rest places and rhythmed by patients' bodies' needs for oxygen, the location of manifolds and cannister stores, and electricity outages that effect the oxygen plant. For a pharmacist's child doing homework on campus, playing ball with other staff' and the vendors' children when done, the hospital is jovial place of play, away from the parental gaze. For a patient, the hospital is an intimate place where his body is exposed, under clinical scrutiny, a place of body

fluids and pain, in stark contrast with the abstract routine doctors approach his body. They are all different hospitals and still one.

While I am using characters to illustrate what people *do* with the hospital, the *hospital multiple* is not a matter of perspective. It is not about how you *look* at something but the *practices* that define the hospital as a space where medical gases and jovial atmospheres mingle, a playground, a liminal place of pain and hope. This is the main concern of Annemarie Mol with regard to medical knowledge in *The Body Multiple* (Mol 2002). In Mol's conceptualisation of the body it is not one object/body that everybody sees differently, but in relation to different practices an object/body emerges as something different; different practices multiply the body/building/hospital, while it remains one.

Annemarie Mol understands objects as things manipulated in practices (Mol 2002: 4). I transfer this to understanding buildings manipulated in practices. If buildings are understood in this way "there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects (in this case buildings) come into being—and disappear—with the practices in which they are manipulated" (Mol 2002: 5). "Reality multiplies" (ibid). At the core of this formulation lies the question: How are buildings handled in practice?[17] A deeply ethnographic question of knowledge production, as Mol points out as well (ibid).

A toilet, rather than a singular space in a series of hospital functions, if understood in terms of practices, translates into a broken body in bed, shifting to the edge of the matrass, a

[17] This question is adapted from Mol's question ''how are objects handled in practice?'(Mol 2002: 5)

fearful drop into the wheelchair, a distance rendered time; will the body make it across the ward early enough to avoid public humiliation? A similar set of practices of bodies in space at the other side the journey. The engagement with the "toilet" through practice becomes more meaningful than number of seats, width of stalls, location, and so on.

To describe the hospital multiple, I use *writing with buildings*. Writing with buildings means teasing out the practices and materiality to see the hospital/building multiple develop. This understanding allows for a more sophisticated analysis along what is actually happening on the ground. As established in the introduction, through a discussion of Gell's notion of indexes/art objects (Gell 1998), buildings are secondary agents. The hospital multiple makes this agency of buildings visible.

Writing with buildings, writing with care and detail and material realities, makes visible the everyday. We start to see the mundane and the unseen; the unspoken relationships between us and the built environment, by extension the natural environment; social relationships mediated by the built environment. Things hidden in the unsaid emerge. Realities of materials reveal smoothed edges by age. Different speeds in the same place happen on the same floor material. Needs and worries for economic survival in a future with a question mark attached by state violence and neglect become tangible.

Writing with buildings unearths all this. And herein lies its politics: seeing what people actually care about. All anthropologists probably attempt this, many achieve it. Writing with buildings inches the material alongside, it integrates materiality with practice. Thus emerges an intensely humanistic way of writing and thinking in a more-than-human world that decentres the human while not releasing us from our responsibilities.

With the people I meet and places and spaces I observe, I see how healing, waiting, working in a hospital is *done*, how people heal, wait, and work; in the same way Annemarie Mol learns "[…] how living with an impaired body is *done* in practice" (Mol 2002: 15 emphasis in the original). Mol learns about the trials and tribulations of living with an impaired body; I learn about the trials and

tribulations of healing, waiting, and working at a public tertiary care teaching hospital (in Southeast Asia). I get to understand what the hospital is as opposed to what people wanted it to be. It emerges in its multiplicity; many hospitals in one that at times contradict each other and in their contradiction constitute one another, sitting together comfortably or uneasy, but in multitude.

WRITING CULTURE DEBATE

The notion of writing with buildings is situated adjacent to discussions on *The Interpretation of Cultures* (Geertz 1973)*, Writing Culture* (Clifford & Marcus 1986), and *Women Writing Culture* (Behar & Gordon 1995), as well as writing social and individual lives in different institutional, religious, and class settings (Bourdieu 1999, 2008; Jenkins 1994).

The debate on anthropological rhetoric initiated in the 1970s opened an important discussion on how we write as anthropologists. Clifford and Marcus, whose seminal volume was mostly concerned with the poetics of ethnography, writing styles and politics of representation, nonetheless highlighted issues of knowledge production and politics embedded in ethnographic representation, ushering in debates on a reflexive and literary anthropology(1986). They were followed, and criticised, by interventions from feminist voices (Behar & Gordon 1995) and others discussing *Beyond Writing Culture* (Zenker 2010), to just name a few titles within this space. This debate continues unresolved. I am not sure if it can be, or if I would want it to be resolved. The more voices add to anthropological rhetoric, or the discussion on how we write anthropologically, the more plurality we are allowing into the disciplines with multiple and diverse experiences and epistemologies. Writing with buildings adds to this debate without claiming to be a portal to a secret world.

More recently, novel voices added to the debate on anthropological rhetoric by moving not only beyond writing culture, but beyond text, investigating the possibility of involving more registers than just written ethnographies (Causey 2017; Cox et al. 2016; Dix et al. 2019; Theodossopoulos n.d.).

These authors who combine text and other media, present a new "turn", some call it the "graphic turn".[18]

This "turn" presents in its different aesthetics (writing and drawing both produce meaning-carrying lines on paper), a continued questioning of ethnographic representation: how to write anthropologically; how to write with care; how to write in a more than human world without losing human agency and, particularly important for me, human responsibility.

These discussions all address the question of how to bridge the gap between the messiness and mystery of life to linear text with its rules and structure.

Ethnography can be written (and read) in various ways (Clifford & Marcus 1986: 265). Writing with buildings sits at the intersection of creative pursuits and anthropological rhetoric. The writing culture movement questioned the rhetoric of ethnographies; topics such as inclusion and exclusion, who writes and how. Very important questions to ask and discuss. However, much of the writing culture debate has been concerned with a literary mode. My concern is not with ethnography as literature or as a literary style.

Instead, I am interested in how different ways of writing elucidate novel perceptions on old phenomena. Here, writing and the style we write in is essentially part of the analysis; writing becomes "thinking through different modes". What happens when I write-out the materiality and practices of a staircase? Atmospheres and rhythms start to run into each other. The deep time of the building, the worn steps and smooth handrails, come to life and collide with the present, in the shape of plastic flip flops on marble floors. The analysis comes through *writing with the building,* bringing a different sensory quality.

Most of us have quite clear ideas of what we think a hospital is. I am not inventing a novel literature genre but use *writing with buildings* as a way to think through old problems in new ways by

[18] For now, I would call this a hesitant whisper in seminars, at conferences, and workshops.

considering the world through and with the built environment which makes much of the world that we inhabit as humans. When I write "considering the world *through* buildings", I conceptualise this "through" a material mode, for example, the caustic tiles that cool the sleeping bodies in the opening vignette of this chapter; while "with" buildings, is orientated towards practices and events, for example, sleeping, eating, rushing from one place to another in the same staircase. Both modes are conflated in the notion "writing with buildings" proposed here. My reason for consolidating "through" and "with" into "writing with" is a strive to eradicating the notion of perspective which "through" connotates, while adding materiality, the reality of walls and stairs, bricks, and pipes, into the analysis of the hospital multiple.

Geertz struggled with the question how to interpret culture, the puzzle of how to get the messy social life he encountered in the field onto the ordered and rule(rs) abiding page. Bourdieu wrestled with "Understanding": How to interpret and get different perspectives onto the page which do justice to his multiple interlocutors (see chapter 'Understanding' in Bourdieu 1999).

In "The Berber House or the World Reversed" Bourdieu employs buildings as bridges but is primarily concerned with symbolism and underling structures (Bourdieu 2000a). I build on this and use the hospital's buildings as bridges to take the notion further.

Buildings are bridges between their makers and their inhabitants. With buildings, the abstract becomes specific, while offering the possibility to abstract. Buildings are born from paper, ideas abstracted into lines (drawn rather than alphabets), adhering to different rules than the lines on paper that constitute text. This abstraction can be harnessed for knowing and writing with them. How we write about something, reflects, and shifts how we think about it; even the way a sentence is constructed constitutes how we think, it is a psychological and social decision as discussed by Gell with relation to writing about art and artist relationships (Gell 1998: 39).

Shore and Trnka point out that "[o]ne continuing challenge for anthropology […] is to construct an *analytical language* that allows us to break out of the dichotomy between localism and universality

to focus on *transversal phenomena* that necessarily transcend local boundaries and interconnect various social and technological fields." (Shore & Trnka 2013: 252 emphasis added) Shore and Trnka put forward as examples "banking and international finance, medical technologies, policy assemblages, new religious movements, migration and human trafficking or popular protests and social activism" (ibid.). Here I add buildings and everything between buildings, buildings are as much as they are not; life is lived in the space in-between, between walls and floors plates, roofs and foundations.

With this thesis I elucidate the "multi-stranded, richly articulated matrices of relations" (ibid.) between buildings and (their) people, understanding how they unfold in people's daily lives. Through drawing and writing buildings I strive to collapse the divide between humans and their own and/or their forbearers edificial creations, transcending local, technological, and social fields. Writing with buildings might be one analytical language (alongside others for example from the aforementioned writing-culture-debate) that manages the feat that Shore and Trnka identified as a "continuing challenge for anthropology" (Shore & Trnka 2013: 252).

"Wild-ing Ethnography" – Two Burma Scholars, Two Environments, One Question.

My notion of writing with buildings resonates with environmental anthropologist and Burma studies scholar Laur Kiik's "wild-ing ethnography". Both our approaches are about writing with care, with "specificity and sensitivity" (Kiik 2018: 232).

What is interesting here is, that two anthropologists in Myanmar, both working on wildly different environments (natural in Kachin and built in Yangon), felt the need and value to write the environment into their ethnographies. The "writing with buildings" project seems pertinent in the contemporary moment. Kiik's is questions came from a puzzle similar to the one I was encountering: how to present something with all its evident textures in text. He proposes to draw on natural sciences in the way we could include interlocutors and indigenous knowledge and practices in our ethnography; similarly, I include architectural knowledge and documents into my ethnography. He

suggests including more than human and non-human actors into the ethnography and distinguish between agencies in a similar way that I am bringing buildings and infrastructures into the conversation. I agree with Kiirk here that this approach avoids flattening all actors into equal agency. Essentially, Kiik's proposition of wild-ing ethnography supports "writing with buildings", suggesting perhaps, something that resonates across the Myanmar landscape to inspire a more than human ethnography.

This resonance does not stop at Myanmar's borders. An anthropological sensibility towards more-than human ethnographies in which sensory experiences of place constitute self can be found for example in the UK and Brazil. In London Alina Apostu writes church buildings, their acoustic properties, materials and space, into the ethnography, to understand how place constitutes the Christian Self of her interlocutors (Apostu 2018). While in Rio De Janeiro's suburbs, smell is traced to understand affective place making and graceful experiences (Denyer Willis 2018).

WRITING WITH BUILDINGS AS CRAFT

Writing with buildings has the potential to bring text to life. Buildings can guide our writing – many writing guides trade tips on how to write ethnographically. For example, starting to write about a place through its sounds or smells. Narayan in *Alive in Writing – Crafting Ethnography in the Company of Chekhov* dissects the eminent author's style and translates it for ethnographic writing, to guide the reader or seeking writer (Narayan 2012). Becker, in his seminal guide on *Writing for Social Scientists* points out how writing is a collaborative effort (2020).

Buildings and their materiality are equally guides and collaborators. They make for an embodied, sensual, and temporal point of departure. In writing with buildings, we might use a dog lying on a cool concrete floor in the hospital's basement to launch into a discussion about material properties, why a dog might be comfortable here, evoking a microclimate, literally the environmental climate, as well as the socio-political climate with its historical tangents.

In this sense, I also use buildings to write evocatively, to enrich not only my prose but also my analysis with materials, surfaces (what they look like but also their touch and history), climate (humidity, temperature), light, sounds, the space all these elements create; these material registers are congruent with the elements I consider when designing a building.

Buildings root these observations in place, make interfaces and relationships visible in details through practices and/with their materiality; the missing nose on a stair tread that might lead to a fall, a door handle broken from too many prying hands, a windowpane cracked by a storm, or a pipe leaking because the material gave into the natural cycle of decay. Buildings allow us to move between scales. A toilet is just one example of how infrastructures lead us into the most mundane areas of everyday life, shedding light on personal hygiene practices, before catapulting us back into the macro realm of public-health, infection control, and institutional processes.

Buildings are a way of knowing the world in different scales and registers. They open a spatial and material epistemology that is inherently social. When I keep seeing broken treads and noses in my sketches, I access the practices done on the stair and it its materiality. The wounded building reveals values and priorities.

Geertz calls for “scientific imagination” that takes us into “the heart of the matter” (Geertz 1973: 18). Writing with buildings is specific, so specific, so concrete and emplaced, that it allows for imaginative thinking with bigger concepts (here at YGH for example man-nature relationships, care, values, (colonial) atmospheres, priorities, heritage) that Geertz calls for (Geertz 1973: 23). Writing with buildings actualises concepts and institutions, making it possible to grasp and craft text about them. The power of ethnographic writing is the “power of scientific imagination to bring us in touch with the lives of strangers” (Geertz 1973: 16), or the daily life of a public hospital campus. A hospital, something so common in our lives, yet so alien. Writing with buildings is a proposal to open the imagination.

It strikes me here that Geertz and Turner have similar proposals or demands. Both writing in the 1970s, they call for imagination and "play of thought" (Turner), and innovation in the way we see and think the world (Geertz). Circling back to Laur Kiik's call for a "wild-ing ethnography" (Kiik 2018), and my notion of "writing with buildings", both emerging from a Myanmar context, it might be that certain times and places crave for new epistemologies; a grand claim, qualified by the modest assertion that the call might be for new ways to write.

WRITING WITH BUILDINGS AS EPISTEMOLOGICAL PROJECT

Writing with buildings is not only a formula for writing, but an epistemological project of shifting how we look at the world, of knowing with the world, how we write and think about the environment we live in. This epistemological project is intensely humanistic.

Buildings are made by and for humans, born from ideas and lines on paper; the environment we live in is not accidental and natural, it is planned. Buildings reflect our pre-depositions how we see the world. Writing with buildings has the potential to challenge the old nature-society divide because buildings themselves are bridges between us (the human world / society) and nature. Writing with buildings collapses two formerly distinct worlds of nature and society.

The world becomes multiple while staying one, leading to alternative narratives of the hospital in which the campus is not "unplanned"; buildings' politics are seen; doors and floor surfaces translate into pathways of pain; "chaos" and "messiness" is less problematic than anticipated.

Three Registers of Writing with Buildings

In writing *with* buildings, I am inspired by Vietnamese film maker Trinh T. Minh-Ha's notion of "speaking nearby" (Chen 1992). For me, this turns into *writing with*; writing with buildings, with emotions, with space, with everything that happens in a space and admits the closeness of bodies.

I am writing with the building, with a staircase. The main staircase leads us first of all to the practices that are going on. Following Mol's example, I am not writing from the perspective of the staircase, or anybody having a perspective on to the staircase. Instead, I am writing about the practices that are going on in and with the staircase. This creates the multiplicity of what is happening in the hospital, what is happening *with* the hospital, and what the hospital is. In the case of this chapter's opening vignette, writing with the staircase brings together all those different practices and materials, developing the staircase in its multiplicity. For example, we see how back of house and front of house are distinguished by different speeds, rather than walls and doors. This subtle shift in frequency is easily concealed by the spatial terminology "back and front of house" (I will come back to back and front of house in Chapter 3), but becomes visible when noticing the sound of food steps on white marble steps; the nun walks very slowly, she's a visitor, whereas the worker who is shuttling blood back and forth, is in the same place but in a different space. The staircase is a staircase multiple. This extends to the rest of the hospital.

But what is writing with buildings about?

The First Register: Place

Buildings' are pivots of social life in the present, made and multiplied though practices and events (I am referring here to previous discussions of Gell 1998; Mol 2002). Their materiality roots them in the past, giving tangible access to their history; their bricks and steel are real, have been real and can be seen and evaluated today.

In the following chapters, materials, non-human elements, and actors feature heavily with their emplaced specificity. By *writing-out* the material reality that contains (I am using "contain" in all its multifaceted meanings here) the daily life of the hospital, I am trying to understand why certain things are *done* in one way and not another, what the tensions that constitute the hospital mean; the tensions that arise from various versions of the hospital multiple, while in tension with each other also depend on each other, as Mol points out with relation to the body multiple, where

different versions stand in tension while mutually dependant (Mol 2002: 6). By looking closely at the properties of buildings, their materiality as well as sociality, which both mutually depend on each other, the materials and shapes reveal narratives.

Writing *with* buildings, allowing buildings to be part of the story, show buildings as mediating, rupturing, and relational. *The Language of Houses* (Lurie & Sung 2014) and Adrian Forty's seminal *Words and Buildings: A Vocabulary of Modern Architecture* (2000) are examples of texts about how buildings communicate with us. Both authors suggest reading buildings, their spaces and materiality, akin to reading text, an archival document for example.

Alison Lurie, Professor of English Literature, describes buildings stylistically and the emotions they provoke; trying to translate a "building language" into English, which remains superficial, and frankly ethnocentric. I do not see much value translating "houses" into language. More productive is meeting buildings on their own terms. Similarly, Architectural Historian Adrian Forty, tries to translate buildings into language, however, more constructive, by interrogating the language we use when we speak about buildings, for example the language of modernism, or why we use feminine and masculine language to describe different types of buildings.

Rather than "reading" buildings, I am proposing to use buildings as intermediaries, building on Ring's ethnography on everyday peace in a Karachi apartment building where doors, corridors, walls, and balconies mediate relationships (Ring 2006). Different, but adjacent to Ring as discussed earlier, Kiik proposes "wild-ing ethnography", writing nature into the text for it to become part of the narrative (Kiik 2018).

Combining both notions – buildings as mediating social relationships, and wild-ing ethnography – I understand buildings as intermediaries between us and nature, the past and the present.

Buildings give structure to our daily lives (waiting rooms for waiting, with chairs or benches that discipline our bodies into the space; wards for sleeping; pathways for movement), they facilitate and

structure our lives, and in turn get used, abused, made and remade by our lives. Materials anchor the building in the past, pull buildings "back" and root them down, while activities are firmly situated in the present. This generates tension where past and present create a continuum, spanned by materiality and activity. This vertical and horizontal situatedness of the hospital is developed into "Place".

Beside the horizontal relations between people and buildings, which I understand to stretch across, in my case the hospital site, in the present, I also see the potential for buildings to lead us into deep time, vertically into a past to which the buildings drop us an anchor. Buildings take us into their past and make this past visible in the present. Writing with buildings brings the past into the present, creating a matrix of relations in both horizontal (present) and vertical (historic) dimensions.

Materiality and history pull the hospital backwards, while its spatial expansion over a city block and connections into the city, its lived daily life acutely present, catapult it forward.

Writing with buildings brings time and different temporalities into the discussion. Buildings have their own material metabolism at which materials decay, things inevitably fail and sometimes die. Buildings have their own time, usually much longer than an individual human's or even a generation's lifetime. They are judged on a different temporality; their time is governed by the rhythms of material decay and history-time/deep-time.

Buildings exist to keep our bodies safe, healthy, warm or cool, and dry. They are "ours". They are built by "us" and for "us" – with the good and the bad. When buildings are built, certain ideas and knowledges prevail that might be surpassed over time. In the case of hospitals often technologies that were new when the design started are outdated when the buildings are finished and occupied, and with it the spaces for these technologies; a hospital planner once said to me that as soon as a hospital is built it is outdated, we as planners, designers, architects, are chasing the future.

Buildings are an ordering category for our social world and an anchor in the writing thereof. Alice Turner shows this candidly in her article about YGH's neighbour, Thayettaw Monastery (Turner 2021). Turner discusses how colonial town planning, directed by secular politics, shaped religious defiance through the development of the monastery complex in the city.

Writing with buildings spans a continuum. At YGH today, I can feel the cool air on my skin on an upper floor of the main building, built 100 years ago with the purpose of good ventilation. I follow this visceral experience of colonial formations that the buildings afford me in the present into the pages of my sketchbook. I trace this experience into the archives and reports by colonial officers, reading about the ideologies, racist, classist and misogynist ideas that will forever linger in the hospital's corridors and corners. I bring all this back onto the pages that you are reading here.

The Second Register: Rhythm

Writing with buildings means noticing. It means noticing materials, light, sounds, textures, time, and the atmospheres created by them. By writing with these properties, we notice interfaces. By extension it means noticing "the whole"; it means seeing holistically.

As an architectural engineer, a designer of buildings, I often felt it was difficult to identify beyond doubt where the design begins and ends, where the building stops (mostly for myself, since most briefs and budgets clearly define the boundaries of a project). A building always connects; to another building, the street; sometimes physically, sometimes figuratively. A front door connects to a stoop, a set of stairs maybe, a front garden or a drop-off and pick-up area, a car park, a city beyond. A ward connects to another, pipes run from one ward to another, one failed water pump might affect three wards while not all of one ward. Electricity lines connect buildings. The laundry, the medical store, the oxygen plant, are individual buildings, but their services stretch across campus. The canopies of sheltered walkways connect without most people's knowledge to the city's wider fire infrastructure, as in when crossing a fire access road, their canopies must be high enough for fire trucks to pass.

By looking at buildings and using buildings as a point of departure, we notice the whole, even if not writing about everything, making exclusions, focusing on aspects – the ethnographer's task and skill – a distinct feeling for the whole manifests; there is always another door to open, more to one ward than immediately meets the eye, cables below plaster, or water damaging bricks from inside, travelling through the entire building from an overflowing roof tank. A sensitivity for interfaces emerges.

As Gell pointed out so candidly in *Art and Agency*, Anthropologists are interested in social relationships (Gell 1998); his Anthropological Theory of Art focuses on the manifold moments when index (the art work), artist, prototypes (artistic subject), and recipient (audience and/or patron) meet. When paying attention to these connections, moments of interactions/interfaces, the social relationships emerge, the manifold rhythms of the hospital.

Like roads and pipes, as seen with infrastructure-based ethnographies in the literature review, buildings are formidable guides. They allow us to move between scales, to discover things we might not have seen, paths and pipes, walls and roofs, lead into conversations that I had never imagined I needed to have (despite my long engagement with YGH before my fieldwork).

Methods (in this case drawing) and representation (here writing) shape the phenomena we report (Atkinson 2014: 171); writing the hospital with its buildings highlight its speeds, times, and atmospheres.

Buildings bring the whole into focus while anchoring the bigger picture in the concrete detail. Buildings are made from individual bricks, millions of small decisions that affect the body in intimate ways, especially in a hospital, where the body is so vulnerable, while being embedded in a wider system. Bodily, material, social, political, cosmic, and historic rhythms co-exist, collide, and collapse on campus, where they meet the hospital's atmospheres and moods in corridors and staircases.

The Third Register: Individual Encounters

On a practical level, writing with buildings is writing with our senses, with materials, their look, touch and hidden properties such as acoustic and thermal (as discussed earlier on writing with buildings as a craft); the light and atmosphere; the heat, humidity, and air quality; the sounds and space. When I write with the buildings of the hospital, I consider all these principles. They are the same principles I consider as an architectural designer when designing a building – a smooth handrail can guide someone through a gallery, a craggy floor in a hospital corridor can rupture the wellbeing of a patient. But most importantly they are all experienced and enacted by individuals.

A building is emplaced and specific while general and generic at the same time. Yangon General Hospital is a collection of specific buildings in downtown Yangon, with over 2000 beds, leaking pipes and blocked toilets. It is also a building type, a public hospital, adhering to standards and norms, operating within a healthcare system. One hospital of many operating similarly. Noticing the specificity of buildings reels-in the hospital's generic character. Materials, as seen previously, situate the hospital. The practices of individuals illustrate this. By writing with "specificity and sensitivity" as Laur Kiik suggests is anthropology's challenge (2018: 232), the hospital multiple emerges through individuals' practices; cleaning a surface water channel, screwing-in a light bulb, changing oxygen canisters, laboured breathing, waiting in the shade.

Building is always emplaced, exact, concrete. Its materials are concerned with concrete realities, precise locations, and specific histories. There is no building "in general" despite the hospital being a "general" hospital; there might be typologies and type plans, but the reality of the building itself is always emplaces, specific, contextual, and in mutual interaction with the individuals who inhabit it.

CONCLUSION

Buildings are links between the past and the future, as Street notes in her ethnography of Madan General Hospital (Street 2014), they relate and rupture, they are interfaces between us and nature.

Buildings are ways of knowing the world/knowing of the world. They come from paper, lines and pens, and have the potential to put daily life back onto the page – the building that has become something different since its inception on paper, guides us back onto a page, into text; producing a text that allows us to know a little more about the world than we did before the text was written and read.

Writing with buildings is a proposition for a humanistic more-than-human anthropology. The built-environment, the focal point of writing with buildings, is intensely human, man*made* (emphasis is on the past tense of making, they are always made in the past), while part of nature, linking humans, our natural environment, and more-than-human entities. Here, I am acknowledging that not all humans are equally responsible for the "making", as Todd's (2015) as well as Maynard and Simpson's (2022) scholarship illustrate candidly.

Pulling all strings together, a distinct form of ethnographic writing emerges, an updated notion for the 21st century. Writing with buildings is humanistic because the built environment, the focal point of the analysis, is inherently human, man-made, while at the same time part of nature, and our interface with nature, with a more-than-human world.

Writing with buildings contracts and expands. It brings into the discussion an intensely human element *via* our buildings, that shape and sharpen the observation. It brings into conversation practices and events, materials and more than human elements. The natural world becomes part of the analysis; buildings inevitable are part of the natural world. Concrete is a combination of aggregates; floorboards are shaped trees.

Writing with (and drawing) buildings makes a new way of seeing and being and writing with *the world at large* possible. It breaks down barriers between "us" (humans) and the natural world, the environment we live in. It is a proposal for dissolving old dichotomies of nature and society and escaping perspective by understanding buildings through practice in following Annemarie Mol's proposal of the body multiple.

Writing with buildings introduces a missing step, the environment that mediates our lives with the wider world. This is why buildings are excellent vehicles to conceptualise a hospital where systems, social worlds, and nature collapse.

Most of us live in cities and settlements, dwellings, every day; most people do not live with the tiger on the path[19]. Most of us live our lives guided by the built environment. But this "built environment" is not a singular category. It is more. It has animals and mycelial, plants and water, movement and animacy, its own temporality. By writing with buildings all this comes to the surface. We suddenly see more than the human relationships. We see why certain relationships never flourish, certain people never cross paths. We see why roofs never get repaired or a water system never get "systematically" improved. With buildings we move between scales and times.

Much of my writing starts with the building, with something particular; hands on wooden handrails; the ward sister on a ladder changing light bulbs; the oxygen department's worker making his rounds of the manifolds; the gurney rattling over the flawed floors. Writing is a noticing and making sense, a way of ordering the world around us, structuring the complex into something we can think with. How we write about the world is how we think about the word. Geertz demonstrates the power of writing, how "rhetoric" has a way to shift what we perceive as important in discussion of anthropologists as authors; a well-crafted argument can change how we think (Geertz 1988).

Writing with buildings makes us think with buildings, and by extension *with* our environment. But the matter of transference is a puzzle, how to move from lines on paper (blueprints/drawings) to sticky, "placey", messy materials, old, new, decaying or well maintained, always changing, back onto paper, pages of text, into a text that stays fixed while illuminating the realities of daily life that we/or I specifically as an anthropologist in a hospital, try to see?

[19] This refers to a lecture by Kath Weston the 2021 "Sensational Ecologies" Summer School (online).

This is the tenor of this thesis: How to write an institution, a large, complex entity that is difficult to grasp and conceptualise? My proposal is to write with buildings. Buildings provide a novel framework to move between different scales, times, and speeds of an institution; its interfaces, relationships and ruptures that are contained within its literal walls.

All this begs the question, how can we get to know and experience buildings to write with them? The next chapter proposes drawing as a method for investigation, the practice buildings are born from, that offers a bridge between the fleshiness of daily life and text on paper.

In this chapter, buildings might appear as magical device through which everything, everywhere all at once can be understood and explored. Here it is important to remember that buildings are one element within multiple material, political, symbolic, and affective domains. I am an architectural designer, I think spatially, with materials, I am trained to understand what lies behind a wall; other people might have other sensibilities. While buildings can be useful anchors for the ethnography, they can also be lead weights that prevent the ethnography from taking flight. While buildings are not the portal to a secret world of deeper understanding, they are one way to generate sharper focus on non-perspectival, extra human, and humanitarian worlds.

CHAPTER 2: DRAWING

"YOU WELL INSPIRED YGH"

I am perched on a concrete ledge outside the Specialist Outpatient Department. Beside me a woman rests supine on a plastic blanket, waiting for her clinic to start, a basket holds her lunch. She smiles at me, but I can see pain in her eyes. The warm breeze of the onsetting hot season hugs my skin; the shade from the walkway above is welcome. My sketchbook is balanced on my knees, colour markers, the ones I brought back from my trip home at Christmas, sit beside me on the floor in a small bag made from recycled plastics by local artisans. I have been here all morning, sometimes someone wanders over to see my sketches, linger for a bit, returning to their group of waiting bodies to report back on what the foreigner is doing. Acquaintances say hello. Covid-19 is only a whisper. I am sensing the change in rhythm as outpatient clinics change over; from Cardiac Medicine, Gastrointestinal Medicine, and Neurosurgery to the Diabetes clinic, Haematology, Medical Unit 4, and Neuro Medicine follow-ups, until Surgical Unit 1 and the Breast Clinic see patients in the afternoon. On days when orthopaedic surgeons see patients, I draw limbs in white casts, wheelchairs, crutches, and attendants holding trauma victims. I am. I draw. I follow what I see with my hands onto the page. I am the artist, slightly strange, but non-threatening, joining everyone in the mood of waiting that prevails the spaces outside the outpatient clinic on a Thursday Morning.

Another day. The sun stands relentless in the sky. I feel impatient, unsettled, unsure. Usual worries and anxieties that come with fieldwork bother me; What do I know? What don't I know? What should I know? I take a breath. With my sketchbook in one hand, my black ink pen in the other, I draw the newly installed water pipes. I have nothing better to do, I feel lost on a campus I know so well. Acutely attuned to the environment through my concentration in drawing, I diligently follow the blue polyvinyl chloride (PVC) pipes. A slapping sound drifts over. Wet cloth on concrete. I find the laundry where a team of four or five wash bodily fluids from the modular operating theatres' sheets and scrubs. I spend a week drawing their work processes, recording their sounds. Drawing their bodies in space and in relation to each other, noting the shapes their bodies must make to accommodate the work. Seeing what I would not have seen had it not been for my drawing practice.

Two years later. I am in my studio working on *Hospital Echoes*, an installation based in my fieldwork sketches. Room-height white cotton sheets hang in the space. As I trace the projection of my original sketches with black fabric pens and water colours, I note the subtle differences; doctors in colourful ainjis and htameins,[20] colour coordinated and floor length, in contrast to the higher tied longjis of attendants, matched with separate blouses. Doctors wear hip bags, some leave their long hair open, while attendants' buns are tied tight and high, tiffin containers in hand. I remember the moment I took the sketches; have any of these doctors joined the civil disobedient movement (CDM) following

[20] Burmese female dress. Ainjis = blouse; Htamein = floor length formal skirt.

the 2021 coup? I take pictures with my phone to send them to some of my interlocutors. The reply is immediate. They are excited to see what is happening with the sketches they saw me making for the year I drew the campus' daily life. One sends back a picture of my drawing of the main building that I gifted him before I left my fieldsite. It is sitting on his desk. "Great! You well inspired YGH" reads his message in response to the announcement of the installation. I hope one day I can bring the installation to Yangon, to the people who inspired me.

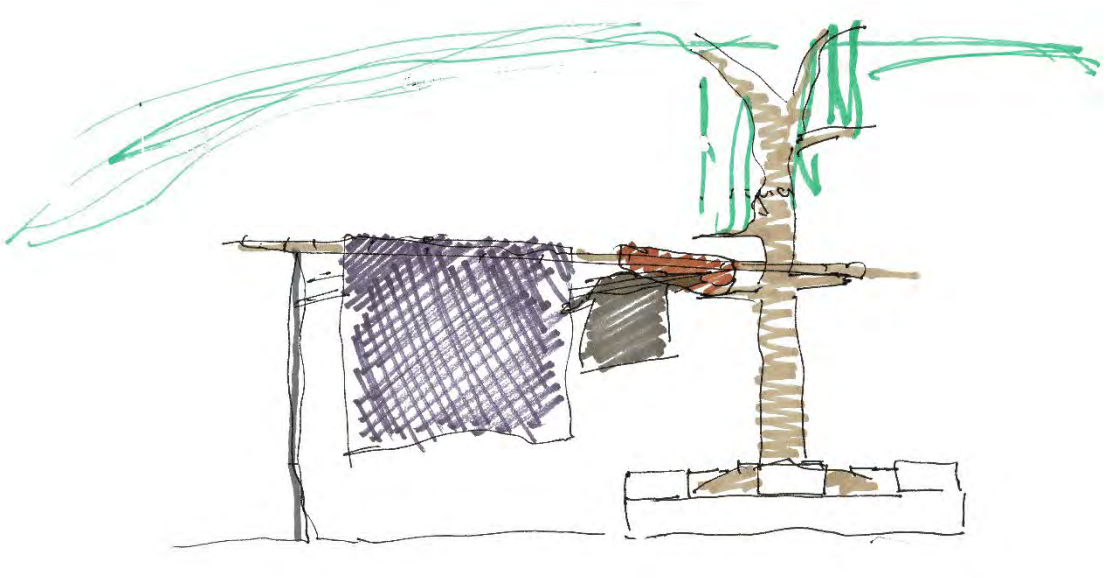
In this chapter, the opening vignette illustrates three registers of drawing: being, seeing, and engaging with myself, my interlocutors, and beyond the temporal confines of the fieldsite. In "Intimacy and Getting Lost", I take you into the experience of drawing before moving into a short theoretical exploration of "Drawing, Creativity, and Play of Thought". Getting "Beyond Illustration" I develop the three registers from the opening vignette, before concluding the chapter with final remarks on drawing and art practice in a wider sense for ethnographic process.

INTIMACY AND GETTING LOST

Drawing is an intimate process of being in the world, seeing it, and engaging with it. With sketchbooks and pens I moved through the hospital's spaces, along its pathways, drawing its daily life on and around campus. As a trained architect drawing is second nature to me. I always have a pen and unlined paper on me to let my hands think. I lost count of the many times I meandered through the campus with my pen on tracing paper overlying the site-plan, studying the location of manholes, planning the demolition of inadequate buildings and the location of new ones, thinking

where gardens could grow and new connections emerge; developing a plan for the decades to come.

As an architectural designer and engineer I would move around site, looking for problems, finding solutions and having opinions, sketching ideas. As an Anthropologist I spent my time being, observing, not looking for something or seeking out problems, but thinking with my hands by drawing what I saw, in search of knowledge about, and familiarity with, the manifold rhythms of daily life unfolding around me.



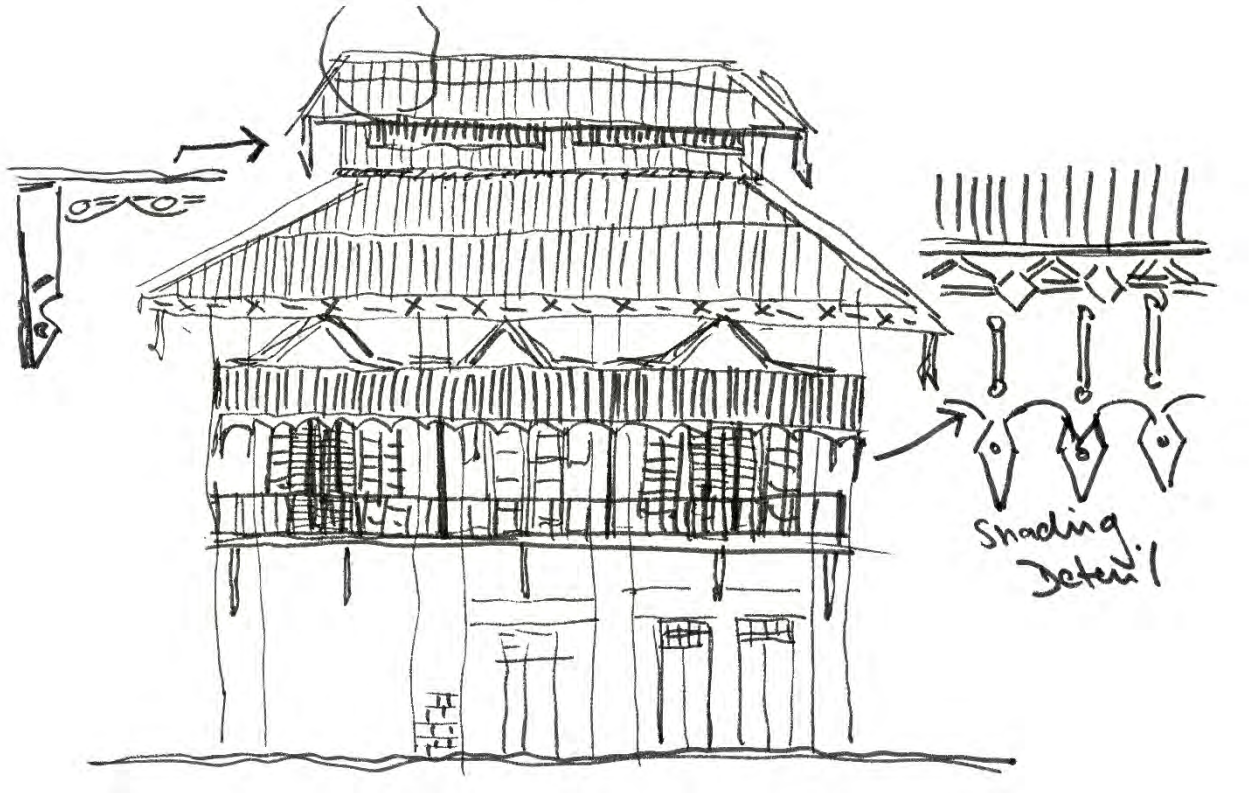
David Mosse said on the distinctiveness of Anthropology that it is a "human-scale discipline"[21]. It is their human-scaleness that Architecture and Anthropology have common. However, while architecture is mostly pre-occupied with a future that might or might not come, with problems, solutions, and necessities, in my ethnographic fieldwork I am intensely in the moment, thinking and recording in my sketch book in real time.

The experience of drawing as an anthropologist and drawing as an architect is different but similar. As an architect I draw speculations about an imagined future. As an anthropologist I draw what I see and use drawing to see.

[21] David Mosse on the distinctiveness of anthropology as a discipline: https://youtu.be/5d_BE5_9oAk

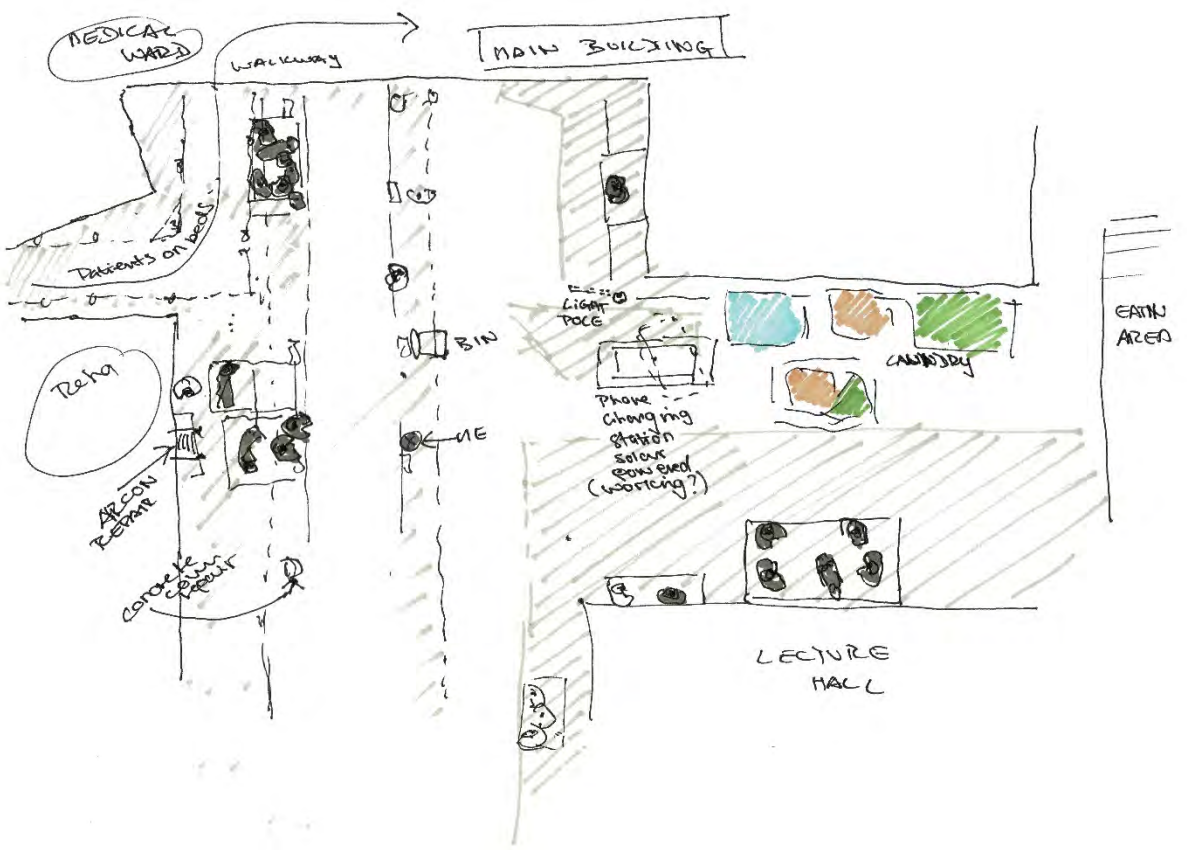
Allow me to elaborate on this point briefly. What and how I see, is influenced by what I know and who I am: "We see […] what we look at" (Berger et al. 2008: 8). But "[…] drawing is discovery" (Berger 1979: 23). The act of drawing forces us to look, training us to see. In a reflexive practice, drawing is able to soften filters and dissolving biases. Drawing gets beyond what we think we see or know to see. To be aware of the pitfalls of seeing is crucial and valuable during fieldwork; drawing is a practice in which positionality becomes visible very quickly, and literally; I saw my biases on my page when at the beginning of my fieldwork, in good architecture manner, I drew roof details and façade elevations. Drawing is a way to understand, to be in place. Drawing is seeing differently. I will come back to this point later.

The visibility of a drawing (to myself and my interlocutors), and the practical process of sketching, its material messiness if you like, are valuable for the ethnographic process. Reflecting on it is



important.

With a hard-back sketchbook and an ink pen we can make quick sketches standing up, moving quickly and flexibly in space. In contrast, using an easel and water colours, you can imagine, is stationary, a strong physical presence in space. Even the difference between ink pen, pastels, and studio markers, the media I experimented with, changed the pace at which I moved through space.



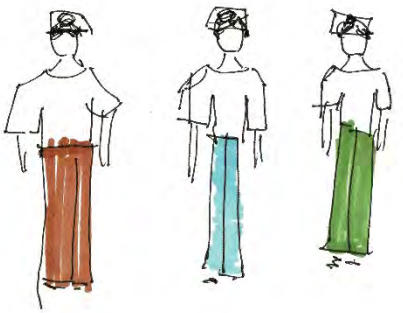
The medium, its materiality, that we choose to draw with plays an important role in this spatial encounter. It sets the rhythm for the engagement with the field.

The medium quite literally shapes how we are positioned in the field. Where do we locate ourselves and why (to have a ledge to balance the pencil box or stand in the shade)? How long do we stay? What does it mean to move around or to stay in one spot?

I had different experiences during my fieldwork in the hospital depending on what materials I chose to take with me in the morning; some days my bag was pre-packed from the day before, other days I had unpacked by bag and my materials were strewn around the apartment, gathering ink pen or pastels, hardbacked sketchbook or loose paper, colours, or no colours. Some days I would forget my pens altogether in a rush to meet someone, picking up a cheap ball pen on the fly from a vendor.

This shaped how I moved and engaged with my fieldsite; the days I used a ball pen identifiable by text-image hybrid drawings.

In the beginning of my fieldwork, I had only a black ink pen, different shades of grey pens, and a hard back sketch book. I would move quickly. I soon realised that I was missing the depth of colours, the tones and vibrancy, in my drawings, and in my observations. In my drawings, I noted the absence of colours. I realised that my material repertoire impoverished what I was seeing; I felt the lack of colour on the page limited by observations.



I started to take colour pastels. But this slowed me down, made me sit in space longer, seek out spots with the possibility to balance the pastel box beside me in the shade. Now I felt restricted in my movement, uncomfortable, with the material that stained my hands, with the space and pace it demanded from me, with the encounters it created.

I abandoned the pastels in favour of colourful studio markers, many architects' trusted companions. I retreated in my comfort zone to

launch into the unknown of fieldwork. I diligently noted the colours of people's clothes, learning about hospital uniforms, fashions, and styles. Through the contrast of vibrant greens against reds or greys, plants encroaching onto and into buildings, I felt the tension of the natural and the built environment, coming to question that dichotomy in the act of drawing, seeing the tableau of "environment" as a whole.

The colourful pens made me engage with hues, shades, light and shadow (literally and figuratively) as well as shaped the rhythm of my movement. I started to move slower, often sitting somewhere for a while with my studio markers beside me, lost in the colourful chaos around me, its ebbs and flows outside the outpatient department or the tranquil religious rituals by one of the holy trees on campus.

Overtime the medium I drew on became less prescribed, reacting in materiality, like the pens, to the demand of the site and my observation. I started to take loose pieces of tracing paper to overlay pathways of goods around campus, and stack flurries of activity throughout the day in little sketches on top of each other onto the page. In layering drawings, my hands were re-thinking with each stroke the use of a space in different ways, allowing me to layer my thoughts, layer my understanding.

Picking somewhere to sit, to be and to draw entails a decision. How did my position come about? What assumptions have been made? In my fieldwork, being guided by drawing was valuable. I would often end up in places that I did expect to find, staying past the act of drawing, starting a new drawing, a new line of enquiry.

Drawing created a precious intimacy with my fieldsite; an intimacy for me with the hospital campus and vice versa. As much as I became familiar with the campus, as much did the campus and its people with me: the artist who "studies the daily life of the hospital to understand how people and places work together".

Drawing allows me (the anthropologist) to acquire an embodied knowledge through seeing and recreating on paper. It is that time spent looking and thinking that allows me to consider something *in situ*. I am not simply representing form, I am looking at context, movement, relatedness, positionality. I understand drawing essentially as composition, relationships, relationality between bodies, human and non-human objects. Relationships are made visible. Abstract notions, such as waiting, or hierarchy, or privilege emerge on my page in practical terms of colours, composition, and intensity of strokes.

In essence my sketches are fieldnotes, not simply aids to the memory; an engagement with a situated reality. A drawing is always unfinished. It can always be retracted, deducted from, and added to; it can be drawn over or fixated with fixative. A new drawing always begins with the previous drawing. Drawing is a process, as is ethnographic research and writing; hence thinking and working with drawings, accessing their power of the unspoken, the unfinished and the movement between a micro and macro focus is so valuable. Drawing makes connections and abstractions, in this drawing incorporates forms of social theory. The author of a text makes connections, prioritising some elements over others, creating a hierarchy of representation, and abstracting complex

realities, akin to what I do when drawing. But drawing is more. As we navigate our world with our senses, drawing engages all sense.

Drawing is more than a visual method. When I draw in the field, I translate my observation through my body onto the page; beyond the physiological processes of light in the eye, and touch of the pen on the page, my body moves, following what I see, making lines. Drawing allows me, the anthropologist, to gain visceral knowledge and recreate it onto the pages of my sketchbook. What is translated onto paper includes smells, climate, comfort with the situation or bodily discomfort perching on a ledge; I can read all this from my drawings in the quality of my lines, the colours, the fluted paper on humid days, the smudges, and crinkles on a windy day when dust landed on the page. Drawings record the subliminal. Drawing is a meditative moment of intense perception.

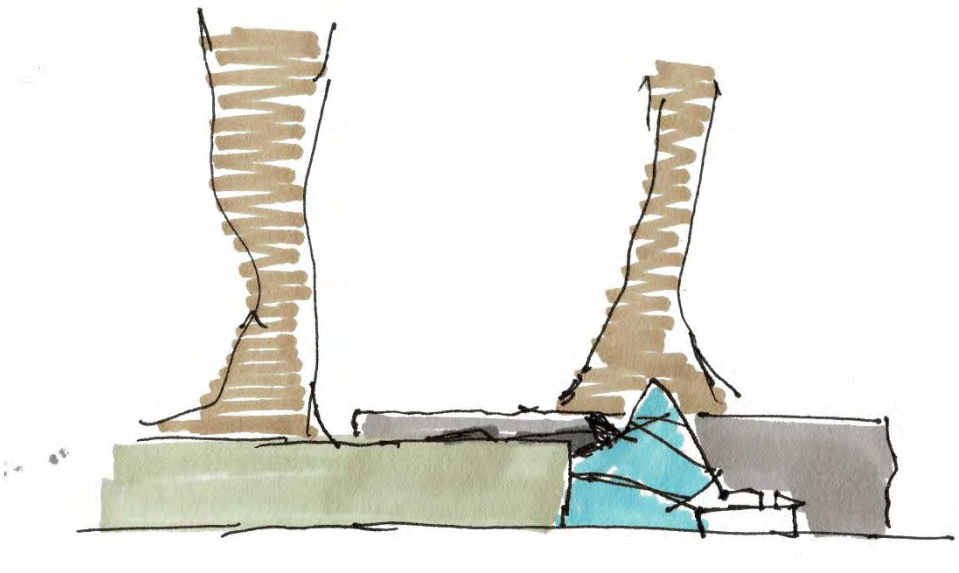
To understand the value of drawing as a sensory, intimate, and situated practice for anthropology as a discipline, I turn to concepts from the mid-1970ies.

DRAWING, CREATIVITY, AND "PLAY OF THOUGHT"

Victor Turner wrote that rituals, carnivals, dramas and films are "liminal areas of time and space […] open to the play of thought, feeling and will; […]". (Turner 1977: vii). I would add to carnivals and dramas the act of drawing, the *making* of art, and the use of sensory methods more broadly.

Turner's work on liminality and communitas has been much discussed in the context of performing arts (Cox et al. 2016: 3), for example to conceptualise performances themselves as liminal spaces. But in (contemporary) fine arts and drawing specifically he has been less present in.

As a drawing practitioner, I argue that the act of drawing (the moment of *making*) has the potential to create a liminal space. According to Turner, this is a space "in-between", full of creativity and innovation, critical thinking, subversive and suspended from constraints (1977). For the drawing practitioner, it is the moment between seeing/perceiving and putting pen on paper, ending, but continuing to resonate, with the lines on the page. Much can happen in this moment. Sometimes the entire subject changes, sometimes a thought process is jolted, a new line of enquiry opens-up, a deeper understanding is gained. It is a moment of intense connection. Turner calls this "communitas". I see "communitas" with what we draw, human or non-human, in which we understand, or not, but in any case, gain acceptance of, what we see. Connecting this thought back to Berger earlier in the chapter, drawing holds the potential to see what we would not necessarily have seen.



This liminal moment can be seconds when sketching, repeated many times during a session, or hours when working in a studio on a larger project. It is difficult to place exact lines where this moment of liminality starts and ends, and in some ways this moment keeps existing within oneself after a drawing has been abandoned; for me, a drawing is never finished or complete, it can always

be continued, added to or (parts) be erased, a new drawing be started on-top of another. Regardless of its temporality, this moment resonates within; the intimate connection can be conjured when coming back to the drawings. They are the artefacts of this experience; my sketches are artefacts from the field.

When drawing I enter a mediative and focused state framed by not knowing and knowing/the non-existence of a sketch and the existence of a sketch; the moment in between is an intense moment of intimacy with the subject, exploration, curiosity, freedom, thinking, understanding, observation and creativity: "play of thought" (Turner 1977: vii).

This moment of liminality during which we experience communitas with our surroundings (human or non-human) is the potential that drawing holds for ethnographic research. The moment of drawing is a moment where something is not yet – the drawing/understanding is in the making – while something else has been left behind – maybe ignorance about the drawn subject. This liminal space is a space of creativity and innovation, freedom, and subversion of the status quo. Through drawing one can open-up such an in-between space of creativity for one's ethnographic enquiry.

As noted in the previous chapter "Writing", Turner's call for "play of thought" came around the same time when Geertz was querying modes of writing, calling for "power of scientific imagination to bring us in touch with the lives of strangers" (Geertz 1973: 16). Drawing offers a bridge between "these lives of strangers" and the text we write as anthropologists; drawings link the said and the unsaid; drawing bridges embodied fieldwork and analytical text.

BEYOND ILLUSTRATION

Where do I see the ultimate value of drawing? Beyond illustration, when drawing is in its verb form, in an investigative mode.

Drawings have always been part of anthropology. Early anthropologists in the 19th century used drawings to categorise and document the world (Kuschnir 2016: 106f), in the 20th century appendixes showed the "others" technology and material culture, for example "The technical culture of the Andaman Islanders" (Radcliffe-Brown 1922) is full of illustrations of weapons, hunting paraphernalia and objects of daily use. The primary focus was material culture. Other illustrations are rare. If they exist, they show diagrammatic maps of villages, remaining largely uncommented in-line with many ethnographic studies of the time. Drawings themselves, the process of making them, their use in thinking through the objects and spaces they depict or the form of engagement with the world through drawing, remains un-reflected, without connection between text and drawings. Even though drawings such as floor plans, maps, and routes of exchange, I am thinking here for example of Malinowski's "Map V - Kula Ring" (Malinowski 1922: 82), will certainly have been tools to think through puzzling phenomena; literally drawing connections. Similarly, drawing of kinship diagrams, however ill-advised and problematic they might have been (in the past), were a way to think through complex relationships; ill-advised and problematic because ethnocentric and biased (mostly patriarchal). This comes back to the earlier point about seeing. Anthropologists of old drew what they *thought* they *should* see, applying their own lens, in many cases European and Northern American kinship systems, onto what they saw. Without going into a deeper discussion, I suggest that had the "artists" reflected their drawing practice, another outcome, and different knowledge might have been possible. This example highlights the importance of *reflexive drawing.*

In the mid-1950s drawing styles changed, less concerned with scientific preciseness, authors were keen to illustrate presence in the field (Kuschnir 2016: 108).

As Anthropology went through the so called "linguistic turn" in 1960s/70s, text was given primacy over images. Taussig writes of the linguistic turn: "[..] let me point out that the hiatus or no-man's land between picture and text in the anthropological tradition raises a further question as to the *general devaluation of drawing in relation to reading and writing* in modern Western cultures and

maybe in many other cultures as well." (Taussig 2009: 268 emphasis added). Around the same time drawing was abandoned in UK art education (Petherbridge 2008: 34). Drawing was seen as a form of knowledge, not a subject to be taught, furthered by a prevalent believe that what naturally comes is best; a focus on talent rather than skill (ibid).

Additionally, with the rise of the camera, drawings fell out of fashion (Taussig 2009: 266), not only in anthropology but across disciplines (Kuschnir 2016: 112). Photography made anthropology seem scientific (Taussig 2009: 266), the way seemingly technical drawings had in the past. Visual Anthropology flourished with the camera, in photography and film (Kuschnir 2016: 112).[22] For a time, drawing, alongside the values that accompanied the graphically inclined anthropologists of old, were out of fashion.

Only in the past fifteen years drawings have made a renewed appearance. As collaborative tools (Pink in Kuschnir 2016: 112f), as objects for analysis of alternative histories of ideas in which the making of the drawing has importance in itself (Geismar 2014; Grimshaw 2001), or yet again as ways to illustrate what one saw, as is the case with most contributions in RIBA's *Illustrating Anthropology* exhibition.[23] Another mostly illustrative mode emerged in the medium of the "ethnoGraphic novel". Outstanding examples are *Lissa* (Hamdy et al. 2017), and *Vanni* (Dix & Pollock 2019), both demonstrating the value of collaborations between artists and anthropologists. In the case of *Vanni* drawing becomes a tool for a collaborative anthropology (Dix et al. 2019). While I never drew myself with interlocutors, nor asked anybody to draw if they did not take initiative themselves, the aspect of collaboration, that Dix also discusses in this sense (ibid), in the shape of the possibility to discuss

[22] When looking at Visual Anthropology MAs today, for example at Goldsmiths University of London, primacy is given to ethnographic film and photography. Few mention other media. Most Visual Anthropology readers only cursory engage with media other than the camera. For many years Visual Anthropology effectively was the anthropology of film and photography. For example sensory and critical anthropology reader *Beyond Text* has sections only on sound, film and photo essays (Cox et al. 2016), Collier's *Visual Anthropology: Photography as a Research Method* (1986) speaks for itself, while *Visual Anthropology* by Hockings (2003) has a camera on the cover. Only few voices straggled from that, for example Schneider and Wright when discussing art practice in the context of Anthropology (Schneider & Wright 2010, 2013).
[23] https://illustratinganthropology.com/

data/drawings in the moment with interlocutors is incredibly valuable as it highlights their concerns over mine; I will come back to this point later in this chapter.

Only few early exceptions veer from drawing in an illustrative mode, developing drawing as a method (Causey 2017) or a methodology (Kuschnir 2014, 2016; Taussig 2009).

With the recent emergence of "graphic ethnography" (Theodossopoulos n.d.), authors etched closer to bringing drawing to the centre of their ethnographic investigations. Theodossopoulos uses comics to resolve ethnographic tensions (Theodossopoulos 2016), while Letitia Bonanno draws to make, emotionally and otherwise, sense of her fieldsite (Bonanno n.d.) and asks if drawing is a "Serious Methodological Turn or Just Some Visual Fun?" (Bonanno 2022). My answer to this question is that drawing, and making art in a wider sense, is both illustrative output as well as methodology. Alongside Peterson and Bakke my concern is with a critical conceptualisation of art *making*/drawing rather than a murky outcome (2018: xiv). Drawing/art as methodology holds the stakes. Draw*ing* warrants an important discussion to rescue art practice in anthropology and for ethnography, from an unfocused "fuzziness" which some art-anthropology engagements have been accused of (Atkinson 2016).

Drawing (and making art) is being in the world, knowing *with* the world.

When Taussig asks in his article of the same name "What do drawings want?" (Taussig 2009), he engages with the process of drawing itself, rather than its mere illustrative nature. In his answer he has a strong focus on *seeing*; as does Causey in his book *Drawn to See: Drawing as an Ethnographic Method* (Causey 2017). Based on my experience I widen the spectrum from "seeing", to "being" and "engaging", creating an awareness of the nuanced and varied modes of drawing which influences the research greatly. Afterall, as seen above, even the choice of pen can change the field encounter.

While spending my days with my sketchbook, common power relations between researcher and interlocutor were challenged. Drawings were tools to elicit feedback and discussions with

interlocutors. They became a mode of analysis and a tool for writing. Drawing allowed me to get lost, find new lines and thought processes, with my drawings as trusted guides. This intense experience of drawing in the field, entering liminal areas and experiencing communitas with my surroundings, gave rise to a close reflection on the more tangible uses of drawing as ethnographic practice. Drawing situates us in the world.

A drawing is an embodied reaction to what we see. Even if we do not understand everything we see, we can draw it and achieve some understanding or at the very least acceptance through the embodiment of the seen by translating the seen with our hands onto paper. Anthropologist and Architect Trevor Marchand explores the value of embodied knowledge in his scholarship expanding ideas of what knowledge is (2009, 2010, 2015, 2016).

Drawing can describe movement and processes. Drawings can show time and passing of time. Edward Robbins, when talking about architectural drawing, describes drawings as social discourse (Robbins in: Petherbridge 2008: 28). A notion that is also seen in Taussig's discussion of the artist William S. Burroughs' scrap books blending "personal history as well as popular culture" (Taussig 2009: 267). Or as artist James Baldwin said, "the artist is the emotional and spiritual historian of our time". Drawing is an assemblage of moments, the many glances that constitute the seen transferred onto the paper (Berger in: Petherbridge 2008: 33). I draw on these

observations to understand how drawings are not simply “notes” to remember or represent something seen. They are engagements with the place and with myself, and everything I bring into the field; my personal history, theoretical predispositions, ways I have learned to see the world.

To unpack the above ideas “drawing (and making art) is being in the world, knowing *with* the world”, “drawing situates us in the world”, and “drawings are engagements with the place and with myself”. I take you through three registers of drawing I find useful to think with: Seeing, being, and engaging.

Seeing

Violet-le-Duc, French architectural theorist, wrote: “Drawing, properly taught, is the best way of developing intelligence and forming judgement, for one learns to see, and seeing is knowledge”. (Viollet-le-Duc in Petherbridge 2008: 30 f) Drawing is a way of seeing the world which goes beyond language, it touches the ephemeral and engages the researcher with the field in an extremely intimate way through the process of seeing.

If one has ever drawn, thinking through drawing is a way to think about the world, and hence enriches and guides what we see in the field. What are the main lines? What do I need to trace, and what not? Where am I standing in the field (literally and figuratively) and what do I see/not see from this vantage point? What the (geometric) perspective? When we draw, we frame our view and give the drawing boundaries. A drawing is as much as it is not. A drawing only exists because of its empty spaces, in the same way ethnography breathes through the gaps that emerge when collecting and compiling what we have learned.

Coming back to Berger, remembering that “[…] drawing is discovery” (1979: 23), we now understand what he means when he writes: "A line […] is not really important because it records what you have seen, but because of what it lead you on to see" (ibid). The value of drawing is its potential for seeing something you might not have seen otherwise; in the field it might go as far as experiencing something unexpected and new.

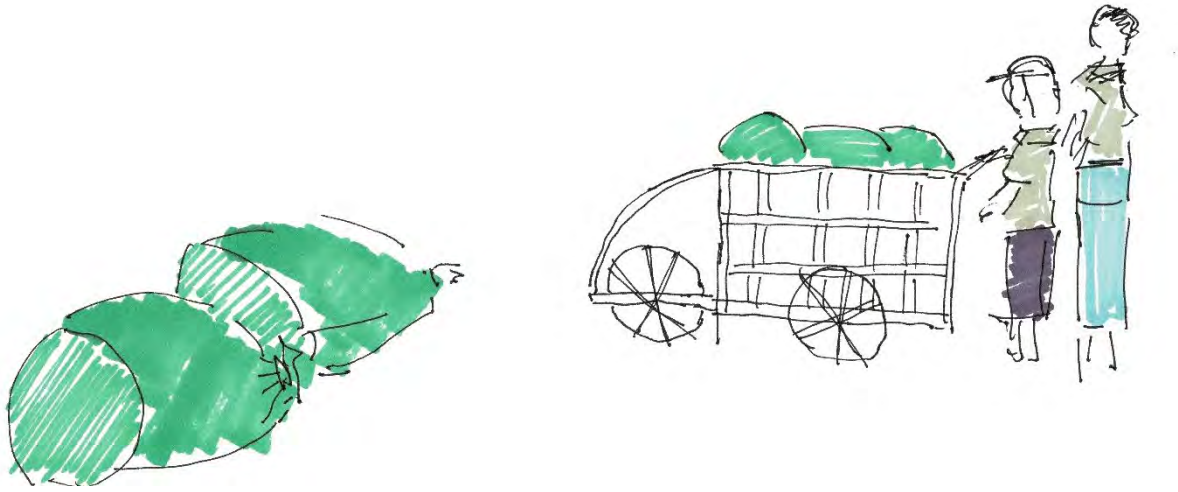
Drawing is immersive observation, as also discussed by anthropologists Causey (2017) and Taussig (2009) about their drawing practice in the field.

The stillness of looking that precedes the action of drawing, a moment of liminality between the intention of draw*ing* and *the* drawing, a moment of creativity, freedom and innovation holds the potential to see. This moment of excitement of what I might see, the outcome of the drawing potentially being something different to what its intention was, never ceases to tempt (and taunt) me. It is this moment where the best laid plans for the day go awry and I would go down another route, follow another pipe or keep sitting somewhere for hours in the hope of seeing something again.

When we draw, we focus on what we see; seeing, observing, the stillness before we put pen to paper is the essence of the drawing. Paraphrasing Berger (1979: 23) with my own experience: The potential that the act of seeing holds is important, not the drawing itself. Every drawing is ripe with potential; the potential of seeing, of observing, of noting (Taussig 2009); the process of drawing is ripe with possibility. This possibility is the promise that drawing holds for fieldwork.

By exploring the margins, what is seen (and what is not seen) representation is surpassed and seeing beyond visual representation of the seen is explored; thinking with one's hands, translating the seen through one's body, where movement, colours, moods find their way into drawing / the drawing. The drawings that carry this quality are the ones that tell me the most about a given moment in the field, a day, an experience.

Coming back to the introductory vignette, drawing what I saw in front of me, I end up in a laundry that I had not known about before, despite my long history on campus. I spent days drawing the team's processes, turning up daily, sharing snacks and listening to my interlocutors' banter while sketching what was going on around me. I looked at them and they looked back at me and my drawings. In the process I learned about the details of cleaning the bloody surgery sheets and scrubs, the problems with electricity and procurement processes. I followed the laundry, mapping its pathways, around site.



Key here is, to draw what you see, not what you think you see. When we draw what we see, the actual lines, the connections, and shapes, focusing on what is in front of us, not the *perception* we have of it, we gain a deeper understanding of our subject. This often challenges the perception we had of something before we drew it.

In the field I kept reminding myself to draw what I see; to take step back, not get flustered by what I *wanted* to represent or *thought* I saw but just draw what was in front of me. Repeatedly, I was surprised by the outcome, by what I apparently had seen but had not *seen* at the time.

Drawing is a powerful tool, it harnesses the stillness of looking carefully, observing intimately. It allows us to be.

Being

At Yangon General Hospital, drawing afforded me access and the ability to inhabit particular spaces in a non-threatening, or state like manner. Drawing allowed me to be, see and think, to recreate my experiences on paper and artistically reflect with my hand in the moment. Drawings are an engagement with the situated reality, with being in a place, a place that includes people, buildings, nature, histories, and memories. When drawing I spend time and analyse the essence of what I want to draw. Movement is observed and a decision is made, how movement and time passing is shown on a page. Where a photograph stops time, a drawing encompasses time (Taussig 2009: 265).

In my ethics review in Yangon, I was asked if I would have a camera, if I wanted to take pictures. When I explained my methodology, describing my drawing practice the board was relieved and delighted. My sketchbooks and pens had unequivocal access. A camera did not.

A camera was seen as threatening, invading privacy. Drawing allowed me to be in place, it justified me idling and looking. The process of drawing helped me to engage, to redress common power relations between researcher and interlocutors, and to negotiate entry to spaces and conversations, into relationships. For example, drawing the oxygen supply points (which I had been asked to do for my former team from Article 25, who was no longer on campus), allowed me to visit the Accident and Emergency unit as they were preparing for Covid-19.

Drawing allowed me to dwell in seeing as well to dwell in place. Drawing is a peaceful engagement with the world when done openly and non-judgemental. But it can also be an unwanted gaze, as Causey encountered with tourists in his fieldsite (Causey 2017: 50). He writes of his “prying eyes” and attempting to not invade their vacation space by pretending to write in his notebook (ibid). Causey’s experience makes my point for me. When hiding, trying to conceal, the gaze becomes unwanted; in a public space even threatening. In my case, I used large A3 sketchbooks, my intention was hardly disguisable. My gaze was open and linked to the page, on offer for anybody who was keen to see. One day my sketchbook was open on the table of a nurse room. The ward sister asked

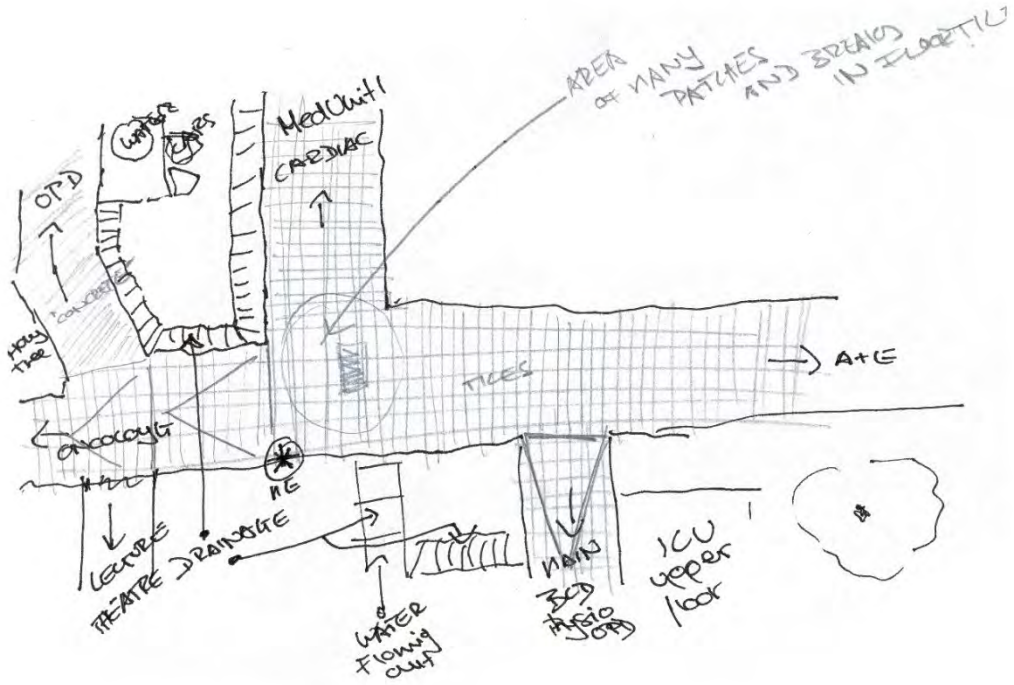
me to see the pages. She commented on one sketch in which a woman in a green longji[24] was resting her head crouched over a patient's bed. She thought I had depicted her, as sisters' longjis are green too. I showed her the woman I had drawn, and we laughed. In this moment I learned about the sister's anxiety, not to be seen as lazy. This happened because of my open sketchbook, because I had been on the ward for a day, facilitate by me drawing life on the ward. People saw what I did.

Even during small medical procedures, patients were happy having me around. They seemed to feel comfortable seeing that I was drawing a window detail, or ceiling fan. My averted gaze, fixed on something my drawing, allowed me to be. Doctors, as long I did not get in the way, would even invite me to look on; here the hospital multiple emerges, where the practices a doctor does, and the patient receives illicit different spaces of appropriateness. My drawing practice did not offend either.

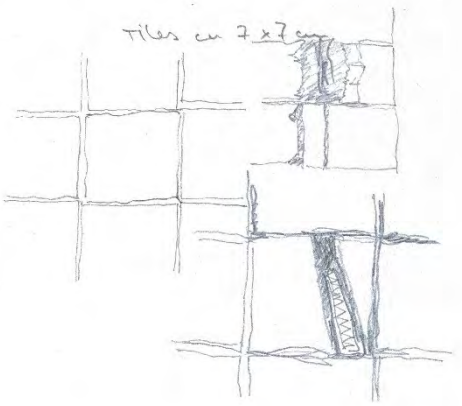
However, there were times I turned away. Moments of intense grief were not moments for drawing. I believe this is because drawing signals attention away from the situation, a moment when intense empathy is required. Similarly, drawing in an interview or during a conversation was not seen favourable. Again, the direction of attention seems important here. While the act of drawing allows me to "be", being in a place allows me to draw. The dynamic is different when I am in a space, drawing and people come and go, then when I arrive in a place immediately starting to draw. The pause before drawing is important.

[24] Traditional leg-dress in Myanmar; a floor-length tube tied up at the waist with different types of knots depending on fashion, personal taste, and occasion.

When I *write* fieldnotes I find myself tuning into a conversation with myself, translating the outside world into my inner discourse. When I draw, my relationship with the world changes; my attunement changes, it becomes an attunement *with* the world. My position in place becomes apparent. In the drawing style my positionality is reflected; what interests me? What do *I* deem important in contrast with what my interlocutors may deem important; I did not think twice about the green longji. Drawing is a being acutely in place. I tap into seeing what is in front of me, I layer this with sound; I become external to my experience.



One day I was sitting still with some interlocutors at a supporting department. Many days had I spent in the shade of one of the large trees on campus. Sitting still with my sketchbook on my knees. Over the days, I started noticing the same repetitive rattle of beds when patients where wheeled past. This set me off on a drawing expedition of the surfaces of patients' pathways. By sketching the broken floor surfaces, the pinch points where movement was complicated, I mapped what in my mind



became “the pathways of pain”. This approach afforded an intimacy with materiality of the site and a deep understanding of the (affective) relationships between human and non-human actors; infrastructure, the people who use them and the people who care for them.

Previously, as architectural designer on campus, my notebooks and camera’s gaze were often unwanted, people looked at me suspiciously. What exactly was I photographing? Why? Why is she taking notes? In contrast, during my fieldwork, dwelling in drawing and the open A3 sketchpad was an invitation.

Engaging – with oneself, interlocutors, relationships, and the object of research

When I am drawing in a public space, people come to me, they are curious. The openness of the drawing process afforded me access into conversations and relationships I had often not expected. Interlocutors initiate interaction, as we saw with Aunty Aung at the beginning of the thesis, inviting me into their spaces. Drawing is non-threatening, curious, and public.

Spending time around campus drawing I was met with interest, opening spaces for conversations. Drawings are visual, breaking-down language barriers. During my fieldwork, people who would ordinarily not approach me, thinking I do not speak Burmese and hence not able communicate with me, approached me, and started conversing about and through my little sketches.

The sketches became bridges between others and myself and the others becoming my interlocutors. Spectators of my art rendered themselves research interlocutors. This inversed common power relations in the field. Instead of me seeking out my interlocutors and ask questions, they would seek me out. A question shifts the power relation in my favour as it implies the expectation of an answer. This is even stronger in a context such as my hospital fieldsite where I was often perceived as foreign doctor, and doctors command utmost respect in Myanmar. When I am drawing at the hospital, I am clearly not a doctor, nor a foreign expert. I am an artist (even though a strange one drawing in a public hospital). An artist is something that is understood. I am approached and questioned. I explained what I did, mostly with “I am studying the daily life of the hospital, how people and places

work for my PhD thesis", this would spur more questions and often a lot of pontifications why I might be doing this and questions about my own daily life which I could easily return alongside my answer with: "…and what about you?". They learned about me and my research and finally, often enthusiastically, participating in my endeavour. As I was doing the seeing and drawing, I was looked at (and talked about).

The act of drawing in the field is an invitation to step closer and see what the artist is making. Drawing is inclusive. I see in drawing as a methodology for ethnographic research, a path towards decolonising, or "de-exoticising", our work.

What makes people comfortable engaging with strangers they would normally not approach? I believe it has roots in the intimacy that the act of drawing creates with its subject. People detect the artist's "communitas" with the seen that comes through the act of drawing. A sense of "communitas" in the liminal moment of sketching; a oneness with the world which makes me feel comfortable within it and hence approachable and engaging. It renders the act of drawing inclusive, democratising the process of research.

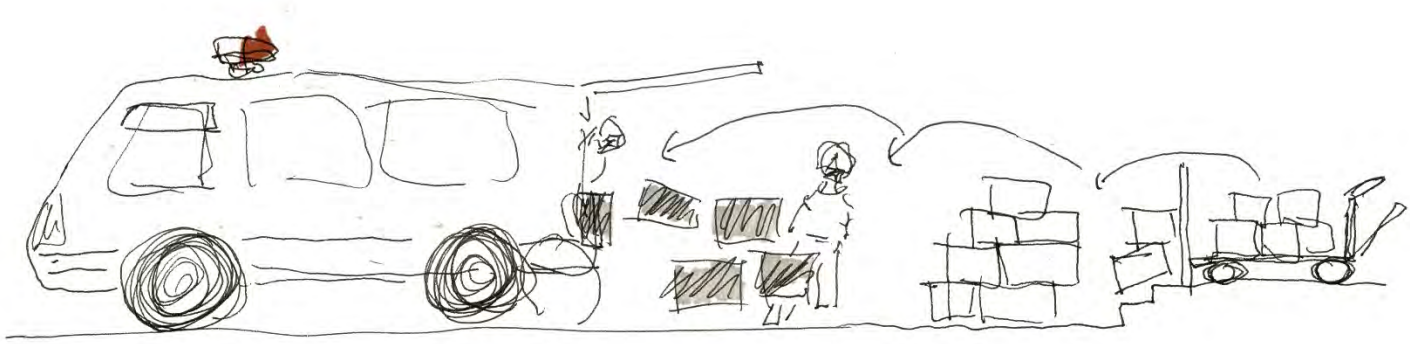
In drawings, sketching relationships in space, tensions, and contradictions can be explored; with oneself, others in the field, amongst interlocutors, with interlocutors and the field. Drawing these out can be incredibly productive; staying true once more to "draw what *is* not what you think*".* Drawings can show relations without having to comment on them or having to take a side; they can stand as part of the narrative while investigating the relationships.

Anthropologist Theodossopoulos uses comics to explore opposing viewpoints in his ethnographic work on the question "Philanthropy or Solidarity?" (Theodossopoulos 2016). Through collages of photos and sketches he explores the tensions between two positions which he wishes not to take a side on (Theodossopoulos at SOAS Anthropology Department seminar series 2018/19). The medium allowed him to explore the tensions without commenting. The two narratives quite literally standing side by side; something infinitely more difficult (not impossible though for a skilled writer) when only

writing, where text is linear and holds an expectation of a conclusive argument. When drawing contradictions can remain. My field sketches are tableaus of relationships, spatial, interpersonal and at times my own relationship to the drawn subject, often expressed through the vantage point I assumed.

Archaeologist Lesley McFadyen describes beautifully how he engaged with his fieldsite during a dig through drawing of the different layers of sediments (McFadyen 2016). The drawings of what was in front of him, choosing how to represent the different layers allowed him to travel through time. In my fieldwork this notion of engaging with my fieldsite and my interlocutors through the act of drawing was very strong. In the end I left prints of some of sketches that I knew were especially liked as farewell presents in the field.

Coming back to drawings, the beauty of drawings is that anybody can react to drawings. As discussed above, drawing reverses usual power structures. I get critiqued and commented on by my interlocutors *in situ*. Rather than the anthropologist "translating" or "explaining" social phenomena, I am told that the samosa looks different or what the name of the fruit is if I mislabelled it. In my last weeks on campus, I presented my drawings with some key "findings" (as it was expected of me to have "findings") to different audiences at the hospital. In one presentation, administrators and nurses, elicit by my sketches on a large screen, heartedly debated the reputation of YGH; in another instance I was told that my drawing was wrong, they do not transport goods in ambulances. I had spent weeks observing decommissioned ambulances transporting good around campus. What was



happening? Well, I learned they *should* not transport goods in ambulances and had recently received vans to do so. I had never seen them; but I am happy to write, as I was asked to, that in April 2020 the hospital had vans waiting to be commissioned.

In many instances drawing allowed me to deal with issues of consent directly. One of my interlocutors kept looking over my shoulder what I was drawing. One day he was not happy with what he saw and told me that I am not allowed to write about what I had drawn. Such direct communication makes the notion of drawing or writing "near" a subject rather than "about" tangible. Benjamin Dix explores this in his article about his ethnoGraphic novel *Vanni* (Dix & Pollock 2019). Here he established that drawings and the process of making the drawings allowed for a collaboration and level of participation that would otherwise not have been possible (Dix et al. 2019).

The process of marking art can be a useful tool to inspire interaction with inhabitants of the fields we observe, opening new and exciting doors for the ethnographic encounter.
My drawings live on and come to new life in other media. For the installation *Hospital Echoes* the tiny scribbles are transferred onto cotton banners, hung in space, echoing the rhythms of the hospital. Sketches that were originally only a few centimetres high, are now almost life-sized. They signal a continued commitment to my fieldsite, to my interlocutors, and engage new audiences. Other sketches live on after I departed on my interlocutors' desks.

CONCLUSION

My drawings went through a journey in terms of media; a journey in parallel to my own from the hospital, the field, to my home in Yangon, my home in London, University of London libraries, with a grand finale in a spatial installation at a gallery in Bloomsbury. Moving between analogue to digital, back to analogue. Also mirroring my own movement between media; the text, drawing, and installation art.

Initially, my sketches were ink on a white page in an A3 sketch book; rhythmed and sequenced by the square pages and successiveness of the book. In regular intervals and at the end of my time in Yangon, I dismantled the sketch blocks and scanned the pages. The sketches moved into a digital realm as JPEGs. I fed them into *Microsoft OneNote*, adding comments, tags and make connections; these efforts in *OneNote* were never particularly useful, as my engagement with my drawings was much more intuitive.

In the digital realm the drawings became a chronological sequence in *OneNote*; thinking back, I might have used this moment going from analogue to digital for the analysis; how am I going to arrange my drawings, are there different ways? What different understandings would have emerged had I arranged/ordered them differently in this digital space? Alternatively, had I used a tablet to draw, with infinite space where drawings can grow in any direction and be linked, how would I have understood the hospital differently had I not had A3 sketchbooks with pages that became boundaries and sequences? Inevitably, I already made the decision when a page was "done" and a new one gets started. In a digital space, those decisions are unnecessary.

Once my sketches were digitalised and "ordered", I put them in *Photoshop*. I cleaned them and isolated the little drawings, putting them back together as visual vignettes, collages of sketches into a tableau, using them as starting points to write; putting visual stories together, retelling my, and my interlocutors', experiences through collages of sketches, their intensity and rhythm mirroring the hospital. And sometimes I wouldn't; sometimes my writing was writing with buildings, employing the modes borrowed from architecture as developed in Chapter 1.

My drawings became again something else when I did *Hospital Echoes*, a spatial installation of the field sketches. I came to a point where I struggled with "rhythm" as a concept; I asked myself: How can I conceptualise and understand rhythms, and what does this idea of rhythms help me to understand? I returned to my drawings, their sheer number (633 individual sketches). In summer 2022, I started reproducing my sketched in near 1:1 to recreate in space the rhythm of the hospital.

Through that concrete process, blowing them up, making the decision what goes in and where in space, I came to terms with the abstract concept. Writing the exhibition text, I realised what the installation and engagement with rhythms was about: the space in-between, between buildings and bailiwicks; between physical and institutional structures. Making the installation, engaging with my drawings beyond text, moving fluidly and intuitively between media, helped me to put into text one of original insights about hospitals.

In any representation, incorporating the flow of time is tricky. Darwing or sketching is no different. Drawing, like writing, diagramming, photographing, and filming, is one way to capture ethnographic data. I believe, especially with my focus on draw*ing*, the process and act of making, that writing is part of an artful ethnography with the (built) environment. Drawing, which in essence is a form of participant/observant-participant observation, and ethnographic writing go hand in hand. This is what sets the ethnographic drawer apart from the artist, or even the ethnographic artist, a protagonist in the ethnographic turn in art; the engagement with the anthropological literature. The ethnographic artist might use aspects of fieldwork as anthropologists do, but their context, or literature that they work within, is art history; ethnography to artists has a different meaning than to anthropologists. The artful ethnographer belongs to anthropological tradition with its deep understanding of ethnography and a particular canon, for lack of a better word.

Coming back to the question of time, while it is difficult to *represent* time, time is very much part of the process; it takes time to make a drawing, even a quick sketch demands several seconds. In this moment, time and movement come to the fore. Unless you draw an unmoving model, and even then micro movements might irritate you, or a photograph, constant movement is part of the drawing; nobody sits “still”, a still live is never really still; trees move, even materials have their own motion. All this is part of the sketch, mini decisions which position to draw, what the storey of the drawing is, maybe some awkward angles or a series of sketches, but all this is not necessarily visible to the person looking at the drawing if they are not familiar with the process. Hence other markings

on the page, words and numbers, might be necessary to communicate better; this is where writing with buildings comes in. This takes nothing away however from the *experience* of drawing for the ethnographer. It is merely a problem of representation, and as I said before, this is not where I see the ultimate value of drawing.

Another criticism of drawing can be the hyperfocus on sight and detail. Here I believe, like with any skill, this changes over time and with proficiency. Focusing on one sense, might at first close off others, but for me, over time, drawing opened-up my other senses as I became more familiar with sketching *in situ*, and switching scales (a skill I acquired already in my architectural training of course). Hence, I started audio recording the infrastructure, at times drawing and recording at the same time, as sketching drew time into the frame, made me sit still, noticing sounds. The focus on sight and abstraction of the seen with lines on paper, I argue, opens all sense. Furthermore, to come to a third criticism of drawing, sketching deepens memory. While the focus of a drawing might seem limiting memory, it accesses knowledge beyond the drawing. As an architectural designer, I often took photographs of building details. More often than not, I was missing exactly a detail just outside the frame. I was unable to remember because I had never looked at it. When I draw, I might only draw one person, or object, or detail, but in order to be able to draw it, it had to observe, the whole scene seen, or the detail's connections to the whole; sketching is exploration. I believe, it is this process that aids the memory now when I am sitting on my desk writing. I rarely look back onto my fieldnotes, anxiously written after a day of drawing that I compiled at the beginning of my fieldwork. I wrote fieldnotes after interviews when I did not draw, and words, written notes, are part of my drawings as well, sometimes I would write reflections, sketches in text, on conversations that did not need drawings; sketches and words are all lines on paper. Like any *method* drawing has its limitations and is part of a toolbox. As a *methodology* for the ethnographer, art is a practice of being in/with the world.

The process of drawing is ripe with possibility, the possibility of seeing – in the field and beyond. Drawing is a record of one's personal discovery of the world (Berger in Taussig 2009: 269). In this sense drawings are autobiographical. When looking back at my drawings I see more in them than I did when I was in the moment; I critically engage with them. Drawing is abstracting, deciding what is important, what the main lines are. Necessarily there is a vagueness about drawings, something undefined and open. Coming back to Turner, it is this liminal space of interpretation that is opened within the beholder that holds the potential for innovation and play of thought. Additionally, the intimate connection we create when drawing can be conjured when coming back to the drawings; drawings are the artefacts of this experience.

Through abstraction we start to see things clearly; something Bourdieu explores in his work with theorisation of abstract ethnographic truth (Bourdieu 2008). Through analysis and re-analysis of an initial vignette of a Christmas ball in rural France, he arrives at a level of abstraction, "[…] the construction of a general model" (Bourdieu 2008: 4), that allows him to speak to wider issues, beyond the French countryside. Drawing, the abstraction and the process of essentialising of what we see in front of us into a few lines, can facilitate this process. Drawing holds the potential to open our eyes to what is in front of us rather than what we think we see and helps tracing the main lines, without getting lost in detail, while not losing the details; making a drawing is an iterative process oscillating between the bigger picture and the detail.

Drawing is being curious, wondering and looking with wonder. With each sketch we make, we will always see something new.

At the start of my fieldwork, my fieldsite and I knew each other for almost half a decade. Given this history, I could easily have arrived on campus with set ideas whom to interview and where to look. I designed my methodology to avoid "seeing what I think I see". Key aspect of this was not to start with interviews but with drawing; drawing was the start and end point for this thesis.

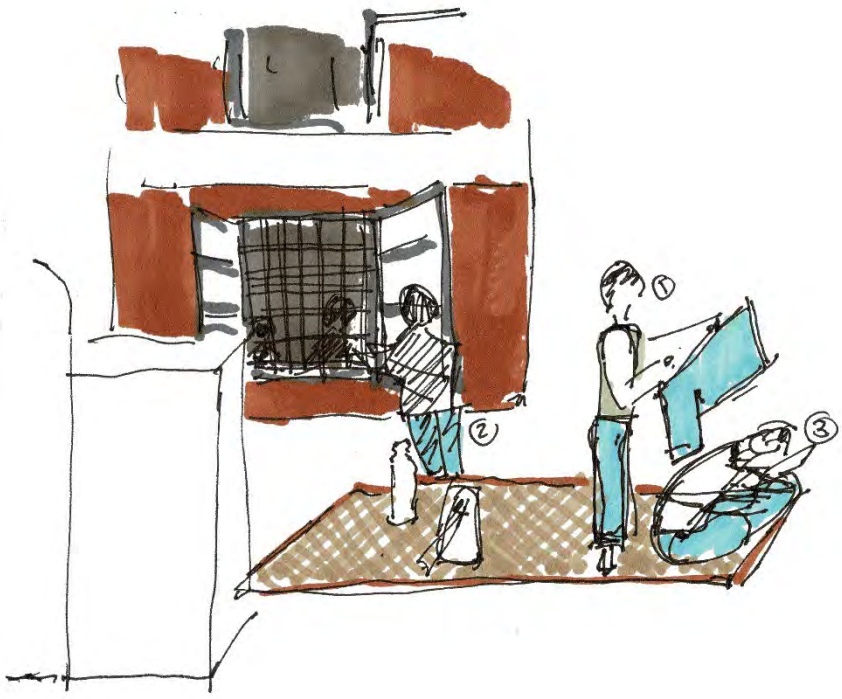
The three registers of drawing, “seeing”, “being”, “engaging”, are not individual pearls on a necklace, they are one in drawing. The reason I disentangle them here is to foster a reflexive drawing practice.

To conclude, the act of drawing, and really any creative, visual, sensory engagement in the field, has the potential to be more than just illustration. As Natasha Myers attests: “Artful ethnographies […] help us break the frame, shake up the ground we thought was solid under our feet” (Bakke & Peterson 2018: xiii). This, to me, is the value of anthropology in general, to change the narrative, see something new, think anew, knowing otherwise. Drawing assists this.

Drawing, and making art in general, is a way to be in the world, make sense of what is around us, beyond assumptions that we might have. In order to harness the potential of art making, we must not draw/paint/photograph/record what we *think* we see/hear/feel, but what we *actually* see/hear/feel; follow the lines in front of us onto the page without judgement. Drawing can be a tool and an outcome. My concern here is *drawing as ethnographic process*, a way of knowing with the fieldsite. Drawings were also tools, a method, to elicit conversations, they are also artefacts from the field in the present text. At the same time, my drawings, and my recordings and soundscapes that I made during fieldwork, are pure process; art for the sake of making it, to be in the moment and understand something beyond words, to sense the place. While sketches are part of the metanarrative, the soundscapes only found their way into this text in the shape of textured description. Without them the observations would have been less acute.

Through a reflected, non-judgemental, and open-ended artistic practice we can find different, new, and often surprising narratives that inform how we see the world, even if it is a world that we think we know very well, as was the case with me and Yangon General Hospital, where drawing allowed me to get lost, without losing myself, in a familiar fieldsite.

Drawings are the bridges between the embodied field experience and the linear text made from individual words strung into sentences, clustered in paragraphs, in the following pages.



II PLACE

What is a Building?

"It takes time to understand place.

And the idea of this piece, of course, is to understand place in order to understand the people […]."

James Benning, Artist / Filmmaker, on his exhibition "PLACE" (Prince 2021: 1)

CHAPTER 3: THE CAMPUS

"IT DOES NOT SMELL SO TERRIBLE AS IT USED TO"

The concrete walkway is polished from a century of feet shuffling from one part of the campus to another. Tin Tin, my research assistant for a couple of days, sniffs the air as we emerge from the cool basement on the main building's south side. Ducking under the elevated reinforced-concrete walkway with the ICU entrance above, we reach the covered path that leads from Medical Unit 4 in the main building to the back of the Accident and Emergency Department. Weaving through waiting families visiting their loved ones, we avoid colliding with stretchers rushing patients between departments. A worker collects rubbish further down the walkway by the Rehabilitation Outpatient Department. "It is smelly, a medical smell, but it does not smell so terrible as it used to"; I know what Tin Tin means. When I arrived at the hospital in 2015, a whiff of raw sewage would linger especially here where so many pathways and bodies converge; it still does when the sewage system cannot cope and overflows into the surface water drainage channels during rainy season. Five or six years ago, a new construction, planned above the campus' main sewer, settled, and crushed the pipe. Black water,[25] nowhere else to go, found its way into the surface water channels until engineers installed a workaround with pumps and its foreseeable maladies of rubbish blocking its motors and power cuts preventing the machine to work. Tin Tin does not know about this and most likely refers to a general atmosphere of stink and chaos that used to be characteristic of YGH. Various interlocutors voiced their surprise at the changes the hospital has gone through since the mid-2010s. Today, Tin Tin looks around

[25] Technical term for sewage; water containing nutrients, faces and other contaminants.

appreciatively. Everything looks and smells better than she expected; the hospital is much cleaner and more organised than she remembers.

INTRODUCTION

At this point you might expect a neat description of the hospital campus. Some elegantly packaged narrative. It is true that if you were a visitor to Yangon asking about Yangon General Hospital you would most likely be told: "Yes YGH! The big red building on Bogyoke Aung San Road!". This seems pretty straightforward. Unless you are injured and in need of acute care. Then you would probably be directed to the A&E (Accident and Emergency Department) on Lanmadaw Road. Or you are dead, then your entry point would be the forensic department. And here the trouble with neat descriptions begins.

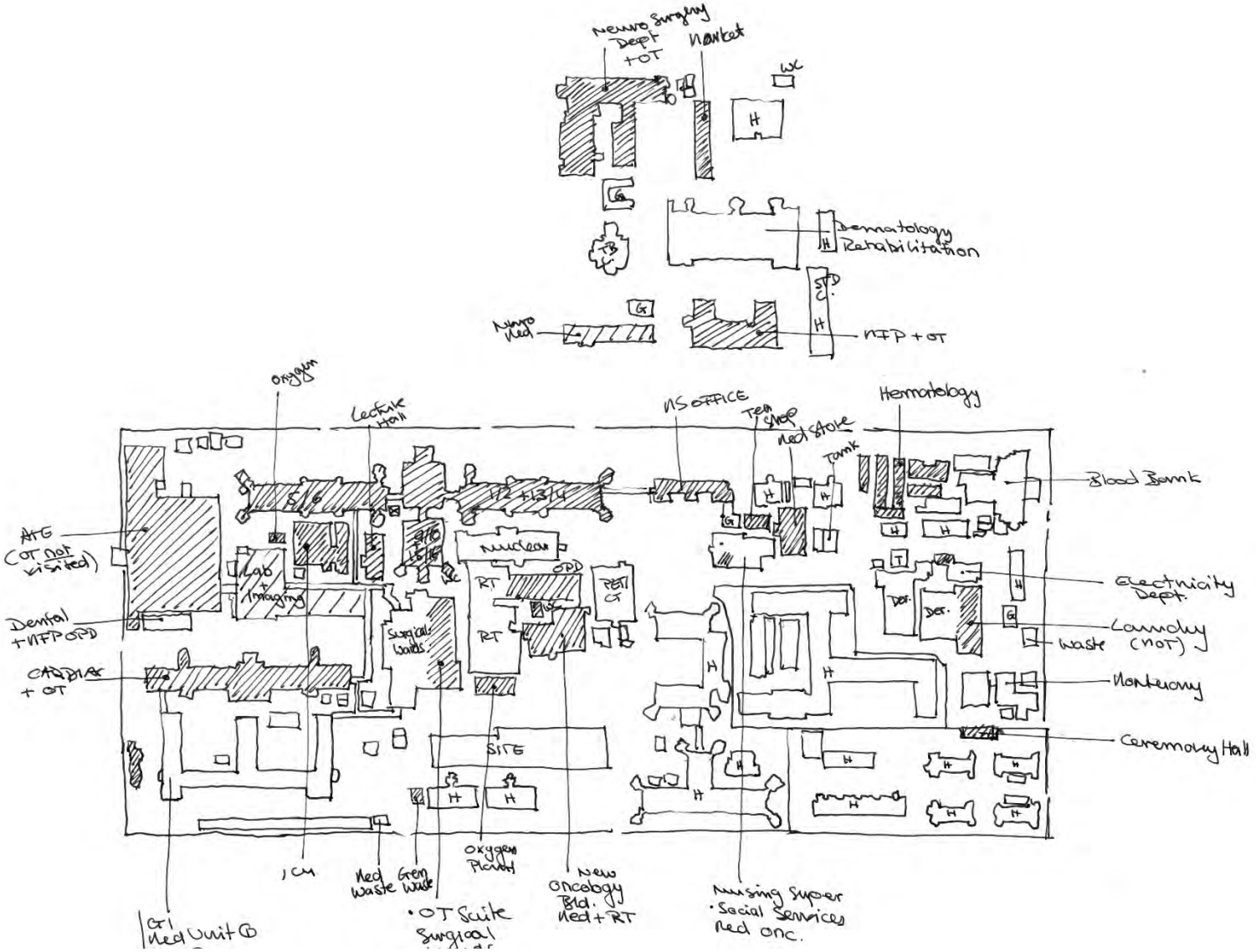
I could also try and describe a bird's eye view, as you would have from the food court on the upper floors of the adjacent Junction City Mall: a sea of green, large tree canopies interspersed with red, blue, or rusty brown roofs. You would not know much more than that YGH presents itself as a surprisingly green site in a grey city.

Or I could try and describe the site plan with walls and fences surrounding the campus; its main buildings, how they connect; its highest and lowest points, where flooding occurs. But this is a privileged view of someone who has access to the site plan, topographic surveys, and the masterplan. Most people do not experience and see the campus like this.

The hospital is different depending on who you are and where you are coming from, or with reference to MoI and the hospital multiple: What you do with/to/at the hospital. Are you approaching as a visitor, or a patient? General worker, clinical or administrative staff? A Yangonite, someone from Myanmar, a foreigner (or all at once)? Are you injured, alive and well, sick, or dead?

I tried countless times to describe YGH. But the hospital is not singular. Centuries of feet shuffled over concrete, polishing the surface of its walkways; structures were added to its colonial edifices over time; buildings settled, shifted, sunk, moved ever so slightly on their own accord with far-reaching consequence. Things changed at YGH, others remained the same; patient families wait as staff rush past; smells linger and disperse.

Nonetheless, the red main building on Bogyoke Aung San Road tends to dominate the hospital's narrative; visually, spatially, and ideologically. Sitting in my flat in Shanghai's French Concession in 2015, eager to start my new job, photos of the main building were the only images I could find of



YGH online. If you image-search the internet now, it is likely that you too are looking at the main building's red painted bricks from one or another angle.

The main building's distinct façade, with pastel yellow cornices, stretches along half of the main campus' northern elevation. With its impressive 5000sqm footprint it is the main aspect from the campus' northern gates. Its red façade and roofs can be spotted across campus, and from vistas in the surrounding neighbourhoods, peeking above eaves, and between buildings, visible from upper floors further away, or you might suddenly find yourself close-up as you explore the campus. It is the colonial main building that was the first to be renovated as part of the hospital's rejuvenation project, an easily communicable scheme to Yangon's public. It was also against the backdrop of its red façade that Daw Aung San Suu Kyi gave her first public speech in 1988; an icon in front of an iconic building.

While the big red colonial brick buildings dominate the imagination and imagery of YGH they are not all there is to it. Today, between the brick structures, reinforced concrete buildings with aluminium

cladding, metal roofs, and brick infills, assembled over the decade of the hospital's existence. They encroach onto the greenery of yore when colonial officers wandered the hospital's lush gardens. Only the oldest and most stubborn of the old trees are left. Today the new structures dock with concrete bridges into the colonial-Victorian style buildings, creating a network of ground and above ground pathways and passages.

In this chapter, I take you into the thick of the hospital campus. While setting the scene, I also engage the question what a hospital is. What is the hospital multiple in detail, in its fleshy "placeyness"? By exploring the hospital's character, when you enter this world for the first time, we meet it as a "Labyrinth" with "Emplaced Hierarchies", painful practicalities *vis a vis* clinical abstraction. Through a visit to the campus' "Holy Tree", "Ghost Tree", and the central "ICU" we encounter its atmospheres. In the second part of the chapter, I discuss the coordinated chaos, in "Back and Front of House Speeds", "Pandemic Paces and Space" and finally, before drawing it all together in the conclusion, I discuss "Change" on campus. We will travel from an emplaced and specific reading of YGH to somewhat universal insights about hospitals. All the while understanding that there is no such thing as "a hospital in general"; hold this contradictory thought for a moment. We will come back to it in the conclusion of this chapter.

For now, as we move in and out of different scales and between different points in time, I am inviting, and maybe challenge (even dare), you to see the people through the built environment; the way I do as an architect. Behind every betel nut stain, worn tread, and crafted teak fitting, is a person, an individual that made use of the hospital, becoming a series of individuals turned abstract "users" over time and space, and once again an individual working, healing, caring, within the hospital's walls. By attuning your attention to the hospital's places, its materials, and physical changes, I invite you to assume a slightly unusual position for a reader of ethnography.

Place is a fact of our lives often overlooked as an analytical category in anthropology: "[Place] goes without saying" (Geertz 1996: 259). But place demands exactness (ibid). And herein lies its value for ethnographic writing. By engagement with the hospital as a place it loses its abstraction. It comes into sharp focus with the realities of daily life; not as an abstract category "the hospital" it's generic form but as the hospital as a lived place. The aim is "giving shape to things: exactness, force intelligibility" (Geertz 1996: 262); giving shape to the abstract category "hospital". In using its buildings to move between scales I add textures to the hospital as a whole, a campus with multiple departments and a long history in a bustling city. Emplaced and specific. "No one lives in the world in general" (ibid). And there is no hospital in general. However much, ideas of best practice and standardised processes would like us to make believe. In this chapter we meet the campus' buildings, pathways, and infrastructures. Its buildings will become processes in front of your eyes, changing and growing over time. I introduce you to the hospital's built-environment, an alive hospital campus, grown from a leafy colonial compound in the British Raj's backwaters, to a 2000-bedded tertiary care teaching hospital at the heart of a southeast Asian metropolis.

After the initial confusion, the difficulty of orientation on this mega-campus, we will discover the campus botanical heritage as guides, a heritage that is part a parcel of the built environment. Many of the trees of yore have been on campus long before it was a hospital. They spent shade, healing properties, and spiritual sanctuary. They grew with the hospital, burrowing their roots deep into its history, their mycorrhizal networks connecting below campus. They change with the seasons. Their roots accommodate new foundations, and their leafage adjusts to new roof lines. They are not the most prominent nor noticed cast members. But it is here, by their trunks and beneath their branches, where the hospital's daily life thickens, congregates, and rests.

While this chapter speaks for itself, describing a dynamic hospital campus, emplaced and exact (Geertz 1996), places are also historical and relational (Casey 1996). Therefore, I urge you to read this chapter in conjunction with its siblings, Chapter 4 “History” and Chapter 5 “Beyond the Campus Walls”, which see the campus through time and as a part of its city and country.

LABYRINTH

I distinctly remember my first weeks on campus in 2015, constantly confused, always wondering about the many corridors and walkways. Sometimes I would deliberately look the other way to avoid being overwhelmed by my task at hand: the renovation of the main building.

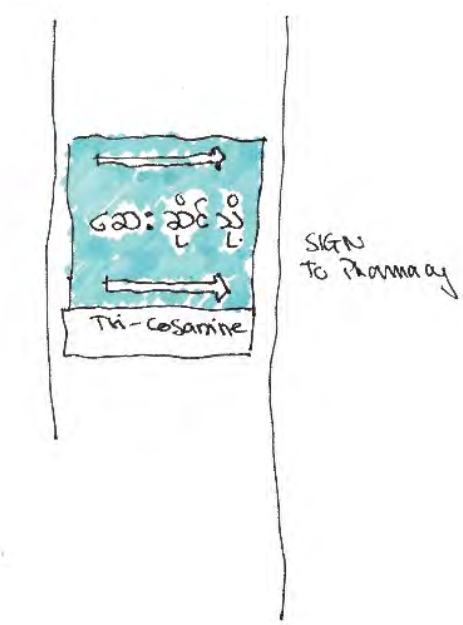
One evening in July, a month after my first arrival in Yangon, I find myself outside the portal connecting the rest of the campus to the Accident and Emergency Department. Yellowish-green, this connection is never closed. The corridor’s slip-proof vinyl flooring is lit by cold fluorescent tubes,

flickering, insects playing in the glow. The corridor is lined with doors left and right to the MRI[26] and ultrasound areas, before, further down behind a right-bend, the A&E's buzz of urgency lurks. On the other side of the covered walkway where I am standing, looking at floor materials and levels converging, steps lead up to the locked entrance of the Imaging Department and Laboratory. It is after-hours. The closed double doors are a key connection to the first-floor walkway system; a tangle of above ground pathways linking the A&E, the Modular Operating Theatre Complex, the Cardiac Building and the Daw Pu Building, with its three departments, as well as the ICU and the main building, containing three medical wards, blood issue room, auxiliary services, and the "ortho kingdom" as one of my interlocutors calls it jokingly. To the left of the stairs a dark ramp, corners stained red from betel nut spit, leads down to the maze of ground floor corridors and connections. They are congruent with and sheltered by the elevated walkways above. The many pathways lead to different stories that go nowhere for some, somewhere for others; people die, or never come back, while others are simply not authorized to enter.

YGH is overwhelming to anybody first setting foot on campus, before becoming familiar with its best spots for drying laundry in the scorching midday sun, silent areas of worship, cool dozing grounds, teashops and coffee spots, fruit trees, icy theatres, waiting rooms, and all the other places we will encounter in the following pages and chapters. In the introduction I tried to "make sense" of the hospital through numbers, area, employment statistics, and beds. These numbers told us that YGH's buildings are the most neglected piece in the puzzle. But they did not tell you what the hospital is, what *a* hospital is. What it feels like to be on campus.

[26] Magnetic resonance imaging.

In the years following my first encounter with the hospital's tangled pathways, I came to intimately learn the buildings' corridors and walkways, front of house and back of house speeds, the long ways around and the shortcuts. I drew every single connection and noting the lack thereof, sketching patients' odysseys, following workers, nurses, and goods around campus.



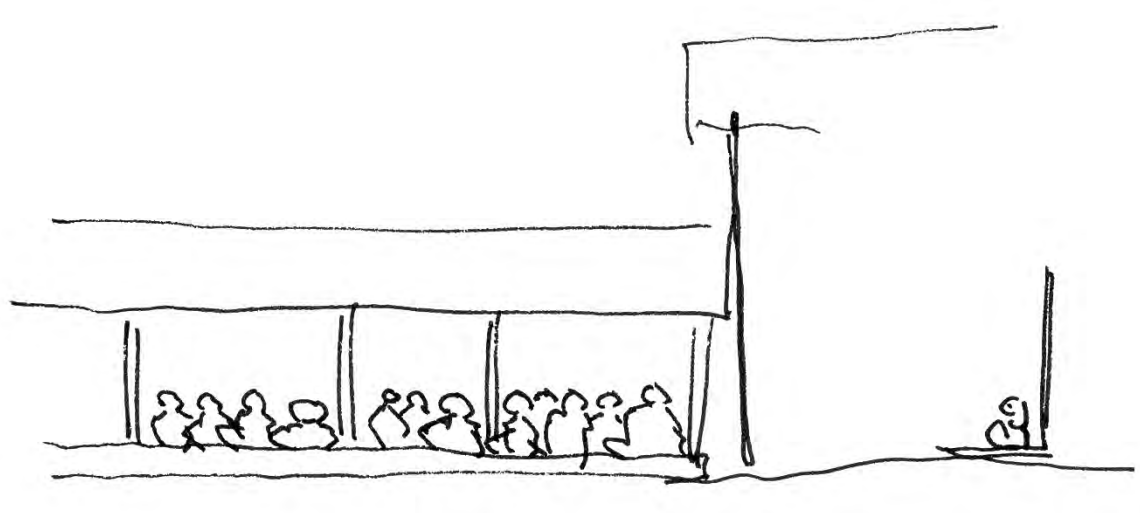
The hospital's maze-like existence is embodied in its so called "sidecars".[27] For many of my interlocutors (administrators, visitors, patients) they are a blessing and curse at the same time. "Sidecars" are individuals, often children of vendors and homeless people on campus, who offer their familiarity with the campus as a service to visitors, reliably charging a 100KS "appreciation fee" for their knowledge. I am hearing of them from interlocutors before I learn to see them; I am not the clientele they pry on. Lying in waiting at gates, main crossroads on campus, and often by the A&E, they guide confused visitors across campus to the right department, ward, or waiting room. When I arrived in 2015 the hospital had no signage strategy, directional signs were inconsistent. Today some strategy has been implemented, many signs are sponsored by pharma companies. But it is not a given that everybody can read the signs in Burmese. Myanmar has many languages, and not everybody can read, especially from older generations; a symptom of an eroded school system, neglected over decades. The sidecars' business continues to be lucrative.

Even though the campus developed mostly *ad hoc* over the past century, thought, mostly sporadic and disjointed, has gone into its densification. Its pathways ensure shelter from the elements, from

[27] My translator explained "sidecars" are named after trishaws. Trishaws in Yangon are called sidecars, referring to the side car the customer sits in.

rain as much as the unrelenting sun, when navigating the maze of clinical and administrative structures and buildings. While YGH is disorienting for some, it is familiar and bodily for others.

The Acute Burns Unit is a cluster of rooms within the Maxillofacial and Plastic Surgery Department. White tiled dressing rooms, empty when I visited, made my skin prickle with the knowledge of the procedures, so intimate and painful. Burned bodies, often female suffering from acid attacks, get medicated with pain killers before routinised clinicians change the bloody and oozing bandages. The pain patients must feel when getting dressings changed is palpable in the empty, well organised, and bleachy clean rooms. The post-graduate student tasked with showing me around explains her intent for specialising in MF&P[28] surgery. She is interested in reconstruction while thinking she could also do cosmetic surgery later on. A Korean team does yearly training sessions for the specialty not taught in Myanmar, surely a lucrative one. The young doctor's abstract career considerations stand in stark contrast to the patients' reality, who are lying in single rooms along the corridor; some in full body bandages, no air conditioning available, fans rotating the stifling air while waiting for the daily dressing change. Abstract spaces, white and tiled, sit together with painful procedures; career consideration overlay with lucrative specialties and care for some of the most disadvantaged individuals in Myanmar's society.



[28] Maxillofacial and plastic surgery.

EMPLACED HIERARCHIES

All these places, the dressing rooms, the pre- and post-surgery wards on the floor above, the operating theatres where the young doctor trains, embody hierarchies. The mentioning of hierarchies is hardly surprising in a hospital; there are doctors' offices, waiting rooms, administrative buildings, protected storage, access-controlled theatres, and procedure rooms with family members patiently waiting outside for the patient to emerge with a clinical professional who has the authority to traverse the magical border (after all, most of the time there is no lock or fence preventing a breach of the order). Most of us have been to hospitals, knowing the disturbing feeling of not knowing what lies behind a particular door but seeing doctors and nurses shuttling in and out. At YGH patients' attendants are issued access cards, two per patient, granting permission to be with the patient on the ward beyond visiting hours for much needed emotional support and practical bedside care. Incidentally, these cards are also part of the intricate way-finding system. Several attendants spoke fondly of kind workers or a nurse who helped them find their way based on what is written on the little cards dangling from blue lanyards.

Beyond the obvious hierarchies more subtle ones are embodied in the hospital places and buildings. In the introduction we already noted that the hospital's model of care is spatially tied to specialties, illustrating the close connection between care and place. I first came to learn of "models of care" as project architect for the development of the hospital's masterplan from Anna, the team's healthcare space planner. The hospital's current "by institute" organisation is slightly old fashioned. It reflects a rigid hierarchy in which the professor is at the top; the Professor is only going to one (" their") department, rather than run all over the place to find their charges, with patients at the bottom, as needs may or may not be optimally met. The institute model is not an inherent law, nor is it necessarily the best for patient convalescence nor managerial efficiency; as noted by other hospital ethnographers, where a patient belongs can be a tricky question of disciplines and responsibilities (Vernooij et al. 2022).

A hospital can be alphabetically organised by patient surnames if it is a considered decision with the support spaces planned around that decision. For the masterplan we organised the model of care by elective/emergency cases to improve infection control, a key consideration in this specific context. However, other models are possible; for example, "by age" (paediatrics, elderly, and adults), or "by acuity" (division by how unwell or "acute" someone is) with critical care, high dependency, acute units, and "base" wards. Another way is by 'length of stay" (one day stay, short stay, long stay etc). Generally, Anna's preference, which was impractical for YGH given concerns about infection control, is based on "care needs"; regardless of what people have wrong with them, a 25-year-old with appendicitis has more in common with a man who came off his bike at the age of 30 than someone who is 60 with bowel disease.[29] White et. al. (2012) show how, at hand of three spaces (A&E, Genetics Clinic and ICU), spatial configurations can be incommensurate with patient care and different logics demonstrate that (clinical) processes are not always congruent with space; as we see at hand of my campus wider discussion of the model of care and wider logics of, for example, infection control (that ties in with national and global health concerns) or patients' complex needs.

To date this part of the masterplan has not been implemented (yet). For now, most buildings, at least entire floors, are congruent with particular departments/specialities; a patient coming-in through the A&E (a self-contained building where emergency physicians reside)[30] with a broken arm is transferred to the same ward as an elderly patient who had elective (planned) surgery for their hip in the main operating suite (orthopaedics); a patient with an acute head injury is sharing a building with someone with a brain tumour (neuro-surgery); while someone with blood cancer/leukaemia is in the same department and buildings as someone with haemophilia (haematology). Each of the mentioned specialities has its own building (except the orthopaedic surgeons who have one floor of the main building).

[29] Discussion of models of care based on personal conversations and email exchanges with Anna.
[30] Emergency Medicine is a new specialty in Myanmar, introduced in the last 10 years; the second cohort was practicing when I did my fieldwork in 2020.

Why some of this might be an issue can be seen especially well at a time like the present when infection control is at the forefront of many minds. A patient coming in as an emergency case might have an infectious disease but is primarily being treated for their highly acute injury that needs to be attended to with immediate urgency, without time for lengthy screening. If this patient now goes into a ward with elderly patients who had planned surgery, the risk of infection is high (depending on context; pre-Covid-19 the risk would have been higher in Yangon than in London given the types of diseases each country deals with). Even with adequate screening standards, not all infectious diseases are quickly enough diagnosed. Hence in a context where infection control is a major concern (such as Myanmar already pre-Covid-19), emergency and elective (planned) cases are better kept separate. This would mean that, for example, a patient recovering from a planned hip surgery would be better off with someone who had a planned cardiac surgery, or someone with a broken arm would share a ward with an individual who was stabbed (both trauma cases). However, in this case the doctors would have to move between departments. In a resource low context where specialists are a valuable, this would mean additional miles on their feet. I am giving only one example for a different model of care, driven by infection control, as was developed for the masterplan. What I hope this example illustrates, are the many, often unpredictable and at times competing, factors that influence considerations around models of care, which is intimately linked to space, translating hierarchies into spatial relationships. The model of care is not an inherent law or "undisputable" science, but based on social, economic, and (micro) political factors.

The correlation between space and hierarchies extends further. Writing about Yangon's court buildings, Girke argues that the judges' and lawyers' struggle to prevent the high court (the home of the law) from being repurposed by private developers betrays the low status of the judiciary in Myanmar (Girke 2015). I extend this observation to the medical professionals who enjoy a high

status[31] and had little issues to maintain a strong hold on Yangon General Hospital. In contrast to the judges and lawyers, the doctors argued successfully and with ease for the preservation of the built heritage on campus; more on this in the following chapter on the hospital's history.

In extension to this observed entanglement of professional status and built heritage, I noticed that the most prestigious specialties (Orthopaedics and Cardiology for example) have their departments in the historic structures, the buildings with the thickest walls, the best thermal capacity, and highest ceilings. The ground floor of the main building has repeatedly been called the "ortho kingdom", while the new Diabetes Centre for excellence is located on its top floor. There are more examples where desirable space (which might be the reputation of a building as is the case in the aforementioned examples or a location on campus) coincides with the high reputation of a department.

The above observations of specialities and their spaces is mine. It is based on years of drawing locations of departments and departmental relationships, which are not necessarily the most logical from a clinical point of view. So is, for example, the neurosurgery department, a department that deals with many trauma cases, often accidents, the furthest possible from the A&E. One of my interlocutors said as much to me, while another denied that there might be a correlation between reputation of specialities and their location on campus. However, as any anthropologist knows, what people say and think diverge from what they do at times. Jenkins shows this beautifully with cattle farmers in France. The story they tell is not necessarily congruent with what was observable, or aligned with historical facts (Jenkins 1994). While my drawing practice revealed a hierarchy in the spaces with relation to specialities, this might also have grown organically and historically over time rather than following premeditated consideration.

[31] I have been told repeatedly that the Ministry of Health and Sports is "the best ministry", the most efficient, "because they are all doctors" (personal conversations). One aspect here is that entry exams for medical school are very hard, and the study of medicine lengthy. Education and time are both expensive in this context.

On an embodied and material level, it is the coolness of air that betrays hierarchies beyond doubt. The more air-conditioned a space is, the higher the occupant's status. This is mirrored in the original plans of the main building where Europeans are located on the upper floors with better air circulation than on lower floors (more about colonial airs in Chapter 4 "History" and Chapter 7 "Bodies and Buildings"). Today, wards are rarely air-conditioned and if they are they have no windows. While the most senior doctors and administrators have offices with air-conditioning and windows, more junior doctors might have cooled air but no window. At the same time, workers strategically choose the department where they would like to work and, according to one of my interlocutors, some do so based on the air (there are additional factors that we will see in subsequent chapters). Therefore, the modular operating suite is not everybody's favourite workplace. The icy air induces fear of sickness; "comfort" is not universal (le Roux 2020), as I discuss in more detail in Chapter 7 where we pay close attention to "Bodies and Buildings", critically interrogating the shared fantasy of "comfort".

The hospital is a maze of open and closed doors; a collection of brick, concrete, metal; a tangle of pathways and bodies. While plastic signs on concrete pillars point a lost visitor in the right direction, it is the sidecars who guide individuals to their destination. Their intimate knowledge of the campus' places translates into. The hospital is a placey-place, sometimes disgusting, with body

fluids and pain. At the same time, it is abstract and clinical with airconditioned offices and professionals pondering career plans. Depending on who you are, and the practices you/your body encounters within the buildings' walls, you confront a different hospital multiple. Its buildings emplace hierarchies in the thickness of walls and ceiling heights. The coolness of a room tells our body the pecking order, bypassing speech; the hospital as a place is in communication with our nervous system.

HOLY TREE

Atmospheres shift across campus; from the frantic Western part of the site dominated by sirens and anxious voices where the A&E is located, into the dense clinical heartland that we will encounter later in the chapter, to the organised and efficiently quiet administrative area with Medical Superintendents' offices and the Medical Store. The eastern site of the campus quietly accommodates housing, and the mortuary in a mood of sullen grief.

The ancient Banyan stands at one of these crossroads, in moment where atmospheres meet.

To the east, the tranquil atmosphere of the part of the campus with housing, the morgue, and supporting departments (engineering and laundry). To the west, the administrative offices and medical store, with the buzzing urgency of the clinical areas of the hospital campus already palpable.

While this majestic tree seems to be standing to the side of it all, a place of worship and refuge, it occupies a central space. Its roots reach beyond the inauguration of Rangoon General Hospital by the British over a century ago, to times when the grounds that are Myanmar's biggest hospital today were the gardens of Rangoon's horticultural society and home to the Phayre museum. It was around

when only twenty-six buildings were scattered over leafy grounds.[32] The tree's roots bury deep into the campus's history, its branches sheltering the present.

On a sweltering day in 2020 they offer me and my drawing paraphernalia shade from the onsetting hot season as I perch on my portable rattan stool. The holy tree allows me to rest while life and death moves around; an electric mortuary vehicle, reminding of a repurposed golf buggy, whirrs out to retrieve a body, while a woman pours milk over the Shiva Linga in Hindu worship.

The tree is a site for Buddhists and Hindus alike. Its trunk surrounded by shrines. To me it is the "holy tree". Hain Thura Kan, a dear interlocutor and hospital worker with generations of forebears on campus, told me once that trees carry our prayers; leaving me wondering where these prayers go. People come to take care of the shrines arranged around the trunk. One woman says she lives in

[32]"General Hospital, Rangoon". (1915), *The Hospital*, Vol. 57 No. 1495, pp. 445–446.

Dala and comes regularly for the shrine; she does not work at the hospital, a relative might. Dead leaves are removed, fresh flowers arranged, and milk poured. The existence of the holy tree on campus points to what Hanning discusses as entanglement of science and sanctity, biomedicine and religion complementing each other, in her scholarship in terms of biomedical and religious practices and narratives (Hannig 2017, 2022), here at YGH, it is part of the physical infrastructure; in the shape of icons under trees, but also in monasteries and churches providing vital secondary services for patients and attendants.

Three roads meet here. One leads to the Eastern gate between the blood bank and the doctors' residence, along houses for ambulance drivers,[33] pharmacists, and the managers of the Oxygen department; critical services for the hospital that need to be on site 24 hours. The other road, away from the clinical campus, leads around the derelict 1910s central power station,[34] a steel frame hall with brick in-fills (Article 25 2017) and a collapsed roof, nature taking over, to the the Forensic Department, with its own gate, located here since the hospital opened its doors in 1911. Both roads meet again here, creating a loop.

The house of the ambulance drivers is a two-storey wood structure. Pharmacists and the oxygen department managers have a concrete building; wooden external walkways, common in Yangon, provide individual entrances to the apartments (as opposed to internal corridors). Past these dwellings the

[33] While Yangon's public ambulance service is still in the making in 2020, ambulance drivers are key for transporting patients between departments. Currently all ambulance services in Yangon are private or charities.
[34] When built contained boiler room and electrical substation of the Rangoon Tramway and Supply company.

view opens-up towards a 1980s reinforced concrete building with four floors, the doctors' residence; the concrete nature of the building might betray hierarchies once again. Opposite the doctors' kitchens and bathrooms is the laundry, also a 1910s steel frame but with concrete annexes. Half of the building is derelict, only in the extension washing machines whirr, the spinner spins, and driers hum, while surgery sheets from the MOT[35] are slapped on concrete; the sound of removing dried blood carries over to passers-by.

From where I am sitting in the shade, a third road leads west into the bustling core of the clinical side of the campus. A gate which I have never seen closed, marks this transition from the tranquil, almost sleepy mood to the east; workers at the laundry department nap after the day's work, drivers of hearses and hospice vehicles close their eyes while waiting for patients or bodies, exhausted ambulance drivers rest in their doorways after a shift, mourners wait for death certificates. An excited bird only occasionally interrupts the subdued soundscape.

The moment one steps from the shadow of the "holy" Banyan tree into the sun in front of the medical store the atmosphere changes.

Cancer patients with their company are waiting for treatment outside the waiting area of the medical oncology outpatient department. The two-storey building used to be the blood bank, lending its name to the teashop ducking behind it. Vendors are crisscrossing the waiting crowd; everybody follows the shade as the sun moves. Outside the medical store is a constant buzz of activity with delivery vehicles, nurses, and workers coming and going; the sound of motor vehicles or hand pushed carts with boxes piled high rattling over the gutter or splashing into puddles that form when it rains. The campus' main water tank towers above.

[35] The "Operating Theatre Complex", as the signage on the building reads, is called around campus the "MOT" for short. The new Operating Theatre Complex has modular theatres not necessarily allocated to specific specialities; a decision made undoubtedly after many discussions. Therefore, it *is* a Modular Theatre Complex. Naming conventions on campus can be ambiguous, but I will use "MOT" or "Modular Theatre Complex" throughout this text as that is what people call it on campus.

Training nurses come and go from the nurses' training school. Usually in pairs, some share umbrellas against the rain or the sun, they wear bright red htameins with crisp white ainjis[36], hurrying over the hot tarmac.

The campus' atmospheres are diverse; many activities making place through-out the day. The main campus is a carefully orchestrated chaos.

The hospital's atmospheres shift over the campus from west to east; from the most acute atmosphere at the A&E on the farthest western extend of the site, across the thick high frequency around the ghost tree, which we will explore next, to the composed administrative zone, the holy tree standing in the middle, with the calm housing and grief occupied area around the mortuary where patients exit the campus for the last time.

This shift in atmospheres goes hand in hand with sound; while the west of the campus is the loudest with ambulances, chatter, confusion, the east is quiet, almost subdued, even during the forensic department's busiest time in the late morning when death certificates are issued, and bodies returned to families. Not everyone would notice the majestic Banyan. But this tree and the practices

[36] Blouse, usually part of a matching outfit with the htamein.

performed by its trunk add detail to the hospital, shine light on the hospital as a place for worship, of different activities on campus beyond clinical care. While there is no official division, focusing on the Banyan blurs the outer vision, and pulls the tension between life and death into the frame, between private and clinical activities; methodologically this hyper focus on this particular place shifts the scale and provides us with texture.

GHOST TREE

Somewhere between the A&E and the medical superintendents' offices the atmosphere thickens. In the centre a Banyan tree is hemmed-in between the MOT and the main building. It cannot claim the same centenary roots as the holy tree; but in its eight decades it has seen many bodies come and go, numerous senior medical superintendents making decisions, British colonialism and Japanese occupation, junta rule and attempted democracy. Buildings have been constructed around it; others

demolished. On first sight, the Banyan seems besieged by buildings; in reality, buildings and their people arranged themselves around its trunk.

When the Modular Operating Theatre Complex (MOT) was built in 2014/15, the ghost tree should have given way, as it was the case with the old kitchen and canteen. But the tree stood its ground. One humid July afternoon in 2020, Hein Thura Kan tells me the tale of the tree. One night, the senior medical superintendent at the time had a dream. The tree told him not to cut it down for the construction of the new Modular Operating Theatre Complex; it would be bad luck. The senior administrator kept the tree, shifting the new building's foundations to accommodate its roots. According to Hein Thura Kan, the story's probability is not in question; so many people have died here. It is not the first time I hear versions of this story. The tree is a keeper of the ghosts; connected to the hospital's dead. Ghosts in Buddhist cosmology exist just below humans (Cook & Cassaniti 2022). They are seen to exist because of residual emotions left behind by the dead; they are about memory, enduring feelings in changing times (ibid); feelings and memories coming to rest by the Ghost Tree. The supernatural has been noted by other hospital ethnographers as seen in the literature review in the introduction (see Varley & Varma 2018). Here, at YGH, at roots of the Ghost Tree, ghostly presences have become part the campus' built fabric.

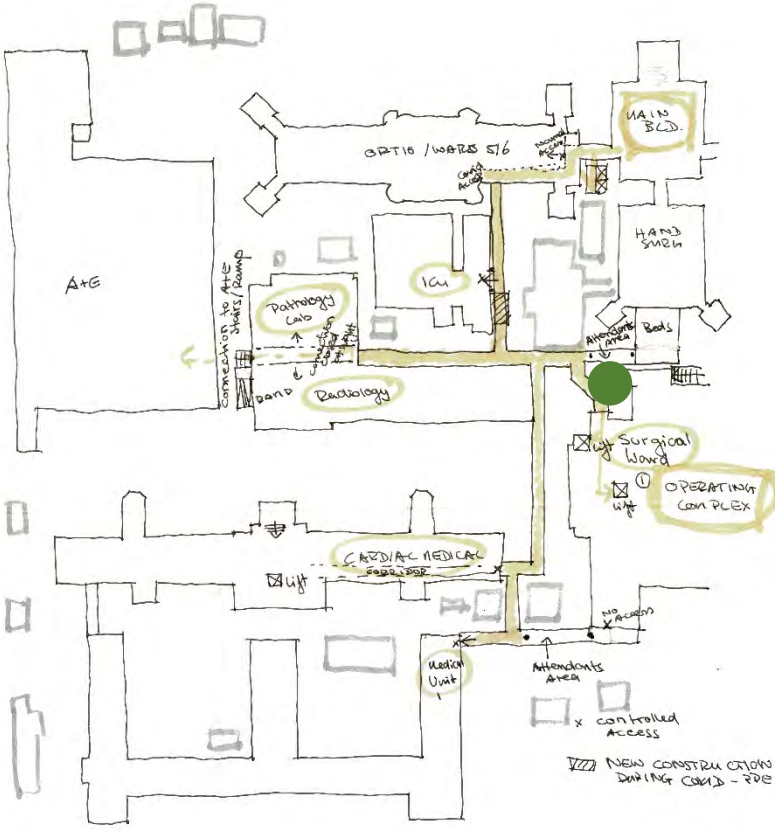
Today its trunk and branches are surrounded by concrete; the side entrance of the outpatient department (which turned medical observation for the A&E when the pandemic started) to its south, a public toilet to the east, and elevated concrete walkways all around, its roots are covered by the cement bonded aggregates.

Below its branches is a popular spot to step off the tiled trails to pause. Patients rest here before appointments, attendants wait for a loved one, their family members scattered around; some lying down on colourful plastic mats, others sitting up. Some become passing acquaintances, chatting with strangers, brief friendships tentatively woven over the shared plight of waiting.

Here, buildings are so close their proximity creates wind tunnels, a welcome arrangement in the hot climate. The old branches and pleasant ventilation make for a comfortable environment despite the density of buildings and bodies. Branches offer shelter from sun and showers while hot air rises through the leafy canopy.

Around the Banyan clinical pathways briefly tangle then find their way to their destinations. On elevated thoroughfares, or below the concrete bridges on ground level, people and goods steadily flow, sheltered from the elements; attendants with bags, lost visitors, conscious and unconscious patients on trolleys and in wheelchairs, workers with blood samples and doctors with stethoscopes and hip bags, house surgeons in scrubs, cleaners with brooms, and vendors with baskets, shuttle back and forth on the concrete arteries. From the A&E to the MOT (with Outpatient Departments on ground level); from the Modular Operating Theatre Complex to the Central ICU and into the main building; Medical Unit 1 and the Cardiac Wards, accessible dry-footed on a rainy day from the main building via the Modular Operating Theatre Complex on both ground and first floor, past the ICU

again when taking the above ground route; Cancer Care is connected on ground level with a wooden structure, cowering between main building and Modular Operating Theatre Complex; in opposite direction of Radiotherapy (part of Cancer Care), Physical Rehabilitation treats its outpatients; gaggles of students frequent the Lecture Hall, a building of its own with a brightly green floor, opposite the Ghost tree. Beside the lecture theatre the cleaners discuss the day's tasks, and the security department next door keeps a vigilant eye out for suspicious behaviour. It is here by the Ghost tree where at dawn long lines of patients gather to see a doctor in the Specialist Outpatient Department (OPD). Some waiting since the previous night, having slept under the Banyan's branches.

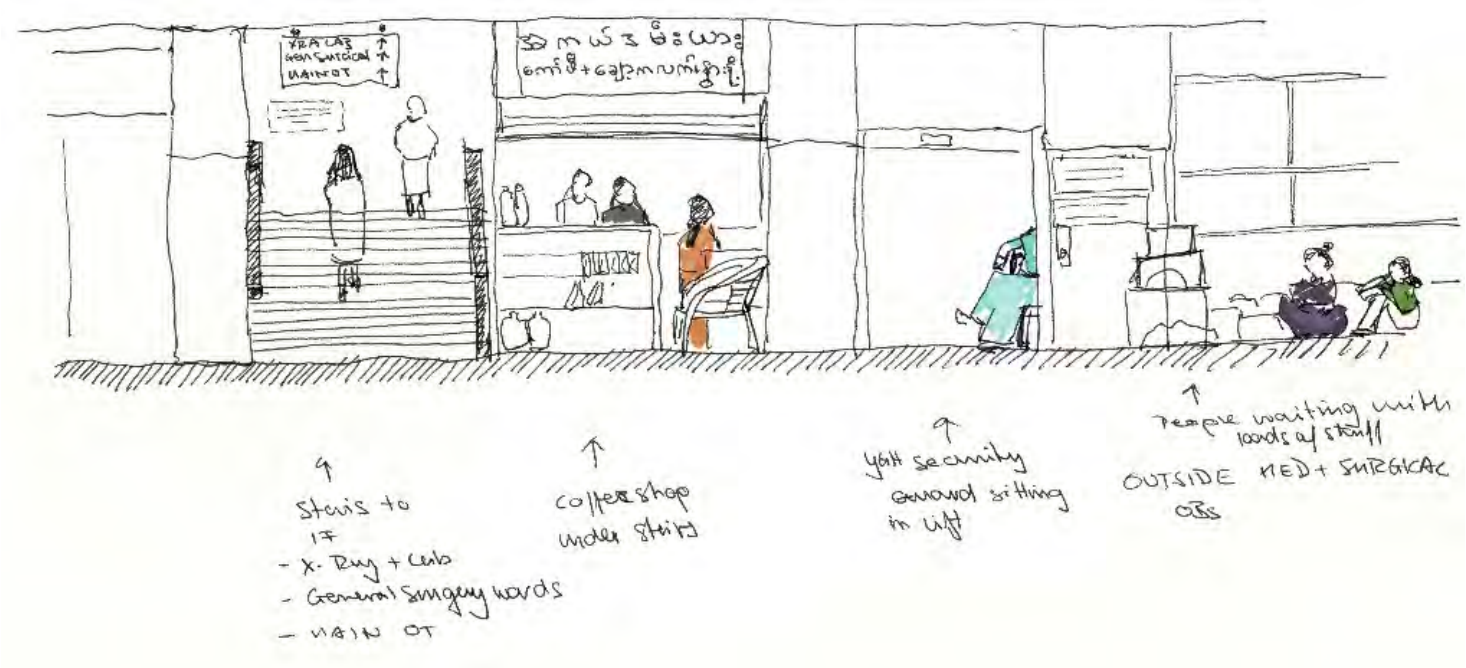


The hospital's spaces are versatile. A corridor can be a passage during the day, a dorm at night, and at times a waiting area. In the afternoon only signs printed on A4 sized paper betray how busy the Specialist Outpatient Department is in the morning. The smell of coffee emanates from under the stairs, beside the lift where a small shop, wedged under the stairs leading to the upper floors, sells hot drinks and refreshments. Signs on the lifts read: "Only patients and responsible personnel are allowed to ride the lift", while at the same time reminding everyone "There is no charge to ride the lift", apparently a problem in the past when lift operators / security guards asked for tips, so I have been told. But the existence of the sign makes me think, the past is maybe not so distant. More signs prohibit littering, instructing the use of wastebins: "Don't chew beetle. Don't smoke. Don't litter";

"Please speak quietly"; "Don't pay a fee to receive a token to stand in line, if found out you will be charged", indicating an issue with bribing oneself ahead in line, a common occurrence before 2015 according to several interlocutors, and again clearly an issue still today given the sign. "You are not allowed to sit on the stairs", indicates the dislike of misuse of infrastructure by the administration, but practical needs make sitting where not to sit tolerable. These signs read like an ethnography of behaviour. Each sign outlaws a behaviour that if it was not common would not need to be mentioned. People smoke, spit, drink, speak loudly, and at times pay to get up or ahead. The contract between hospital and its users goes both ways as one interlocutor, an administrator, points out; for the hospital to be a better place, all must do (or stop doing) their bit.

From a position by the Banyan's trunk, one has a formidable view of all these activities.

Pathways and fates converge, swirl around, and go their way around the trunk of the Ghost tree, quietly sheltering the theatre of life and death underneath its branches. A close-up view highlights the tension between nature and buildings, the tree becoming part of the built environment, hemmed in by concrete, becoming an extension of the hospital buildings; a place where people wait, eat, and sleep. Its existence offers an in-between-place, a place between buildings, clinical functions, and structures. A place for in-between activities that have no other spaces. We will come back to



this in-betweenness of people and practices in the thesis final Chapter when we encounter individuals and their "Spaces of Responsibility" (Chapter 8).

ICU

Not far from the Ghost tree, in fact you can see its entrance on the upper walkway while resting under its branches, is the central Intensive Care Unit or ICU.[37] A ramp leads up to it from the elevated walkway connecting the main building, the Imaging Department, and the MOT.

Outside, family members of the hospital's most acute patients are sitting on mats, their back propped up against the concrete railing, or on bright orange plastic bench-chairs. The serene mood betrays the serious state of their loved one.

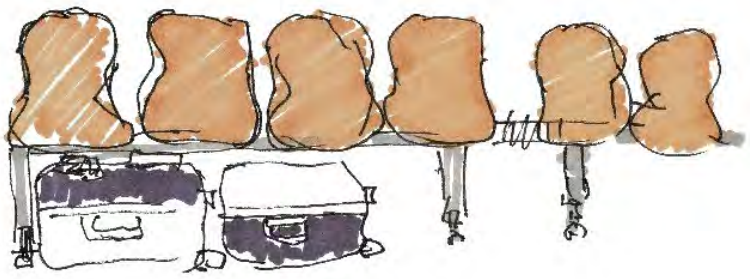
Some might have gotten news that they need to get a medication that is near impossible to find in Myanmar. Others are readying themselves to spend time inside the air-conditioned space to do their charge's oral hygiene, or other bedside care tasks.

During the day, the domestication of the walkway is held at bay; it is possible that ICU staff warned family members, perhaps security staff passes from time to time.

Most of the unit's twenty patients are in a coma. In countless conversations with ICU staff and administrators my team and I, while developing the masterplan, discussed the need for family

[37] Specialist departments have their own ICUs for example Cardiac, Neurosurgery and the Acute Burns Unit.

spaces for the ICU. It is the lack thereof that necessitates suitcases being squeezed under orange benches.



At dusk, the hospital's daily routines and everyday panic quiet down. Deckchairs unfolds on the concrete walkway, a son massages an elderly mother's feet, waiting on whoever is being treated inside the ICU. A woman skilfully changes from her day clothes into pyjamas, settling on a mat. Others come with dinner for the waiting. The Imaging Department is closed, the operating theatres are cleaned-up after the day's work, no more patients are shuttled between departments, except from the A&E below where the woman gets a foot massage.

The atmosphere is private; I feel like an intruder into this nominally public space when I pass at this time of day**.** Private and public is fluid at the hospital. Most private bodily functions are performed on open wards, clothes are changed in public space, pyjamas signal privacy.

BACK OF HOUSE SPEED

Behind the ICU, Ko Than waters the yard of the old Oxygen Plant. His longji is tied high, a habit of someone who moves much and purposefully all day long. It is the hottest days of the year before rain falls on the city continuously for months. The water from the hose keeps the dust down while evaporation cools the air.

Workers are sent here to refill portable oxygen bottles, others like to stop while running errands, all enjoy a passing chat in the shade of the tree; I never saw any fruit but was told with authority that the branches stretching over the single-storey concrete Oxygen Plant, hissing rhythmically throughout day and night, belong to an almond tree. People like to sit under trees. They provide shade while allowing hot air to rise and escape, actively cooling spaces as water evaporates from their leaves; the process is called transpiration.

Under the almond tree, gossip is shared and feet are rested for a few moments in the tranquil atmosphere of this backwater between the main building, the Imaging and Laboratory Building, the ICU and the A&E. Patients, attendants, and visitors drift past on the walkways beyond the wire-mesh fence; a lost visitor might ask the workers for directions. Attendants spread blankets off the path close enough to be sheltered by the tiled roof that covers the walkway. Workers on duty wave a friendly hello or join the banter for a few seconds while hurrying on.

It is not only the tree that attracts the chatter. The oxygen team is jovial, especially Ko Than who likes Facebook and jokes. He put a statue of Kyaiktiyo Pagoda (Golden Rock), a major pilgrim site in Myanmar's Mon State, on the tree's lower branches. He found the icon "somewhere". Hospital workers, he explains, discard old icons, icons that no one wants anymore, under specific trees on campus. This makes sense to me, only a few weeks later on the way to the Haematology department, passing by the Medical Superintendents' residences; my translator points to broken

paintings, picture frames, and statues placed at the the trunk of a large tree. I realise this is another one of the hospital's centenary Banyans, loved and cherished by many (see Natural Heritage section in Article 25 2017). I came across numerous idols on and in roof structures, always wondering what they are doing there; maybe this is a connection to the prayers and the trees, the discarded idols by trunks.

I like thinking of the oxygen team as the keepers of air, wardens of the hospital's breath. They supervise the oxygen plant, making sure the backup steps in when electricity cuts. Their days are lived on a schedule dictated by patients' breathing, changing the oxygen cylinders at the manifolds around the main campus.

Following Ko Than on his rounds, I encounter a different hospital to the one under the Ghost tree or by the Holy tree's trunk. Back of house urgency moves in parallel to the slow wandering and waiting of visitors, attendants, family, or friends. The front of house and back of house is in most parts of the campus only distinguished by speed.

Hurrying alongside Ko Than we greet different people, workers and guards, nurses and their aids, who rush alongside us. We overtake patients and attendants exploring their way. We move in back-of-house speed. While the interior of hospital buildings has back and front-of-house areas, external spaces have a distinction by speed of movement and atmosphere. As described above, time of day and type of dress signal public and private space; here speed separates front from back-of-house.

Inside buildings, some doors only staff are allowed to enter, such as the waste area of the operating theatres, which even I never saw, or storage carved out of valuable floor area on wards where every inch has been dedicated to patient care. Pathways around campus lead to little back-of-house nooks and crannies, such as basement rooms with oxygen manifolds; the central waste collection areas, fenced-in and locked; generator buildings squeezed between buildings, hemmed-in by pathways, their steps and ledges used as benches by the waiting; a locked local mortuary where bodies are stored before the little cart arrives.

I propose, rather than thinking of front of house and back of house *spaces*, to consider front and back of house *speeds* and *connections*.

Studying floor plans and old google map images, the hospital used to have more back of house spaces. But space is at premium and patients always win out. Some back-of-house connections severed over the years, in favour of more clinical floor space.

The A&E is a 1960s reinforced concrete structure, built with American USAID loans.[38] Long before my time, there must have been a direct connection from the A&E into the main building. A roof build-up serves as circumstantial evidence alongside a break in the A&E's curtain façade, visible in the plans and the façade, a portion closed off by a brick wall rather than the prefabricated concrete cladding that dresses the A&E and the Pathology and Imaging Building. Emergency theatres occupy the floor area in the A&E were the connection used to be. Today this connection is gone.

[38] According to accommodation schedule complied for the masterplan, the A&E was built in 1964 (like the Radiology building), MHA Engineers' seismic report however details it was built in 1970s/80s with Japanese Aid; latter information is based on conversations with the hospital's engineer. The same person told me that the radiology Building which looks the same as A&E, was built "by Americans" during U Than times, when he was with the UN (interview 3.07.2021). USAID did indeed build the radiology building in the 1960/70, as archival documents (MNA) and USAID reports confirm; these documents detail the construction of an outpatient department and auxiliary services. The construction of the A&E in the 1960s matches reports by interlocutors of when the A&E moved from where the blood bank is located today.

With Covid-19 the public areas, formally occupied with slower speeds, started to feel private; booking systems were introduced, travel was more controlled, and people generally were afraid to come to YGH in fear of getting the unknown virus.

My attention turned to delivery routines and trajectories, workers' pathways, spaces in-between departments, patients' transfer routes, floor materials, the laundry, and oxygen supply.

Most of the slow-moving days of lockdowns, when I could go to "work" at the hospital, I spent with the Oxygen team. Following the men around campus, I mapped timings onto pathways, I traced the oxygen cylinder delivery routes, I sat still under the almond tree noticing the back of house choreographies. The patient transport from the A&E to the Neurosurgery department on the extension campus, often small bodies caught in accidents; the flurry of "people under investigation" for Covid-19 (PUIs), hurried from the A&E to the PUI wards; a patient getting X-rayed behind the A&E for infection control measures; workers passing for a chat, telling tales of different departments; an atmosphere of excitement for the break in the routine, mixed with fear and uncertainty.

Yaneva contrasts the mode of enquiry of architects and ethnographers as "quick" and "slow" epistemology (2017: 34 ff). As an anthropologist working in an architecture faculty, she distinguishes

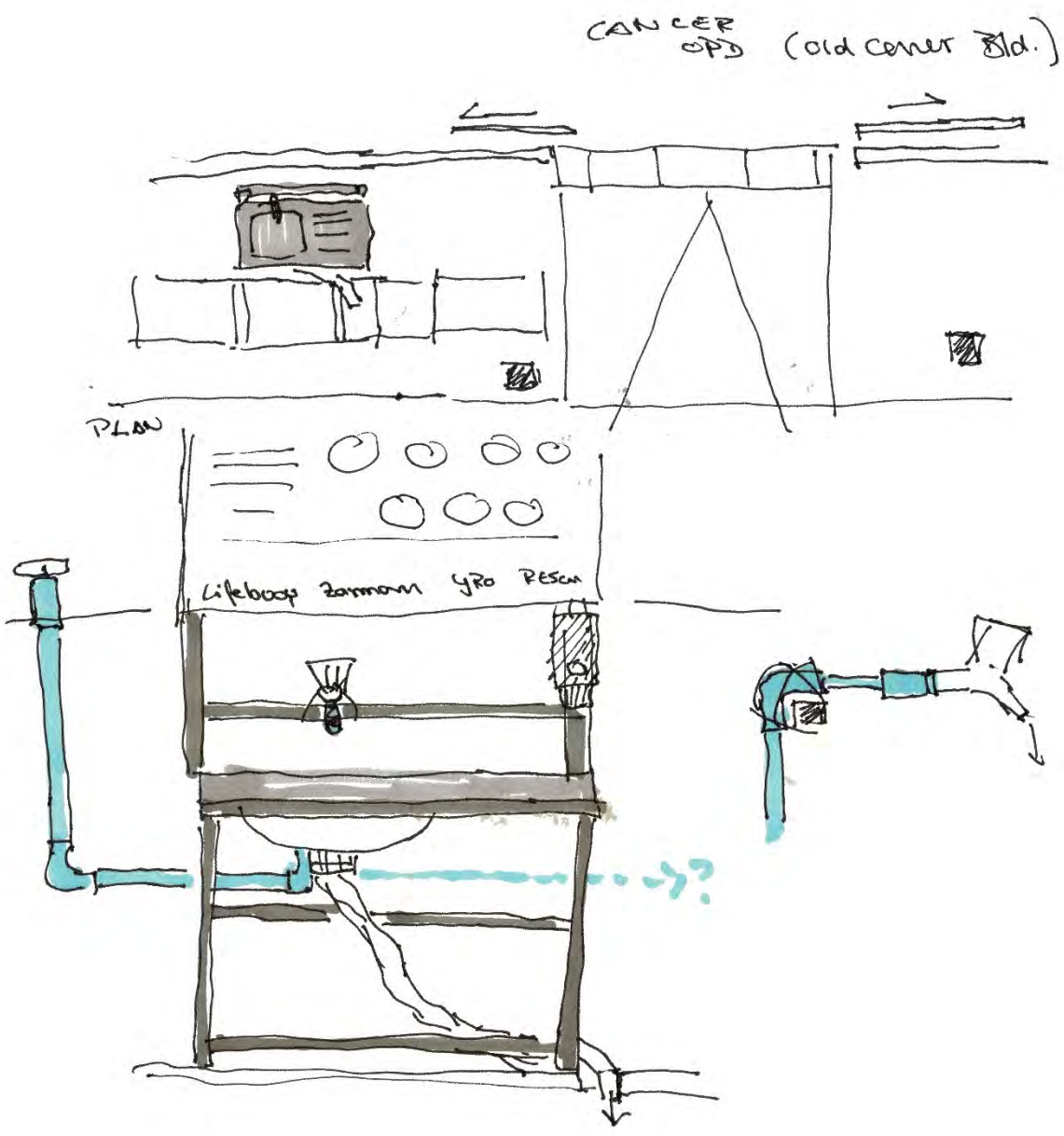
two speeds when engaging with built environments, each rooted within the two disciplines she bridges. One is home in architectural practice; a "hasty sightsee[ing]" where buildings are turned into aesthetic objects with the click of a camera, and assuming what interviews to have or what to talk about, asking concise questions that yield nothing one does not already now (Yaneva 2017: 36 f). The other is slow, careful, open-ended observation, found in ethnographic methods. I encountered the hospital by "Slowing Down" (Yaneva 2017: 37 ff), *being* in it, experiencing the places and spaces with their distinct paces, being led into conversations by the ethnography through my drawings. As an architectural designer I planned back and front spaces for the hospital's masterplan. While temporality of back and front of house (for example there are fixed times for deliveries and waste disposal) was obvious, speed in itself was not something that occurred to me until I "slowed down" and rested in place as an ethnographer.

While the back-of-house speed is fast and purposeful, it is also easy to miss; fleeting feet in flip flops rushing past, goods transported in vehicles, gone when not looking carefully. To engage with this back-of-house speediness I had to slow down. I was patient, waited for the right time, followed someone on their heels, sat and listened to the chatter of the workers, all the while drawing.

Expanding Yaneva's emphasis on speed, I would add "ways of seeing" to her description of slow epistemologies. As an architect I recognise Yaneva's mode of "Quicker, quicker…" (2017: 36 f) from site visits when I renovated the main building; a mode I was trained in as an architect. At the time I was guided by common narratives, such as that the hospital is "unplanned", narratives that alongside my training as an architect made me see problems and think "solution", rather than meeting the places and their people. My drawing practice as an architect was future oriented, planning what *could* (I thought *should*) be, rather than what I was seeing in the moment in front of me. Both modes are valuable, distinguishing them helps to understand how different people encounter places and buildings, and going forward can mutually benefit from each other in their understandings of hospitals.

PANDEMIC SPACES

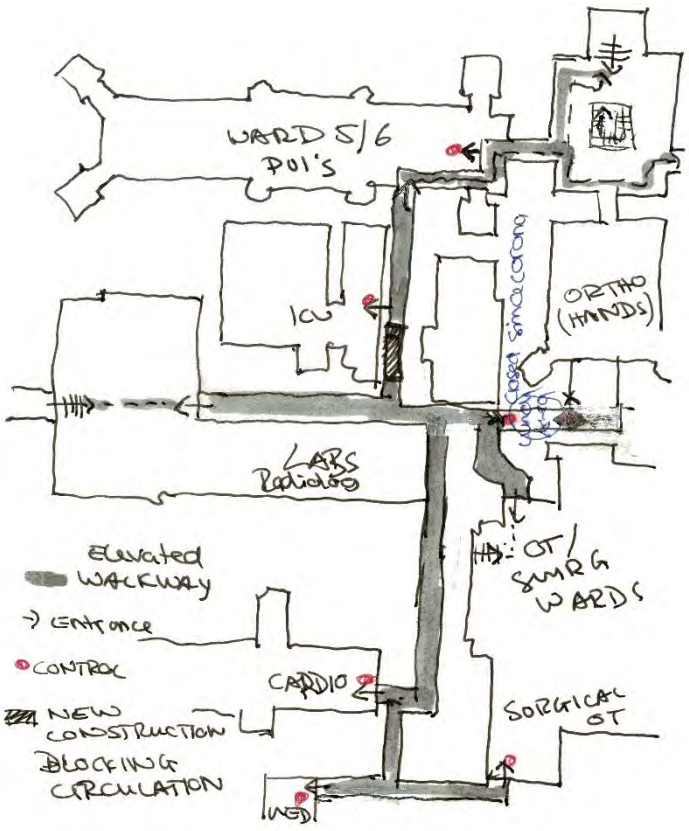
In all the years I spent on campus only the Covid-19 pandemic quieted the humdrum that never fully subsides. When Covid-19 arrived in Yangon, it was the hospital's engineers' actions that were most visible. The teams installed hand washbasins at every building's entrance, some donated by charities



and pharmaceutical companies. Signs informing about Covid-19 and infection control emerged all over campus, alongside masks, face shields, hairnets, gloves, and temperature guns.

A new PPE[39] room was built outside the ICU, severing the direct connection between the main building and the Imaging Department, the Modular Operating Theatre Complex, the Cardiac Building, and the Daw Pu Ward. A little later, makeshift screens from blue PE[40] pipes (water pipes) and transparent plastic sheeting appeared all over campus.

One of the orthopaedic units on the elevated ground floor of the main building, closets to the ICU, was turned into an PUI ward (people under investigation). Another PUI ward was prepared on the second floor of the south wing, but not used while I was on campus. New oxygen pipes and a manifold were installed for this ward.



While this central PUI location confused international consultants, the hospital administration had chosen it with good reasons. The wards are close to the ICU, and it is possible to fully isolate these wings, while the centenary ward provides the best ventilation of all buildings on campus, with its high ceilings and windows, and adequate space for social distancing. At the same time, due to lockdowns, movement restrictions, and closures of factories, the orthopaedic ward, mostly dealing with trauma cases form traffic and work accidents, was in less demand; one unit could handle the caseload of two at that particular time.

[39] Personal protective equipment.
[40] Polyethylene.

The A&E was reorganised. Non- Covid-19 Medical Observation (Med Obs.) moved into the ground floor of the Modular Operating Theatre Complex, where it displaced the specialist outpatient department (OPD) to a local high school across the road. Later, when schools reopened after the summer break, the specialist outpatient department moved into the former radiotherapy outpatient department. Access to the outpatient services became strictly by referral only, which caused confusion because referrals must come from government services; many patients were unclear why they would not be seen if a, presumably private, doctor had told them to go to YGH.

Departments dealing with high-risk patients, for example diabetes and cancer care, introduced Viber[41] aided booking services. They worked surprisingly well, according to clinicians and patients. The new system reduced wait time and emptied the spaces around campus, the waiting areas became less congested. Diabetes patients did not need to come on campus at all, their monitoring done remotely by themselves and reported regularly. Of course, only individuals with access to this system would be able to tell of their experience at the time; I have no idea who and how many patients might have been left outside the digital vail in a country where internet access is patchy at best, and digital literacy generally low, especially with older generations.[42]

The government received a world bank loan to build new ICUs in hospitals across the country, assisted by UNOPS.[43] In a conversation with one of my interlocutors he was slightly cynical about this: Who would staff these wards? While ICU nurses are trained, only a fraction is able to practice due to the historic lack of ICU beds. This meant that trained ICU nurses had never worked as such and would have to be trained anew. Lack of facilities impacts expertise, training and knowledge.

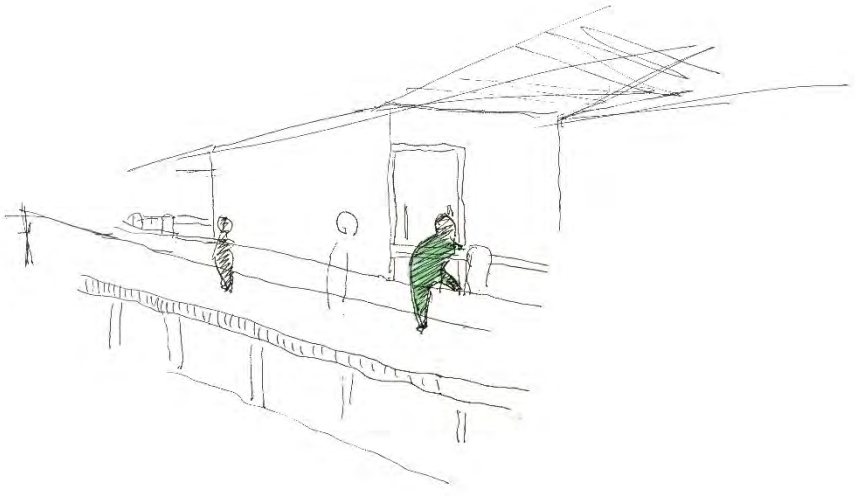
The campus quieted down; spaces' use was adapted. The specialist outpatient department was still busier at certain times than others, but overall less so. The orthopaedic department, usually one of

[41] In Myanmar, most popular instant messaging service.
[42] Following the 2021 coup, the military uses regular internet blackouts to terrorise the population. Before 2015 I have been told, cell phones were a rarity, as sim cards were prohibitively expensive.
[43] United Nations Office for Project Services; see details of the support scheme on their website: https://www.worldbank.org/en/country/myanmar/brief/world-bank-myanmar-covid-19-support

the busiest was, operated with only one unit. Diabetes and cancer patients had a booking system introduced. A nationwide lockdown was imposed for Thingyan, the national holiday over Buddhist New Year, celebrated at the water festival. After this, the city and the country started to open up again, speeding up the life on the hospital campus once again, though not to pre-pandemic standards. I left Yangon and YGH in the week when the second, more deadly and severe Covid-19 wave hit Myanmar. Interlocutors sent me photos of temporary shelters built outside the main buildings, and the new Oxygen supply infrastructure. I cannot comment on these developments as I was not on the ground at the time.

In an interview with the senior medical superintendent after the first Covid-19 wave, I asked if extraordinary events were ordinary. I remembered an avian flu outbreak in 2016 which passed YGH unperturbed. She agreed in general, but vehemently denied it for Covid-19. This was new. It affected everybody; clinical staff were at an unprecedented risk, and it was unclear how to protect oneself at the time. Especially at YGH, where many nurses lived in shared accommodation on campus while others travelled from home, many were worried; the fear of a mass outbreak amongst hospital staff travelled as high as to the minister, I was told.

The hospital spaces, structures and systems adapted to the challenges of a new pandemic. As they always do. What I find most notable is the close connection between spaces and healthcare,



buildings and disease, that the pandemic highlighted so starkly. Something forgotten, or side-lined, during "ordinary" times when the hospital's engineering team remains understaffed.

CHANGE

My first reaction upon visiting the main building on my return in 2020 is:" This is not as bad as I thought it would be". A reaction echoed by Tin Tin at the beginning of this chapter as well as many others, Yangon friends, and former colleagues alike, and corroborated by Coderey's observation of YGH in 2016: The scene entering YGH "was inconceivable just 3 years earlier. Hundreds of patients and their families sat here and there on the floor in the halls, the corridors, the stairs, waiting their turn to see a doctor. A place which was traditionally avoided, used as the very last resort, was becoming popular and was even chosen by patients as the first option in the health seeking process." (Coderey 2017: 279)

The front entrance and central staircase of the main building, with the smooth handrail from Chapter 1, underwent a fundamental transformation in the first months of my arrival in Yangon in 2015, still benefits from the reinstatement of the original organisation; the improved condition is appreciated and used by staff, patients, and visitors alike. At the same time leaks found their way back into the system. Pipes and taps flood bathroom floors. Even though betel stains are not as severe as years ago, the familiar red corners persist. Habits of throwing leftover food or rinsing out bowls, discarding of the greywater[44] out windows, is a firmly rooted daily practice; no number of renovations seem to alter this.

While much has changed between 2015 and 2020, the hospital remains a public hospital, chronically over capacity since its inception, as we will see in the following chapter, always in tension of being a workplace, a place of routine and structure *versus* a bodily place where infrastructure needs to follow physical needs (for example the Oxygen rounds dictated by patients' breath). It is a "placey-

[44] Also spelled "gray" water is the technical term for wastewater without faecal contamination, with less pathogens than black water; usually from showers, sinks, and laundry.

place", hot and cold, where bodies are broken and hurt. A place intimately known to some, unknown, alienating, and abstract to others. The hospital's buildings encompass all this. They embody hierarchies and different atmospheres, literally and figuratively. Life roars within the hospital physical and literal structures as we will see in Section III "Rhythms". But life rarely bursts these structures. Buildings adapt, stretch, and accommodate.

The main building was designed with open verandas around the wards.[45] Arches with iron wrought, teak topped balustrades ensured generous circulation and ventilation. As early as the retreat of the Japanese at the end of World War Two, staff started using verandas as catchment for overflowing wards because of rising demands on the hospital (Woodruff 1967: 533). Over the decades departments took-over entirely. With light partitions, the original circulation spaces were repurposed as offices, rest areas for staff, and additional bed space, blocking the original ventilation, and circulation, the latter a problem especially for fire-safety.

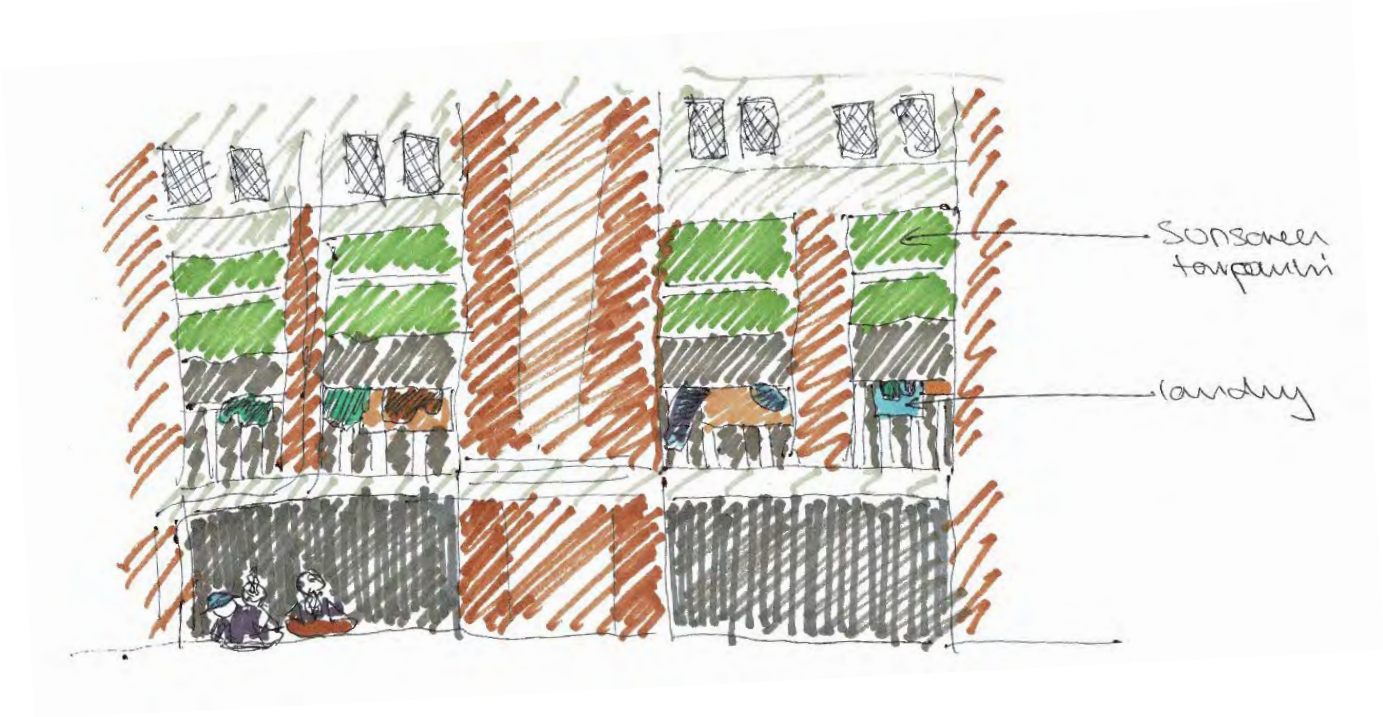
During the 2015 renovations, through discussions with departments, the verandas were reinstated to their original purpose: circulation and ventilation. In conversations with staff spaces were reorganised to make this happen. Much of the changes that lead to verandas being turned into offices and the like had been *ad hoc*. Someone needs an office? Put up a partition! Such developments were not holistically planned by surveying existing spaces, possibly repurposed where other functions had gone obsolete. My team found that, in some cases, a locked filing cabinet, a well-designed desk station, or an area for lockers, could replace an entire room. Staff would worry to lose ground, quite literally, but we discussed our proposals with the clinical and administrative teams and continuously iterated them.

[45] Verandas might have had widows (General Hospital, Rangoon 1915), but by the time I arrived on campus there was no evidence of glazing and no historic photographs or plans show windows. It is possible that the report in *The Hospital* is referring to the glazed doors to the wards.

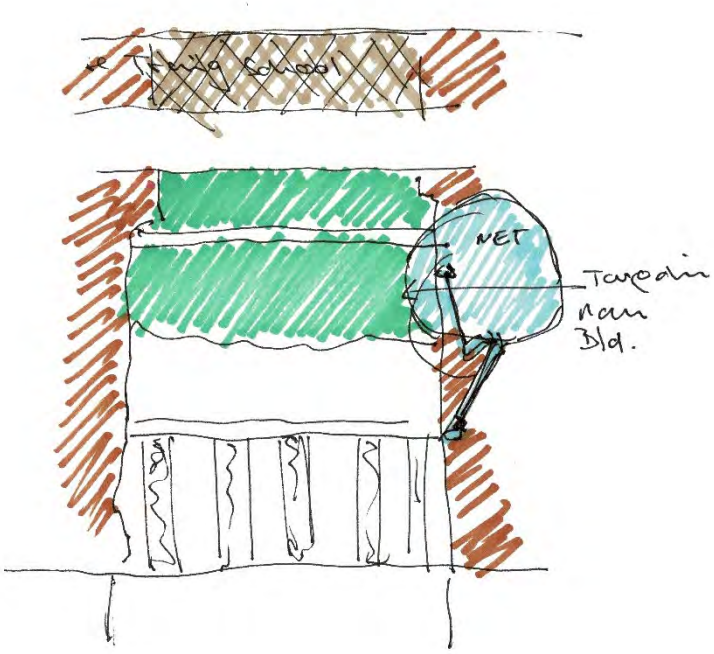
However, once the construction crews, engineers, and architects left, not even the best filing cabinet could prevent necessities, born from structural issues beyond the designers “technical solutions”, from encroaching on the carefully planned wards. The free-of-charge hospital continues to take on ever more patients. The reputation-boost that accompanied the renovation, which was widely reported in local newspapers, did not quench admission numbers. In the desperately over capacity hospital patients were moved back onto the verandas.

Today the walkways are mostly used as additional ward space. Since offices found accommodation elsewhere, ventilation has much improved as the verandas are often kept open to the wards via the restored glass doors, large and intricately crafted.

Common green tarpaulin prevents the walkways from getting wet; a versatile material used all over the country to protect stalls, outside areas of tea shops, market goods, and, at YGH, patients, from weather. Makeshift awnings created with sticks and ropes off the veranda’s balustrades colourfully enliven the elevations. Especially during the rainy season are the facades of the main building an interplay of red and green.



By the time of my first introduction to the main building, tarpaulin already found its way back into the aesthetic vocabulary of the renovated parts of the main building. In the first months as architect for the rejuvenation project of the hospital in 2015, tackling this "eyesore" of tarpaulin was one of my key briefs. The architectural team felt the tarpaulin needed a "better" solution. Additionally, one professor (a senior doctor, the head of a clinical department) in particular, with wards on the upper floor, was worried about her patients "falling" (or jumping?). To pacify the insistent professor, the contractor had hastily installed aluminium louvers on the top floor. Now I was tasked with designing and overseeing the construction of "heritage sensitive" wooden louvers for the openings, with openable glazed windows. The idea was to replace the tarpaulin and the aluminium louvers which had been deemed "insensitive" to the fabric of the building by the international architects' standards. This project went into many design iterations but was never implemented. Tarpaulin remains the cheap and cheerful solution of choice, with its bright green, sometimes blue colour, contrasting the red of the main building. The "hasty" aluminium louvers still last. The seemingly "makeshift" architecture/infrastructure prevails; if something is important, it will be done in one way or another. Similarly, years before Covid-19, I had been working on a hand hygiene strategy, assessing locations of, and for, handwash basins, and supply chains of hand sanitiser, slowly working with the hospital towards implementation; when the pandemic happened, handwash basins were installed over night all over campus; at the back of my mind I was begrudgingly questioning their quality (an old habit). Change is constant. Everything moves all the time.



CONCLUSION

As an architect for the rejuvenation project and masterplan development, I could have given you a privileged overview of the hospital, in schemas and diagrams, with abstracted ideas of functions. This perspective would not have told you much. Only the detailed ethnography of practices shows what Yangon General hospital is and by extension what a hospital is for its inhabitants.

At the end of this chapter, I would like to come back to the question: What is a hospital? A building for sick and injured people, a cluster of clinical specialisms, a place with ambulances; these are some answers I tend to get when I pose this naïve question. However, as this chapter showed, the answer is more complicated. Yangon General Hospital is multiple and different depending on who you are.

Visitors get lost in endless sequences of corridors; different times of year evoke different smells; room temperatures and materiality betray hierarchies of individuals and departments; plastic surgery is considered a lucrative career choice in Myanmar; women with acid burns dread the daily bandage change; Buddhist and Hindu deities are worshiped under the holy tree, betraying a hierarchy of religions, also in the absences of religions, in the country; workers, clinicians, administrators, patients, and visitors' activities concentrate around the Ghost tree; front and back-of-house is found in terms of speed; the pandemic changed the hospital organisation and spaces, and multiplied its number of hand washbasins; all the while change is constant, exemplified in the endless demolition, renovation, and construction around campus. In short, the campus is more than the sum of its buildings. This chapter illustrated in miniscule detail how the hospital exists on many levels at once; something hospital ethnographers showed in their scholarship with reference to wards, ICUs, clinics, laboratories and other biomedical spaces (see the 2012 special issue of *Space and Culture* 15/1 for examples). Here, I am adding an understanding what this means across an entire campus and the spaces between the clinical purview of the hospital.

At this point, I am going to make a move from the specific to the general, employing what to my mind is a classic Bourdieu-ien manoeuvre: the ethnographic abstraction.

While we established that there is no hospital in general, that hospitals are emplaced and specific, we can abstract certain truisms from Yangon General Hospital which can help us to assemble a fuller understanding of the institution. A hospital is a workplace for clinicians, as well as for engineers, and administrators; it is a place with career ambitions and hierarchies; abstract and disgustingly concrete at the same time; a place for worship and for grief which often go hand in hand; it is a gigantic waiting room; and of course, a place for healthcare, emplaced and specific, very real and visceral for individuals, both doctors and patients, including the worker who needs to treat the clinical waste at the end of this encounter. A hospital has private and public atmospheres, highly acute and less acute, a centre and a periphery, equally dependent on each other. Hospitals are part of a city or town. Its buildings are changed by bodies occupying its places, and these buildings, as later chapters will show in more detail, discipline bodies.

Buildings emerge in diverse contexts through space and time, as Buchli convincingly demonstrates in *An Anthropology of Architecture* (2013) by taking us through a wide whirlwind of examples. In my ethnography I show the same, but by carefully focusing on one public hospital, I can understand the detail and realties on the ground. Buildings are functions of space and time, places with their own rhythms moods and atmospheres as we will see in subsequent chapters.

Yangon General Hospital is not an insulated subculture. Here, I join Zaman (2013) in his observation about indispensable patients' families for bedside care on his orthopaedic ward in Bangladesh. The hospital has a porous membrane that stretches and moves, but a membrane, protective and selective, nonetheless. Alongside other scholars (Hull 2017; Livingston 2012; Street 2014; Zaman 2005) I show that the hospital is segregated and permeable at the same time.

At YGH, history, people, ideas and knowledge, flow in and out of the hospital. Concurrently, certain knowledges and places, pathways, and connections, are not accessible to everybody, some spaces

are highly specialised. Buildings are mediators for healthcare. As much as doors become political in Ring's ethnography about the daily life in a Karachi apartment building (Ring 2006), in the hospital, corridors connect, portals open to some and close to others, knowledge is sometimes private, and at other times shared.

This chapter, beyond setting the scene for rest of the ethnography, explored the specificities of the campus' emplaced-ness and its multiples. Reading the campus through its buildings in place, paints a multidimensional picture, more complicated than being a "large medicine building" (the literal translation of the Burmese word for hospital ဆေးရုံ *seijoun*). The hospital is geographically and

historically situated. In the next two chapters, I will explore Yangon General Hospital's history (Chapter 4) as well as a place in the city (Chapter 5), further complicating "the hospital".

CHAPTER 4: HISTORY

"I WAS TRAINED AT RANGOON GENERAL HOSPITAL"

I am standing in line for entry to a Myanmar fundraiser, one of the many of summer 2021. We are in London. The military coup of 1st of February is fresh in everyone's minds. Military and police violence is flooding Yangon streets, spreading all over the country, as we queue to enter the event; in anticipation of tea-leaf salad and noodle dishes; waiting to reunite with people who understand the pain and shock. The news from Yangon then and now, two years later, sounds like history on repeat; 1988[46], the SLORC[47] and SPDC[48] years.[49]

The queue is getting fidgety. How long might this take? We start chatting to each other. Behind my partner and me a Burmese family is waiting. The son is a doctor in the UK. As I tell him about my work and research at Yangon General Hospital, he introduces me to his parents. They heard about the renovation of the main building and are keen to meet the project architect, learn more about the changes on campus; it has been a while since they have been to YGH. As I speak about my research, I quickly learn that the father was an orthopaedic surgeon trained at Rangoon General Hospital. He tells me with much affection about his time at RGH and working alongside colleagues. We compare functional layouts. The queue moves. Before we dissolve into the crowd, I hand him my business card in the hope he contacts me for an interview. Sadly, like so many from this generation I never hear from him again.

This encounter is not unusual. Every Burmese doctor I have ever met anywhere in the world was trained at Yangon/Rangoon General Hospital. When my friend had a motorcycle accident on the

[46] On 8th of August 1988 students initiated the famous "8888" revolution. At 8.08am dock workers staged a walk about and thousands of people took to the streets (Fink 2009: 51).
[47] State Law and Order Restoration Council (SLORC) installed in the aftermath of summer 1988.
[48] State Peace and Development Council (SPDC), in charge of the country from 1997-2011.
[49] For an ethnographically oriented account for how the 8888 revolution unfolder and the aftermath see Christina Fink's *Living in Silence* (Fink 2009 see chapters 3 and 4).

sandy coastal roads by Dawei, the anaesthetist who treated her open wound had been a student of a professor I knew well at YGH; by the end of the treatment, I was reminded to tell the soon-retiring Professor of his good work next time I see her. All Burmese I meet know of YGH, most have a connection; some relative who passed away, an aunt who received treatment, a friend they visited. The majority of Myanmar's clinical workforce was trained on the centennial campus at one point or another.

INTRODUCTION

Despite its importance in people hearts and minds, Yangon General Hospital remains surprisingly undocumented. Its sporadic and often fleeting presence in publications, archives, the press, news, and journal articles is puzzling for a hospital of its size and significance. One might expect to see more than just a few pages in architectural guides, books on city development, and publications on heritage buildings of Yangon. I was surprised to find that the "New Rangoon General Hospital" was hardly mentioned in *Annual Reports on Architectural Works in India* or the architectural press at the time. The hospital was hidden in Public Works Department reports (the agency in charge of its construction), buried in specialist journal snippets, and aloof passing notes in news items and books.

Combined and contextualised, the disperse sources, often not more than fragments, are numerous when collated. Together, they form a picture of the hospital's story: a symbolic and memorial place in the city; its material existence and imbued ideologies in tension with real or imagined futures. The hospital's bricks and concrete anchors it in the past, while daily life pulls it into the future; the hospital's buildings are links between past ideas and future aspirations. As we will find in this chapter, the hospital is a constantly changing place of cultural significance. Here, the hospital you encountered in the previous chapter,

creaking and leaking in place, will come of age as we travel to the roots of the centennial Banyans dotted around campus.

In spirit of King's study of bungalows (1984), from the discussion of relevant literature in the introduction, this chapter is not an architectural history, nor a detailed archival study of Yangon General Hospital, but a cultural study of the hospital and its buildings; we are looking at the conditions that produced the campus, its figurative and literal structures, as they present today.

We will start with "The hospital in Literature and Archives", before tracing its development in the main body of the chapter. The hospital has had many names. Rangoon General Hospital (RGH) pre-1989; in colonial records it can be found as "the New General Hospital in Rangoon" or "Rangoon New General Hospital" following the hospital's move to its current location. Until 1989, Myanmar was called Burma. Since 1989, the hospital is known in English as Yangon General Hospital (YGH) while in Burmese, its name includes "public". At hand of the hospital's name changes "From RGH to YGH", I will take you along the hospital's journey from the 1850s onwards. Throughout, I am using Burma and Rangoon, therefore Rangoon General Hospital (RGH), for events prior to 1989; Myanmar, Yangon, and Yangon General Hospital (YGH), after 1989. "History in the Present" provides a short, by no means exhaustive, insight into contemporary Yangon and contested colonial buildings, before I conclude with thoughts on Yangon General Hospital, and hospitals in general.

THE HOSPITAL IN LITERATURE AND ARCHIVES

Authors of published books and numerous online posts[50] tell the same story in little variation: The hospital was constructed in its current location from 1905 (ground-breaking was in May) and opened officially in 1911, while partly in use since 1909. Hoyne-Fox and Serton-Morris are cited as architects, not much credit is given to the public works department engineers and medical department officials that executed and influenced the designs greatly. The hospitals' development over the past century is mentioned only in passing, mostly noting its delipidated state, rarely mentioning the accumulation of buildings since the hospital's imperial inception that crouch behind and between the colonial structures. Only a handful of published books recount the history of the hospital beyond a passing mention of its existence.[51]

In *30 Heritage Buildings in Yangon – Inside the City that captured time* (Rooney 2012) published by the Association of Myanmar Architects, three pages tell of Yangon General Hospital. The book's sub-title hints at a romanticised view of the city and its British colonial built-heritage, playing into the common narrative of Yangon's "isolation" from the 1960s until the 2010s. Bansal, Fox, and Okra's pages in *Architectural Guide Yangon* (2015) describe the hospital in contemporary downtown Yangon, for its colonial architecture they refer to Rooney (a recurring source in many publications following her), while covering the campus' development only superficially. Dr Myint Swe presents us with a detailed personal account

[50] For some examples of YGH's presence online see:
https://www.myanmars.net/yangon/yangon-general-hospital.html
https://en.wikipedia.org/wiki/Yangon_General_Hospital
https://www.yangongui.de/yangon-general-hospital/ (online version of: Bansal et al. 2015)
https://proxclinic.com/clinic/yangon-general-hospital (includes factual errors)

[51] Pearn in his 1939 *History of Rangoon*, describes the development of the hospital through its locations in the city from 1854 in half a page, not mentioning the new Rangoon General Hospital's architecture and facilities. He seemed more interested in the Phyre Museum and Zoological Gardens, which were displaced by the new Rangoon General Hospital. In contrast to Pearn, Wright shows a photograph the new RGH in his 1910 published *Twentieth Century Impressions of Burma* but only mentions the new hospital in relation to its position within the Civil Medical Department, which as he points out was largely military, while serving civilian needs.

of RGH's exile during the three years of Japanese occupation: *The Japanese Era Rangoon General Hospital: Memoir of a wartime physician* (Myint Swe 2014). He covers the period between 1942 to 1945 when the hospital was displaced to the Anglican Diocesan School of Rangoon while its buildings on Bogyoke Aung San Road were used by Japanese doctors for Japanese soldiers; a nod to the building's functionality and preferability to other facilities in the city. Dr Tin Shwe takes a more longitudinal view in his two part *Medical History of Myanmar* (Tin Shwe 1995). He traces the history of RGH back to its roots on the shores of Rangoon River[52] (in Part 1) and explains the overall development of the hospital and some of its specialities (in Part 2). He lists the senior medical superintendents from after second world war, reiterating the importance of RGH as the country's biggest hospital, which meant that senior medical superintendents would often be reassigned to the position of head of the Health Department.

At the same time, YGH/RGH's presence in physically and linguistically accessible archives is hard to grasp. For half a decade, ever since my first encounter with YGH/RGH in 2015, I tried locating the hospital in documents, collecting historic photographs, and hunting for its original plans without much luck; I was only rewarded with a schematic plan of the main building and reproductions of some plans in the journal *The Hospital* ("General Hospital, Rangoon" 1915). According to the hospital administration, all plans were lost when the document room was flooded; when or where remains a mystery, illustrating the point Ann Stoler makes in her studies of archives, that these records are intimately entwined with spaces (2009). Historian Dr Atsuko Naono kindly shared her photography collection of the hospital.

In many hours steeped in the musty smell of old paper shipped from continent to continent, I reviewed un-digitalised Public Works Department (PWD) and other India Office

[52] Most of this account seems to be based on Pearn who published before him (1939).

(IO) Records at the British Library in London. Documents pertaining to nursing were found in the National Archives at Kew, also in London. The Indian National Archives in Delhi, where I have been told records from Kolkata would have been shipped, never replied to my requests.

Myanmar National Archives in Yangon (MNA) allow access to pre-1962 records only. While slim, the MNA documents add detail to the hospital's contours, especially for some of the buildings constructed between Burma's independence until mid-1960s. Here I found mentions of foreign construction projects on campus which led me to USAID archives for some further detail on international involvement in the construction of the campus as we see it today.

Historic journal, magazine, and newspaper articles thicken the plot. Here, curiously little, mentions of the New Rangoon General Hospital and Burma(h)[53] in architectural/building related magazines, archived at the Royal Institute of British Architects library in London's Great Portland Street, complement the story. The *AJ* (Architects Journal), *Architectural Review*, *The Builder*, and *The British Architect* did not cover RGH when it opened its doors to the public.[54] Only a short notice on type-plans for hospitals in Burma in a 1911 issue of *Building News*, which we will come to later, piqued my interest.

However, in 1915, four years after RGH opened, *The Hospital*, a specialist journal on healthcare and healthcare institutions published in London from 1886 to 1921, dedicated two pages to RGH.[55] The muteness of the architectural press is contrasted by *The Hospital's* detailed reporting. Here I see changing awareness regarding the importance of the environment and the design thereof for clinical care from the side of healthcare

[53] The "h" at the end of Burmah is a colonial spelling found in some articles.
[54] Years checked: *The British* Architect – 1910, 1911, 1912; *AJ* - 1905, 1906, 1911, 1919; *Architectural Review*- 1910, 1911; *The Builder* – 1872, 1911, 1912; *Building News* – 1904, 1905, 1910, 1911, 1912.
[55] "General Hospital, Rangoon". (1915), *The Hospital*, Vol. 57 No. 1495, pp. 445–446.

professionals rather than an interest in the hospital's architecture. This interest was undoubtedly influenced by Florence Nightingale's writings on Hospitals and Nursing first published in 1860s, gaining traction at the beginning of the 20th century.

In fact, Consulting Architect to the Government of Burma, John Begg, harshly criticise the architectural design of New Rangoon General in the "1909 Annual Report on Architectural Works in India". While being complimentary about the facilities such as kitchen, laundry, general dispensary, and the ventilation and light of the modern wards, noting that "(h)ardly anything […] is omitted from his hospital that would be found in the best equipped modern European hospital", his verdict of the architecture is damning. He writes about the buildings that "rather too much "design" has been expended on certain portions of their external appearance. A hospital ward can hardly be too plain and business-like. Nor is the exterior very pleasing after all. The colour scheme it shews of light-red brick and yellow plaster is distinctly unhappy".[56] This is the only mention of the hospital's main building in these annual reports (auxiliary buildings are mentioned in subsequent reports). Neither does the report or subsequent reports which are usually generously illustrated, show plans, sections, elevations, or photographs of RGH.

A talk by Begg to the Royal Institute of British Architects (RIBA) in 1920 might shed light on the Architectural press' muteness on RGH, and its absence in reports on Indian Architecture; a hospital so phenomenally equipped (see Begg's quote above).

During his presentation at RIBA, Begg proposed his vision for an "Architecture in India" [57], which aimed to strike a balance between two dominant schools of thought. The first, which he referred to as the "Roman school," sought to impose English architectural styles onto

[56] Annual Report on Architectural work in India for the Year 1909-1910 (IOR record at the British Library: IOR/V/24/204); p.16.
[57] "Architecture in India. By John Begg [F.], Consulting Architect to the Government of India. Read before the Royal Institute of British Architects, Monday, 12th April 1920" reprinted in *Journal of the Royal Institute of British Architects* Vol. XXVII. No. 14.—29 May 1920.

India's colonies, while the second school of thought rejected all imported forms and ideas in favour of an indigenous architectural tradition. Begg's position was that English architects should bring their skills and knowledge to India, learning about local traditions and ideas for a new, distinctly Indian architecture, training local architects to “create a strong, healthy indigenous profession”. This stance was progressive for its time, although it ignored the existence of local and proficient architects and building professionals, assuming the British Architect had to train the Indian Architect.

Begg illustrated his talk with images of his own buildings which were much simpler and less ornate than RGH, a building he so scaring criticised ten years earlier. RIBA's president at the time remarked that in India, where the sun is much stronger than in England, working with shadow and light is key to effective design; light and shadow become the ornament.

In sum, RGH’s architecture was not what Begg considered great design. It embodied an ideology of conquest and imposition which he, alongside other RIBA members (reading responses to his talk), did not subscribe to. As the main building’s architect had passed away shortly after completion of RGH, no one was left to defend its architecture. It seems the building’s aesthetic fell out of favour with the architectural press at the time because of ideological differences on what architecture in India should be. While the new Rangoon General Hospital’s facilities were radically up-to date and praised many times over, its architecture was out of fashion and disappeared from the archives.

At the same time that the buildings’ aesthetic was criticised, people working and using the facilities, medical professionals, alongside the *British Medical Journal* reporting on the hospital’s opening in 1911, were excited. They were especially enthusiastic about the modern amenities, particularly electricity and smart ventilation, proclaiming RGH “probably the largest and most perfectly equipped institution of the kind in the East” at its opening (The New Rangoon General Hospital 1911). Similar excitement was echoed over a decade later in 1926 by Miss Meiklejohn the new nursing

superintendent at the time, who was impressed by the nurses' accommodation and provision of electrical light throughout.[58] Even though the colour scheme and ornamentation were aesthetically and ideologically off, the spaces and amenities were efficient and impressive.

In the following pages I will draw on diverse sources to paint a picture of RGH/YGH through the years with an ethnographic architectural lens, keeping in focus the buildings and their entanglement with society and politics as we travel through the decades. Subheadings serve as orientation through Yangon's/Rangoon' and Myanmar's/Burma's major historical events.

FROM RGH TO YGH

First Anglo-Burmese War 1926 – Burma's first hospital

Rangoon General Hospital was not Burma's first hospital. Sittwe hospital, or Akyab as it was called by the British colonisers, opened in 1926 (Tin Shwe 1995: 11; White 1923: 123) in north-western Burma, an area occupied during the first of the three Burma-Anglo Wars. The opening of Sittwe/Akyab Hospital coincides with British economic interests in the town's port.

However, contrary to commonly perpetuated colonial narratives of "benevolent" Europeans bringing healthcare to the world, usually with not so benign economic, missionary, or military motives, it is important to note that the establishment of hospitals in the region started with a 12th century Khmer King.

King Jayavarman VII created an entire hospital system in Cambodia that extended into Thailand (*Buddhism and Medicine* 2022). 250 years before the nuns of Beaune opened their doors to the unfortunate in 1443 in France, wooden hospitals were located around the Khmer empire in quiet

[58] Miss Meiklejohn to Miss Riddle - Letter sent from the Office of the Nursing Superintendent, Civil General Hospital Rangoon 11th October 1926 (National Archives, Kew: DT18/101 1926 Oct 11 - 1935 July 12).

locations outside city walls (ibid). The notion of infection control might have played a role in its location; in Europe hospitals were located outside city walls to prevent the spread of disease. Rangoon General Hospital at its inception was North of downtown, with prevailing south winds, blowing "disease" away from the city.

The Khmer hospitals were spaced-out sensibly along major roads; on the Ankor-Phimay road, patients were never more than 20km from a hospital, the total distance between hospitals was 40km (ibid). This means it took three hours walking, two-and-a-half hours riding an oxcart, two hours by elephant, or just thirty minutes on horseback to reach a hospital (ibid).

As far as I know, there is no evidence of a hospital system established in Burma akin to the Khmer example. Prior to the establishment of Sittwe General Hospital in 1926, and Rangoon General Hospital about thirty years later, medical care radiated from the royal courts, the main sponsors of Buddhism and medicine (Edwards 2010: 34).

Most people used "traditional medicine", a homeopathic system akin to Ayurveda but less systematically practiced than in India (Skidmore 2008: 197), which continues to be popular today.[59] Initially many local/traditional practices resonated with European medicine which meant that European medics took note and commended traditional practices such as massages and cold baths (Edwards 2010: 31f). However, in the 1870s this synergy fell out of fashion (Edwards 2010: 32). A main divergence between traditional and "western" medicine[60] was the absence of surgery (Edwards 2010: 34), which seems to resonate still today, as many interlocutors told me of a fear of surgery amongst the general public.

For the previous government (military councils) traditional medicine had been a priority (Skidmore 2008: 195). The current healthcare system that is, or was until the military coup in 2021, underway

[59] Short report from "Asia Calling" 2013 on use of traditional medicine in Burma: https://www.youtube.com/watch?v=ajHG20hhpwE

[60] For a good discussion on "the unity of Western medicine as trope" see Annemarie Mol's literature discussion in *The Body Multiple* (Mol 2002: 2ff).

to being designed, aimed to integrate traditional medicine as well as the research thereof (Ministry of Health and Sports 2016: 27). The infrastructural implications of this policy are interesting here; a hybrid system of biomedicine and traditional medicine, both practiced in the same institution, needs different spaces than a dual system, where the two traditions do not overlap, as is the case today.

Traditional medicine, dietary changes and pharmaceuticals are a common first step in dealing with illness (Skidmore 2008: 196). In many cases, patients seek symptomatic relief from traditional medicine before arriving at YGH, particularly when coming from further afield. When symptomatic release fails from traditional medicine, nutritional changes are tried. However, nutrition is a constant battlefield in Burma due to poverty and food scarcity (Skidmore 2008: 197).

Even though biomedicine with is rapid effects is increasingly the first port of call for most Burmese, prohibitive costs and a fear of surgery, this does not include injections or acupuncture, is still stopping many to seek bio-medical treatment (ibid). Biomedicine's "quick" response to disease, compared with gradual changes from dietary adjustments and homeopathic healing systems, have been likened to magic at times (ibid). The awareness of importance of nutrition combined with the awareness of the lack therefore and magical attributes to biomedicine has led to increased consumption of food supplements (ibid). Mostly, patients consulted traditional medics when their families run out of money for biomedical care (Skidmore 2008: 198). Lacking access to public hospitals, ethnic minorities tend to rely greatly on traditional medicine due (Skidmore 2008: 200).

In parallel to this brief excursion into traditional medical practices in Myanmar today, Penny Edward's in her important article "Bitter Pills" (2010), discusses the negotiation of the authority of science and shows that medical science was more about economic progress than local welfare (Edwards 2010: 25). At same time Edwards notes the parallels between cartography and "modern"/biomedicine, that came with colonialism, and analogies of "western" understandings of the body and the nation state can be observed in Burma (Edwards 2010: 51).

Second Anglo-Burmese War 1852 – Rangoon General Hospital on the Shore

When considering today's dense campus, that came to life in the previous chapter, it is hard to imagine its leafy origins.

In the early 20th century only 26 structures dotted the grounds of what used to be Rangoon's agri-horticultural gardens with links to Kew in London. Many of the old trees that provided shade to my drawing forays date back to this time. A couple of seconds of a film shot in 1930, by a visiting ship surgeon, document the lush hospital gardens.[61]

It is quite possible this visitor came to RGH by way of one of the electric tram routes that connected key landmarks in Rangoon at the time, with the electric substation located on the hospital campus (Frasch 2012). Today, electrical trams have been replaced by a more or less efficient bus system with an associated app. Bus stops, same as the tram stops of old, are located near all hospital gates.

Most authors, except Dr Tim Shwe, writing about YGH focus solely on building style and functions, yet failing to recognise or mention the hospital's entanglement with its city's social and political life, then and now. But RGH grew-up with Rangoon. Its location today, at the northern edge of downtown, was the third in a row of campuses, and it could be argued that YGH is still on the move with projects such as the currently under construction JICA[62] funded New Neuro and Cardiac Hospital.[63]

The hospital's trajectory through the city starts out on the shores of Rangoon River. Opened in 1854, two years after the Second Burmese Anglo War which annexed Lower Burma to British India,[64] it was mainly supported by captains and ship owners, while a hospital for sailors it also

[61] *Rangoon Hospital and Scenes from the East* (1930), filmed by Dr Battersby. National Library of Scotland, Reference Number 2816. Available online: https://movingimage.nls.uk/film/2816.
[62] Japanese International Cooperation Agency.
[63] This new hospital was supposed to open in 2021, but I have no current update (New Yangon Specialist Hospital to open in 2 years 2019).
[64] Until the third Burma Anglo War in 1895, Upper and Lower Burma remained sperate provinces within the British Raj.

supported a wooden outpatient clinic nearby for civilians (Pearn 1939: 202). A brief closure followed due to controversies over its management, battled out in the newspapers of the time, leaving people with the only option to patronise the prison hospital against a fee which inmates did not need to pay (ibid). This clearly was a strong point of contention.

In 1856, a committee was formed to establish a new hospital in the location where Rangoon General Hospital would find a home 10 years later, on the site where since 2016 Junction City Mall stretches high into the sky, opposite today's campus at the junction of Bogyoke Aung San and Shwe Dagon Pagoda Road. These plans were thwarted by 1860 and the clinic on the shore reopened under the supervision of two doctors. However, the building was unhygienic and dirty, while inpatient numbers more than doubled, and outpatient numbers grew tenfold from 1860 to 1868. This was a reflection of Rangoon's economic growth,[65] reinforcing the need for a new hospital, a hospital closer to the city's increasing civilian population.

Around the same time the hospital first opened on the shore, town planning of the "clean slate" that was to become colonial Rangoon started by the British. A well-rehearsed exercise, town planning was a symbol of the British Empire (Metcalf 2002); a "physical pedagogy" going hand in hand with a (not so) baffling blindness towards the existing buildings and their heritage that had survived the second Burmese Anglo war of 1852 (Turner 2021: 34).[66]

The dismissal of the committee's recommendations to move the hospital from its shoreside location at a time when planners were busy reorganising and drafting daily life of Rangoon, reflects the status of Burma within the British empire. Burma was a secondary colony under the administration of British India, governed from Calcutta. Only by 1937 did Burma become an independent province within the British Empire. Commerce was Rangoon's key driver, trading teak,

[65] Population 1863 is 61,000; by 1873 Rangoon has 100,000 inhabitants.
[66] For a detailed account of planning of colonial Rangoon and the referred to "physical pedagogy" see Turner, A. (2021), "Colonial secularism built in brick: Religion in Rangoon", *Journal of Southeast Asian Studies*, Vol. 52 No. 1, pp. 26–48.

cotton, salt, rubies, and later rice and particularly petroleum, with its strategic location as a port, Rangoon was primarily an economic colonial endeavour (Sugarman 2018). Corroborating this view from a biomedical perspective is the lack of medical training in Rangoon and Burma by the British administration in the 19th century, which was primarily driven by financial interests (Edwards 2010; Saha 2012). All this is reflected in the initial shoreside location of Rangoon's main hospital.

Rangoon's downtown was constructed from 1854 onwards (Turner 2021). Planned on a grid, a trade mark of Yangon's downtown still today, the downtown has a broad strand along the river and drains for flood prevention (see Cangi 1997, Chapter 4), from which the area still benefits; while townships like Golden Valley suffer severe flooding every year, downtown streets have comparatively moderate issues with flooding.

Streets are arranged in north-south and east-west direction. East-west roads (today Bogyoke Aung San Road, Anawratha Road, Mahabandoola Road, and the Strand which is Kana Road today) provide the main orientation by dividing the downtown into upper, middle, and lower blocks. Wide primary north-south roads were earmarked for commerce; wider than residential roads divided the blocks between the commercially oriented main roads further. This grid secured good ventilation with dominant winds from the river in the south. Administrators hoped ventilation would prevent disease; hygiene and public health was a key concern of the colonial town planners who had seen the spread of plague in South and East Asia diminishing the empire's workforce (Sugarman 2018: 1856).[67]

Hannah Le Roux points out in an African context, a good century after Rangoon was planned, with regard to post-colonial tropical architecture, that the aim to "improve" living conditions, increase "comfort", getting "better" sleep, and having "good" light for work, is to eventually increase efficiency. Planning well-ventilated buildings, using cooling and allegedly more hygienic materials

[67] For an interesting traveller's description of Rangoon around the turn of the last century: Franck, H. A. 1910. *A Vagabond Journey around the World - A Narrative of Personal Experience*. New York: The Century Co.

such as stone(as we will see in the following pages), disguises the aim to make people more efficient behind a veil of supposedly "universal" ideas of comfort (le Roux 2020). The reflection of economic interests in the materiality of city planning, as noted by Le Roux with regards to post-colonial tropical architecture, is visible in colonial Rangoon, and remains visible in Yangon's downtown. Alice Turner evocatively shows how the new town plan, building regulations, and materiality provided an efficient system in which functions are sectorised and the city secularised (Turner 2021). Under the guise of hygiene and public health the colonial town planners turned a blind eye to existing structures, built, social, and religious (ibid).

Architectural designs were borrowed from local architectures, for example ventilation and fast wood-construction methods (see Cangi 1997, Chapter 4). This well researched and carefully developed routine, planning streets on a grid and contextualised planning, lead to environmentally adapted structures.[68]

One of the examples in use today are YGH's main and cardiac buildings. Both have a colonial aesthetic that feels implanted and foreign, as discussed above with relation to Begg's comments. At the same time, the spaces function in harmony with the elements, borrowing from local and regional architecture such as verandas for shade, good ventilation, and high ceilings. Some of the more recent structures do not afford the same physical advantages as we will see in the following chapters. These new buildings have been built on, what to my mind are, "international" templates with little consideration of the environmental and social context. The functionality of colonial architectures is not incidental. It was part of the insidious colonial system with its anthropologists, engineers, planners, administrators.[69]

Before RGH was moved from the shores of Rangoon river, closer to its civilian population, the city's Lunatic Asylum opened in 1870. In this prioritisation of the Lunatic Asylum over the hospital I see a

[68] For a detailed discussion and example of adapted architectural form see King's *The Bungalow* (1984).
[69] See Metcalf *Imperial Vision* (2002).

reflection of the disruptive times, and traumatic experience of colonialism, for the population of Rangoon.

Finally, in 1872, Rangoon General Hospital moved into a purpose-built "attractive" and "well equipped for the time" teak-building. The site chosen was the one that had been suggested a decade earlier in the 1860s (Pearn 1939: 202). The "attractiveness" of the new hospital would not last very long; less than two decades later the hospital was once again deemed unsanitary and out of date. In 1893, Sir Addis, a visitor to Rangoon, described the hospital as "ghastly" in his diary.[70] In the same year Sir Addis noted his horror of RGH in his private diary, a commission recommended that the state of the hospital is so abysmal, a new Rangoon General Hospital should be built.[71] Nonetheless, RGH would remain in the overcrowded teak structure for forty years.

The delay in constructing a new hospital could possibly be attributed to the depression of 1882-1885 that originated in the United States. The 1882 report on the administration in Burma notes that outpatient numbers fell from the previous year, explaining this with a reduction of the "floating population" due to a general economic downturn.[72] This "floating population" the report refers to are mostly unskilled Indian labourers who fuelled the colonial economic endeavours (Sugarman 2018: 1866ff); Burma had a relatively small, yet educated and wealthy, population who was not easily subjugated. Hence British administration brought workers and clerks from India, which contributed mainly to Rangoon's population-explosion at the end of the 19th century.

Unsurprisingly, depressions generally impacted the hospital. They affect inpatient numbers as well as construction projects. No direly needed new accommodation was built from the late 1920s until after the Japanese Occupation in 1954, which coincides with the Great Depression of 1929-1941.

[70] Diary by Sir Addis from 1893, 12 Sept, at SOAS archives.
[71] India Office Records at the British Library: "Rangoon Medical Institutions, and a scheme for a new General Hospital'" IOR/P/6/812 Dec 1904 nos 34-36 Mar 1904-Dec 1904.
[72] The Report on the Administration of Burma, during 1892-93, in Three Parts, Part I.- Summary, Part II- Departmental Chapters, Part III.- Statistical Returns; p 60 (http://archive.org/details/dli.granth.108066).

Third Anglo-Burmese War 1885 – Rangoon becomes capital of Burma

Following the third Anglo-Burmese War in 1885, Upper and Lower Burma become a single province within British India with Rangoon as its capital. Six years later, the discussion around the hospital reignites in 1891 with recommendations for new buildings, and to develop an entirely new campus. The initial proposal suggested that parts of RGH move to new facilities, constructed from bricks for better infection control, on a neighbouring plot. Following the initial proposal, thirteen years of "movements and counter-movements" ensue in which different committees made proposals for extending the existing hospital or building an entirely new one. Reports tell the story of a contested project, and disputes over who should pay for the new facilities and their operation. When the responsibility for RGH is transferred from the municipality to the government, in 1902, the matter seems settled.[73] The rising civilian population of Rangoon needs a hospital in line with "modern science", and with potential for expansion.[74]

Mr Jacobs, engineer in the Public Works Department, details the above mentioned back and forth, as well as the proposed scheme for a new hospital, in a 1904 "Report of the Committee appointed to consider and report on the scheme of a new Hospital in Rangoon". He describes the old hospital as systematically overcrowded; its wooden buildings "hardly […] suitable for housing the sick".[75] The new hospital scheme affords special consideration to separate infectious and non-infectious types of accommodation. The report also details that buildings should be placed on the site for full benefit of the winds which blow unobstructed across the grounds; a detail I will come back to in Chapter 7 "Bodies and Buildings".

In the same report the above-mentioned "floating population" appears again. Jacobs refers to them as "a class of patients not met with in any other similar institution in India, namely Natives of

[73] Scheme for construction of a new General Hospital at Rangoon (British Library IOR/L/PWD/6/681).
[74] *Rangoon Medical Institutions, and a scheme for a new General Hospital* (British Library IOR/P/6/812 Dec 1904 nos 34-36 Mar 1904-Dec 1904).
[75] Scheme for construction of a new General Hospital at Rangoon (British Library IOR/L/PWD/6/681); p 3.

India", workers brought to the province to do the work the British and Burmese did not want to do. These "filthy to the extreme and quite helpless" patients have no family ties in the city, they are brought to the hospital by friends as a last resort. The report strongly recommends a ward for "pauper incurables" as nursing "these disgusting cases" with the acutely sick would be "cruel". This will result in the special nursing block. The report recommends building this ward with recycled wood from the old hospital; a clear reflection of class difference in materiality. If you remember, the old hospital and its materials, particularly the wooden structure, had been deemed unhygienic and infested with disease, but for the "special nursing block" it was good enough. The story does not end here. As we will see later, in design iterations, the materiality changes due to less economically driven considerations of infection control. In the discussion of the special nursing block, we see much more than just biomedical considerations. The amount of ink expended on the discussion of the "pauper ward" suggest a colonial anxiety (Stoler 2009) around this population who was mainly male, unattached, and on short term contracts from India (Sugarman 2018: 1868); a possibly uncontrollable risk to the colonial order.

In the end, the site chosen for the hospital was that of the agri-horticultural society in Rangoon[76], west of the location of the existing General Hospital. The society sold the land to the government for the new hospital.[77] Full or partial change of ownership was anticipated as already as 1891 when the scheme for the new Rangoon General Hospital first appears in archival documents.

It took over ten years, from 1891 to 1904, for the new scheme to be negotiated and sanctioned. I noted above the lengthy dispute over who is responsible for the hospital: the municipality or the government. Additionally, in a letter to Curzon, the Viceroy of India, Barnes, Lieutenant Governor of

[76] The gardens of the Agri-Horticultural Society of Burma were established in 1852. The society was entrusted with the planting and collecting rare specimens. When RGH moved onto the grounds the garden of the Agri-Horticultural society was relocated to Kandawgalay (today Mingalar Taung Nyunt Township). The Phayre Museum, dedicated to the first Commissioner of British Burma from 1862 to 1987, was also formerly located on YGH Campus was moved to Yangon Zoo in 1902 (Article 25 2017).

[77] The Report on the Administration of Burma, during 1893-94, in Three Parts, Part I.- Summary, Part II- Departmental Chapters, Part III.- Statistical Returns; P. 46 (http://archive.org/details/dli.granth.108067)

Burma, explains, in early 1904, "why the scheme for the new general hospital has hung fire so long" is due to Burma's high construction rates, which are double compared to India. In the same letter he sets out an interesting prioritisation: Rangoon also needs a high court and a museum. In this, the hospital must give way to the high court, while the museum is postponed in favour of the hospital;[78] rule of law is more important than health, while art is second to both.

Nonetheless, the scheme outlined in 1904 is approved and "an excellent start" is made at the New General Hospital in the first part of 1905.[79]

The New RGH is now located on the northern edge of Rangoon's new downtown. Its immediate neighbours at the time were the central jail to the northwest and the Thayettaw Monastery complex to the west where all Buddhist monasteries form across Rangoon found refuge when the downtown was (re)drafted (Turner 2021). Thayettaw Monastery complex is still active today and a central part to YGH's daily life, as seen in the thesis opening vignette. Rangoon College was North of the hospital, with the convent school on the western part of the plot. Both convent and school are also still around today. Similarly, to Theyettaw Monastery complex, the convent gives refuge to family members and outpatients of RGH, while the school buildings were used for the outpatient department during the first Covid-19 wave in spring/summer 2020. The cathedral is to the northeast, opposite the old hospital (where Junction City Mall is today). South of RGH the downtown grid still stretches to the shores of Rangoon River, while North of RGH the city used to be, wild and lush; stories of big cats roaming "Tiger Alley" beside the infamous "House of Memories" restaurant are proudly told by descendants of the original owners.[80] Over the decades to come, the "wild" landscape receded and was tamed until no tigers remained. Today, Yangon General Hospital is located in the most southern part of the city; still in what is referred to as downtown, but with a sprawling metropolis north of its iconic red façade. Over the next century,

[78] 1904/Feb/Barnes to Curzon CIE/Part1/Reels27/Vol3/60.
[79] 1905/Jan/White to Curzon CIE/Part1/Reel28/Vol1/179 (p 275).
[80] Aung San secretly negotiated with the British over independence at this house.

scores of buildings are added, demolished, and extended, growing YGH into its existence as we see it today: a 2000-bedded tertiary-care teaching hospital.

The hospital's physical expansion, and its trajectory from the shores of Yangon River to its prominent location in downtown, mirrors the emancipation of Rangoon from a backwater naval station to a fashionable international metropole with a fancy tram system, electrical, and water infrastructure, and a state-of-the-art hospital for its people.

In 1909 the *British Medical Journal* (BMJ) reports on the dismal state of the Burma medical services, mentioning "the new Rangoon hospital" as an exception. RGH carried (and continues to carry) high hopes. But this came at a cost and some historical accidents.

Building New Rangoon General Hospital

As we have seen, it took over a decade for the New Rangoon General Hospital to get sanctioned and a scheme to be drawn up by 1904.[81] It will take another five to seven years for the hospital to be built. Like with so many construction projects, delays, disputed costs, and the juggling of blame feature heavily when studying the archival documents, reports, and letters between the Government of Burma (regional government) and the Government of India.

It all started with insufficient documentation. As plans and detail designs were missing, costs had to be based on lump sums, which resulted in too low estimates in 1904/05. Unsurprisingly, in subsequent years this first scheme was called "crude".[82] The original estimate seems to have been produced in haste. Not only were the sanitary provisions not up to date, but key items, even such obvious ones like U-bends for downpipes, were outright missing. Possibly the scheme that had

[81] See summary of the dispute over building a new RGH and the estimate for the original scheme ("Estimate no. 1 of 1904-1905") in the Proceedings of the Home Department, December 1904. File reference: *Rangoon Medical Institutions, and a scheme for a new General Hospital* (IOR/P/6812 Dec 1904 nos 34-36: Mar 1904-Dec 1904).
[82] See *L PWD 6 762 969* (handlist) – Enclosure to PWD Despatch No.10 PW Dated 30.4.08 (1908); p5.

been in discussion for thirteen years was rushed so the outgoing Governor of Burma could see the project starting before his retirement.

In March 1905, the contractor Bagchi was appointed with an ambitious completion deadline of three years; the architect and the engineers were struggling to keep up with the pace of construction. At the same time, Colonel King, the new Inspector General of Civil Hospital for Burma, a sanitary expert, was appointed to the post in September 1905, four to five months after ground-breaking and with construction well underway.

Colonel King's two-page obituary, in the *Transactions of the Royal Society of Tropical Medicine and Hygiene* in 1935, gives some background to this crucial character. King had been a key figure in the Indian Medical Service with many innovations to his name, especially in the field of sanitation.[83] The obituary calls him "the father of public health in South India". After his retirement he continued to stay engaged with developments in his field and authored articles, for example on operating theatres in the tropics, and ventilation of wards.[84] The King Institute of Preventive Medicine & Research in Guindy Chennai was named after him.[85] In 1905, this authoritative figure joined the project at the height of his career, bringing all his expertise with full force into the planning of the new RGH. He retires a year before the hospital officially opens its doors. It seems safe to say that the new Rangoon General Hospital was his success.

However, while his title (Inspector General of Civil Hospital for Burma) appears in many reports, his name is mostly omitted. To me, this suggests no one wanted to attribute blame to him personally for the excessive costs that his suggestions clearly caused. However, as mentioned above, it was not only him responsible for running up the tally. When the original plan was drawn up the estimates had been wanting and up-to-date expertise was missing. Once construction was

[83] Obituary Walter Gawen King, 1935; Transactions of the Royal Society of Tropical Medicine and Hygiene, Vol.XXiX Vol 1 June 1935.
[84] King, 1910, "Operation Rooms in the Tropics", *Indian Medical Gazette*, June 1910; p201-207.
King, 1912, "Air Movement in Association Wards" *Indian Medical Gazette*, Feb 1912; p60-64
[85] Obituary in the *BMJ*, April 13, 1935.

underway, the engineer's and architect's frequent presence on site was needed to resolve questions not detailed in the drawings. This meant they had no capacity to prepare detailed material and cost-estimates for the updated designs coming in from the medical department with its new inspector general; resulting in un-quantified changes to the design that were built as speed was of essence for the contractor. [86]

Colonel King was dissatisfied with decisions his predecessor had approved. His department demanded changes, making new suggestions that the engineers tried to catch up with. While the designing architect, Henry Hoyne Fox, was on leave for six months, studying up-to-date hospital design in Europe, his deputy was not qualified to evaluate and cost the new requests. Around the same time, unanticipated issues with water infrastructure emerged. Upon Henry Hoyne Fox's return from leave in January 1907, his stand-in had not been able to keep up. The architect needed almost four months to grasp the changes that had been made to the scheme, and to develop a revised estimate. However, the new estimate was also not satisfactory. The chief engineer found gaps, while Colonel King, the new Director General of Civil Hospitals, was unhappy that he had not been sufficiently consulted.

It is not entirely clear from the documents who was responsible for what exactly. However, referring again to Begg's discussion of architecture in India, architects for the longest time had been seen as designers of facades (the exterior) while engineers were responsible for the rest; Begg criticises this division of labour vehemently.[87] Archival documents mention that architect Henry Hoyne-Fox returned from his Europe trip with state of the art knowledge on, for example, operating theatre design, suggesting that he started to have more say in functional layouts as well.

[86] See summary of the dispute over building a new RGH and the estimate for the original scheme ("Estimate no. 1 of 1904-1905") in the Proceedings of the Home Department, December 1904. File reference: *Rangoon Medical Institutions, and a scheme for a new General Hospital* (IOR/P/6812 Dec 1904 nos 34-36 : Mar 1904-Dec 1904).
[87] "Architecture in India" by John Begg [F.], Consulting Architect to the Government of India. Read before the Royal Institute of British Architects, Monday, 12th April 1920" reprinted in *Journal of the Royal Institute of British Architects* Vol. XXVII. No. 14.—29 May 1920.

What we are seeing played out at the construction of RGH is not only a leap in scientific understandings around hygiene and biomedicine, but also a shift in the architectural profession's self-understanding. As a result, by the time the buildings went on site the original scheme, based on old science and antiquated design processes, was outdated.

By mid-1907, two years after ground-breaking with construction in full swing, chief engineer, architect, and the inspector general met to develop a revised scheme in collaboration. This new scheme was up to date and thoroughly in-line with modern medical and sanitary science.

In essence, by the time the hospital went on site in 1905, a new actor, the above-mentioned Colonel King, had arrived on the scene with the latest developments in medical and sanitary sciences, and possibly a new understanding of architecture and the architectural profession. Paired with the realities on site, a contractor under pressure to pay his staff, to source materials at a price he had offered, and complete on time according to his contract, the provision of revised estimates was delayed by years. Changes were made and built immediately. At no point was construction stopped entirely by the provincial government to get new costs and changes sanctioned by the Government of India. By the time the drawings and numbers caught-up, electric (instead of hand operated) pukka fans, Malik over Marseille glazed tiles for corridors, improvements in the operating theatres, and a general replacement of timber structures with masonry (mostly justified by more economical maintenance going forward despite higher capital cost), to just name a few items in the list of changes, had made their impact.

The New Rangoon General Hospital had become one of the most expensive hospitals in the world, as noted by Begg in his report on *Architectural Work in India* from 1909; hardly anything was omitted that would be found in the best hospitals in Europe, making the new RGH the best facility in the East.

The cost had exceeded the original estimates by 51%. In the end, the Government of India had to agree with the local government that the updates were necessary and could only ask for sufficient

explanations in an effort to avoid such excessive costs in the future. This process seems to have indeed resulted in a new directive. In 1911, *Building News* announced a new guidance, advising officers to: "[…] frame their designs with due regard to *economy*, and to meet, as far as possible, the *reasonable* wishes of the medical authorities; but suggestions from sanitary experts, who think only in [millions], are to be disregarded, as such proposals will usually involve considerable resources of the provincial exchequer".[88]

Reading the report on the excess expenditure together with the short note in *Building News* from 1911 suggests that the administration was riled about the costs. With new type plans for hospitals, announced in the above-mentioned *Building News* item, the Public Works Department wanted to make sure expert engineers and the medical department were kept out of design processes to avoid excessive costs.

While praised for its state-of-the-art facilities, this hugely expensive institution had not been planned to be a beacon of biomedical science. Colonial administrators had accidentally built a hospital at the epitome of scientific knowledge in a difficult to govern secondary province which carried mainly economic interests.

However, construction quality did not necessarily match the hospital's advancements; when I inspected the hospital with an Indian UNHabitat engineer in 2016, for a seismic safety project, he pointed to masonry corner details which he described as dilettantish. Apparently, in India similar buildings exhibit much better detailing and construction skills. Yet another nod to Burma's status as a province with mostly economic interest.

In a short notice, the *Times of India* reports on the official opening in April 1911. Alongside mentioning of the costs, the author is evidently impressed by "the idea and magnitude of electrical and central heating systems" giving exact details on pipe lengths for steam and hot water (six miles)

[88] 1911 August, *The Building News*: News on guidance by PWD Burma on hospital design (emphasis added).

and electrical conduit (fourteen miles) alongside the accommodation of nurses and provision of "lamps of various candle power" (2500 in number). Fifteen years later, in 1926, Ms Meiklejohn the new Nursing Superintendent at the time, will be equally enthused about the nurses' accommodation with its provision of lamps throughout.[89] Throughout, these reports mirror sentiments of the time, when electricity was a novelty.

According to the 1915 report in *The Hospital*,[90] the "Rangoon Electrical Tramway and Supply Company" that provided electric tram services from 1906[91], one year after ground-breaking at RGH, had a substation at the hospital. Considering that electricity for trams was needed during the day, while the hospital's needs were highest at night, and generators had to run 24 hours (Frasch 2012: 98), the hospital as a high energy user was an ideal client for the *Rangoon Electrical Tramway and Supply Company*. Additionally, the substation's steam and heat kept sheets dry during the wet season, as the linen store was designed to be in close proximity (General Hospital, Rangoon 1915: 446). The closely intertwined stories of electricity, the city's infrastructure, and the hospital's facilities start with the campus' inception, and will continue into the present.

Following the official opening, the *BMJ* reports in 1913 that the hospital is now fully equipped; during 1913 the mortuary and laboratory buildings are added (India 1913). Additional buildings were completed in 1915 and designed by Consulting Architect to the Government of Burma, Henry Seton Morris, who took over from Henry Hoyne-Fox; namely the police surgeon residence and the administrative building.[92] The site plan published in 1915 by *The Hospital* does not yet show these buildings; also, the area where a canal will be paved over years later is not yet built up. A scheme for nurse quarters and workers which will be built in the canal area is first mentioned in 1923/24. In

[89] Miss Meiklejohn to Miss Riddle - Letter sent from the Office of the Nursing Superintendent, Civil General Hospital Rangoon 11th October 1926 (National Archives, Kew: DT18/101 1926 Oct 11 - 1935 July 12).

[90] "General Hospital, Rangoon" (1915), *The Hospital*, Vol. 57 No. 1495, pp. 445–446.

[91] Steam trams have been running in Rangoon since 1884 but were abandoned due to health and safety concerns (Frasch 2012: 103).

[92] Annual Report on Architectural work in India for the Year 1914-1915.

the same year, several other schemes are approved by administration of Burma, as well as a diabetic clinic which is established at RGH.[93] The hospital starts to stretch and grow.

In 1918, a country wide flu epidemic breaks out. RGH is heavily affected and struggles with the large number of patients despite its state of art buildings. Satellite clinics are established to meet the demand (Pearn 1939: 290).

In 1926/27 (additional) theatres are completed.[94]

When in December 1930 the Pyu earthquake hits Rangoon, it can be inferred that some of the original domes collapsed, including the one above the main staircase, since the Secretariat Building's domes, designed and constructed around the same time and by the same architect, faced a similar fate.

In 1931, the *BMJ* reports that the Burma medical services are met with "stringency"; it is the time of the Great Depression (India 1931). The article notes that this economic austerity makes the construction of new, much needed dispensaries and hospitals difficult, while RGH is over capacity (ibid). Even though electric trams are at the height of their popularity (Frasch 2012), the reason for overcapacity is rising motor vehicle accidents (India 1931). The car becomes a commodity, a harbinger of modernity, and commonplace on Rangoon's streets. Acute emergency cases from car accidents competed with chronic and palliative cases (ibid). While sword wounds were a frequent occurrence in Burma in late 19th century (according to a resident surgeon in an annual report), times change, and so does the trauma. In his visit of the old RGH's "ghastly" teak building, Sir Addis also noted:

> *Rangoon is a quarrelsome place. Here is a large ward full of broken heads and broken limbs, wounds and contusions. Then there is this ghastly female ward […]. Full of horrible*

[93] Report on the Administration of Burma for the years 1923-24 (Public Library India http://archive.org/details/dli.granth.108086).
[94] Report on the Administration of Burma for the years 1926-27 (Public Library India http://archive.org/details/dli.granth.108088).

> *mockeries of what once were human beings, grim monuments of man's inhumanity to woman.*[95]

When my friend was treated by the friendly anaesthetist who trained at YGH from the beginning of this chapter, he remarked that in Myanmar doctors know well what to do with flesh wounds. While motor vehicle accidents are still frequent, he alluded to another type, the one inflicted by bullets.

1937 Burma became a colony of the British Empire, no more a province within British India. Despite Burma's change in status, RGH's dire overcapacity was not addressed, and, five years later, another army with its rifles and bullets took hold of Rangoon.

Japanese Occupation 1942 – 1945 (350)

The Japanese conquered Rangoon in March 1942, and occupied the city for three years.

According to Myint Swe's memoire *The Japanese Era General Hospital*, from 1942 to 1945 RGH Campus was seized by the Japanese army and exclusively used and staffed by Japanese. RGH's operations moved to the Anglican Diocesan School of Rangoon and became the Burma Independence Army (BIA) hospital. Here, Aung San Suu Kyi's parents met. Ma Khin Kyi, a nurse at RGH, treated Bo Gyoke Aung San, Burma's founder of the Myanmar's army (also referred to as Tatmadaw) and the Father of the Nation of modern-day Myanmar (Myint Swe 2014).

At the end of August 1942, the BIA hospital was renamed the Burma Defence Army (BDA) hospital for two months (ibid) reflecting the shift in Burma's army's position in its relationship to the occupiers; from "independence" to "defence". In late 1942, the BDA hospital was again given a new name, this time the "Public General Hospital", with expanded services for the wider public, yet again marking a shift, this time from a military facility to a public one. A maternity ward was added; a service not needed during its time as BIA/BDA hospital for military personnel (Myint Swe 2014). Yet again, spatial provisions reflect social relations, as soldiers were exclusively male, their wives at the time not treated at military hospitals (this will change in the following decade as military

[95] Diary by Sir Addis from 1893, 12 Sept, at SOAS archives.

hospitals become well equipped facilities for military personnel and their family). The hospital shifted its names in line with politics and alliances, but in the minds of the people working there it remained firmly the "Rangoon General Hospital", as reflected in Dr Myint Swe's book title *The Japanese era Rangoon General Hospital* (emphasis added).

Following the BDA revolt in Spring of 1945 the Japanese retreated, leaving Rangoon in chaos (Myint Swe 2014). When doctors went to investigate the abandoned RGH Campus it was littered with bodies. They suspected, timed bombs or booby traps had gone off following the Japanese' departure. In July 1945, RGH was re-occupied by the Burmese doctors and nurses that had ensured the continued operation of the Japanese era hospital (ibid).

Independence – U Nu

The British civilian administration returned, but not for long; they found themselves in a new political landscape, with unfamiliar counterparts, and old alliances and signposts gone (Tharaphi Than 2014: 6). Without Indian troops, and the financial resources to maintain a large military presence, they were forced to enter negotiations over independence (Fink 2009: 21); also in its independence, India and Burma are entangled.

Three years after the end of the Japanese occupation Bogyoke Aung San spearheaded Burma's independence, which was realised in 1948. Aung San himself, however, was assassinated in the summer of 1947 before he could see the fruits of his labour. Once again RGH provided the backdrop to a historical event; it was in the main building's basement, as I have been told by interlocutors, where people paid their last respects to the well-respected General.

Following these events, the newly established nation fell into a period of chaos and economic struggle.

While 1948 to 1958 was a decade of freedom of speech and vigorous and open debate, the Burmese government had a severe problem: trained Burmese professionals where rare (Fink 2009:

23). Most government posts had been held by foreigners and Indian civil servants (ibid). Most had fled during World War Two, afraid of what the Burmese might do to them once the British were gone, given that the colonial powers had been so adamantly supported and favoured them (ibid). At the same time, social welfare programmes had little impact because the central government neglected to include local communities (Fink 2009: 25). Initiatives did not meet needs on the ground and villagers themselves felt little commitment to them; programs were often pegged to political allegiances and used for strategic manoeuvring rather than social wellbeing, public health, and widespread economic prosperity (ibid).

In 1949, a civil war stared which continues to be unresolved to this day. Ethnic minorities were (and remain) feeling betrayed by the new government which oppressed any contrary voices and movements towards a federal state (Tharaphi Than 2014: 8). Myanmar is the arena of the world's longest civil war. Ethnic conflicts, most fought in rural areas, led to displacements of large number of people and accelerated urbanisation (Sugarman 2018), adding pressure on Rangoon's main hospital which improvised to keep up with the influx of patients.

Bed numbers expanded from 750 beds to 1400 (Woodruff 1967: 533). This was achieved by repurposing verandas and the so-called basements into wards (ibid). Around the same time, children were moved out of the hospital (even though Rangoon Children Hospital would only open a decade later in the late 1970's), alongside the EENT (eyes, ears, nose and throat), and tuberculosis departments. Neurosurgery, urology, orthopaedics, hand surgery, plastic surgery, leprosy reconstruction units, cancer care, and cardiology were added to RGH in the 1960s (ibid). This major restructuring, which went hand in hand with a construction burst on the grounds (Article 25 2017), demanded for more clinical staff. Therefore, a new training school was built on the grounds around 1964.[96] Infrastructure needs people.

[96] See *BMJ* letters 1967, 9th of September; p. 677 (Woodruff).

From 1951, hospitals in Burma were nationalised, transferring responsibilities to the Union Government.[97]

The Canadian Government under the Colombo Plan[98] established radiotherapy unit in 1957.[99] The project provided the infrastructure as well as training for Burmese doctors, while their Canadian counterparts ran the unit at Rangoon General Hospital (Layton 1962: 246). Given the success of the project, seen in an immediate study thereof, a second cobalt unit[100] was approved alongside the construction of additional ward facilities for the radiotherapy department, including clinical training for staff in Canada (ibid).

1958/59 a new Outpatient Department (OPD) building was planned. According to MNA files, this was at least partially funded by ICA, the International Cooperation Administration, the predecessor of USAID.[101] An American loan was to cover construction and fixed equipment of a new OPD and a building for adjunct services.[102] The project was only completed in 1972 [103] following numerous delays and alterations.[104] Undoubtably, the military coup in 1962, and subsequent change in the government, contributed to the delays.

1958 saw economic recovery but political disintegration (Tharaphi Than 2014). Ensuing ethnic struggles throughout the country arguably paved the way for the 1962 military coup. The cup heralded General Ne Win's xenophobic and superstitious military dictatorship[105] under the Burma

[97] Myanmar National Archives: Series 3/14 Acc.No.3999.
[98] The Colombo Plan is a commonwealth alliance established in the early 1950s for "the economic and social advancement of the peoples of South and Southeast Asia" (https://colombo-plan.org/history/).
[99] See documents at MNA on cancer care from the 1950s.
[100] An external beam radiotherapy machine.
[101] According to USAID website, USAID left Rangoon in 1962, following the military coup; ongoing projects continued. In 1966 a loan was agreed (https://www.usaid.gov/burma/history).
[102] Myanmar National Archives: Series 11/11 Acc.No.56 (1959 Rangoon General Hospital Project).
[103] United States Economic Assistance 1950 to 1985_pcaab719.
[104] 1967, Report of Examination Rangoon General Hospital (construction of an outpatient building and an adjunct services building).
[105] See Christina Fink's illuminating remarks on this topic (Fink 2009).

Socialist Programme Party (BSPP), which lasted in power until 1988, ending with a brutally supressed student uprising.

1962 Coup – General Ne Win and the Burmese Way to Socialism

The time from 1962, marked by brutal military rule, was a time of economic downturn, repression and mismanagement (Thawnghmung 2019: 19). Rangoon, and its population, have a history of being tormented by whatever military, and their bullets, is in charge; the British, the Japanese, and in 1962 the country's own army is entering the stage.

In the early 1960s, both clinical buildings and staff housing were built (Article 25 2017), congruent with Ne Win's coming to power in 1962 and the institution of the Revolutionary Council (RC). It could be speculated that the substantial addition of staff accommodation was part of the "socialisation" of the country, as it came at the same time when the government nationalised private companies and businesses in 1962 and 1963. The official policy, "The Burmese Way to Socialism", under Ne Win (1962-1988) "was a system of centralised economic management and economic autarky".

In 1966, the Neurosurgery Department was established, first with one bed in the general surgical ward in the main building,[106] subsequently, according to my interlocutors at the hospital, the department moved into its own new building on the extension site in the following years.

In the 1970s the "Daw Pu Ward", a concrete structure, was built; its style reminiscent of "tropical architecture" that was fashionable at the time. South of the colonial cardiac building concrete brise soleil and narrow floor plans for good ventilation became home to the Gastrointestinal Department, a specialist department with a specialist building. Oral history tells of Hajima Daw Pu as a well-known Muslim philanthropist from Pindaya with good relations to both General Ne Win and Bogyoke Aung San's widow Daw Kyi Kyi, Draw Aung San Su Kyi's mother. According to my

[106] Information from website of Yangon Medical University 1; not accessible since 2021 Coup.

interlocutors, the philanthropist funded parts of the building that the ministry of construction designed and built.

The construction of only one, mostly privately funded, building in over a decade reflects the period of the country's greatest economic decline and wilful neglect of public healthcare (Oehlers 2005). A third, small, wave of construction at RGH took place in the early 1980s. Most buildings in the 1980s were constructed across the road of the main campus where the neuro-surgical building had been built in the 1960s.[107]

As Rhoads and Wittekind point out, as well as disprove with regard to landownership, Burma/Myanmar's popular historic narrative is often centred on isolation and decline (2018). This idea of "stasis" under the military regime might seem perpetuated by the above narrative of RGH and the lack of construction. However, I would like to point out that this "lack" was an active "neglect" as discussed in detail by Oehlers (2005). While RGH fell into disrepair military hospitals flourished (ibid), essentially militarizing health care. As the majority of the population struggled to sustain basic needs, military generals and their families amassed fortunes through monopolies of many of the most lucrative businesses in the country (Fink 2009: 99). This did not happen without trade. According to personal conversations, Ne Win was a regular on Berlin's Kurfürstendamm, a luxury shopping street in West Germany, where he spent months at a time.

1970s - End of RC, Burma Socialist Program Party (BSPP) and a new Constitution

In the early 1970s, Ne Win turned the Revolutionary Council (RC) into a civilian body, in the shape of the new Burma Socialist Program Party, essentially a collection of generals (Thawnghmung 2019: 20). He banned all other parties and drafted a new constitution based on "The Burmese Way to Socialism" (ibid). Foreign trade was restricted, and foreign companies expelled, local business

[107] Based on cross-referencing of maps and plans over that period.

nationalised, while movement, political, and economic activity was severely controlled (ibid). At the same time, the military renewed brutal campaigns against non-state armed resistant groups (ibid).

Although the government may have isolated itself to some extent, particularly in its rhetoric, the generals did not completely sever all international connections. In 1978, U Kan Hla, from the Moscow Institute of Architecture, writes about historic town planning in Burma, indicating continued Soviet influence in Burma.[108] Additionally, during a pleasant afternoon spent with the late contemporary artist Ko Ko Gyi in the shaded courtyard of his studio in Mandalay, he shared with me and a group of friends his experiences studying psychology in Hungary as a young man. He originally had anticipated studying in the US as his professor and mentor had done, but international relations pivoted, and he ended up in Hungary. At the same time, in 1972, the Foreign and Commonwealth Office advertised for a "Consultant Orthopaedic Surgeon" for the Rangoon General Hospital in the *BMJ*[109], further suggesting that the country was not "isolated".

From 1962 to 2015, healthcare is increasingly instrumentalised to coerce Burmese civilians into submission. Especially public healthcare becomes a political tool; the government systematically underfunded the public healthcare system (Oehlers 2005), leaving RGH operating on less than a shoestring budget.

Public hospitals were unable to offer reliable services (ibid). They routinely ran out of medicines, a circumstance manufactured by the government through unreliable supply. Public facilities were left understaffed, and the little staff there was, were underpaid (ibid). Patients had to content with forbiddingly long waiting times (ibid). In a bid for popularity, the military visibly sponsored township clinics, claiming the government's incompetence to care for its people; concealing behind the vail of a pretend division of power that the military essentially was the government (ibid). At the same

[108] Between independence and 1962 British and American Architects were commissioned for key buildings around Yangon, such as for example Tripitaka Library (US) and University of Medicine-1 (UK), while the Soviet Union gifted Burma the *Rangoon Institute of Technology* Campus (Bansal et al. 2015).
[109] See p. vi in "Front Matter." *The British Medical Journal*, vol. 1, no. 5800, BMJ, 1972.

time, military hospitals were well equipped and staffed, but only military personnel and their family members were allowed to use them (ibid). Given the poor state of the public system, the lure of the much better healthcare provided by the military became an incentive to join the ranks (ibid). In parallel, family members of high-ranking generals established an unregulated, highly lucrative, private healthcare sector. Even though one had to pay, the time saved often outweighed the costs (ibid).

The spending cuts at RGH were apparent not only in the lack of medicine. In the 1980s services started to disappear. According to interlocutors, the kitchen and the laundry closed, and the hospital's much loved football team stopped playing.

These years were marked by a loud silence and economic hardship. A quote in Christina Fink's *Living with Silence in Burma* illustrates well what the 1970s and 80s were like: "If we had spare time, we wanted to do some work to earn money. People were only thinking about survival" (Fink 2009: 49).

But this is not the entire story. This decade was also spiked with opposition in urban centres. For example in Rangoon, especially unattached and young, university students were organising (Fink 2009 Chapter 2). Students as protest leaders and political activists is a distinctive Burmese feature since 1920s (Zöllner 2018: 20). While Fink does not mention Rangoon General Hospital specifically, we must remember that RGH is, and was at the time, Myanmar's main teaching hospital. Political discussions and pro-democracy sentiments would have whispered through its corridors.

August 1988

Rangoon's main hospital featured heavily during the events of August 1988. The 8888 revolution,[110] originally a student uprising, was fuelled by a devaluation of the local currency in a country ridden with brutal repression of anti-government sentiments. In subsequent days after the 8th of August,

[110] While this event is popularly also referred to as the "8888 Uprising", I follow the prodemocracy movement in calling it a (unfinished) revolution.

marches would start at RGH (Fink 2009 Chapter 3), and many wounded and dead protesters, mainly students and monks, were brought to the hospital. Aided by military intelligence who had been hunting down leaders of the uprising, the military entered RGH on August 10, 1988 (Renaud 2009). Military Intelligence agents tracked "agitators" down inside the hospital; killings were reported, including deaths of blood donors waiting outside the hospital to donate to the victims of gunshot wounds (ibid). The military shot at doctors and nurses with machine guns, while they were trying to hang banners at the entrance asking to stop the killing (ibid). This violation of the hospital as a safe space turned the population even more against the generals (ibid). RGH had become a gathering ground for protesters (Burma Watcher 1989: 177). The shootings at RGH were some of the worst during the 1988 protests (ibid).

RGH also provided the backdrop for Daw Aung San Su Kyi's first public speech, a "dry run" for her speech at Shwedagon Pagoda a few days later. RGH's red façade yet again the coulisse to a key historical moment.

SLORC – Rangoon General Hospital becomes Yangon General Hospital

Following the brutal repression of the uprising, the State Law and Order Restauration Council (SLORC) took over the running of the country from 1988 to 1997, launching a campaign "to wash the city with sweat" (Bansal et al. 2015). The ensuing a highly controversial "urban works program" saw the city scape altered to avoid any future uprising (ibid). Crowd control examples, amongst many others, is the relocation of universities across easily controllable bridges from the city centre (ibid). Everybody was ordered to paint their houses; to wash the blood off the walls (Bansal et al. 2015 chapter 'Remoulding the City after 1988'). Interlocutors told me the instructions were to paint houses white so unfavourable dark shadows, curfew breakers, could be spotted more easily. Around this time, many overpasses were built over major junctions; passing over one, I can never not think what a formidable shooting stand they make.

In 1989, State Law and Order Restoration Council (SLORC) changed Burma to Myanmar and Rangoon to Yangon. Rangoon General Hospital is now Yangon General Hospital.

In 1990, the Netherlands donated the installation of a new fresh-water system to YGH (ibid). Further clinical buildings were added to YGH in the mid-1990s (Article 25 2017).

According to a World Health Organisation report in 2015, the Myanmar government traditionally favoured economic and political stability over socio-human development; health was not seen as contributor to peace nor economic growth (World Health Organization 2015). From 1988, the previously mentioned, notorious underfunding of the public healthcare sector was utilized to further the military's political ambitions (Oehlers 2005). From this it could be concluded that public healthcare was a key tool in a war between the government and its citizens in the aftermath of the 8888 revolts (ibid). YGH, its people and buildings, suffered severely under the generals' increased efforts to control its people over the coming decades.

1997 – SPDC

In 1997, almost ten years after the State Law and Order Restauration Council's (SLORC) initiation, SLORC was remoulded into the more aspirational sounding State Peace and Development Council (SPDC); the same year that Myanmar became ASEAN[111] member. The SPDC stays in charge of the country until the election of Myanmar's first civilian president Thein Sein in 2011. However, despite the name change, not much transformed in these for fourteen years in terms of SPDC's attitude to its people, nor the country's economic prosperity.

In the 1990's, electrical blackouts became more and more common in Yangon, while some rural areas only had electricity every three to five days (Fink 2009: 99). Only a fraction of the population has piped water even today. In the tea houses of Rangoon, a popular joke emerged that civilians were fortunate the military controlled provision of electricity and water; not the air people breathe

[111] The Association of Southeast Asian Nations.

(ibid). Considering the 2021 military coup and its aftermath that collided with the country's worst Covid-19 wave, this joke takes on a rather different colour and sinister tone today when the military indeed had control over much needed oxygen supplies.

Anthropologists know of the power of jokes (Scott 1985), their hidden meanings (Radcliffe-Brown 1940), and understand them as socially constructed (Douglas 1968). Two jokes circulating at the time speak for themselves. They give us an insight into popular, but hidden, sentiments around freedom of speech, repression, and the country's seclusion; their existence is proof of opposition to and criticism of the regime within the population through hidden humour (Matelski 2024):

> *"An American, A Russian and a Burmese are bragging about their countrymen's achievements. The American starts: 'an American man has climbed the Mount Everest with only one leg!' The Russian continues, 'a Russian man has crossed the ocean with no arms!' Finally, the Burmese man responds, 'our leader has ruled the country for twenty years with no head!"*
>
> *"I came all the way to Thailand because I have a toothache.*
> *Do you not have dentists in your country?*
> *Yes, but in Burma we are not allowed to open our mouths."*[112]

Amidst repression and electricity shortages, the early 2000s saw substantial additions to the campus' infrastructure. Yangon Electricity Supply Board (YESB) buildings and an Oxygen Plant amongst other facility-management structures (Article 25 2017) went up.

In late 2005, the military junta moved from Yangon to Naypyidaw, a city built from scratch in the middle of the country (Fink 2009: 97). Its design and construction took place under extreme secrecy; few people knew about the project until the move. While billions of dollars had been

[112] Jokes are also from Matelski's forthcoming volume (2024).

invested to develop the new capital, no improvement was seen in ordinary citizens' lives; less than half a dollar (458 kyat) per person was spent on healthcare in the same year (ibid).

With the new capital came a mass migration of government officials, ministries, departments, and agencies from Yangon to Naypyidaw, leaving many Yangon downtown buildings vacant and up for re-development. A short survey of the many coffee table books, published a decade later, show a romanticised view of Yangon's colonial heritage buildings, perpetuating a narrative in which Rangoon awakens from a "rip van wrinkle sleep" (see for example Bansal et al. 2015; Heijmans 2016; Henderson & Webster 2015). I would contest this notion, alongside other observers of built heritage at the time (Girke 2015; Rhoads & Wittekind 2018). The city's colonial heritage had been continuously used, remade, and repurposed since the country's independence, and from 1962 by the military government. Downtown did not grow vertically until the 2000s, but it was not "asleep" nor "in stasis". Neither was Yangon General Hospital; it continued to grow and adapt.

When the government moved to Naypyidaw, the buildings of the Department of Medical Science became available on campus. The National Blood Bank and the Haematology Department moved in and repurposed the former office buildings, using them until today; a legacy we will come back to in Chapter 8. The Haematology Department, heavily reliant on the Blood Bank, was delighted at the new proximity to the source of the many transfusions its patients need. Since the 1980s, the Haematology department had been located on the extension site, while the blood bank was on the main Campus where medical oncology outpatients' services are today. Similarly, to the reshuffle on the hospital campus, buildings in downtown Yangon were re-purpose.

2007 – Safran Revolution and Nargis

Almost ten years after the student uprising, and only two years after the generals' move to Naypyidaw, Yangon saw another revolution sparked by the removal of subsidies on fuel prices. These had devastating effects on the poorest in the population (Fink 2009: 101). In 2007, monks, following initial protests by the 88 Generation Students Group, took to the streets (Fink 2009:

101f). This revolution was also dubbed in international media the “Saffron Revolution”, the colour of the monks’ robes. The military’s reaction was less brutal, but only marginally so. Tear gas and rubber bullets were used, especially against individuals with cameras to supress any imagery that could circulate and leave the country (Fink 2009: 104f). Once again, RGH treated many (rubber) bullets wounds and beaten bodies.

Only six months after the monks had taken to the streets, in May 2008, cyclone Nargis hit the Irrawaddy Delta and Yangon Division with 160kph winds. While humanitarian relief was direly needed, the regime refused international aid. The UN Security council was activated, but in the end ASEAN negotiations succeeded in permitting access for foreign relief into the country (Fink 2009: 107f). The regime’s refusal of international relief efforts was paired with a suspicion of local volunteer networks; it did not want to be seen doing less than foreign aid or the civilian population, while mistrusting both to plot other political subversive activities under the vail of humanitarian aid (Fink 2009: 108ff).

In Yangon, YGH was once again the first port of call in a mass emergency. At the same time, the hospital itself was injured alongside its population, as so often is the case with natural disasters. When hospitals are needed most, they are vulnerable themselves; infrastructurally or on a system-level, as is the case with pandemics. In 2008, YGH’s roofs were blown-off and severely damaged. They seem to have never stopped leaking since. From conversations with interlocutors, I got the impression that department heads mobilised donations through private networks to repair the damages at YGH, rather than with government aid.

2011 – President Thein Sein to the National League of Democracy

With elections in November 2010 President Thein Sein, Myanmar’s first civilian president since 1962, came into government; a government still heavily dictated by the old sentiments that had ruled the country for almost 50 years. The same year Daw Aung San Suu Kyi was freed from 15 years of house arrest. In 2011, the State Peace and Development Council was finally dissolved. In

President Thein Sein's four years in government, from 2011 to 2015, he brought many reforms underway. Despite his allegiance to the military, this was a signal of hope for many. After decades of sanctions, international actors engaged Myanmar, US and UK state leaders visited the country in quick succession, and investment started to pour into the country (Thant Myint-U 2020 Introduction). In 2014, Yangon General Hospital's rejuvenation project went underway; a year prior to the countries first "free and fair" elections.

The historic elections of 2015 brought Daw Aung San Suu Kyi's National League for Democracy (NLD) to power. This was a decisive moment for the country and for YGH. In an interparliamentary committee, people from both sides of the political spectrum (military and democracy movement) were brought together over the plight of Yangon General Hospital. When I arrived on campus in summer 2015, renovations of the main building were in full swing. It became clear very quickly that great efforts were made to finish the renovations before the elections in November; at least to a point that could warrant a photo-op for the sitting Minister of Health of Thein Sein's government. Despite all his best efforts to claim the project, whispers in the city clearly attributed the improvements on campus to Daw Aung San Suu Kyi and her party, the National League for Democracy, who ended up winning the elections.

The new NLD government made great efforts to improve health and education, their two major priorities. In this, they had to contend with the decades-long mismanagement and abuse of both sectors, which had left public education and healthcare in shambles. For YGH and the healthcare sector, this meant that healthcare staff had to be trained as universities had been closed the best part of the 1990s (Fink 2009: 93). Many of the senior doctors I spoke to at YGH mentioned the difficulty in obtaining their degree. Additionally, basic education had been eroded in the country. In the decades before 2015, children had been actively discouraged from reading books outside of

school which meant that many people were poorly educated. [113] In a recent podcast, contemporary artist Bart Was-not-Here recalls how useless and brutal his schooling was.[114]

As a first step in achieving their priorities with regards to healthcare, the new government published the "Myanmar National Healthplan 2017 – 2021" (MNH), in December 2016. Aligned with the UN's Sustainable Development Goals for 2030 (SDG), Universal Health Coverage (UHC) is a key target in this plan (Ministry of Health and Sports 2016; SDG Goal 3: Good health and well-being n.d.). Health expenditure as share of GDP started to rise; in 2018 to 4.9% (World Health Organization 2018). In comparison 2017 only saw 2.3% health expenditure as share of GDP (World Health Organization 2017). While great efforts were made, two years later, in 2018, Myanmar had only 40% of the recommended global health worker density of 44.5 health workers per 10.000 people, and 33% of the recommended hospital bed density of 18 hospital beds per 10.000 people (World Health Organization 2018). At the same time, the Universal health coverage index, a key SDG, was at 50% (ibid). A Japanese study from 2018 showed that Universal Health Coverage (UHC) is still far off the target (Su Myat Han et al. 2018). In global as well as in regional comparison all above numbers are very low (Win, 2016 and WHO reports). Sustainable and systemic change takes time, but the population was restless after years of oppression, and made their voices heard in tea shops, in private conversations, and on social media. As doctors and administrators discussed in my final presentation at YGH, some patients would praise the improved facilities, for example in Facebook posts, while others would complain and demand more: more accountability, more investment, more free healthcare.

One could argue that YGH's rejuvenation project, which brought together stakeholders from opposite ends of the political spectrum in an effort to improve Myanmar's main public hospital, provided a literal as well as physical apolitical space for discussion. A discussion between parties

[113] Personal conversations.
[114] *Insight Myanmar* Episode #140: "Myanmar's Voices for Freedom" on 30.12.2022 (https://insightmyanmar.org/podcasts).

who had never before worked together. For the first time, contrary forces united to the benefit of the general public.

While the renovation of the historic main building received most media coverage, around the same time the new Modular Operating Theatre Complex was built, commissioned, and occupied in 2015/16. It is for this building that the kitchen was demolished, but the Ghost tree stood its ground.

During my time on campus, the PET/CT Building, a new Cancer Care Building, and the much contested former "12-storey building" (now the "7-storey building"[115]) that crushed the campus main sewage pipe, were started. Other infrastructure projects such as new generators and substations went underway as well. 2015 to 2020 were years of hope, on YGH campus and beyond.

HISTORY IN THE PRESENT

In the mid-2010s a plan emerged to demolish or repurpose YGH's historic main building. People talked about a museum and administrative offices, stripping the building of its original purpose; I even heard expatriate businesspeople saying they would like to turn it into a hotel (who would want to stay in a former hospital with this history, is another question all together). Demolition or adaptive reuse, altering its original purpose, is a fate many colonial structures throughout Yangon face. YGH is a gauge for political and social transformations, and the city's moods. While at Yangon General Hospital the value of the old structures in their original use was recognised, during the same years, many of Yangon's colonial buildings saw contested fates.

During my time in Yangon, the city's colonial buildings were immensely fashionable amongst expats and local elites. Yangon Heritage Trust (YHT), [116] spear headed by U Than, the former UN Secretary's

[115] Following technical investigations, twelve stories became seven, and the new construction known as "the 7-storey building".
[116] Website is not online anymore in February 2023; last posts on their Facebook page are from January 2021, before the 2021 Military coup in February.

grandson, vocally advocated for preserving the city's British colonial heritage. They organised walking tours, training for architects and builders, and developed a heritage strategy for the historic downtown. [117] At the hospital, the YHT team were advisors to the contractor on the renovation of the main building, while my organisation, Article 25, sat on the Technical Committee[118] for the rejuvenation project.

Around the same time that YHT was active in Yangon, Turquoise Mountain[119], a charity founded by Prince Charles, started to operate in the country. Their team renovated prominent downtown buildings and trained local craftsman in European conservation practices. Doh Ein[120], still active in Yangon after the 2021 coup, is a social conscious business run by a Dutch entrepreneur. Their team rejuvenated alleys between buildings in downtown, repurposing them from backyards where people throw rubbish and food waste to playgrounds and urban gardens; people still throw rubbish, access is controlled by gates, and the city's rat population still rummages the sewers below as pigeons defecate from awnings above. Doh Ein also renovates apartments throughout downtown with a local team of architects and contractors, overseen by a British heritage conservation architect. They work in partnership with the original apartment owners who get a cut of the rent-increase following the installation of water pumps, air cons, and seated toilets, southeast Asian chic decor, and cool kitchens. This endeavour banks on the romanticised view and continued attraction of the colonial buildings to expats moving to the country, and certain local elites, while many Yangonites prefer modern condos with double glazing, reliable plumbing, and views across the city.

[117] YHT's "Heritage Strategy": https://www.burmalibrary.org/docs23/2016-08-Yangon_Heritage_Strategy-en-red.pdf
[118] The "Technical Committee" consisted of hospital administrators as well as local engineers and experts to advise YGH on technical and design issues; Article 25 was the only international team on the table.
[119] https://www.turquoisemountain.org/myanmar
[120] https://www.doheain.com/en

The foreign gaze is interesting here, as is its financial background. Much of the funding for the hospital's rejuvenation project came from the UK's defunct Department for International Development (DFID).

While the above-mentioned actors were focused on preserving Yangon's colonial heritage, UNESCO collaborated with the government on listing Pyu Cities and Bagan, two key Buddhist heritage sites, as World Heritage. The government, in contrast to actors in Yangon's colonial-built heritage space, was keen to celebrate and preserve their Buddhist heritage.[121] State actors was resistant to have the UNESCO team engage with the Secretariat Building.[122] The Secretariat was the seat of the British colonial administration, built around the same time as the new Rangoon General Hospital. This refusal to allow UNESCO to engage with the buildings suggests an ambivalent stance from the government towards the city's colonial-built heritage. While the Secretariat was *the* symbol for colonial rule, it is also the site where Aung San, the father of the nation, was assassinated in 1947. Other buildings in Yangon's downtown had been used as government departments, until the 2005 move to Naypyidaw, but the Secretariat had been empty and inaccessible for decades, until renovations began by a private investor in the late 2010s. Many rumours were circulating as to who was renovating the Secretariat at the time; ultimately, Kentucky Fried Chicken (KFC) moved in alongside high-end offices. Other colonial buildings around Yangon were turned into luxury hotels by private investors. From my own observations, I have to agree with Girke when he points out, that much of Yangon's colonial downtown buildings were "preserved" (as in: not demolished) through neglect, rather than reverence (Girke 2021).

At YGH, a century ago the "largest and most perfectly equipped institution of the kind in the East" (The New Rangoon General Hospital 1911), its original buildings are still used, adapted, and

[121] For a detailed, and complicating, discussion on built heritage and Buddhism, at the example of Bagan, see: Rellensmann, C., *Appropriating Sacred Spaces: Heritage Politics in Myanmar*, Springer Series: Studies on Art, Heritage, Law and the Market, (forthcoming in 2023).
[122] Personal conversations with UNESCO employee at the time.

repurposed. In many ways they are better buildings for basic healthcare than newer structures on campus. I see this directly reflected in the use of the main building's wards for people under investigation (PUIs) during the first Covid-19 wave. They have taken on different meanings over time and should not be revered or shunted for their colonial history but seen for what they are in the present: workhorses, and, in my opinion, be treated as such.

Although the main and cardiac buildings are valuable for basic services such as general wards, and teaching rooms, it is crucial to thoroughly evaluate the reasons for preserving the colonial legacy. Their upkeep is expensive, spatial standards are not up to date, and they are difficult to clean. I believe, at this point, Yangon General Hospital needs the accommodation and does not have the financial means to demolish the colonial buildings and rebuild facilities with the same construction quality. New buildings constructed in recent years all have substantial construction faults, from the lack of ventilation to problematic plumbing, and lack of earthquake safety to mention just a few issues. These problems, I would agree with one of my interlocutors, a local contractor, can be attributed to the issues the country faced with regards to education and vocational training over the past decades.

Yangon General Hospital is more than its colonial heritage. It is history in the present, a history richer than the imperial debris. Buildings are diachronic, they embody a deep time, the buildings' time in the current moment; their inhabitation is also a habitation of the past.

CONCLUSION

> "*I prefer that [the main building] because when your friends ask: "Where do you work?", [I say] I'm working at the Yangon General Hospital. [They say] "I know it's the big red one!" - this is the signal; this is the signage (symbol) of the Yangon General Hospital. In Yangon everybody knows Yangon General Hospital is the big red building. That is why we prefer to*

> *work over there [in the main building]. [Even though] the nature of the work is the same, the place is not the same; the inspiration [is not the same]*
>
> *When you stay in an apartment, or you are staying in a village house, the place is not the same. Even though the responsibility and the job are the same, the environment, the inspiration is not the same".*

In these words, spoke by one of my interlocutors, it becomes clear that YGH's colonial buildings are a symbol in the city. They are the image of public healthcare in downtown. Everybody knows them. At the same time, buildings, their spatial design, and I would argue their history, have yet another function: they inspire.

It is not the hospital's colonial history that makes YGH the memorial, the symbol, it is today; it is its recent history that lends YGH its weight, certainly its physical candour, since most of the sixty-three odd buildings on campus today are not part of its original scheme. In the previous pages we saw that Yangon General hospital, in its many iterations, and with its name changes, has been an anchor and a moral backbone to its people. It is here where many conversations between students must have taken place, where protestors gathered and came to find refuge; in 1988, in 2007, and again in 2021.

It is an afternoon in August 1988, Aung San Suu Kyi is 43 years old, her birthday was the month before. A photograph shows her, the recently returned from the UK, with Khin Thida Khun, a famous actress and the author Thaw Ka (Zöllner 2018: 17). Backdrop to this scene is RGH; two nurses look on from one of the elevated ground floor windows (ibid). RGH was chosen as an auspicious location on Bogyoke Aung San Road, a main road named after her father, and the place where demonstrators would later gather after the shootings in the hospital buildings on August 10. The photograph is black and white. It is not the red façade as an attractive backdrop that made the organisers choose this location, but what the place meant to them at this point in time. Rangoon's main teaching hospital was a refuge and friendly place for people and ideas.

It was here again in 2021, following the brutal military coup, where some of the first and most outspoken voices for CDM[123] were heard.[124]

This chapter has provided the historic backdrop to the hospital as we see it today; and offering an alternative history of Rangoon/Yangon, Burma/Myanmar, Southeast Aisa, through the country's main public hospital, and the regions formerly "best equipped facility", akin to what Horwitz and Mika offer with their hospital ethnographies in South Afrika and Uganda (Horwitz 2013; Mika 2021), demonstrating the hospitals historical, political and economic entanglements. At the same time, the hospital's history demonstrates what a building is: memorial and part of the city's built-heritage, alive, and adaptive. The construction of its first buildings by the colonialists could almost be read as a historical accident; they never meant to build one of the world's best hospital facilities of its time in a secondary province of the Raj; but they did, and it was a pride for the people who worked and continue to work here. Since its inception, RGH grew. Specialties were added and buildings with them; structures were reused, and others demolished. All of them make what the hospital is today. The tea shop on campus that is called for blood transfusions keeps the memory of times-past alive, even when bullet holes have been plastered over and painted.

The hospital's materiality roots it in the past, physically and ideology, giving meaning to its memorial and symbolic character. At the same time, this materiality stands in tension with the hospital's future aspirations; the high-tech spaces needed for specialist services, as we will discover in following chapters. This friction of past and present, built in brick at the hospital, is an echo at the root of much of human cultural tensions. A building is never only a collection of materials. Materials have meaning, the bricks over teak, the malik tiles over the Marseille tiles, and, as we will see later, the metal roofs that replace tiles have consequences that are not neutral. A building is

[123] CDM = Civil Disobedience movement; with the 2021 coup many civil servants joint CDM. Most prominently railway workers and doctors. With the outbreak of a third Covid-19 wave many doctors returned to their posts in public hospitals, but most not without ethical doubts regarding their return into government service.
[124] https://www.mmtimes.com/news/medical-staff-yangon-readies-patients-during-cdm.html

built from materials and ideas, ideas of how the world should work tomorrow. In a way, architects build for a future which might or might not come, while their buildings are always part of a time by-gone.

Hospital buildings reflect economic and political conditions. At the same time, as we have seen through the chapter from sword to bullet wounds, from “pauper” to tropical disease wards, a hospital always also reflects the conditions of the time and geography in its patient’s' bodies. While the hospital is an investment, we see through its history that we would do better understanding hospitals as insurances (Wuttke 2020). They provide care and relief in times of crises, individual and collective, during so -called natural catastrophes and pandemics; at times when the hospital is the most vulnerable itself and in need of robust (infra)structures.

This chapter activated the hospital’s history against the backdrop of changing national times, illustrating its symbolic and memorial character, the meaning of its buildings, offering a vertical/diachronic engagement with the hospital. In the next chapter, I will follow the hospital’s daily life horizontally into Yangon and around campus, understanding it’s entanglement with the city that is its home. As we will see, the history and its grip on the hospital is never far below the surface.

CHAPTER 5: BEYOND CAMPUS WALLS

"I DIG A HOLE WHEN I NEED TO POOP"

"I dig a hole when I need to poop" (ချီးယိုချင်မှ ချီးပြတင်းပေါက်ရှာတယ်), slightly embarrassed, Kaung

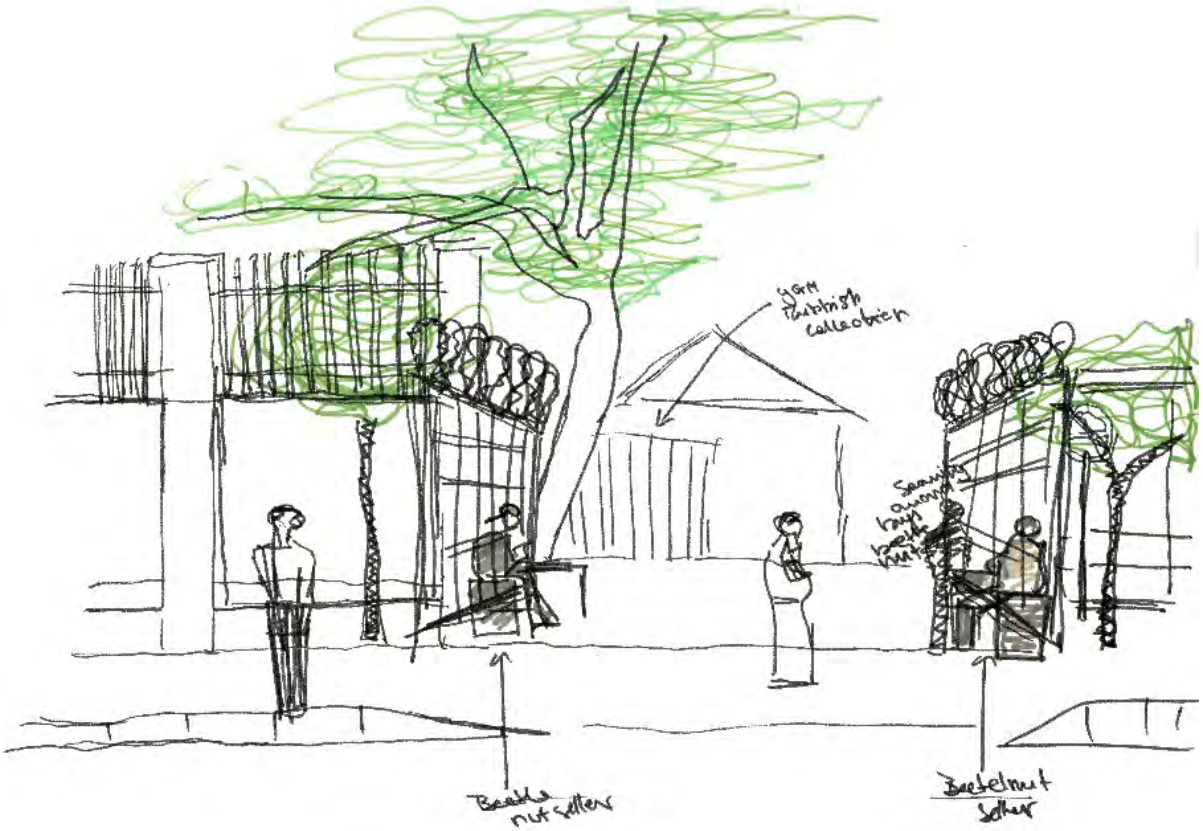
Htin, my translator, explains this crude Burmese proverb to mean: "I will fix it when it breaks", or "I do it when it cannot be avoided anymore". The proverb came up as we discuss the effects of decades of military rule on the hospital's infrastructure. We just had coffee and pastries in the cool air of Junction City Mall, separated from the humidity outside by automatic doors and security guards checking bags and body temperature, a new access regime since Covid-19 spreads in the city and across the world. Walking over to YGH for an interview with one of the engineers, Kaung Htin speaks of the absence of any kind of reliability. Decades of military violence has hung a question mark onto the concept of future; a question mark that reaches beyond buildings and infrastructures into people's daily decision making. Currency was devalued overnight; arbitrary arrests were frequent, alongside erratic policy changes; the government moved from one day to another to Naypyidaw; economic hardship for a mostly rural population with little hope for the future; weak, and deliberately weakened, public health and education systems (Dunlayaphāk Prīchārat 2009; Fink 2009; Oehlers 2005; Skidmore 2004; Thant Myint-U 2020). In Kaung Htin's paraphrased words: in the face of a rogue government people developed habits that became so engrained, they manifested in their bodies and minds. What my translator speaks of here is a deeply rooted habitus; a "presence of the past in the present" (Bourdieu 2000b: 210).

The hospital's boundaries are porous, ways of doing things, goods, and services travel across its confines.

Several gates open the campus to all cardinal directions. Each one of them has a distinct atmosphere, twinned with the atmospheres across campus described in Chapter 3. The "Cardiac Gate" near the A&E is the busiest and most industrious one. The gates on busy Bogyoke Aung San

Road, to both campuses, main and neuro campus, are dominated by traffic and taxi drivers, while the ones to the south on Anawrahta (of which one is closed due to construction of the godforsaken 12-storey, now 7-storey building that crushed the hospital's main sewage pipe) are utilitarian; cars go in and out, one or two betel and cigarette sellers, not much humdrum.

The gates to the East have distinct functions: One is the gate where bodies leave the campus for the last time after release from the morgue, the other, beside the blood bank, is mostly used by people who are familiar with the hospital and those who live on campus. During the months of my fieldwork, an elderly security guard picks up dead leaves with a litter picker, while leaving the rubbish where it is. I learn that security is a retiree's game; when retired, many elderly men become security guards.



INTRODUCTION

In this chapter I discuss notions of partnerships and circulation; formalised as well as agreement-based economic links, circulation of goods and services across campus, between different actors, and spillage beyond the campus' walls. Hospital life overflows into the city in multiple ways, and *vice versa*. In this chapter I tell tales of "lack" and "need", where absence of (adequate) infrastructures become business opportunities. We will see informality, porosity, liminality, flows, and peripheral goings on of all sorts, as opposed to the more "official" uses of the hospital as seen in Chapter 3 when we discovered the "Campus".

At the same time, I sketch the daily life of ordinary people in Myanmar. Everyone we encounter in this chapter is a potential patient of the hospital, fleshing out not only who the different actors on and around campus are, but also the background and social context of patients, doctors, and nurses.

The opening vignette illustrates through a popular proverb the long shadow of decades of military dictatorship. For more texture, Christina Fink (2009) turns her attention to the penetration of military rule into households, communities, prisons, schools, barracks, and religious centres. Fink gives a solid idea of the habitus, its extent and deep rootedness, that people live with today. Monique Skidmore's *Karaoke Fascism* (2004) delves into the backdrop of fear and mistrust people operate within. I add to this with an ethnography of a seemingly different time, but a time in which Fink's and Skidmore's observations still have resonance.

Against this shadow, daily life in Myanmar is lived ferociously over long lunches, extended naps, and long conversations that favour human connection over meeting schedules *versus* imposed, and often opposed, structures. I am thinking here specifically of the many altercations I had with a colleague over missed and late meetings; in response to my questions why he was late, he would often accusingly tell me that after all it was me who had asked him to drop off the plans or a letter. How could he leave without having a conversation, enquiring about a senior's family and children? Impossible to be impolite and cut the conversation short! Many meetings come to mind in which I

witnessed futile discussions of unsafe structures or fire exits, never being able to address them in the meeting for the sake of harmony; harmony and respect for one's seniors is the honoured currency. Issues are addressed in the background, quietly, in private, and often over tea.

Relationships are important in a world where "everyday economic survival", to borrow Ardeth Maung Thawnghmung's recent book title, is a reality for most ordinary Myanmar people. Many live with or amongst severe economic hardship and uncertainty. Thawnghmung's *Everyday Economic Survival* (2019) maps in ethnographic detail what she calls "coping strategies" of ordinary citizens surviving day to day within an unpredictable system. They accommodate the state, passively resist it, sometimes using their voice, and/or as a last resort exiting the country all together (Thawnghmung 2019). At YGH, accommodation can be found in the way "quick fixes" are employed to adjust to the sluggish system, which we will encounter in more detail later in the chapter; passive resistance is reflected, for example, in this chapter in vendors' tactics to make ends meet, and offer services and goods the hospital does not provide, turning a "lack" into a business opportunity; voice is used by some doctors and nurses in their political leanings, especially their participation in CDM following the brutal 2021 military coup, and reflected in RGH having been the start and end of point of choice for protests in 1988 (Zöllner 2018); lastly, exiting the country is a strategy YGH suffers from severely. Healthcare Brain Drain[125] exacerbates issues the sector endures already. Following decades of weak educational policies, years of closed universities due to pollical unrest, something we see yet again in 2021, and few opportunities, a restriction on manpower demand for the highly educated was the result (Tharaphi Than 2014: 12ff). This conflated with poor healthcare infrastructure means that many clinical professionals prefer to "exit" the public hospital. They work in private healthcare or leave the country all together for regional hubs such as Singapore where hospitals provide a less challenged infrastructure, affording a better working environment. As one doctor said to me when I worked on the masterplan: at least give us running water and chairs to do our work. The running

[125] See 2016 *Frontier* article "The Great Medical Brain Drain" (May Thandar Win 2016).

water and chairs are euphemism for basic infrastructure; it is not only running water and chairs that are challenging.

For further context to the healthcare system, and recent reforms, I refer to Coderey's detailed summary in her chapter on Health in the *Routledge Handbook of Contemporary Myanmar* (Coderey 2017) where she describes the legacy of the neglect by the military government that I discussed in the previous chapter. Most important to remember is that the healthcare system was chronically underfunded; an issue that YGH's infrastructure is catching-up with today. At the same time, healthcare was used by the military government to coerce its population into submission. Despite reforms and visible improvements, mistrust in the public health system (and the state in general), alongside struggle for economic survival for most, remains unchanged (Coderey 2017: 286f.).

This is the backdrop against the following pages should be read, at the start of which we meet "The Laundry Lady". With her we see items of clothing travel in and out of the hospital and get a glimpse of formal and informal activities around campus, before I turn to a brief discussion of "nalehmu", a notion of "Understandings" as it pertains to the campus. Under "The Golden Tree", "lack" as opportunity comes to life when we look at the goods on offer by vendors. In the section on "Monastery/Radio Therapy" we return to Aunty Aung and her sister; now on campus. In "Systems and People", the two meet for us to gain a better understanding of the hospital's contingency on the city, while in "Forensics" we see entanglements of YGH with the police, courts, and the wider research environment, before we turn our attention briefly to the hospital as knowledge hub in a section on "Public Health". In the conclusion all themes will come together over the hospital multiple.

THE LAUNDRY LADY

It is July, rain falls on the city daily. Kaung Htin, my translator, and I find the laundry lady after a morning of interviews. It will rain later; the air is humid, and our skin feels muggy.

As we approach, she is spreading laundry on the concrete slabs by the southern car park to dry in the sun. Back in March and April the area was a construction site when new high-density polyethylene (HDPE) pipes were installed from behind the Daw Pu Ward across the car parking areas' northern edge. Now the gaping wound is closed again, and the old concrete slabs cover unevenly the drainage.

The laundry lady notices us and smiles, greeting friendly, busying herself with finishing the task at hand. Still today, I wonder if the lack of laundry lines for patients' use has purely to do with the lack of available space or might also be intentional; many Burmese believe that men walking under a htamein (full length skirt worn by women, also called longji) will lose their influence and power, hence clothes, especially women's clothes, are dried lying on the ground in the sun.[126] The answer is probably a mixture of both.

Kaung Htin and I sit on the stairs leading up to the locked doors of the single-storey transformer building with its pitched roof waiting for the laundry lady to join us. The electrical equipment, alongside the generator nearby, have been placed above ground level to protect it from flooding; their stairs and ramps built for flood protection serve as welcome urban furniture for waiting attendants and others alike.

The laundry lady finishes spreading the wet clothes on the floor in front of us and joins Kaung Htin and me in the shade under the concrete structure of the elevated walkway. The walkway connects the 2015 completed, but

[126] Because of the belief that htameins hung above men's heads robs them of their power, during the "Spring Revolution" following the coup on February 1st, 2021, a movement called the "Htamein Revolution" started in which women hung their longjis across the street. Soldiers were seen to climb up and remove the fabrics before moving on, to not have to walk below a woman's skirt.

already ailing, reinforced concrete (RC) structure of the 5-storey Modular Operating Theatre Complex (MOT) to the 2-storey "Daw Pu" ward. The "Daw Pu Ward" accommodates the Medical Unit 1 of which the Tropical Medicine and Infectious Disease Departments are part, and the Gastrointestinal Department, the buildings original occupant.

The laundry lady is one of the first people that exchanged smiles and nods with me when I started my fieldwork. She was always around, until Covid-19 banned her from campus, which making her life infinitely more difficult. Her strong presence and friendly smile combined with her obvious familiarity with the people and spaces on campus conveyed a confident openness. I would often see her at the centre of a group in friendly banter. On days I hurried past without greetings, I would later have to explain myself.

She has been doing the laundry of hospital inpatients, for a fee, for eighteen years.[127] Offering her services to patients and their attendants, she takes their dirty laundry home to wash in her washing machine, which I suspect she owns for the purpose of this business; washing machines are not a standard white good in Myanmar households. From acquaintances I heard about similar services being offered in other public hospitals. One recounts her story of giving birth at Yangon Central Women Hospital where she asked for a longji to be washed and never saw the garment again. These informal arrangements are common across public hospitals and vital for many patients and their bedside carers.

The laundry lady has not always washed patients' clothes. Her career at YGH started as a clerk in the cancer outpatient department. In her job, she observed how patients would pay 3000MMK to get ahead of the line; some not being able to join the line at all if they could not pay. Today, the signs around waiting areas at YGH tell a tale of this in their warning that such behaviour is forbidden. Interlocutors also mentioned approvingly that such arrangements have been outlawed; but when

[127] Interview was done in 2020, this means she has been doing laundry since 2002; the following incident with bribes and jumping the line was around 2002. This was the time of the SPDC.

the laundry lady reported her observations to a technician about 20 years ago, she was "berated in front of everybody", causing her to leave her employment. This was in 2002. By quitting her job, she not only forwent a stable income but lost her right to staff housing in Dala. I suspect this heroic tale has other motivations as well, such as freedom to work when it suits and possibly a higher income. Salaries for unskilled government workers is very low; today around 1.4 lakh which is 140.000MMK, plus housing and other benefits such as rice and cooking oil for Thingyan.

The laundry lady moved to Mingaladong, near the highway bus station, and is taking care of her elderly mother. Since then, she has been doing laundry for patients at her home, in her washing machine, travelling to YGH by bus with the laundry bundled under her arm, a journey that must have become increasingly time consuming over the years, as traffic in Yangon increased.[128]

She likes to reminisce about the changes she witnessed at YGH over the two decades she has been working here: "YGH used to be a happy place". Like many others, she speaks fondly of the old canteen which was demolished in favour of the new operating complex constructed in 2014; even though the canteen had been closed since the mid1990s. Other than that, she keeps the source of the happiness vague but speaks how unhappy she is with YGH's administration today. She discusses how the superintendents clamp-down on the campus' informal economy, which inevitable includes her. One particular thorn in her side is a female superintendent whom she perceives as especially unpleasant. I am told from all sides: everybody knows that services like hers are necessary. The laundry lady feels, the administration needs to be seen to enforce order. So, everybody plays along in the back and forth of berating, warnings, and unperturbed industriousness.

[128] In 2015 when I moved to Yangon one could make the journey from Aung Mingala Highway Bus Terminal to downtown Yangon (where YGH is located) in an hour, even 45min. In 2020, I would calculate at least 1.5h, better 2h, for the same journey during the day; at night, the traffic is still light and once can make it in 1h.

UNDERSTANDINGS

From around 2016, I started to note more concerted efforts to rid the hospital of its informal economy. Formal market areas were established, one on the main campus and one on the extension site, while vendors lingering by the gates are regularly removed, mostly when they are obstructing access. Until most vendors disappeared with the onset of the first wave of the Covid-19 pandemic.

Until then, some doctors from the administration team would come with workers from the cleaning department and confiscate, for example, portable betel nut stalls and other paraphernalia. I never saw any police involved.

The notion of YGH as a "happy" or "good" place varies with the narrator. I suspect, the laundry lady's perceived former happiness was tied to a level of anarchy around campus which allowed individuals certain freedoms of enterprise. Ko Hlat Myint, a worker who grew up on campus and whose grandfather already worked at the hospital, later in the afternoon, after our conversation with the laundry lady, tells stories of unruly vendors, ones that spend the night in their stalls, not going home, treating the campus like home. He tells of aggressive vendors who threaten administrators with boiling water, or strip naked and claim they were sexually assaulted, when asked to leave. He clearly has a less romanticised vision of the economic activities on campus.

In this dance between service providers (formal or informal) and hospital administration and patients (the receivers of services) I see "nalehmu"; "an understanding"[129] between parties that Jayde Lin Roberts and Elizabeth Lugbill Rhoads call Myanmar's "hidden-

[129] နားလည်မှု (nalehmu) is translate into English "understanding" (noun).

in-plain-sight social infrastructure" (2022). "Nalehmu" is an ambiguous concept of mutual "understanding", often used colloquially, which can include monetary exchanges as well as other "understandings", for example favours returned in other than financial ways. Roberts and Rhoads put "nalehmu" forward as an alternative to thinking with bribes. They defined "nalehmu" as a system of understanding, in which goods, favours, services, and empathy circulate (Roberts & Rhoads 2022).

Administrators' efforts to "clean-up" the campus are almost performative at times; everybody understands what needs these informal services meet which cannot be provided by the public hospital. At the same time, administrators work hard on finding non-performative long-term solutions; for example, the establishment of dedicated market areas on campus or public toilets rented and run as small (often family) businesses. It is a constant rehearsal, trial, and error to see what works.

For the laundry lady, business has gone down. YGH is a public place where increasingly more people come offering laundry services to patients, but she is keen to point out that she is the only one who has been doing laundry for patients for as long as she has. When asked, she says there are no informal arrangements around who can come and offer services or sell things. Additionally, with the pandemic patient numbers declined and her business with them. While Covid-19 is hardest on people already struggling, day labourers have difficulty making ends meet which means more people offer their services (such as for example laundry) to patients, while at the same time patients spend less on such services.

Flying vendors walking around campus are mostly women and children. With little translucent snacks filled plastic bags, hung from hooks held together by a metal pipe, they trawl the densest areas on campus. In places where outpatients and their company wait for consultations or treatments, they sell little plastic bags of seasonal fruits, boiled chicken or quail eggs, and nuts; a small bag of steamed peanuts goes for 500MMK. Others sell cold water in PET[130] bottles, carried in plastic bags or baskets, and handed over with a plastic straw.

Some vendors, wander the wards offering their products to bedfast patients and their carers; rattan fans get the air moving in stale wards where ceiling fans are not rotating, backscratchers for relieving itches in casts and other hard to reach body parts, plastic bowls, combs, and other colourful, cheaply made, synthetic polymer paraphernalia are sold.

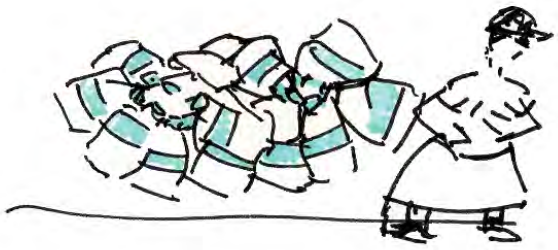
Newspaper vendors sell their paper for 300MMK to 800MMK, rubbish collectors pick up waste for 500MMK a bag.[131]

Water bottles are big business. One interlocutor tells through betel nut-stained teeth about his "business model" collecting big 5 litre PET bottles. He is resting in the shade when my translator and I approach him. He reiterates multiple times that he does not resell the bottles to anybody who uses

[130] Polyethylene terephthalate; a recyclable plastic.
[131] I suspect YGH's cleaning department pays this, but I am not 100% sure; it has never been confirmed. Not because it is a secret but because it did not seem important or too obvious to tell me.

them for drinking water; a sure sign that business with re-used bottles and unsafe water is rife, which he confirms. His buyers, however, he emphasises again, use the bottles for motor oils and other liquids. Per bottle he makes about 50MMK. Collecting bottles from people around campus, he pays them 50MMK per bottle, which he washes overnight and resells for 100MMK.

Throughout my time on campus, I often come across collectors of small (1L or 500mml) discarded PET bottles on the ground, in surface water drains, and from bins. Some wards initiated to collect plastic bottles separately. One aspect is that bottles take up a lot of space in bins, which means bins need to be emptied more frequently, another is that the PET bottles are sellable; the recycling business is



striving in Yangon. Throughout the day shouts of people collecting plastic bottles or paper are the city's soundscape.

With the onset of the pandemic, at the end of March, vendors around campus disappear. Only delivery drivers remain. The folx working for Food Panda, Yangon Door-to-Door, Grab, and the other countless companies that sprung up in the last couple of years, bring iced milk tea and other treats to staff who consume them in airconditioned offices.

While delivery services kept cycling through the pandemic, the laundry lady was not able to come to campus for three months. From the time of the Thingyan-lockdown [132] in April until the beginning of July, she could not leave her township. When Covid-19 took hold of Yangon, the ward officer of the township she lives in made her sign a statement that she would not travel to YGH. Her landlord was instructed to report her, should she defy the order. Knowing that she works at YGH, the township officials were scared that she might bring the virus into the neighbourhood. In contrast, in downtown Yangon, my neighbours knew where I was going every day; nobody stopped me.

The performative nature of some of the administrators' clean-up efforts suggests to me that everyone is aware of the reciprocal relationship between the hospital and the providers of goods and services. Hospital administration dedicates specific areas for conducting business. The lack of a hospital kitchen turns into businesses, in the shape of stalls selling snacks and meals suitable for low-fat, or low-sugar, or low-spice diets; boredom and waiting in an overloaded healthcare system translates into snacks and newspaper consumption (even though I saw more people sitting on newspapers than actually reading them); power cuts, energy saving attempts, or no air-

[132] 10.04 – 19.04.2020

conditioning on some wards, spike the sale of rattan fans; while collection and recycling of plastic bottles and rubbish is linked to the functioning of the sewage system where plastic bottles and other litter get discarded or flushed into, blocking and breaking sewage pumps. The hospital, its inhabitants as well as its buildings, wires, and sewage channels, need the vendors, their circulation of goods and services.

THE GOLDEN TREE

An old Banyan, its trunk with thick arial roots, gilded gold, and ordained with icons, guards the hospital's West-gate, which to my mind is the Cardiac Gate (given its proximity to the Cardiac Building). The A&E entrance is only a few steps north from here. Ambulances with and without sirens come and go.

When I attempt to sit on the tree's knee-high concrete encasement, I am given a blue little plastic stool, commonly used around town for pop-up tea and food stalls, by one of the vendors. I am not

sure if the seat is to protect me from the tree or the tree from me.

Under the old Banyan's branches, it is always the same group going about their business. A rotund lady in a low plastic chair placed by the trunk is the keeper of the money. Young men sell cold drinks

to passers-by, hospital visitors, and the occasional doctor from styrofoam boxes, filled with ice, a few feet away by the gate, shutting back and forth with change. A young woman is cutting fruit beside me, a melon, and green mangoes. Working fast, she carefully places all discards into a rattan basket for the rubbish collectors at the end of the day.

I come here to observe the interface between city and hospital. The atmosphere is busy and business like. The group under the golden tree is a constant while other vendors rotate with the sun, leaving when their goods sell out. The smell of cooked rice is in the air at lunchtime. Different foods are on offer for breakfast, lunch, tea, and dinner. Boiled eggs can always be found. Busses thunder past and sirens keep going off. Birds sit on electrical wires, observing the spectacle below, sharp eyes looking for morsels to pick, while the occasional rat sticks its head out of the gutter.

The smell from incense sticks is in the air, stuck into juicy watermelon pieces to keep flies at bay. The incense mixes with traffic fumes and becomes hardly detectable. Plastic bags hang on the golden tree's trunk, their purpose unknown to me.

Attendants are identifiable by the ID cards hung around their necks; official permission to enter the wards outside of visiting hours. Some of them seem slightly disoriented; bustling Yangon is an unfamiliar terrain.

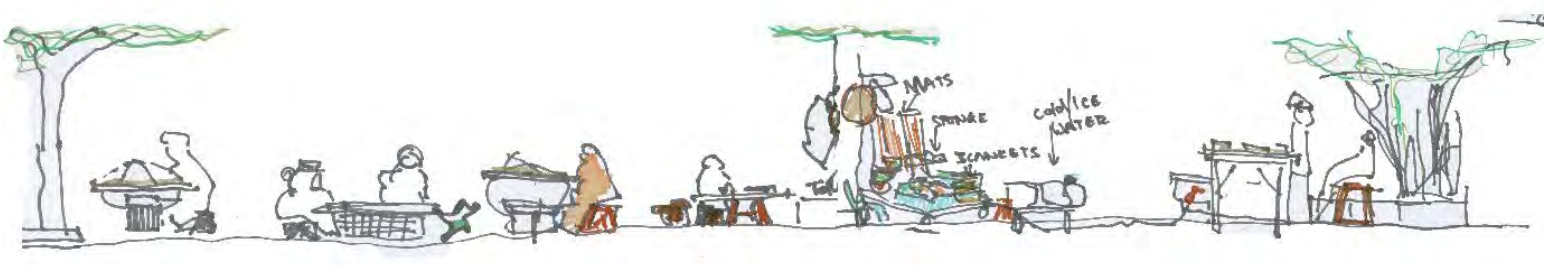
Haberdashery sellers come with carts offering colourful wares. Anything one might require to be comfortable in a public hospital, which has no budget for sheets

and pillows, is on sale; things one might need when arriving at the A&E in a haste, under observation until the next day, and a ward transfer.

Carers of wheelchair users struggle over the varying heights of curbs and ditches; pavements high enough to deter flooding when relentless rain bedevils the city from as early as May in some years to September/October. Yangon is not made for wheelchairs.

One morning a commotion breaks out when administrators from the hospital tell the cold-drinks boys to move their cart as it is placed inside the gate's depth, obstructing taxis, private cars, steel-fighter trucks,[133] and ambulances.

A little down Lanmadaw road, before the junction with Anawrahta road, a shop is purged into the side of a public toilet. Here, anything can be bought from toothpaste, to clothes, laundry powder, adult nappies and bed protectors, to urine bottles and bedpans. The plethora of paraphernalia for bodily waste tells the tale of the hospital's toilets: wards are often overcapacity, accessibility is an issue, and possibly not enough in the right locations, centralised toilet blocks for large wards make it hard for some to get there, alongside issues with cleanliness, so much so that sometimes family members help with the cleaning.



[133] Steel Fighter truck = Mostly a Daihatsu Hijet truck with a steel construction on its loading bed, sporting foldable benches on each side and a soft roof, for transporting people and goods.

The goods on offer indicate patients' needs and reflect the hospital facilities. The wares can be read like a ledger of lack and infrastructure inadequacies the hospital is facing; and as an ethnography of the hospital's daily life.

MONASTERY / RADIOTHERAPY

Before the pandemic, I took a bus every other day from Hledan where my language school was, back downtown to my fieldsite, the hospital. On the bus outside of rush hours, around 9.30am, I usually find a seat. As I revise my vocabulary cards, my fellow passengers just sit and look out the window, from time to time a silent prayer passes their lips with hands to the forehead, as we pass a pagoda, most prominently Shwedagon Paya, on the hour-long journey. Few people are on phones, usually only the younger generations play on mobiles. Nobody reads a book or newspaper, a hangover from the education policy of the previous government.

The bus drops me off opposite the Golden Tree, by one of the beautifully ornamented brick and teak monk dwellings of the Thayettaw monastery complex, west of the hospital campus, where I met Aunty Aung for the first time as I was drawing. Thayettaw has its own history, intrinsically interwoven with Yangon's city development and the hospital's daily life. As we saw in the opening vignette, Aunty Aung had come with her sister to Yangon for radiotherapy treatment at YGH.

Outpatients who come for ambulant treatment of any kind often stay at monasteries close to the hospital campus for the duration of their treatment. Some, like Aunty Aung's sister, stay for up to three weeks, only going home for weekends when treatment is paused. "Nalehmu", the country's social infrastructure, is at play here; monks weave urban-rural ties. Patients and attendants will find a monk from their village based at a monastery in Yangon to stay, for free or a small donation. In lieu of such ties, I have been told, nuns across the road from the hospital's northern gates also allow patient's family members to stay. These arrangements were severed with the onset of Covid-19. Hostels had to close, and monasteries and households were not allowed to host guests.

Most patients I met at the monastery had cancer. Throughout the day they wait patiently for their radiation therapy treatment between the backs of buildings: the main building, the Modular Operating Theatre Complex (MOT), by the entrance to the waiting and treatment rooms of the Radiotherapy Department. A smell of sewage lingers; in the rainy season, sewage spilled over into the surface water channels.

External metal stairs for fire exits of the MOT come down here. They are emergency exits as well as the surgical wards' ultimate exit, part of the infrastructure of death. Prince describes hospital spaces in a Kenyan hospital through the experience of death that is highly visible and audible, with wailing from family members of the deceased and the sound of trolleys carrying bodies to and from the mortuary (2018: 448f); death experienced spatially. At YGH, death is handled discreetly, with separate pathways and the mortuary set apart from other clinical areas. An infra-structure of death emerges.

Most buildings have a special exit for lifeless bodies. Here only hand drawn hearses are allowed; the little electric carts used around campus have no way of manoeuvring here.

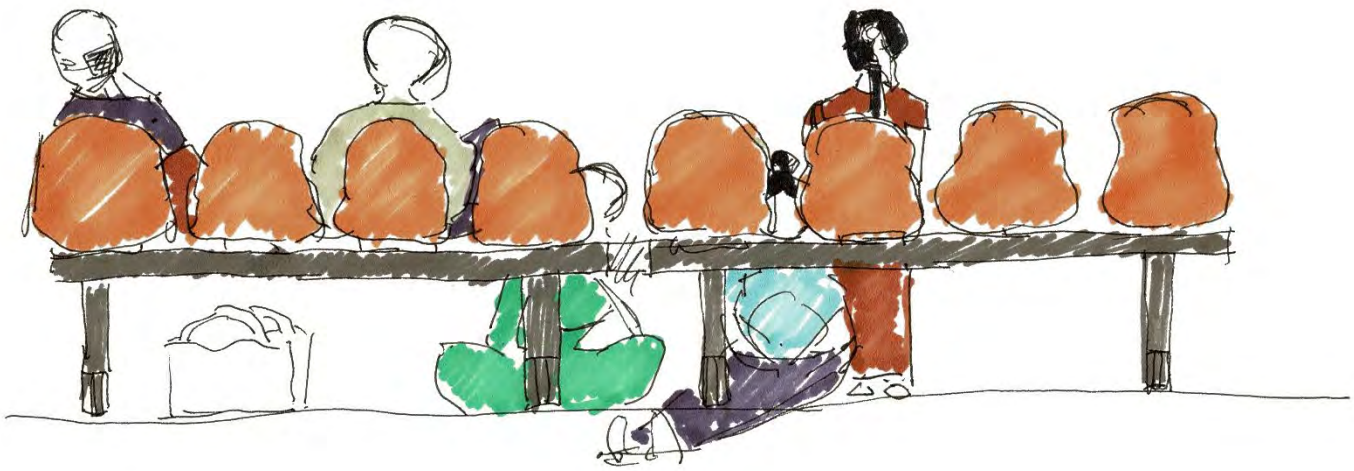
A 24h coffee cart materialised here sometime after the worst of the first Covid-19 wave, in late July 2020. Selling plastic wrapped processed cakes and *Premium* coffee in disposable cups. A rubbish-ring arrived with the cart, the radius congruent with the time it takes to walk and drink the black brew.

Bright orange bench-chairs frame the walkway, but most patients sit on plastic mats on the floor, off the tiled track on which clinical staff and visitors shuttle back and forth, preferring to sit cross legged or lying down. Bald women make themselves as comfortable as possible in small groups, sharing snacks and affections, chatting with acquaintances made over the shared experience of having cancer; getting treatment; leaving family behind in a village; coming to Yangon; coming to the unfamiliar environment of a hospital. Some came alone, others are accompanied by a family member, a sister, a son or a daughter, someone who might be familiar with the hospital and its processes. Most come daily for three weeks consecutively to get treatment. A camaraderie is palpable.

Men tend to sit alone, some with a wife or a brother for company. Many with tracheostomies. Most hold colourful plastic bowls, in primary reds or blues, lined with plastic bags to spit or throw-up into.

The atmosphere around cancer care is calm and routinised. Here, patients, attendants, doctors and nurses have "space to understand each other" as one of my interlocutors will call it in the next chapter (Chapter 6); time and places to meet, appreciate what it means to be at a hospital, what it means to be a patient. From before dawn until late in the afternoon, the technicians call out patients' names. The treatment is a fraction of the time spent waiting, often not more than ten minutes; some patients wait for hours, others by choice keep the waiting company. The hospital is a theatre of waiting, a study in the aesthetics of bodies suspended in time and space; sitting, lying

down, standing, pacing, dealing with pain, anxiety, boredom, repurposing benches to tables, to beds, to sunshades, and thinking about the cancer in their bodies, life after treatment, after the hospital.



SYSTEMS AND PEOPLE

Electricity

A woman is wearing a beige t-shirt with lace at the bottom. Throwing a plastic bottle in the bin, she proceeds to cleaning dishes, wiping them with her hands, framed by the large opening where the steel sink outside the ward's patients' toilets is located for this purpose. The air's temperature is around 30C but the open corridor that connects the ward-block to the bathrooms is breezy. Blue PVC pipes leak at her plastic flip-flop wearing feet. The sinks overlook the lawn in front of the main building. She shakes water off the stainless-steel blows with quick, forceful, movements. Wiping her hands on her black longji, decorated with a tiny pattern of household items and moons, she returns to her patient's bedside; the patient might be her mother or an aunt, or a friend from her village who has no close female family. She is one of the many attendants. Behind her, as she leaves the bathroom area, laundry dries draped on airers made from blue water pipes, gently moving in the breeze by the open bathroom window. Inside one of the cubicles flatus is expelled loudly.

Patients' bathrooms with toilets are located in the northern towers of the east and west wing, and the southeast tower of the south wing of the main building; fifteen bathrooms on ground to second floor, plus two for Medical Unit 4 in the basement. There are more hidden toilets for staff and in doctors' offices. A ward of 25 to 30, at times up to 45, patients use one bathroom. Each bathroom has four squatting toilets, two sitting toilets, one shower, and one sitting toilet with shower, all in individual cubicles.[134] Overall, YGH has adequate numbers of toilets, but their location is often inconvenient. For most bed spaces in the main building the centralised bathroom facilities are far away and difficult to reach; a business opportunity for the vendors selling bedpans and urine bottles around campus.

YGH's bathrooms are sanitary facilities, kitchen sinks, and laundries; a meeting of bodily functions and of infrastructures. Key systems converge here: fresh water, grey water, black water. And none of them function without electricity; all of it is contingent on power(s) beyond the campus' walls.

Fresh water comes from eleven tube wells[135] around campus and is stored in three ground

[134] This is 7 toilets for up to 45 patients, which means up to 7 patients per toilet. NHS England's "Health Building Note 04-01 – Adult in-patient facilities" suggest in their example schedule one toilet per 4-bed multipurpose space. (https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_04-01_Final.pdf; page 24) For the masterplan the healthcare space planner scheduled one toilet per 8-bed multipurpose space.
[135] Water supply from the city is unreliable with highly variable pressure. The hospital relies on their tube wells. (see Appendix D "Utility Assessment" in *Masterplan for YGH Campus*, 2017)

tanks, before it is pumped to roof tanks for taps that are powered by gravity. The pumps do not work without electricity. When power cuts, overhead tanks are not refilled, leaving hands unwashed and toilets unflushed.

Currently, YGH discards its sewage untreated into the YCDC[136] system which is discharged into Yangon River.[137] In 2015/2016 a new building appeared on campus. As it grew it settled and crushed the main sewage pipe connecting to the city; more pumps and pipes were introduced to circumvent the building and the destroyed connection. Sewage pumps, like the water pumps need power. None of this works without electricity.

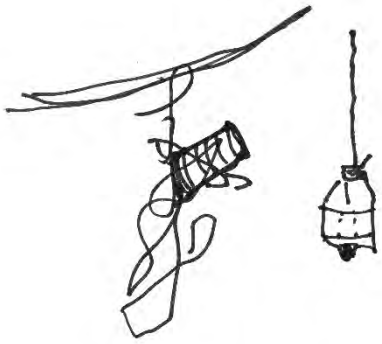
While sewage pumps need electricity, they are also fragile. When plastic bottles or other rubbish clog the system; someone inhabitants of the campus discard bottles or the like in toilets or use an open utility access hole as a bin, some are unfamiliar with flushing-toilets, others just do not care while worrying about a loved-one receiving treatment. Waste management is a word I despise. It hides so much complexity behind a technically technical problem, the "management of waste". However, it is also the first line of defence against problems the hospital has with its sewage system.

Nonetheless, however much waste is managed, and water stored in overhead tanks, none of this works without electricity. When power cuts, taps sooner or later run dry, toilets don't flush, sewage backs-up, lifts rest suspended between floors, the lights go out; until the hospitals eleven generators kick-in.

The electricity department is hence also responsible for water and sewage because the latter do not work without the former. Under their responsibility are all lift operators, workers at the pump houses and ground tanks, as well as the MOT's laundry, a place where water and electricity meet.

[136] Yangon City Development Committee; the is the administrative body of Yangon.
[137] The hospital plans to introduce sewage treatment.

The campus' electricity, water, and sewage infrastructures are intimately entwined with the city's systems. That the hospital functions is contingent on Yangon's grid; an infrastructure in dire need of upgrade and helplessly overloaded (Roberts 2017: 70). But where systems meet, people meet. Where pipes connect, people connect. It all depends on networks and relationships. Like for every individual living in Yangon, we create our networks to buffer the poor infrastructure. When the electricity goes, I have my loaded power bank ready, a fan at hand, and candles in the drawers. At YGH, the responsible engineer picks up the phone and calls the local substation to obtain an update on how long the power will be out. In the meantime, surgery teams try to phone him for an update.



"Doing it the Burmese Way."

When speaking with the understaffed teams tasked with keeping the hospital on the grid, I learn about "Doing it the Burmese Way". This typically refers to the ability to think on one's feet and finding a solution on the face of adversary. The "solution" is usually a "quick fix" and "finding a way". This can be anything from improvising materials or tools, usually quite ingenious solutions: A "lampshade" or cable protector made from used plastic bottles; drums of water as taps; blue PVC pipes assembled to be drying racks or, in combination with plastic sheeting, partitions for infection control. Usually, these quick fixes are not sustainable and are not only "quick" in their implementation but also lifetime. A fixed roof is not a new roof.

At the same time, budget rounds rarely align with urgencies. In such cases "finding a way" might be "borrowing" the money from the company that does the work or supplies the materials and

reimbursing them with the government money once it comes through (often less than what was actually spent, the discrepancy might translate into a "donation" to the hospital).

On the other hand, YGH also has, what Grant would call, orphaned technologies (Grant 2018). For example, a freshwater system, on campus referred to as the "Netherlands system" was left behind with replacement parts unavailable in Yangon. Here, the hospital engineers have become caring foster parents for the infrastructure. However, the team also learned from this experience and others alike; today YGH considers donations carefully, weary of well-meaning but unintended consequences. In Yangon, as in Phnom Phen as discussed by Grant (ibid), donors and aid agencies are out to make friends or partners, ending up with leaving orphans behind.

People working in the maintenance departments know how to "fix quick", they know what resources, materially, financially, and politically, are available. They know the local context. For the hospital to work, and to work sustainably, they need more money and more people. For now, they do it the "Burmese Way".

FORENSICS

While the YGH is contingent on Yangon and its systems, it goes both ways; the relationship between a hospital and its city is reciprocal and interdependent.

In January 2020 I move from China Town to Pabedan, south of the Sri Kaali Amman Tamil Temple. My daily walk to the hospital takes me out the door, down five flights of stairs, past Mr A who may or may not guard my apartment building, up the typical Yangon downtown street planned on the infamous colonial grid, onto the main road. At the corner of the main road, vendors switch with the sun: in the morning ladies sell breakfast snacks, then shoes move in, before DVD's take over in the afternoon. Along the main road I pass two market streets and one of Yangon's biggest markets in downtown. I walk diagonally across a big junction via an overpass, constructed after the 1988

uprising, past public toilets, before turning left into the campus of Yangon General Hospital at the mortuary-gate where bodies leave YGH for the last time.

I greet the cigarette and betel vendor that is always here, come rain or shine. I pass a group of sombre youths, or elderly men, some women wait in the shade just inside the gate. They have a multitude of colourful bags, in different shapes and sizes; the paraphernalia needed for a hospital stay, packed away in bags. They are probably waiting for the patient that was not fortunate to leave the hospital through one of the other gates. Vendors rest in the shadow alongside.

A proud Banyan stands at the end of the driveway where a yard opens between the old mortuary and the open funeral hall, its branches affording shade to the sad and waiting; waiting for death certificates of loved ones and the release of the body; waiting for customers, death is a good business I am told. The dead need much care, a cask, a hearse, music, and flowers. Many profiteer from the death of one.

Crooked and curiously high stone benches surround the Banyan's trunk; mostly men are waiting here, sitting on the benches in anticipation of something to happen. Women tend to squat on curbs nearby.

The Banyan has seen many dead bodies and been witness to many stories; some of which I have been told and do not feel inclined to repeat.

The morgue has its own gate, its own tree, and its own atmosphere. It stood here when the Forensic Department was built a century ago; a brick structure consisting of a single-storey morgue, shelves along its walls for bodies,

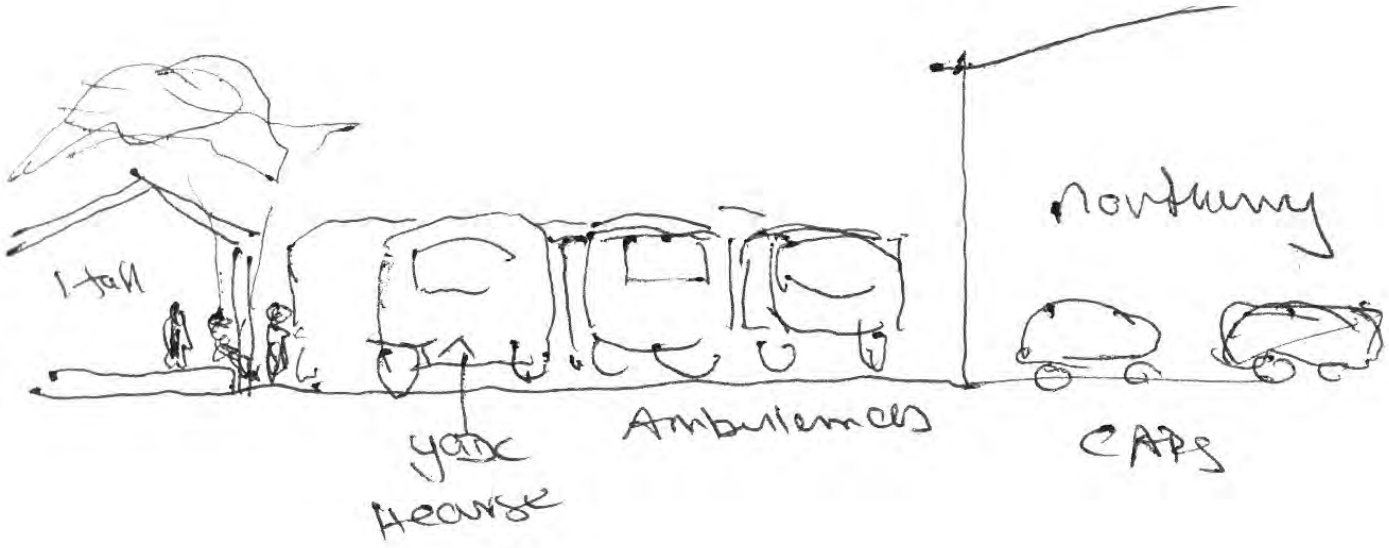
with preparation rooms, and a two-storey office and lecture theatre building, the two connected by a canopy.

Until mid-day the yard is filled with hearses and people waiting; family members, police, funeral professionals, and anybody who is involved in the business of death. Sometimes musicians and monks are waiting for a ceremony to start in the funeral hall.

The ceremony hall, mostly used by Buddhists, sometimes Hindus, as Muslims always take the body away, is being renovated in July; its roof is asbestos contaminated. During the ongoing construction, a temporary hall, a large marquee, is erected behind the mortuary; the hospital could not go without a ceremony hall for the weeks where construction takes place.

By 11am, bodies begin to be released and the solemn chaos dissipates into the early afternoon. Throughout the day, the little cart scouting out from the forensic department to retrieve bodies comes and goes. Bodies arriving until 6am will be processed the same day.

When passing the tree in the afternoon, without fail, the pot-bellied man with a long ponytail will be sitting somewhere around the abandoned yard on a colourful plastic chair; sometimes under the canopy connecting offices and morgue of the forensic department, sometimes sheltered by the Banyan's branches where he has a good view of both the driveway and the Forensic Department's entrance.



On days with is a swell, a decomposed body will surface on the shores of Yangon river and subsequently arrive YGH's Forensic Department. Decomposed bodies get their post-mortem done in a separate building, right of the Department's main entrance. Swell days are smell days. Unfamiliar with the putrid stench, I had noticed the smell but was not able to place it. The laundry department near the mortuary, where I spent my days in April, lifts the mystery of the irregularly recurring stench. I learn later, in a conversation with the forensic team, that most decomposed bodies, one or two a month, are drowning cases, very few are single people who die alone in their apartments.

When power cuts at YGH, the hospital's eleven generators kick in. None of them supply the Forensic Department and its two mortuaries. The old one is from 1909, the new one was built within the last 10 years. Generally, this is not of too much of a concern for the Department. The morgues are designed to keep cool, without windows and with thick walls, also the dead do not care too much.

Besides the hospital's routine post-mortems and death certificates, the forensic teams do police work, they examine injury cases, and giving court evidence. The police have no forensic surgeons. "Injury cases" are individuals harmed in a crime. They usually arrive with a police officer, ranging from sexual violence and domestic abuse, to establishing age of victims and perpetrators, some kidnappings. This link between police work and the hospital goes back to British colonial times as

described in the responsibilities of the Civil Medical Department by Wright's 1910 published *Twentieth Century Impressions of Burma* (Wright et al. 2015), and annual Medical Department Reports.

While the Forensic Department is one of Yangon General Hospital's oldest departments, closely linked with the rest of the city by its police work, and today jointly headed by a consultant from YGH and a professor from University of Medicine 1, they do some of the hospital's most cutting-edge research.

Most post-mortems are done for academic interest, including DNA sampling. As Myanmar has no DNA law (a draft was in process in 2020), DNA evidence is not used in police cases, only for research purposes. It is here where old infrastructure and unreliable power become an issue.

While Yangon General Hospital has the DNA, University of Medicine 1 has the laboratory space. YGH's Forensic Department has not only issues with power cuts, reagents and samples need a closed cold-chain, there is also no space for labs, coolers and other necessary equipment. Given the unreliable nature of electricity in Yangon, the cold chain between YGH and University of Medicine 1 is a problem for researchers, and for science in Myanmar.

If electricity fails, the laboratory in University of Medicine 1 can keep its temperature for 8h, but if a power cut is longer agents and samples need to be transferred to the Central Medical store which has first priority for electricity. Agents and vaccines for the whole country are kept here.

In general, the team who explain all this do not seem too worried about power cuts; if they are not unusually long. This year during Thingyan holidays, which was also the countries nationwide lockdown, the scientist working at the DNA lab explains that she had to bring the samples to the National Blood Bank on YGH campus which has a -20C store, as a power cut was too long. I wonder how DNA research, agents and vaccines, are faring post-coup; at the beginning of 2022 I hear from friends in Yangon about arduous and day-long electricity outages.

The hospital relies on city infrastructure, while the city and country need the hospital's facilities: the forensic department and its teams for crime investigations, the hospital's research and training, its healthcare provision, and its production of knowledge.

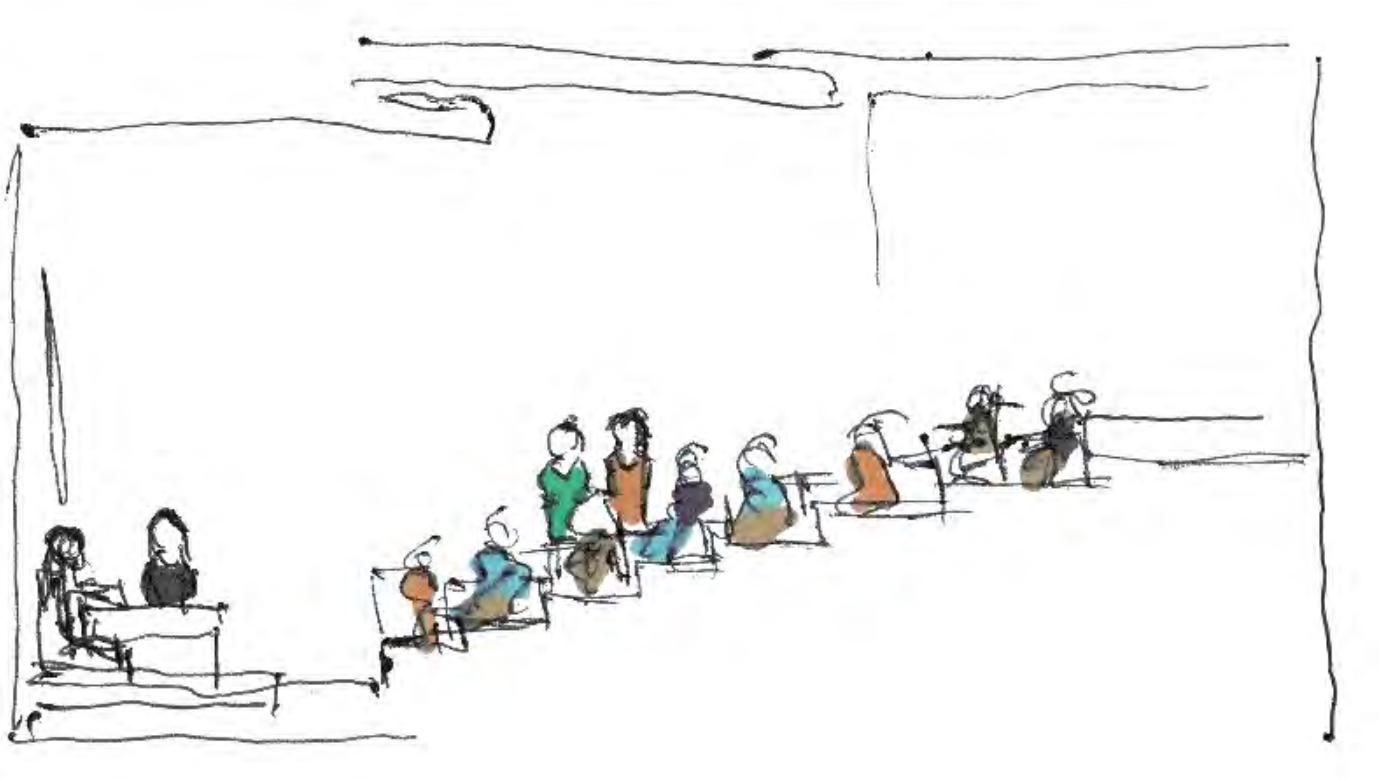
PUBLIC HEALTH

Infrastructure, cables, pipes, electricity, and water, circulate in and out of the hospital, with knowledge alongside.

The lecture theatre is half full. People, evidently unfamiliar with sitting in pews, fill the rows, looking uncomfortable, curious at my presence. I sit in the first row. The social medical services team invite attendants from a different department to a public health talk every week. Today invitees come from cancer care and Medical Unit 4. The talk covers behaviour in a hospital. Smoking is strictly forbidden, for health reasons, unpleasant images are shown, and safety; fire near oxygen pipes and canisters is dangerous. Fire detectors are explained. Beside smoking, another peril is discussed, betel nut chewing. Spitting betel is forbidden, horrific images on the slide presentation, but also the warning that spitting in corners and bins spreads disease; infection control is a priority.

The talk continues with general health advice, reminding everyone to eat vitamin C, and which foods contain it: papayas, mangoes and other fruits appear on the screen. Sleep and exercise are also mentioned. Lastly, the familiar WHO recommendations for handwashing, which I know well from developing a hand hygiene strategy for YGH in 2018, are shown in Burmese. I am attending this talk mere weeks ahead of the first Covid-19 lockdown. The clinician in front demonstrates how to sanitise hands. After half an hour, everybody grabs a "Towards Tobacco Free Myanmar" pamphlet with the Ministry of Health and Sports crest in front and files out of the lecture theatre. Together with the pamphlets, ideas, and knowledge spill from the hospital into the city, and wider Myanmar. Most patients come from rural areas. Many never heard of vitamin C.

Another influential source of information are ward sisters and nurses. One sister explains to me that "some patients are so poor, they do not know how to take care of themselves"; she speaks of nutrition, of healthy foods, and bodily hygiene, how and how-often to wash bodies and clothes, and



about sleep patterns. Many patients and attendants learn about the importance and benefits of nutrition, hygiene, sleep, and exercise for the first time at YGH. Hospitals are important and influential; doctors, ward sisters, and nurses, alongside monks, are well respected and their advice revered.

In the Neuromedical Department, family members of stroke patients are trained to care for the convalescent at home. Many cannot afford extensive hospital stays. As mentioned before, staying in Yangon is an economic burden not many can shoulder. Bedside carers in all departments learn from nurses how to care for a sick person, how to change a dressing, to hold someone so they can use a bedpan, and to wash a bedridden individual. This knowledge from the hospital is carried beyond its porous borders into villages and homes.

CONCLUSION

In this chapter, we have seen that the city needs the hospital as much as the hospital needs the city. Its walls are porous, and the relationship is reciprocal. “Lack” comes into circulation as an opportunity.

When the number of dogs grew out of hand, anecdotes tell of night-time battles by rivalling packs; I am not sure how much embellishment is going on here, but the problem was undeniable. The administration planned to remove all dogs from campus, but a proposal was made in the weekly admin meeting to keep a small pack, neutered, spayed, and cared for, to avoid a hostile invasion of city dogs of the hospital campus. The proposal is simple, easily executed, probably quite common-sensical in Myanmar where many households keep dogs for this purpose. However, in the context of an institution, a hospital, a perceived space of hygiene where dogs are “normally” not allowed, someone had to think of it, draw up a plan, and organise execution. Today, the hospital’s dogs, a former street pack, do not only tackle the city’s dogs, but they also keep cats, rats, and probably other pests in check.

Nature, animalistic and otherwise, goods, services, and knowledge circulate in and out of the hospital. This porosity and circulation is based on institutionalised “understandings”. The hospital is dependent on this circularity and defined by its context. If the the context was different, the hospital would be different. Many issues the hospital faces, such as patients who are “too poor to take care of themselves”, to quote my interlocutor, are specific to Myanmar. The notion of “nalehmu” is specific to Myanmar, a country where capitalism, or capital gain, is not necessarily a primary motivation; I had a colleague who quit her job because we paid her “too much”. Despite several attempts to explain to her that we expected to train her, provide her with guidance, she left us. A friend left his employment with an extremely high salary, to concentrate on his artistic practice; claiming that he had been unprofessional in leaving at short notice, his team was left hanging, but implying that European notions of “professionalism” were misguided.

At YGH, comfort lies in numbers, in care for each other.

Through drawing and writing I illustrate in very particular ways that the hospital is not an abstract space, a touchstone of biomedical knowledge, “universal” as some planners, and maybe some doctors, like to believe, but a place, emplaced in the world, in a geographic location and in history. Behaviours and habits are shaped by decades of military rule in which the military violence eradicated much plannability, which fostered a “Burmese way” of doing things.

Goods, services, people, knowledge, and “ways of doing things” circulate in and out of permeable campus walls. What this chapter shows are the complex material connections and entanglements, for example with basic infrastructure such as water and electricity; but also, the detailed and very personal embodied and habituated behaviours such as water bottles in sewage pipes, rather than collected, cleaned, and recycled. In these ethnographic moments we see how the girl collecting water bottles around campus is intimately interwoven with the larger sewage system that ultimately leads into Yangon river and the ocean beyond.

Connections are manifold and complex, and context specific. While there is an understanding and discourse on context specific design/architecture, the social anthropologist in me is not convinced that everyone involved in hospital planning understands the intricacies of what that might mean and/or has the potential to translate into. It is complex. This thesis proposes a framework to think with this complexity and shows complexity.

Against the backdrop of the hospital as a place, we now delve into the rhythms of daily life on campus to better understand the interplay between buildings and infrastructures, and the people who inhabit them.

III RHYTHMS

How do we live with our buildings and they with us?

THE MERRY-GO-ROUND (JARDIN DU LUXEMBOURG), Rainer-Maria Rilke[138]

UNDER the roof and the roof's shadow turns
this train of painted horses for a while
in this bright land that lingers
before it perishes. In what brave style
they prance – though some pull wagons.
And there burns
a wicked lion red with anger ...
and now and then a big white elephant.

Even a stag runs here, as in the wood,
save that he bears a saddle where, upright,
a little girl in blue sits, buckled tight.

And on the lion whitely rides a young
boy who clings with little sweaty hands,
the while the lion shows his teeth and tongue.

And now and then a big white elephant.

And on the horses swiftly going by
are shining girls who have outgrown this play;
in the middle of the flight they let their eyes
glance here and there and near and far away –

and now and then a big white elephant.

And all this hurries toward the end, so fast,
whirling futilely, evermore the same.
A flash of red, of green, of grey, goes past,
and then a little scarce-begun profile.
And oftentimes a blissful dazzling smile
vanishes in this blind and breathless game.

[138] 1971, MacIntyre; *Rilke Selected Poems*; University of California Press, Berkeley (P 85-87)

CHAPTER 6: TUNING IN

CHINLONE

The cleaning and the security departments do their mustering in the late afternoon. Not long after, the birds start their evening clamour in the ancient tree outside the medical superintendents' office. The building is a two-storey red brick structure, aging but well maintained. Little plants grow at its eaves, and air conditioning units whir outside most office windows. Shrieking and cawing the flock sit in the old tree's branches, from time to time rising high above the campus, the sound of a hundred wings in the air, only to settle again shortly after. Following the cleaning and security departments gathering, I hear the soft creaking of a small rattan ball being kicked around. Some men whose workday has ended play chinlone.[139] A few of them have their longjis tied-up high between their muscular thighs. The sounds are a sign for me too that the day is drawing to a close.

While I was working on campus in my role as architectural engineer for the hospital's rejuvenation project, I awaited these calming sounds as the light was getting softer and the shadows elongated; a mix of daily rhythms (the birds' evening commotion, the change of light and the sound of chinlone) and institutional routines (the daily mustering and shift patterns) marking the patterns of time in space on campus.

It is these rhythms that I came back for, that made me turn to ethnography; the opportunity to tune-in to the realities of the campus' daily life that I never had time to "take seriously", to borrow from Tim Ingold (2018), while on the job as the rejuvenation project's architect. Working on campus from 2015 to 2017, I was embedded in the hospital's rhythms and

[139] Caneball; a Myanmar ball sport.

routines, adding layers of my own and adjusting my day to the hospital's pace. However, with my job as architectural engineer on campus, I was always too busy to attend to their meanings, and their social and material entanglements. During my ethnographic fieldwork in 2019 and 2020, I came back as an observer. While slightly set apart, my life was none the less determined by the hospital's ebbs and flows, especially wider ones beyond the campus' walls: the lockdowns and curfews of that year, bus schedules and traffic movements. The pandemic, or what society made of/from it, changed the hospital's density, some of its routines and with it rhythmic patterns (rhythms determined by routines), while the campus' pulse remained; day and night, seasons, breath and blood, do not alter because of external circumstances.

The opening vignette illustrates the layering of rhythms, cosmic and human, with institutional structure and routine. The bird song and changing light are nods to the subtleties of ethnographic sentiments. While obvious to the ethnographer, they remain elusive to others, like the architectural engineer on campus who, for years, was concerned with bricks, figures, and meetings; preoccupied with the hospital's literal and figurative structures. Rhythms need a different attunement.

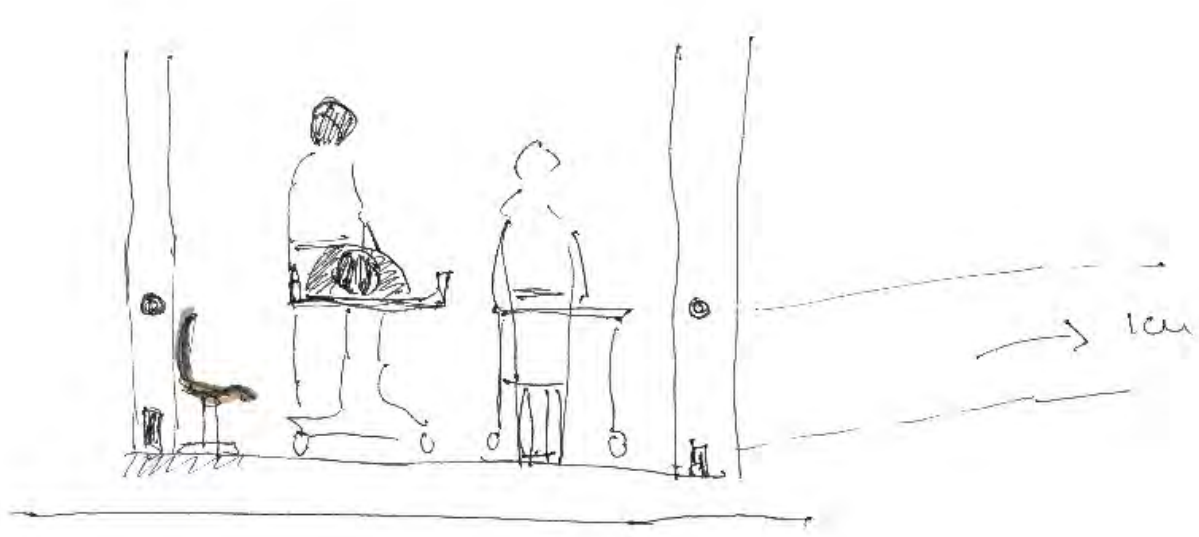
In this chapter I show the hospital as a place that is part of the natural world with mould, plants, and atmospheric conditions; at the same time, the hospital is a place of institutional systems, rotas, and processes. Buildings are and contain both, while all of it is part of a larger system. Following the chapter's introduction that attunes us to the campus' oscillation, we learn about the hospital's "Infrastructure of Comfort". In tracing the movements of an inpatient attendant, their life structured by cosmic rhythms, bodily metabolisms, and economic considerations, we see the hospital from the point of view of care. A close

look at the outpatient departments' fluctuating density offers insights about life on campus wedged between structures, routines, and the greater system that suspends the hospital's daily life in a choreography or an "Aesthetic of Waiting". Weekly admission rotas show how bodies and structures can clash, and rhythms are context specific. The campus' rhythms come to life in contrast to its institutional routines and physical structures in what my interlocutor calls "Spaces of Understanding". We see how all influence each other, overlap and/or collide, concluding with the multiple affective hospitals that emerge.

INTRODUCTION

Having gained an understanding of what the hospital is in Part I "PLACE", the hospital as more than the sum of its buildings, with a rich history, and enmeshed with its city, we are now turning to the question: "How do we live with our buildings and they with us?" For this, we attune to the *practices* that make the hospital multiple, the different hospitals within, which are at times in constructive, at others in competitive relationships, and in their contradictions often mutually contingent.

Although Lefevre's *Rhythmanalysis* (Lefebvre 2017) might offer itself as an obvious reference point for a section on "RHYTHMS," I have found alternative approaches and wider understanding of



rhythms more productive, as discussed in the literature review. In the two chapters of Part II, the present chapter, "Tuning-in", and in Chapter 7, "Bodies and Buildings", I draw on Bourdieu's notion of fields (Bourdieu 1981) and expand it with ideas of non-human agency (Gell 1998), affect, and atmospheres. Mol's practices (Mol 2002) offer an additional significant touchstone as we observe the hospital's oscillation.

With changing frequency, co-dependant on factors beyond the campus's walls, bodies, human and non-human (animalistic, rhizomic, natural) squeeze and creep into its spaces, cracks, and crannies. Human bodies flood the hospital's pathways. Patients and their attendants occupy every centimetre with waiting; waiting to see a doctor, for visiting hours, for recovery or death. Their bodies adjust to the spaces they wait in; sitting on stairs or curbs, chairs or benches from metal, wood or plastic; lying or sitting cross-legged on mats on the floor, above drain covers, under trees, beside pathways; leaning at walls or railings, lying in hospital beds and on trolleys. All follow the shade as the sun circles overhead or shelter from the city's relentless rain.

Workers and clinical staff shuttle between departments with samples of body fluids, goods, patients, and their data. Cleaning staff collect rubbish, and administrators discipline vendors to an invisible schedule. Workers and engineers maintain the many pipes and wires, tend to machines and buildings. The few campus dogs remaining after a purge in 2019 follow their own invisible rhythm when the pack, from languishing in a sunny sandpit, suddenly whizzes into action with howls and barks to battel without apparent reason. Mosquitoes herald the night. All the while plants quietly slide their roots into crevices between bricks with a special favour for eaves, the areas where materials meet, bursting bricks, concrete, and tarmac. A one-sided battle fought veraciously by the

hospital's maintenance teams. Water imperceptibly erodes its corsets of pipes and channels, while fungi find fertile ground in aircon units, between suspended ceilings, and along water pipes, a wonderful place for mosses too. Salts create efflorescent patterns on brick walls of the colonial structures.

At night, and on holidays and weekends, the machines' buzz and hum are loud, while inaudible over the workdays' humdrum; the air-conditioning and electricity, the continuous hissing of the oxygen plants, dripping water from leaking pipes. The hospital is never empty, constantly oscillating at varying frequencies.

The hospital's daily life roars within its structures. The rhythms of life crash into its buildings, its shift patterns, and institutionalised rules and routines; like waves overflowing quay walls.

INFRASTRUCTURE OF COMFORT

Washing Bodies, Washing Clothes

The sun heats-up the hospital's tarmac and concrete surfaces that seal the ground, and forbid rainwater to percolate, causing flooding and surface water run-off. But on sunny mornings, its antiseptic and antibacterial rays bring out colourful fabrics all over campus. YGH has no communal area for attendants to wash and hang laundry. Wet longjis and ainjis, blankets and t-shirts, are laid out on plastic sheets over the hot concrete, above surface water channels, and out of the way of main throughways.

I am sitting in the shade of the pump house, I could also be resting between the main building and the lecture theatre, with six or more other people waiting for laundry to dry. They are all attendants, inpatients' family members or friends, or a close neighbour. I catch a young woman's eye, her hair draped

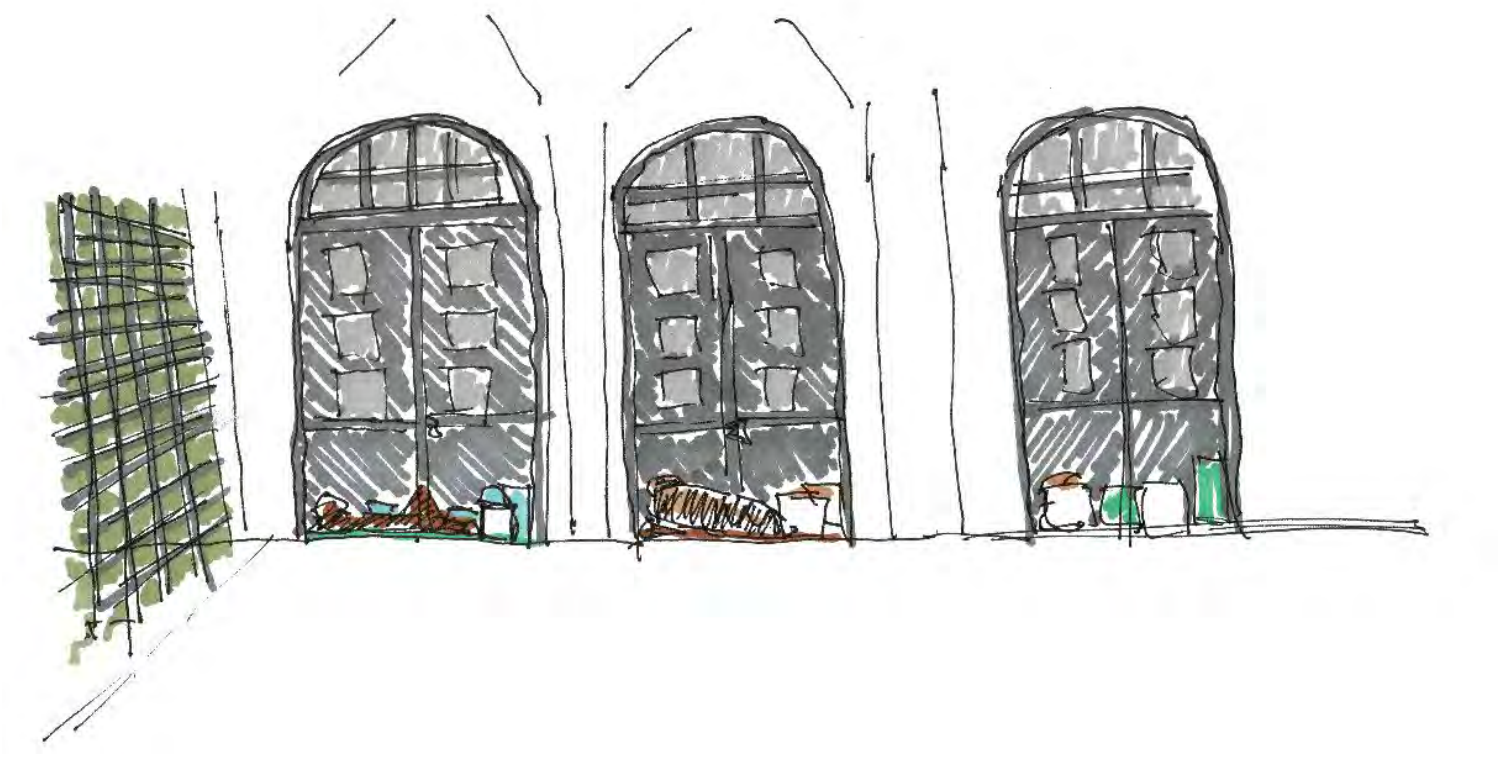
around a red comb, pinning it high at the back of her head. She is intrigued by my presence, my pens and sketchbook, curiously enquiring about my life as much I learn about hers. It is the beginning of a conversation.

She has a familiar story: Her uncle, a monk, is an inpatient on the surgery ward, in his case for an operation at the abdomen. They live in a village three hours from Yangon. She came with two others, to attend to her uncle. In this section we will follow attendants throughout their day as they create the infrastructure of comfort for patients they care for.

While doctors do their rounds on the wards, we are waiting for the laundry to dry; weeds stretch their tiny green leaves towards the sun through the cracks in the concrete we are sitting on. I ask her where she does the laundry. She talks about the difficulty of doing it on the ward, the lack of space, that it is not "really" allowed. She tries to explain where she goes to do the laundry but, in the end, after some comic communication failures, we cross the car park under scorching sun in front of the cardiac building together to find the place.

Uncle is at the hospital for two weeks. She is here to support the bedside carer, the person on the ward with the patient. Laundry, food, and medications structure her days in a rhythmic dance with the other people she came with. They rented a room nearby for her and her companions who cannot be on the ward outside visiting hours. Each patient has one attendant who is always allowed on the ward, the others dose off across campus in between errands. Other patients and their families cannot afford a room in Yangon, sleeping when and where they can in the campus semi-public spaces; and yet others might be able to afford accommodation or bus fares but do not want to leave the hospital while their husband, mother, or cousin is treated. In the afternoon, access to wards is not "*that* strictly controlled", visitors can join the patient by the bedside. Attendants nap with the patient while the bedside carer goes for a walk.

We arrive at one of the five public bathrooms on campus. In Myanmar, washing clothes and washing bodies is often done at the same time; in many villages, people do the day's laundry while bathing in the river or a lake; a longji tied at the collar bone or at the waist for decency. Attendants at YGH use public bathrooms with shower facilities to wash bodies and clothes, but not all public bathrooms have showers. As shower here is a cubicle with a low tap and a large bucket of water.



On the way back to her drying laundry the young woman explains that doing laundry at the hospital is complicated: she must collect all the laundry and plan when to do it. At home she can do laundry as and when necessary. At the public bathrooms, the fee is 200MMK[140] for a shower and 100MMK for toilet use; not cheap, better not forget anything for uncle.

Public bathrooms are clean and well taken care of by their proprietors who lease them on yearly contracts from the hospital.[141] Doing laundry while showering is not encouraged but neither strictly forbidden. The caretakers of the facilities are sympathetic to the predicament of attendants, and sensitive to patients' needs in the face of the (un)available facilities. Afterall, everyone experienced a hospital stay themselves, as patient, attendant, or visitor; the logistics do not stay hidden.

As we arrive back where the laundry dries in the sun, most other attendants already disappeared, their clothes with them. Only the one, watching over my company's possessions, is still waiting for us; a small camaraderie, one of many between attendants. Someone walks over as the young

woman collects t-shirts and longjis; one of the other two attendants she came with to the hospital to care for uncle. He needs medicine and a test. Her colleague holds a little bag with urine samples in one hand. They want to go. I can feel the impatience. I say goodbye to the young woman, and the red comb holding up her hair disappears in the crowd in the direction of Anawratha road, towards a pharmacy shop they know; the hospital's pharmacy is too expensive for them.

[140] At the time of my research (May 2020) 100MMK were ca £0.60; at the time of writing in March 2022, 100MMK is £0.40.

[141] Monthly rent for a public toilet facility is 400.000KS or 1.000.000KS (e.g. the toilets by the A&E are more expensive as they have more traffic) and entails a yearly contract with YGH.
Every patient has at least 2 people with them, mostly more. There are over 2000 beds, this means even if all attendants on wards use the facilities on the wards, there are 2000 people plus approximately 1000 outpatients per day using the public toilets, that makes 750 people per toilets per day (4 toilets); hence ca 75.000KS per day (one person = 1 WC use; no showering) makes 2.250.000KS per month; a potentially lucrative business, compared to a government job at about 140.000KS per month.

They also need to find a private medical test centre, recommended by a doctor or ward sister, to accelerate the process, shortening the wait-time for results.

Brown, in her article on "Hospital Domestics" (2012) conceptualises familial care in a hospital in Kenya, focusing on ward spaces. At Yangon General Hospital, I extend similar observations into the spaces in between wards and clinical buildings, introducing the idea of an infrastructure of comfort that reaches beyond the ward, even beyond the hospital compound. Here, I am not so much interested in the question of "authority" (familial or medical) but in attendants' work, between the buildings and purviews of biomedicine that become institutionalised. In Brown's careful ethnographic account, this "community of practice" (ibid: 22f) is delineated by familial and biomedical practices; at YGH they are rendered spatial in their occupation of the spaces in-between buildings and wards.

The people who provide the infrastructure of comfort for the patients, who organise their daily life, exist between cosmic rhythms, institutional routines, and the physical and figurative structures of the hospital: The sun's rays are strongest around midday, which means clothes are washed in the morning, at the same time that doctor-rounds necessitate attendants to leave the ward, while their movements are directed by ward-bathrooms, or the lack thereof, the design of public toilets, and surface materials around campus.

Food

Outside the Daw Pu Ward, near the pump house, where fabrics dried a few minutes ago, people line-up with bowls, plates, and tiffin containers. A boy joins the queue. Someone plays music from a phone. The atmosphere s chatty and merry. A little steel fighter truck arrives with large steaming pots on its loading area.

Stalls around campus sell vegetable and meat curries, plain rice, samosas, and other deep-fried goodness. Alongside favourite snack-foods and popular dishes, stalls also cater to special dietary needs with low-fat, low-sugar, non-spicy, and lean foods on offer.

Food stalls and vendors follow their own patterns. Breakfast vendors pack-up once all goods are sold, but before lunchtime when curries and rice is on offer. Colourful stools welcome patrons, and little clear plastic bags of cooked rice are sold; afternoon is the time of snacks. I would suggest, this

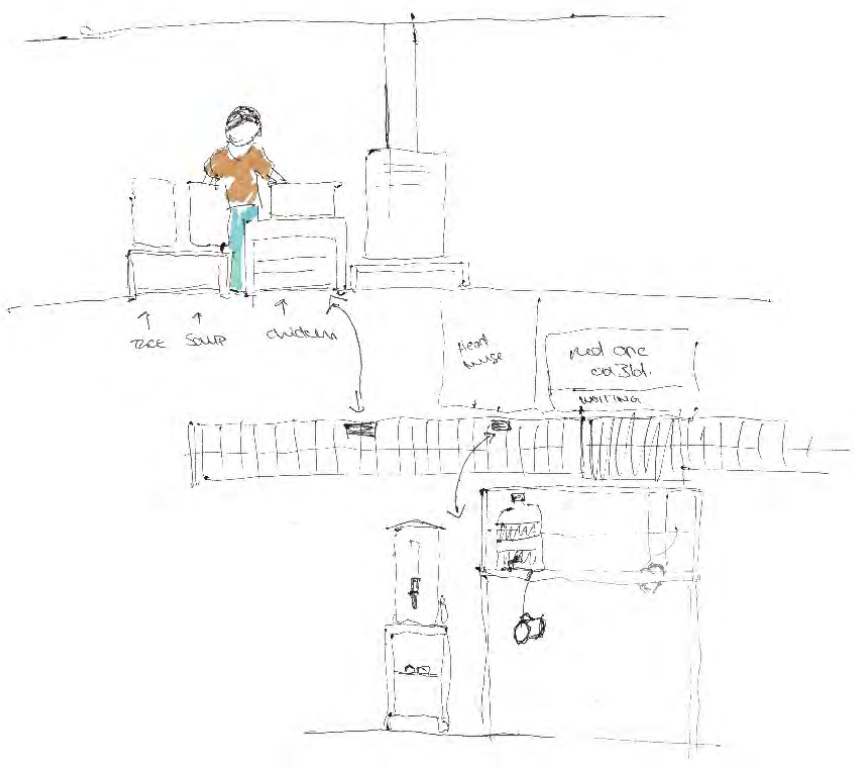
choreography is organised by Myanmar's "hidden infrastructure" (Roberts & Rhoads 2022) discussed in the previous chapter. Here, I suspect, "nalehmu" is present in the shape of a mutual understanding about whose turn it is to sell their wares; an unofficially official agreement between individuals or groups in the absence of regulations and/or the enforcement thereof. Police and/or hospital administration are part of the "understanding", benefiting from the presence of the vendors; conveniently buying lunches and tea snacks, or more sinister arrangements that I, as a foreigner, am ignorant of, and nobody wanted to elaborate on for me. Patients and their family have services and commodities readily available in times of need, as we saw in the previous chapter; the wares on offer indicating what the hospital does not provide.

The hospital has no kitchen, patients must feed themselves, as they have to bring their own sheets and pillows. But not everybody at YGH can afford the curries on offer from stalls and the markets. Many patients come from outside of Yangon where life is rural, the country's economic hardship more pronounced than in Yangon. Others come from Yangon's outskirts, where the factories are, or live in precarious environments across the city. Most ordinary Myanmar people cannot afford downtown city-life with its shiny malls, bank headquarters and booming real-estate market (see Thawnghmung 2019), and even the need for regular cash payments for subsidence is too much for

some to bear. Numerous patients and their families cannot buy food, nor medicine, nor can they rent accommodation for attendants during the hospital stay.

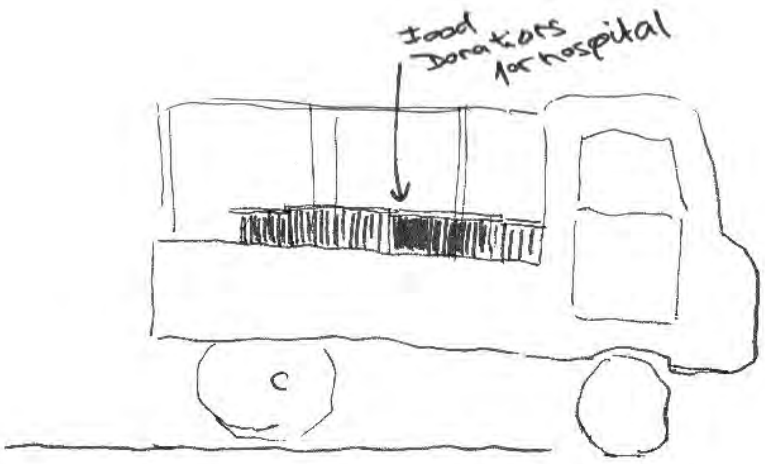
As we saw in Chapter 5, they might find shelter in a nearby monastery. Others are taken-in by the Christian nuns across Bogyoke Aung San Road. Many sleep on campus wherever they find shelter; they make camp in its versatile pathways, and hidden corners for as long as their patient convalesces. Especially with Covid-19, when monasteries could not host guests, families with patients at YGH were at a loss, spending their days on campus, out of the way of the daily routines and atmospheric rhythms, out of the rain and the sun; exhausted, napping in doorframes, on or under benches, or as the woman with the red comb in her hair told me, by their patient's bed during afternoons. They make their way improvising, fitting-in in-between the hospital structures, coming to represent structures, and institutional failure, of their own.

Many patients come to YGH already stripped of their meagre reserves, having paid for transportation and often other medical care ahead of arriving at the public hospital (see Coderey 2017 for a detailed discussion of healthcare in Myanmar). Even though YGH's services are free of charge (FOC, an often-evoked acronym), the hospital-stay bears hidden costs. When medicines run out at the medical store, patients need to purchase drugs themselves, or medicines are simply not available at YGH, or even Myanmar, and need to be found elsewhere. This adds up: bus fares across the



country; taxi rides; food for patients and attendants; drinking water; adult nappies, blankets, bedpans, and “outsides” for workers. “Outsides” are the campus’ flow of monetary tokens of appreciation for a worker helping patients and their families to settle or extending a kind hand in moving between departments.

The young boy queuing where the steel fighter truck just arrived is waiting for the NGO workers to unpack their goods: a table with pots of rice, a protein, chicken on bones, beef, or fish, and vegetables, sometimes bags of milk tea and a sweet treat, depending on the day’s donor. The number of portions donated, alongside the names of the donor(s), are written on a white board displayed beside the buffet.



In the morning, from ten, and in the afternoon, from around two, people flock to three designated spots set-up by the NGO. The team of three start by Medical Unit 1 at 10.30 a.m., move to the hospital’s Medical Social Services department or the back entrance of Radiotherapy by 11 a.m., and on to Haematology at around 11.30 a.m.; times are fluid, and everybody needs to wait. In the afternoon, the same round repeats with dinner; at about three, the team is usually outside the Haematology department.

The hospital's Medical Social Services Department distributes food-tokens to claim this charitable service to ward sisters, who pass them on to the patients in need. The boy is holding on to this token, a piece of cardboard that qualifies him for a free meal, while waiting for the donors to arrive so the spectacle can begin.

Donating food to patients at YGH is well known throughout Yangon. The donation of food portions is a popular birthday merit-making activity. In conversations with administrators, I learn that previously Yangonites would come with wedding remnants, unhealthy party-foods, handing them out unregulated on campus; not the food patients need. Nor was there any quality control. Today, the Medical Social Services Department coordinates donations to patients; donors are traceable and accountable.

Where the boy waits, the day's donors join the NGO workers. Together, they ladle rice, fish, and a lentil soup into the bowls stretched towards them; one piece of fish per portion. People disperse rapidly once they receive the food. The boy hurries back to the ward with his family member. Hospital workers and a homeless person are waiting to see if any food is left over once attendants are served.

Later that day, I see the boy sitting by the Ghost tree. In the afternoon, he is queuing again to collect a warm meal for his father, or an aunt, or a brother. I see him all week, and we greet each other until he is gone, the patient discharged or dead.

Donors take copious amounts of pictures, selfies and group photos, while ladling soup and rice, some make video calls, or live social media feeds. Having grown up with the anonymity of the protestant collection box, the photographs and boards with donors' names, and number of meals donated, bewilder me. A friend challenges my perception when I voice my discomfort at the performance of charity: is it not a matter of respect to bring alms by hand? In Myanmar, when Buddhists donate robes to the monks they must hand-deliver them to the benefactors out of

respect. I am not convinced the flurry of social media activity is a sign of respect and piety, but I leave the conversation at that, noting the notion of respect and merit-making.

These donations also have a deeper history. They are part of a tradition of socially engaged Buddhism that originates in a response to colonial powers, fighting for political and economic justice (Hsu 2019: 28f). During the military regime, the development of a modernist Buddhism that is socially engaged was discouraged by the government (ibid). Only Nargis in 2008 sparked socially engaged Buddhism again (ibid), as we saw in Chapter 4 with relation to the General's suspicion of volunteering networks. This translated into religious and social giving (ibid). Here, as a monk in Hsu's ethnography puts it: merit making through civil engagement is a "[...] practical experience[s] [that] can touch one's heart; [...]" (Hsu 2019: 17); a direct engagement with messiness of life, for example on campus at YGH, has more value than lighting a few candles.

When the pandemic hit Myanmar, hunger, and need for donations, did not vanish; but the donors did. While donations kept coming, the fear of the virus seemed stronger than the pull of photos for Facebook, alongside movement restrictions; I might be unkind with my assessment.

Food moved from large pots and patients' own tiffins, into styrofoam containers, increasing food hygiene, stopping people from gathering, and increasing litter. The pandemic's toxic waste is one of

its worst collaterals. Now, one NGO worker alone quickly hands out the prepacked containers, rendering the entire process highly efficient. No more chatting and joking in line, waiting for a friend, or extra portions out of fear of infection.

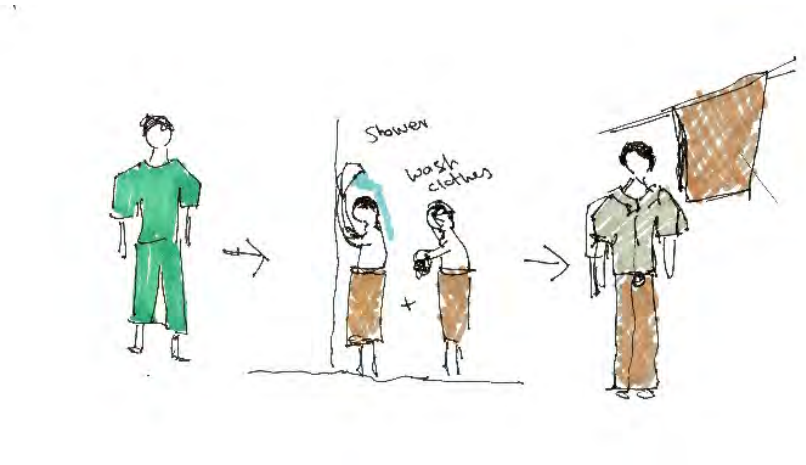
With the pandemic, the frequency changed but the routine (times) and rhythms (digestion) underlying donations remained the same. Only the aesthetics were modified; pandemic aesthetics of infection control and hygiene took over. The need persisted (possibly even increased). The process had to adjust as was the case with the many hand washbasins that popped up around campus (and the city in general) and Viber facilitating a booking system that some departments implemented. Quick action is possible if vital, and when improvisation and makeshift infrastructures are "good enough" in the face of the challenge.

Mosquitoes

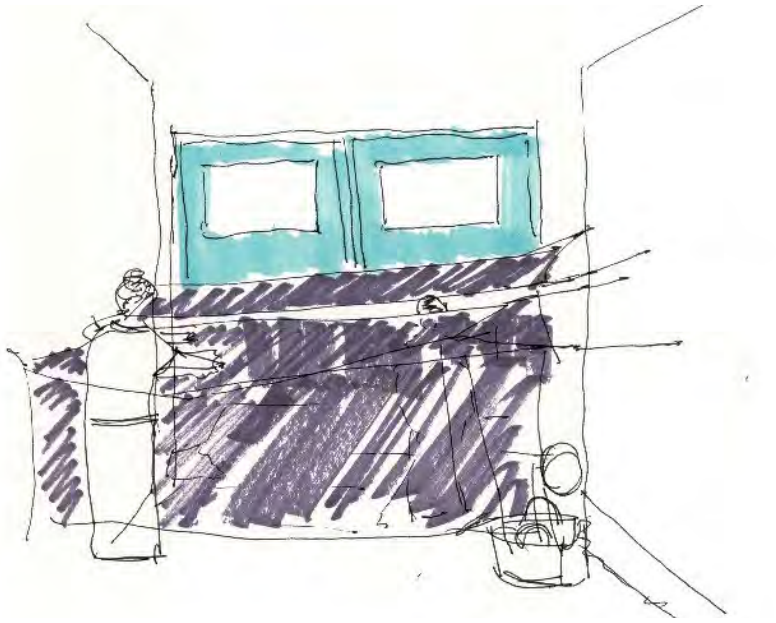
By the time the little steel fighter truck leaves with its empty rattling pots, the hospital's frequency adjusts down. Mosquitoes ready themselves to come out to play. Only a few outpatients are still waiting in the departments' waiting areas or around the specialist outpatient department, and the medical oncology waiting room is mostly empty. Doctors will continue to see patients until the queue is done, but no new patients arrive for the day's clinics or treatments.

As the men from the opening vignette kick the chinlone ball the car parks around campus empty. During the height of the first Covid-19 wave, buses and mini-buses driven by volunteers wait to take office staff home, so they do not risk infection on public transport. Administrators, laboratory, and radiology staff, as well as outpatient services, and the day shift from wards pour into the public spaces, and into the city. Some are heading home, others rush to private sector jobs, readying themselves for a night of surgeries at one of the many private hospitals around Yangon.

Some of the workers, security guards, and cleaners, make use of the availability of clean water. They wash the day's labour from their bodies in barely private locations, half hidden between buildings where taps are located, near their place of work. Longjis provide the decency the infrastructure does not; the garment compensates for lack of privacy. I am not the first to note the infrastructural properties of the longji. Wendy Law-Yone in her novel *Road to Wanting* (2010) beautifully describes the versatility of the garment, to change clothes, to swim in, to sleep under.



As the night shift arrives, the hospital settles-in for the night. Patients need water, food, company, adjustment to their position, a pillow or comforting hand, the bathroom and other million-minute things day and night; healing and pain does not adhere to office hours. Attendants are patients' primary bedside carers. They listen to what doctors and nurses say, vigilantly keeping the patient company, giving medicines, turning and massaging bodies, doing exercise with them, helping with sanitary needs, and other tasks as instructed by the nurses. At the same time, at least one attendant, like the young woman drying her laundry, often more, is on standby outside to jump into action as needed; one person is on stand-by right outside the ward, while someone else runs errands. Each of them might have somebody to keep them company. Attendants are an indispensable part of the hospital's day to day, something Myanmar has in common with its neighbours (Bhalla et al. 2014; Zaman 2005).



At dusk, attendants who did not make it onto the ward, into the all-night shining fluorescent light, change from their day clothes into pyjamas in the hospital's waiting areas or corridors. Spaces converted to informal dorms. Longjis serving once again as an extension of infrastructure to maintain privacy.

Experienced attendants settle into deckchairs they brought along. Others find any spot for their plastic or rattan mat near their charge's ward, sheltered from the elements, hidden from prying eyes under blankets. In an effort to support each other, temporary friendships form. Public toilets close at 8 p.m. The sun sets, and the mosquito frolics. The nightly wrestling with nets, to protect fragile bodies from vicious bites, begins on wards, in public spaces, and everywhere in-between.

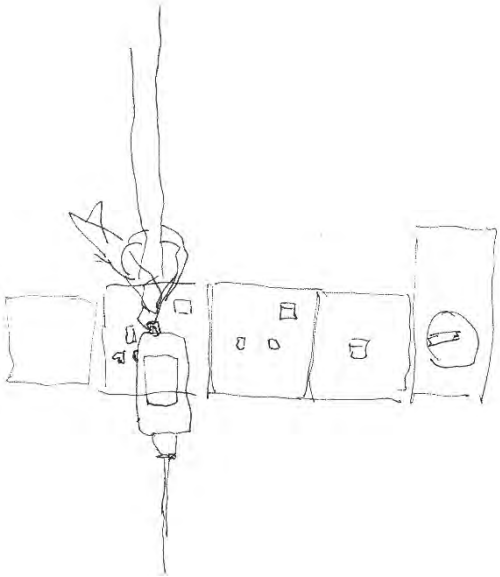
At the orthopaedic ward's nurse station, the handover from day to night shift is in full swing at 7 p.m. Nurses explain medications to attendants. They are the orchestra's conductors rather than musicians themselves; there would not be enough violins otherwise. They train family members in bedside care, keeping an attentive eye on their charges, without being much hands-on themselves.

Nurses, doctors, and administrators lament how *many* attendants populate the hospital, but all are very clear about the vital importance of attendance for patient care, and the running of the hospital. Research shows, that bedside care from loved ones reaps better convalescence than if cared for by strangers, and smoothens the transition from the hospital to home (see for example: Carr and Fogarty, 1999; Bhalla *et al.*, 2014; Olson, 2019).[142] Maybe, YGH (inadvertently) is following so called patient-centred-care, currently seen as "best practice".

A green cooling box arrives at the doctors' station, a purple file on-top. A house surgeon makes notes, and goes to the residents' room, the doctors-in-training's refuge. Instructions are given. After a while, a resident arrives. He takes a blood bag from the green box. Along with the file he sets off towards the ward; as in Brown's ethnography of a Kenya ward (2012), here too the patient file orders flows (in this case blood, not the patient) in and out of the hospital (ibid:20f), the only difference is that at YGH patients do not need to buy the files themselves.

[142] The sentiment that patients have an easier time transitioning home when cared for by family in the hospital was also voiced in conversations with YGH's clinicians, especially Neurologists who dealt with stroke patients who have very long convalescence periods but whose families cannot not afford to stay in hospital. Training family members how to care for the patient at home was seen as favourable and ensured that fewer returned.

In his stiff white shirt and a longji I startle him with my pursuit, but he bears with it, crossing the ward in flip flops to the bed in the far corner, on the external walkway near the bathrooms. The patient is a young woman buried under thin blankets. The resident patiently talks to her before he removed the empty drip-bottle, one of the many DNS transfusions (sodium chloride and dextrose to treat major blood and fluid loss) stocked in piles of boxes at the Medical Store. The patient's attendant puts the bottle and tubes in the bin by the bathroom; adding to the piles of medical waste the hospital produces (Hodges 2017).



Adjusted by the flow regulator the blood slowly drips into patient's veins, dying the clear plastic tube dark red. Gravity feeds this system, like the water tanks on the roofs feed the taps below. The transfusion bag is hanging from a hook nailed on a wooden makeshift drip-stand. On wards where improvisation is the ever-present lifeboat, transfusion bottles hang from light switches or trunking, and water bottles become sharps-bins. Here, material details and their meanings are easily missed. Why is a specialist product necessary if wood batons and a hook, a nail even, do?

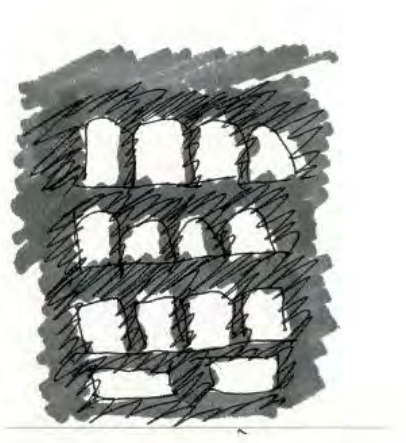
Drip stands around this ward are old, others are new, some are purpose-made drip stands, made from metal, with hooks and wheels, some are broken and fixed, while others are in good working order. The makeshift drip stand by the patient's bed in the external walkways near the bathrooms is made from untreated wood, the surface is rough, not easy to clean, a risk for infection control; a stand from metal is easier to disinfect. The hook is not a pig tail, the drip-bag could slide-off if

someone trips over the contraption, rocks it, yanking the needle from the patient's arm; a stand with wheels would follow the movements. In the UK, HBNs tightly regulated materials used in hospitals.[143]

Here, at night in this orthopaedic ward in Yangon, not all stands can be metal, with wheels and pigtail-hooks, but the position on the ward reflects the precarity of the makeshift drip stand. The one with the blood dangling from a simple hook stands between the bed and the wall, with few chances for anybody tripping. It is in the middle of the ward, by the beds place in the centre of the space, where the rolling drip stands can be found.

As the new blood continues to flood the patient's system, the junior doctor rushes back to their room. House surgeons are circling the ward, following an invisible pattern, while the ward's worker rings a bell alerting all visitors to leave. The tag-teams leave the patient and their bedside attendant, returning to monasteries, or rented rooms near campus, someone settles on the wooden bench in the open corridor that connects the ward to the central block. Others retreat into the hospital's nooks and crannies, making camp in door-reveals of offices, abandoned for the night in the main building's central block, around the staircase, suffusing the space in an atmosphere of sleep, a smell of unwashed bodies, quietly sweating as the sweltering night spreads its blanket.

[143] See NHS Healthcare Building Notes.



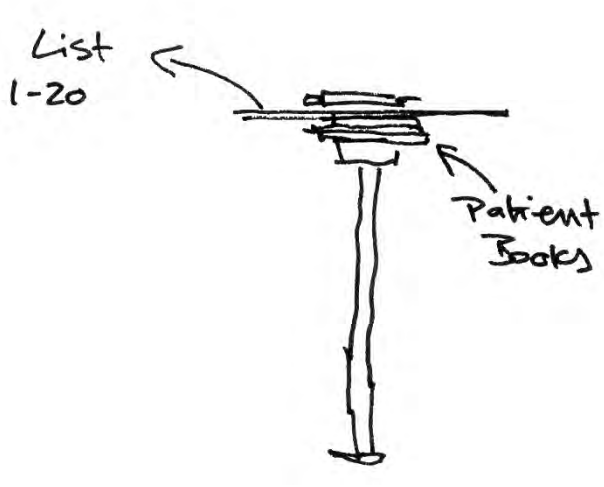
At night, YGH is inversed. The sound of infrastructure, air conditioning units, beeping fire alarms, and the humming of fluorescent lights are suddenly loud against the quiet of the night. The hospital's openings shine brightly into the darkness. During the day, the arches of the main building are dark, contrasting the red brick. At night, the building disappears against the black sky, merely a shadow in a moonless night.

The hospital's lights never go out; arcadian rhythms butting-up with institutional routine. Nurses and house surgeons keep circling the wards, emergency cases are referred throughout the night, patients and their carers try to sleep, the tag-teams are inventive in finding a spot to rest. Blood and oxygen continue to flow. Both these vital support departments are staffed twenty-four hours; the oxygen worker on duty makes his rounds; the blood issue room sends transfusions across campus in green cooling boxes carried by tired workers, past plants stretching their leaves through the concrete into the night-air.

Croaking and chirping from the sleeping city drifts onto the wards. A monk's rhythmic prayer, quietly recited at a patient's bedside in the high dependency unit (HDU), adds to the wards' subdued atmosphere. Confused muttering, a heavy snore, the sounds of sleep, is audible on the ward.

There is a moment of silence in the dead of night when even the singing and strumming of guitars from the ambulance crew subsides, the campus' dogs sleep, and only the security guards keep their vigilant eyes open (or not so open) before attendants and patients arrive in the early hours just before dawn, when the carousel starts up again.

Between 4 and 5 a.m., attendants sleeping on the hospital grounds start stirring to get ready to buy breakfast for the patient on the ward and themselves. A young man, a 10th grader, still in school, is worried for his diabetic mother. The mother is on one of the wards nearby the spot where he spent the night on a mat on the ground; a female neighbour is with her on the ward.



On the railing outside the radiotherapy department patient books start piling up, a list with names of the first twenty patients. Some patients arrive themselves; many send family members to put their name down hours before the department starts giving out waiting tokens.

The early hours are a slow crescendo that speeds up as 8 a.m. approaches when the doors open, doctors come to see patients, and ward rounds start; the merry-go round accelerates. And just like in Rilke's poem at the beginning of Part II: "[…] now and then a big white elephant" comes along; something unexpected yet not surprising. Every turn the same but never quiet, variation is the name of the game, with the occasional white elephant.

At 8 a.m. medical oncology patients or their attendants are given meds for the day, trotting off towards the day-care ward, along a cover walkway, partially tiled, partially sheeted with corrugated metal, into the cool basement of the main building with its thick brick walls; the basement not a souterrain but rather a low ground floor.

The east wing, where the medical oncology day care and palliative care are located, I have been told, is where Bogyoke Aung San was paid his last respects following his assassination in 1947. It seems an unfortunate collision of past and present spaces, a rhythm of history, that this is where today's sickest patients are, palliative cancer care and medical oncology day-care.

On wards, the days choreography starts. A dance of patients, their attendants, nurses, and doctors, around toilets and hand washbasins. Attendants take mosquito nets down, shake them off from balconies and folded way until night falls again. Nurses encourage patients to be washed and ready by the time the doctors start their rounds. Attendants rush around before the arrival of medical or surgical teams, sometimes several clinical teams orbit simultaneously.

On the orthopaedic ward, where I spent the night, partially in the sisters' room on a bed with the option of air-conditioning, one team specialising in spines and another in general trauma cases check their patients' progress, their recovery process. Timings slightly differ from department to department, and even within departments different specialities have varying times, yet in all departments AM is the time for the doctors.

Mosquitoes seek out rest in cool places, in wall cracks, brush, thick weeds, holes in the ground, and trees, unseen until nightfall.

While ideas of comfort have been constructed around colonial ideas of efficiency and labour, as we saw in chapter 4, and as discussed by decolonial architectural theorists (Chang 2020; Ferng et al. 2020; le Roux 2020), my ethnography at Yangon General Hospital of its

"Infrastructure of Comfort" shows that comfort is more than temperature and humidity; comfort is social and cultural.

AESTHETICS OF WAITING

Waiting tokens are given out from 8 a.m. at the Specialist Outpatient Department. Many patients and their company arrive the night before, most travelling from far away for specialist consultation, referred from other hospitals around Myanmar to YGH[144].

Other patients come to see a doctor of their own accord, taking the chance to wait until they are seen. With the pandemic this practice subsided as YGH became extremely strict in only taking referral cases; either from YGH's A&E, other public hospitals and clinics, or for follow-ups after discharge.

[144] Mandalay General Hospital is responsible for Northern Myanmar, but in some rare cases, and for specialist treatment, patients are still referred to YGH.
Yangon General Hospital is mostly responsible for Irrawaddy region, Bago, and Lower Myanmar (Dawei and below). Improvements have been made in the general hospitals in Mawlamyine (500 beds), Bago (500 beds). Mawlamyine and Bago can treat every emergency but have no Neurology, Cardiac surgery, nor Cancer Care.

On a Thursday morning at 7.30 a.m. the line is a hundred metres long. All the way back to the autoclave department in the radiology and laboratory building people are waiting to wait; waiting to receive a token to be in line waiting to see a doctor. Some of them will not get a token, as they are finite for the day. Those must try again the next day or week. Thursday is the busiest day, with eleven clinics.[145]

During the night water bottles with numbers were lined-up so the first sixty patients do not need to queue all night long, a bottle in their place; like the patient books on the railing outside the RT department.

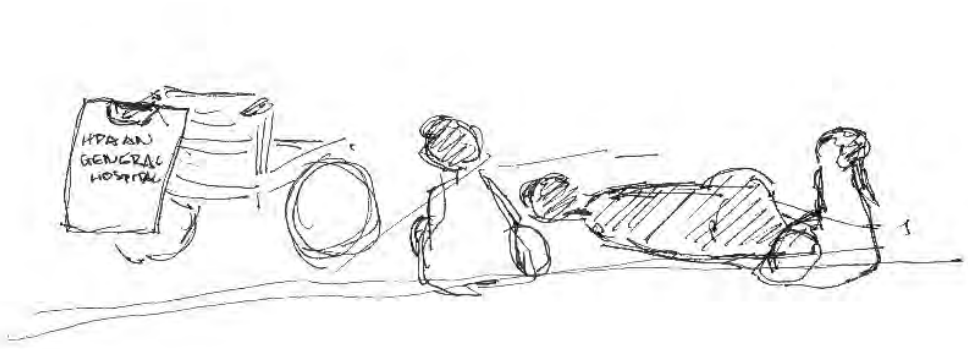
At 8 a.m. the spectacle begins.

Administrators arrive alongside security staff, and workers organise the crowd that formed overnight and in the early hours. Waist-high movable barriers made from cheap metal are set-up, creating an ante-space in front of the four counters where waiting tokens are given out. An administrator oversees staff calling out the numbers on the bottles with a megaphone. Patients come forward with their patient-books to prove they are registered and proceed to the counters behind the fenced-off area in front of the large waiting room, only accessible to patients. Family members and carers must wait outside.

[145] Before Covid-19 this was the schedule for Thursdays:
8am-10am (2h): Cardiac Med/GI/Neurosurgery
10am - 12pm (2h): Diabetic/Haematology/Medical Unit 4/Neuro Med (follow-up)/Surgical Unit 1/Breast Clinic
1.30pm - 4.30pm (3h): Tropical & Infectious Diseases (follow-up)/Intervention Radiology

At the counters, the patients receive their waiting tokens by speciality they are seeing. Some patients proceed to the airconditioned waiting room with rows and rows of metal bench-chairs, while others, whose clinic is in the afternoon, re-join their company outside.

By 9.30 a.m. the main hubbub is over, and the barriers packed away. The day settles into its usual ebb and flow around the specialist outpatient department, in line with clinic times. Following the morning buzz, taxis and cars line up in a flurry of activity to drop-off or pick-up patients between 12 p.m. and 2 p.m. and again from 4 p.m., before everything settles (literally and figuratively) in the late afternoon. By 5 p.m. the campus has quietened down to a tranquil hum.



Most days, three to five clinics run simultaneously in the morning (9 a.m. – 12 p.m.) and the afternoon (2 p.m. – 4 p.m.). These times a seldom strictly observed, as patients outnumber time available. Often patients are being seen over lunch breaks and into the early evening, especially in the RT department I often find waiting patients as late as 6pm.

The Specialist Outpatients Department's flurry in the morning, and the rise and fall of patients waiting with their company throughout the day, is set by the hospital's routines, its clinic times and shift patterns, as well as by the wider context. Bus times, traffic flow (or non-flow which makes travel times during the day unbearably long)[146] influence when people come and go.

[146] This changed with Covid-19 and the coup; streets are empty.

The hours until it is a patients' turn to see a doctor they pass in the shade. Armed with food-filled baskets, water bottles, and blankets to make the waiting time more comfortable, patients use newspapers, mats, tarpaulin spread on the floor to sit on. Everybody follows the passage of the sun to stay in the shade. Groups chat, eat, or sleep. As in every hospital, as we saw in the literature review, a mood of waiting hangs in the air, hot and stifling, or balmy in the rainy season, sharply contrasted with the bustling activity of coming and going in line with the day's air-conditioned clinic schedule.

This mood of waiting links to a lack of tertiary care outside of Yangon, and the wider infrastructure. Patients often travel long distances. Hence, many choose to arrive the night before, or wait the entire day on campus for their turn with the doctor. Lack of access to digital infrastructure is related to the (un)reliable availability of electricity, rendering the introduction of booking systems difficult, as eloquently explained by one of my interlocutors: not everyone has access to a mobile phone, let alone reliable access to the internet (which is dependent on the modern world's life-juice: electricity). The same administrator explains, the need for electricity hinders the introduction of digital patient records. Imagine what fifteen minutes of downtime mean in a closely synchronised outpatient clinic where understaffed and overworked teams of doctors, nurse, and workers must be as efficient as possible. Having said that, when the first Covid-19 wave hit the country, Viber was

used for makeshift booking systems by individual departments. Changes are possible when the need is great enough.

The rhythm of patient density is synchronised with traffic flows, bus times, travel distances, and personal preferences, such as not wanting to travel when it is dark. For example, Aunty Aung would arrive on campus in the early morning when it is already light because she is afraid to walk across the road from the adjacent monastery when the sun has not yet risen, and even then, at 6 a.m. when the day is bright, she would take off her jewellery to cross the road. This however means that her sister must wait longer for her radiotherapy treatment.

Day-night rhythms are colliding with clinic times and infrastructure. Waiting areas overflow and are improvised, colourful plastic chairs (in some instances bought out of pocket by department heads)[147] are shuffled around with the sun's trajectory outside the medical oncology Day Care Department. Patients waiting for radiotherapy lie-down in small groups on mats. The campus is doused in a collective mood of waiting.

Mood

Mood is affective, a collective "being together", according to Heidegger (Gammeltoft 2018). One of the most coherent experiences at YGH is waiting. The mood of waiting is the "melody" that synchronized the rhythms of the hospital; waiting is the hospital's background melody. Movements on campus, bodies in places, and more non-verbal registers, betray this mood of waiting, this a suspension in time and space. Waiting is a reality for almost everybody on campus at one point in time: patients, attendants, engineers, administrators, and infrastructures all wait.

[147] Anecdotal evidence gathered during masterplan development.

I am waiting for a meeting, an appointment, access; patients on wards are waiting for treatment, for a doctor or a nurse; patients' families are waiting everywhere for their loved ones to get better, sleeping on deckchairs outside the ICU, sitting on blankets on the floor, the waiting time is passed with chats and snacks; cancer patients wait outside the RT department for their token number to be called for their ten minutes of radiation; buildings are waiting to be tended too, leaking roofs wait together with the benefactors of the leaks for repair; engineers are waiting for budgets; administrators are waiting for the cycle of the financial year to apply for new funds; vendors are waiting for customers, the list goes. Even though it seems like everyone is waiting, collectively, egalitarian, waiting is not a classless endeavour. Not all of us wait; not even at traffic lights as Bani Abidi's 2006 video installation *Reserved*[148] beautifully and painfully demonstrates; the VIP in her film

[148] Bani Abidi; Reserved 2006.
https://www.tate.org.uk/visit/tate-modern/display/artist-and-society/bani-abidi
Vimeo Full Film: https://vimeo.com/99471568

does not wait. Waiting is tied to privilege. Others showed how waiting is tied up with power (Varley 2022; Wamsiedel 2022). With my ethnography I am showing the embodied act of waiting.

In this collective mood of waiting, campus' bodies move across campus with the seasons. The short cold months, usually between October and Mid-February, have a palpable relaxed and joyous atmosphere in all of Yangon. It is also the time when leaking roofs are fixed, because the rains stopped, and it is neither too hot nor too humid. By the end of February, it starts getting hot. Suddenly sunhats and UV protection parasol are ubiquitous in the city and on campus, and flip flops sticky on hot tarmac when crossing roads. The swelter lasts until the rains start, sometime in May/June, sometimes as early as April but in any case, after Thingyan, the regions water festival marking the Buddhist New Year. During the hot season, the buildings with natural ventilation get tested. I personally always felt that the general wards in the colonial buildings, which have no air conditioning, fare pretty-well, producing a mild breeze even during the hottest hours of the day, even though thermal mass is not a principle highly suitable for Yangon due to its marginal change between day and night temperatures.[149]

[149] Creating buildings with thermal mass means building with heavy and dense materials, for example bricks, constructing thick walls (similar to medieval castles in Europe) that cool down at night, cooling the spaces in the day, keeping spaces warm at night, reducing the need for artificial heating and/or cooling.

Rhythmic patterns change throughout the day, the week, the month, and the year, from the cold season to the hot season into the rainy season, a trinity of varying heat, humidity, and slip levels. On campus this translates into the emergence of puddles and slippery surfaces during rainy season, rendering tiled floors health hazards with warning signs displayed. The rainy season is a bodily experience, not only for me who tends to slip and slide along the hospital's tiled pathways; I am rushing too much. In Yangon, rainy season is the time of sniffles and (perceived) bowel issues (because of contaminated water through flooding).

The rainy season is also a time of lush greens and the most ferocious plant growth on buildings, leaking roofs, and overflowing drainage channels.

Materials have a rhythm in their wear and tear. Atoms, that make up the material, move in time and space, expending energy. This means that pipes need maintenance in line with their internal decay and environmental rhythms, in turn this determines the routines of the engineers tasked with their upkeep, and financial planners' who must provide the means for the maintenance works.

SPACES FOR UNDERSTANDING

Boris

The main building is freshly renovated; the entrance stairs are newly tiled in white stone, the turquoise betel-spit-stained walls are whitewashed and clean, without unnecessary signs littering its appearance, wards at capacity (as opposed to over). The new lift is up and running, while a breath of fresh air sweeps the central staircase with the reinstated natural ventilation since the old lift had been removed. Toilets are working, and the rains a couple of months prior did not, for the second year in a row, flood the basement. Everybody was proud to show what the UK's taxpayer's money had realised.[150] The main building was on its best behaviour.

[150] The renovation of the main building was partly funded through DFID who later also funded the masterplan.

In 2017, Boris Johnson, who was to become the UK's Prime Minister a couple years later, visited Yangon General Hospital in his capacity as the country's Foreign Secretary. Bored with the order and cleanliness he turned around, confusedly muttering “Where is the A&E? Something must be happening at the A&E… we should see the A&E”. The delegates from the hospital administration, doctors, nurses, the DFID team, and my team all looked at each other in consternation. The A&E is the last place you want visitors disturbing the workflow. We chose Boris’ path to least interfere with the running of the hospital, while showing him how far donor money can go, and how it can make a real impact on people’s lives. But Boris was convinced that the A&E is the place where he can get some “action” on a Saturday morning. The gaggle waddled off in the direction of “the action”, after all no one wants to upset the person who might have the power to fund the next stages of the project.

The arrival in the A&E was utterly underwhelming. Boris was unimpressed. It was orderly and quiet. The absence of “action” prompted him to recount how full London A&Es are on Saturday mornings, the week’s busiest time according to him, following the previous night’s drunken brawls and accidents. We all looked politely at each other. I cannot remember if anybody actually spoke up.

Saturday, alongside Sunday, is one of the quietest days at YGH. Cancer day care patients leave for the weekend, and in general, Friday afternoon evening/sees an exodus of people leaving Yangon for their villages to spend two days with family, rendering the Saturday morning in a downtown A&E quiet. The A&E’s busiest time of the week is Monday morning. Workers travel back into the city in overloaded, dangerously unmaintained, cars, minibuses, motor scooters, and bikes, hurrying through the city’s traffic to make it to work on time; or not if they have an accident.

The rhythms of the hospital are utterly contextual. The specialist outpatient department is besieged on a Thursday morning because this is the day with the most AM clinics scheduled (the clinic schedule an institutional routine); the A&E is quiet on a Saturday because workers leave the city over the weekend; the area in the shadow of the main building in front of the waiting room of the

Nuclear Medicine Department buzzes on its clinic days, but is a quiet backwater the rest of the week, its trees spending shade to people charging their phones on solar powered charging-stations. More subtle rhythms can be found throughout the week, gently ebbing and flowing within the institution's structure, while dictated by institutional routines and forces larger than the hospital; such as the healthcare system planning (for example catchment areas and specialist care provision), bus schedules, policies on working hours, and curfews.

Admission Wards

"One can skip a wedding, it is just another social event, but visiting someone in hospital, and going to the funeral, is important" explains one of my interlocutors, an administrator whose life is complicated quite a bit by the obligatory hospital visits of so many patients' friends and families. Cultural values are aspects out of the hospital's control that dictate the hospitals frequency.

As we have seen, it is the attendants who tend to and create the infrastructure of care. Hospital visits, showing support and care for a sick family member, providing comfort by presence is important. All administrators I spoke with understand the psychological and cultural importance of friends and relatives at the bedside when feeling unwell (even if not necessarily being fully aware of the earlier-mentioned clinical value). Ring discussed a similar phenomenon in her apartment block in Karachi: on a day she is sick, her neighbours insist on visiting her, quite contrary to her personal need for privacy; to her neighbours and friends not visiting a poorly friend is akin to severing social ties (Ring 2006: 52). As my interlocutor said above, you can skip a party, but this is life and death; so, the hospital's visitors are more numerous than its patients.

Balancing the hospital's structure, its spatial and infrastructural provision, its routines, and the rhythm of daily life, is tricky. On my explorations I often passed an empty or near empty ward while others are bursting with bodies.

Throughout the week, each “admission ward” has one or more admission days. Admission wards are the Medical Units, admitting patients once a week, the Orthopaedic Units, alternating intake on a

daily basis, as there are two, and the three surgical wards, admitting patients twice a week each from Monday to Saturday (I believe Sunday’s surgical emergency cases, following surgery, stay in the surgical observation until Monday).

Highly specialist departments such as Neurology (surgical and medical), Cardiology (surgical and medical), Cancer Care, Haematology, the MF+P and Burns Unit, Haematology, Dermatology, and Gastrointestinal are not so called “admission wards” and follow their own routines.

All departments are aware of this schedule and send/refer patients accordingly. For example, a patient coming in as an emergency medical case to the A&E on a Sunday, following an observation period, would be transferred to Medical Unit 4 in the western basement of the main building.

The rhythmic frequency of admissions resonates in the beat of ward life; general wards have a faster tempo than specialist wards. Dr. Myint is an administrator responsible for buildings accommodating both specialist and general wards. He is responsible for the wards’ day-to-day; each of YGHs patient-

accommodating-buildings is allocated a responsible administrator to whom doctors, and ward sisters refer to with problems.

Dr Myint's and his colleagues' remit is wide ranging across so called "social problems", for example disputes between sisters and workers, nurses and attendants, or visitors who don't follow the rules, as well as infrastructural problems. These range from blocked toilets and broken doors, to leaking roofs and brittle concrete. His role is that of a mediator and coordinator. While he mediates disputes, he is not the one climbing the leaking roof or removing plant growth from the eaves, his job is to call the right person to take care of the presenting problem.

In his air-conditioned, windowless, office a faint smell of fried snacks lingers in the air, the sole residue of an earlier visitor. He speaks of blocked and broken toilets, overwhelmed infrastructure on the "admission wards"; the breakage is a diagnostic tool for over-capacity and overwhelmed systems (pipes, wires, hinges). Here, the turnover is fast, and the hospital-stay often unexpected and unanticipated by patients and their families. They are overwhelmed by the disease, by the unfamiliar environment, and new to hospital life. They do not know where to go and what to do. In contrast, specialist units, like the other wards that Dr Myint is responsible for, have patients who are referred

from the “admission wards” or other hospitals. They are often elective patients (patients with planned procedures such as heart surgery or cancer treatment). They might have been to the hospital before, and their families with them, all of them are accustomed to the hospital’s rhythms and routines.

Dr Myint’s admission wards have a high turn-over, 60 to 70 patients are admitted per day. In contrast his specialist wards have a tenth of these admissions daily, and patients stay longer. Additionally, the building his admission wards are located in was designed as a specialist ward building; the one specialist unit within this building “has no problems”. The issues brought to Dr Myint that are most acute concern water supply and toilets, or the lack and inadequacy thereof.

While patients from all walks of life come to YGH for specialist care, often *choosing* to get, for example, heart surgery here (only two private hospitals offer heart surgery in Yangon in 2020, and not everybody is fit to travel to Bangkok, plus the reputation of YGH’s doctors is very good), non-specialist services are often chosen for economic reasons. Patients on the general medical, surgical, and orthopaedic wards tend to be economically less well off, often from rural Myanmar with little exposure to city life and city infrastructure. However, this does not factor in the problems Dr Myint and I discuss. While there are major differences in ward capacity between specialist wards and “admission wards”, the main factor is time.

In Dr Myint words, on specialist wards patients and staff (from cleaners to professors) have “space” to understand each other. They have physical and temporal space to build relationships. On admission wards, patients are "fast in, fast out". In a unit with one hundred patients, staff have little time to build relationships; nurses, sisters, ward aids, cleaners and

doctors are "faced with new patients everyday". Admission wards have infrastructural problems, because they have more patients and a higher turnover of patients who are unfamiliar with hospital life.

Admission, time, and infrastructure are connected. Infrastructures “work” when admission routines and social rhythms chime; toilets block and break, and water supply runs dry, when routines and rhythms collide. Infrastructure, routines, and rhythms are intimately intertwined; they need to be thought in conjunction.

Due to this stiff system of admission days, beds are empty on certain days of the week, when patients have been discharged already but the new admission day has not come around yet. Bodies do not heal within the institutionally prescribed routines of admission and discharge.

A digital bed-management system tracking admissions and discharge in real time, telling departments where beds are available, rather than managing beds by days of the week, could go a long way in improving occupancy and capacity; it might well be one of the principal tasks to tackle as

beds are the most valuable currency in a hospital. A digital bed management system could reduce the number of beds, while upping the hospital's overall capacity. However, such a system would be dependent on data infrastructure and, more crucially, on reliable electricity; reliability is key here, just imagine the chaos when such a system fails.

On a Monday Morning, the area outside Medical Unit 4 is buzzing. As we know now, Sunday is Unit 4's admission day. Relatives are trying to understand what they need to do, where they need to be, and what the patient needs to be comfortable on the ward. At the same time, visitors crowd the entrance to the ward and the area around ahead of visiting hours to see the "person in pain", the literal translation for "patient" from the Burmese word "*luna"* (လူနာ).

Space to understand each other is intricately linked to the infrastructure of comfort.

As we saw, visiting friends and family in hospital is important; patients will often ask for specific people, a grandmother, or a favourite uncle, finding solace in their company. Comfort is as much social as it is atmospheric (temperature and ventilation). I am not alone in noting this. Hannah LeRoux discusses the notion of comfort as not only atmospheric, when analysing comfort as a category in tropic architecture (2020). She highlights that the category of "comfort" in architectural discussions is often paddled as "objective" and "universal", tied to atmospheric conditions (rather than social), such as temperature humidity and ventilation, when it really is based on European ideas and feelings of comfort (European bodies), which, as we have seen above with Laura Ring's (a US American) experience of sickness in a Karachi apartment block, can vary substantially.

Comfort is a tool for biopolitics, as also Morales (2020) notices in the Andes. Dismantling and challenging common narratives of comfort seem paramount to me in understanding what hospitals are, and how we live with our buildings and they with us. As Simpson noticed with roads (2022), the meaning of infrastructure is not congruent with its narratives. For the hospital this means that, despite a "functionality" and "comfort" discourse, spaces do not work, nor are they comfortable for

patients' wellbeing. Most fatally, they can never be, as long as we do not redefine what comfort is. Here, in Myanmar, at Yangon General Hospital, comfort lies in numbers as well as air, light, and temperature. This means future developments need to design with the practices and processes of comfort. At YGH this means space for attendants and visitors.

CONCLUSION

In this chapter we saw the interplay and the role that systems (wider and localised), structures (figurative and literal), and rhythms (cosmic, bodily, and social) play in the hospital's daily life. Through the hospitals "infrastructure of comfort provided" by attendants, its "aesthetics of waiting" as a general mood on campus, and the "spaces of understanding" (or lack thereof) the hospital multiple came to life.

The intensity of the sun's rays dictates at what times of day clothes are dried; doctors rounds displace attendants from wards to public spaces; economic means influence how time is passed,

which pathways are taken (to the hospital pharmacy or the market stall), and available nutrition; light and dark cycles make it safe or unsafe to traverse the city for queuing at the outpatient department; understandings of comfort tie-in with wellbeing. I challenged narratives of comfort and offered a novel avenue to understand bodies and buildings, specifically hospital buildings.

Practices to create an infrastructure of comfort for patients explored the hospital through practices of well-being and care; how daily life of attendants is structured by cosmic rhythms, bodily metabolisms, medications, and economic considerations. Private activities are conducted in public; everyone can see every one's laundry.

A close understanding of practices of waiting, and the aesthetics thereof, the placement of bodies in space, reveals the hospital's overarching mood. A mood of suspension and anticipation. Hope and despair sit close together, share snacks in the cancer care's waiting areas. Rhythms of hunger, pain and nausea overlap with bus schedules, working hours, and shift rotas.

One afternoon at Thayettaw monastery complex, following an interview with Aunty Aung and her sister, a woman comes over and asks me to listen to her story too. Her brother lies sleeping on a mat beside us, a tube emerging from his nose. They recently moved from another monastery in Thayettaw to the hall where Aunty Aung and her sister stay. They moved because the other building was being renovated and the sharp smell of paint was nauseating for her cancerous brother. Here, the wider healthcare system, which necessitated this family from Mawlamyine[151] to come to Yangon for treatment, overlaps with the informal understanding that YGH patients find refuge at the nearby Monastery, while materially colliding with the brother's bodily comfort and wellbeing.

"Spaces of understanding" provide the figurative and literal infrastructure for staff, patients, and attendants to meet, unfolding a constitutive relationship. Here the wider healthcare system (catchment areas, reputation, and trust) meets the YGH's finite campus, butting-up against the

[151] Capital of Myanmar's Mon State; 300km drive southeast from Yangon.

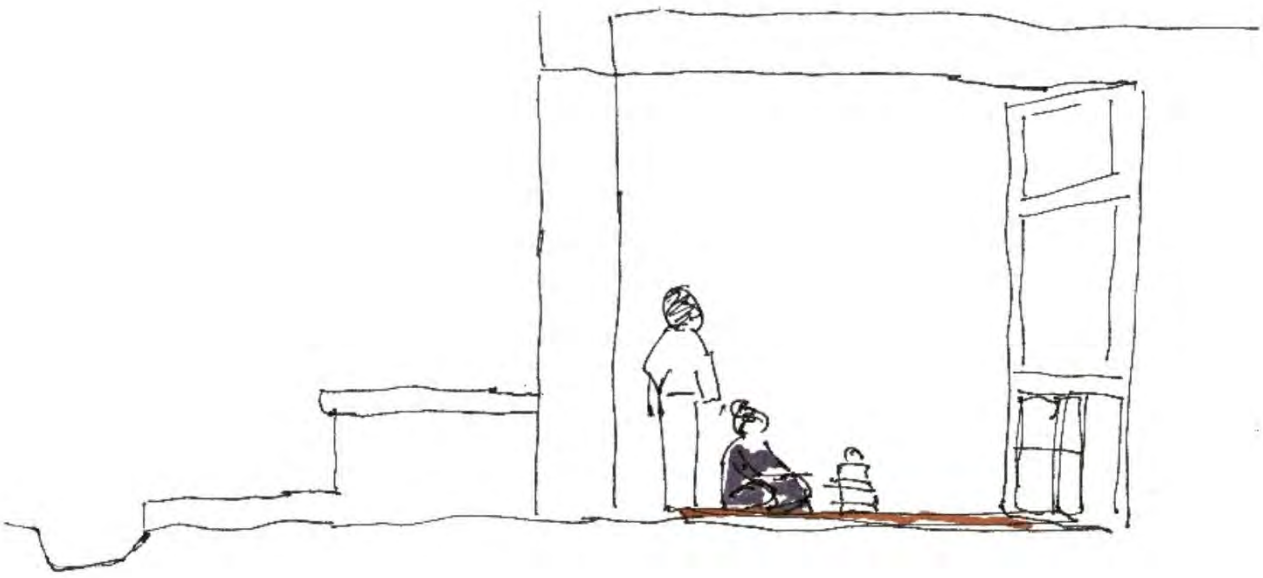
hospital's toilets, taps, and door handles that break under the density of the admission wards; while specialist wards offer spaces of understanding.

All three concepts, "infrastructure of care", "aesthetics of waiting", and "spaces for understanding", illustrate a key tension the hospital contends with: the existence of the hospital "professional" and the hospital "personal" or "private". For the doctors, nurses, and the workers hoping for "outsides", laboratory staff and administrators, the hospital is a workplace; somewhere to follow shift plans, make money, forge a career. For patients and their attendants, it is personal space where they might be experiencing the worst days of their life, all-consuming moments, when nothing else but the present matters. As an architectural designer working for private clients on their homes, I know this tension well. For them, their new home is the most important thing in their personal life, while juggling a day job; for me, the design of their house, it is my job. When a client calls me at midnight, to come to a Shanghai karaoke bar to hear about his latest ideas for the kitchen (a true story!), I could not care less.

Of course, at the hospital, private and professional is not as clear cut (and neither is it for me as a designer). We will see in Chapter 8 "Spaces of Responsibility" how workers content with and consolidate the tension between work and affect, their professional lives and patients' personal grief.

Coming back to the hospital's rhythms, metabolisms, and moods, I reach for Mol's multiples. One hospital is personal, private, full of grief and pain, hope and anticipation: the person changing pyjamas "in public" and feeding a loved one. The other hospital is a workplace, and if we remember the postgraduate student from Chapter 3, a career path. Both sit in tension. They compete when attendants struggle to find spaces to exist within the literal and figurative structures. At the same time, they are constitutive, and in need of each other. On a simplified level, doctors would have no professional hospital without the patients' personal experiences. The hospital's multiples are contingent.

Having tuned-into “a day at” the hospital in this chapter, and identified the hospital’s multiplicity though the daily practices, we will now turn our attention to larger rhythms across space, time, and species. In the following chapter we see how winds directed the position and volume of buildings; temperatures are bound-up with colonial airs and global atmospheres; ideas linger from times past, constituting our present, while colonial debris becomes seed for renewal, and entanglements of bodies and buildings will comes to life through detailed ethnographic writing, illustrating the relational consequences of infrastructure.



CHAPTER 7: BODIES AND BUILDINGS

A PIGEON EYES ME AS I CHANGE MY SHOES

Crossing the threshold into the operating suite of the Modular Operating Theatre Complex, or the door to the Cardiac Surgery Department's theatre in the colonial building, both constructed mid-2010s, chilly air washes the tropical mugginess off my skin. In contrast, the temperature hardly changes as we enter the neurosurgery department's operating suite.[152] Here, on the extension site, where Neurosurgeons have been operating since the mid-1960s. The minimal change in climate is down to less bodies in the space paired with natural ventilation; not air handling units artificially cooling the space. Subdued sounds drift through the double doors of the operating suite, while a pigeon peers curiously through the open glass louvres as I change my shoes to visit the neurosurgeons' domain. Yangon received a new neurosurgery centre at North Okkalapa Hospital three years ago[153], since then the caseload at YGH has stayed stable as opposed to the steady rise of previous years. The building seems on life support since it has become known that JICA will build a new Cardiac and Neuro Specialist Hospital nearby; all elective neurosurgery is planned to move into the new and improved facilities. This means that surgeons must shuttle between YGH campus where emergency procedures continue, and the new building. For now, broken equipment is not replaced in anticipation of the move, a circumstance with consequences we will see later in this chapter.

My trained eyes immediately note the lack of a route for waste. This means, it is on the team, through temporal organisation and individual responsibility, to ensure clean hands, hygienic equipment, and safe handling of infectious, non-infectious, and human waste. The emergency theatre that runs 24 hours for 365 days a year, is accessed through a room of which half of it is used

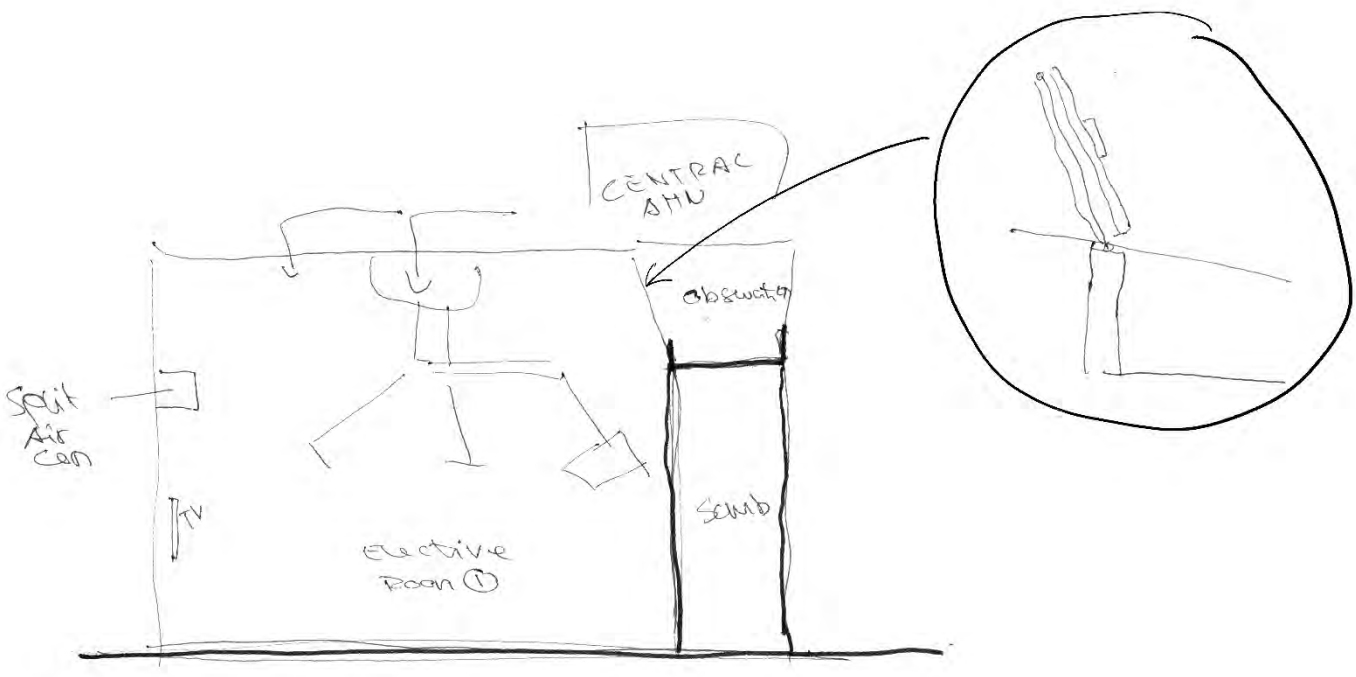
[152] I am using "operating suite" here for the entire area where surgery takes place, including the operating theatre and associated spaces such as storage, recovery rooms, and nurse stations. I use "operating theatre" for the operating room itself which might contain auxiliary rooms such as equipment and scrub rooms.

[153] Myanmar has four Neurosurgery Centres: two in Yangon, Yangon General Hospital (since 1966) associated with University of Medicine 1; and North Okkalapa Hospital (since 2017), associated with University of Medicine 2; two outside Yangon, of which one is in Mandalay since 1988, and one in Naypyidaw since 2008.

for storage. The scrub room is accessed through the operating theatre; the surgery team must walk through the sterile area before scrubbing. The autoclave is tucked under the stairs, past a rest area for general workers. YGH's specialist surgery teams prefer to take care of sterilisation of their own equipment rather than using the Central Sterile Supply Department (CSSD) in the Modular Theatre Complex on the main campus. One aspect is logistics, another is control over cleanliness of equipment in the face of unreliable structures: cold chains break, accidents happen, systems and resources are not always in place and/or trusted.

The emergency theatre has split air-con units, no air handling unit (AHU); therefore, the cool room smells faintly of medical gases and disinfectant from lack of ventilation. I learn about patient and blood transport across campus and what this means for the patients' bodies under the scalpel.

The bigger, elective, operating theatre with an observation area for students is used only four days of the five-day work week from 8am to 4pm; neurosurgery is a lucrative specialty in the better paying private hospitals *vis a vis* the measly paid but prestigious job at YGH. In the elective theatre, patients enter on one end, while surgeons and nurses enter through the scrub room; here infection



control is designed into the space. My interlocutor, a senior surgeon, explains that this operating theatre has better light, better ventilation with an AHU, is better for teaching as it is bigger and has a viewing gallery, and it has screens for intra operative monitoring.

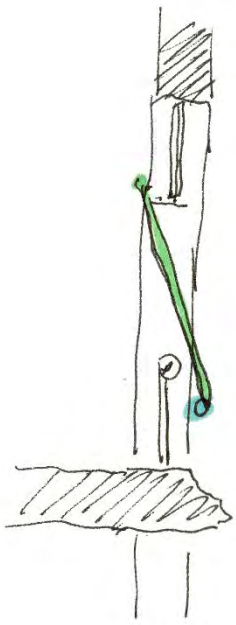
In the staff common room, a gecko scuttles away into a corner as we enter. Everything is clean, but it is not a sealed environment. Seeing this operating suite in contrast to others, I wonder how sealed any system can realistically be.

In conversation with Dr Smith, a senior foreign neurosurgeon who works and trains in many resource-low contexts including Yangon, I learn that most procedures that US hospitals can do, are possible at YGH (95%). His teams were always humbled coming to work here, realising how little fancy equipment one really needs to provide good care. Aftercare, and training of nurses and surgeons thereof, is more critical for outcomes than the infrastructure. What is important to note is that even though the senior surgeons have excellent skills, and the infrastructure does not prevent procedures, the environment surgeons operate in effects their behaviour. Dr Smith points out, the more sterile the aesthetic of the theatre, the less likely a surgeon is to walk into an operation with a mask half-on. The same surgeon would never walk into one of Yangon's fancy private OTs like that; a clean street is more likely to stay clean. Similarly, if nurses and doctors walk right by a handwash basin, they are more likely to wash hands before seeing a patient or touching equipment than if they must actively seek it out. In operating suites, the organisation pathways, or the lack of infection control designed into buildings, expose vulnerable bodies to bacteria and viruses, while disciplining the bodies of the staff. Mesman, in her article "Moving with care" (2012) shows how space is integral to patient safety by following an admission to the neonatal ICU. Here, I bring together spatial configurations that necessitate staff to take extra care and carry more responsibility; with patient safety, extending spatial configurations to questions of risk and staff safety, for example risk of unintentional malpractice, rooted in inadequate organisation of space and associated practices.

Highly technologized rooms and equipment are not strictly necessary since good care can be done with careful attention to bodily rhythms and individual needs, including localised ideas of care and comfort that are constructive for health outcomes and wellbeing. A sentiment echoed in many conversations; but someone must pay this attention, and extra so if the infrastructure disrupts rather than relates.

In the following pages, I will show how rhythms of bodies and buildings are intimately intertwined. This chapter takes you on a sensory journey across time and space into the daily life of the hospital. I show how bodies and buildings are rhythmed by colonial and other airs; how infrastructures relate and rupture, arguing for a practice-based understanding of the hospital. The ethnography will animate the horizontal and vertical, past and present, entanglements of the buildings and bodies, of patients, staff, attendants, and visitors, all striving for life at the site of the hospital. On this journey, I rethink the hospital through its daily practices and materialities.

The aim here, is to understand how buildings affect human relations and existence in the hospital buildings on a vertical (historical) and horizontal (present) axis in a composition of daily rhythms and



historic echoes. The chapter first explores the hospital's past and present "Atmospheres", followed by an ethnographic discussion of human/non-human relational entanglements through "Air, Blood, and Buildings", before bringing both themes together in the conclusion.

ATMOSPHERES

Colonial Atmospheres[154]

I feel refreshed as the warm breeze caresses the damp skin of my heated face. The thermodynamic effect of wind on sweaty skin cools my body as I am looking south over the roofs of the radiotherapy buildings. Over my head bows the Victorian style arch, as I am leaning against the iron-worn railing on the top floor of the main building. I am standing on one of the open walkways amongst recovering patients outside ward thirteen. They, like me, emit body heat. All of the main building benefits from the prevailing south-winds coming from Yangon River and the Andaman Sea beyond, but on the top floor, overlooking the neighbouring buildings, natural ventilation is best.

I have felt this breeze many times, its soothing chill after long hot site visits that ended on the upper floor. Even between the buildings on ground level, the prevailing wind can be felt. Only the study of archival documents, the original site plan (General Hospital, Rangoon 1915), and explanation of the hospital scheme from 1904[155], made me fully appreciate the "imperial formation" (Stoler 2008) of this visceral experience.

[154] I am borrowing this term from Asher Ghertner's "post-colonial atmospheres" (Ghertner 2020) to bring together past and present materialities.
[155] "Rangoon Medical Institutions, and a scheme for a new General Hospital" at British Library: IOR/P/6812 Dec 1904 nos 34-36 : Mar 1904-Dec 1904.

YGH is built on principles of colonial air, and continues to operate within what Ghertner calls "colonial atmospheres" (Ghertner 2020). While the coolness of air reflects hierarchies within YGH's buildings today, as we saw in Chapter 3, these atmospheres are echoes of the empire. They are "imperial formations"; ongoing relations built in stone at the beginning of the last century (Stoler 2008).

Colonial airs are deeply rooted in the campus' DNA, through its location in the city and the position, layout, and shape of buildings, and down to the design of individual spaces. Imperial formations of race, class, and gender relations linger in the building's corridors, consultation rooms, and ward spaces, informed by atmospheric conditions.

Air was a major factor in the original scheme. Its planners chosen its site for good exposure to winds.[156] The rectangular plot's long sides are north-south facing, the direction of the city's prevailing winds. When the hospital was constructed, the area between the river and hospital was not built-up, providing ideal exposure.

The main building, with the bulk of patients, is located on the northern edge of the site, while the Cardiac Building, originally the Paying Patients Block, is at the south-western corner of the campus. The most lucrative patients were located with the best ventilation; class is inscribed in the hospital's site plan through atmospheric conditions.

[156] See at the British Library Report on the hospital scheme from 1904; file: IOR P 6 812 Dec 1904 nos 34-36 Mar 1904-Dec 1904.

While the imperial planners arranged the site plan so that all buildings accommodating patients have their longitudinal facades perfectly exposed to Yangon's prevailing winds, reflecting class and race relations in the positioning of buildings on campus, the same principles are repeated in the building-designs. Both the main building and the Cardiac building are slender structures, their long facades north-south facing, allowing for ideal cross ventilation. As noted above, the higher-up in the main building we go, the better is this ventilation, and it was on the top floor where the Europeans' wards were located. At the same time, Europeans did not only benefit from the top floor exposure to wind. They were also fewer patients per ward; twenty-two "Europeans" versus thirty "Natives".[157] Less bodies means less body heat; therefore, cooler temperatures.

In her sensual ethnography of birthing rooms in Bolivia, Morales points out that temperature is rarely discussed in anthropological literature on hospitals, despite being a key aspect for hygiene, infection control, and clinical procedures (Morales 2020), as we will also see in the discussion on air in operating theatres, later in this chapter. In Bolivia as well as in Myanmar, temperature and ventilation, the lack thereof in Yangon or its abundance in the Bolivian highlands, are part of racialised discourses. In Bolivia these continue to penetrate today's birthing rooms, and in Yangon linger as imperial formations in building mass and campus layout.

While Ghertner discusses colonial atmospheres on a much larger geographic scale between Delhi and Shimla, where today's local elites replace the colonial officers from yore (Ghertner 2020), we see the same principle at the scale of YGH's city block in Yangon. Quality and temperature of the air individuals breathe in their offices or on wards mirror hierarchies, as we saw in Chapter 3. At the same time, the location of buildings and their shape reflect ideas about class and race from a time past, grounded in prevailing winds; YGH's corridors and spaces trap colonial airs, unable to release them.

[157] See schematic layout from 1904 at British Library: *Rangoon Medical Institutions, and a scheme for a new General Hospital* (OR P 6812 Dec 1904 nos 34-36 Mar 1904 Dec 1904).

Alongside the building's spatial design, class and race are also inscribed in the building materials. Different ranks (officers, colonels) had distinct types of accommodation, marked by their materials. The hospital's senior superintendent enjoyed accommodation akin to a colonel, while the resident medical officer's quarters were designed for a married captain or a major. A class division which translated down to the lowest in the hospital's ranks, from bricks to timber. As we saw in Chapter 4, the so called "pauper ward" or "special nursing block", a space for the treatment of a "special category of person", unique to Yangon, poor day labourers from India who lacked familial relations in the foreign city, was originally planned to be built from teak recycled from the "disease infested old building". The need for this building reflects the economic and political conditions of Burma at the time, while its materiality echoes the treated bodies' status. Even more than the placement of the main building and the paying patients block on campus, the "special nursing block" is an example of economic and political conditions translated into site and building layouts, and materiality.

As we saw in Chapter 4, the original plan to construct the "pauper ward" from recycled wood of the old hospital was vehemently criticised by Colonel King[158], the eminent sanitary expert and new Inspector General of Civil Hospitals for Burma at the time of RGH's construction. Under his influence, the special nursing block became a rotund masonry structure, reminiscent of Bentham's panopticon; a layout evocative of prisons, built for easy oversight with minimal personnel. The buildings do not exist anymore, but their legacy lives on. Today as well as then, the hospital is a harbour of the homeless and people without familial relations to take care of them; a circumstance not unique to Myanmar hospitals.[159] At the same time we see, as Sullivan notes in her contemporary ethnographic account of a clinic in Tanzania (2012), materiality and the place (environment and climate) make patients; different spaces, the local ward *vis a vie* the donor funded CT clinic in Tanzania (particular

[158] See: 1911, "Explanation re excess expenditure on General Hospital Rangoon"; British Library: IOR L PWD 6 845.
[159] For example, currently in the UK, countless patients who are fit to be discharged remain in hospitals due to a lack of social care. See for example: https://www.theguardian.com/society/2022/nov/13/hospital-beds-england-occupied-patients-fit-discharge

clinical services), the design of buildings “pauper ward” or native wards of old, create compliant, uncompliant, desirable or undesirable subjects of biomedicine.

Where the layered landscape of Madang General Hospital becomes a canvas for Street (2012, 2014) to explore the complex interplay of hope and disappointment, improvement and decay, and the enduring legacies of colonialism, colonial atmospheres and historic rhythms continue to echo through YGH’s corridors where today oncology gets new buildings, and the centre of excellence for diabetes care occupies the top floor of the prestigious main building.

As seen in the discussion of the hospital construction in Chapter 4, material changes were made at this inception that caused an excess in expenditure, but going forward rendered the hospital economical in its maintenance as well as more durable; two aspects that often go hand in hand while raising capital (construction) costs. What would the hospital look like today if glazed Marseille tiles had been installed instead of the robust encaustic ceramic tiles from Stoke-on-Trent? Or if more auxiliary buildings had been built with teak rather than masonry? The hospital today benefits from the outrageous cost extension over a century ago which bestowed it with lasting materials and sturdy designs. While these are “imperial formations”, they also ensure the hospital’s continued operation and the ability of the hospital spaces to accommodate changing healthcare needs.

Ruination/Renewal; from Stoler to Tsing

Despite its continued operation, YGH, especially the main and the cardiac buildings, the two most prominent colonial structures remaining on campus, are undoubtably ruins of the empire that built them, in the sense that Ann Stoler discusses ruination: "’Ruin’ is both the claim about the state of a thing and a process affecting it" (Stoler 2008: 195). Here, I am mostly interested in her notion of the ruin as a process. While YGH’s buildings might appear “dilapidated” (Article 25 2017), a narrative often evoked in documents used to inspire international aid, the campus is by no means a ruin; a place abandoned by humans. However, the colonial buildings are ruins of the *colonial empire*, they are imperial formations as demonstrated above. At the same time, much “rot” visible today derives

from Myanmar's military government that purposefully and actively "ruinated" the public healthcare system for their political ambitions and personal economic gain (Oehlers 2005); "Ruins are not found, they are made" (Stoler 2008: 201).

Healthcare-infrastructures play a vital role in anthropology of conflict and crises, as Varley showed in Northern Pakistan (2015), as discussed in the literature review. As Varley noted, hospitals are political infrastructures that mirror movements and counter movements of wider conflicts. Here, at YGH, its buildings served both as "exclusionary infrastructure" for the government's active neglect of public healthcare and cohere citizens into collusion with the military, as noted in Chapter 4, as well as a nucleus for renewal when the, in the introduction mentioned, interparliamentary committee found in the campus renovation a fantasy of an apolitical space in which the hospital could be "rejuvenated".

As historians have pointed out, Yangon or Rangoon, has been besieged by whichever army was in power at the time, from the British to the Japanese, to Myanmar's own military whose generals terrorised (and terrorise again since 2021) its own people. All left their "imperial formations" and "colonial airs" behind. While some are more imposing, such as the colonial buildings on campus built by the British colonisers, others are more subtle in form of international development aid: some only a continuation, for example of Japanese influence in the shape of the new specialist JICA hospital, while others are seen in absences, for example of kitchens, laundries and the like, reflecting the active government's (military) neglect which left its mark on minds and buildings. I am including all these in this discussion on imperial formations and colonial airs, which make the hospitals atmospheres.

Even though I am speaking of ruins, this does not mean that the hospital is a ruin (in the state of ruination); the hospital is alive, contending with the ruination of an empire that is no more, which left imperial formations behind, continuously remaking itself. Stoler points out that ruins have the possibility to be "epicentres of renewed claims [...], as sites that animate new possibilities, bids for

entitlement, and unexpected political projects" (Stoler 2008: 198). This is exactly what happened at Yangon General Hospital where the rejuvenation project was arguably only successful because of the involvement of buildings, the hospital's material reality, as anchors; the literal imperial formations from which renewal grew. To add another cautious thought, without the hospital building's colonial past, their ties to the former Empire and the commonwealth today, funding for the project might have not been secured beyond the initial seed corn funding. As mentioned in Chapter 4 when we looked at "History in the Present", financiers for the preservation of the colonial heritage tend to have a connection to the UK. Is it possible that with the imperial ruins comes a responsibility? Certainly, some have an unspoken pride for the Empire's built heritage, its preservation. The hospital at large might have benefited from this on a very practical level.

Understanding the hospital through the concept of ruins allows us to see what is otherwise not readily visible. The analytical categories that Stoler provides us with are useful models to discuss the colonial and military actions/decisions that linger in the buildings. In order to find a positive way forward, this needs to be seen and analysed to allow "consequential histories" to "open different futures" (Stoler 2008: 195), rather than an uninspired heritage discourse as seen in the afore mentioned (Chapter 4) coffee table books by snappy happy foreigners. In Yangon General Hospital's staircases, the colonial and post-colonial meet; at every hospital, in fact in every building, past decisions are today's active present.

YGH's colonial buildings are seeds of renewal, of change. Over the past century, the hospital has become a bastion of activism, as is evident in its role during protests in the past decades, and the military's response to the country's healthcare professionals following the 2021 coup.[160] The hospital's "rejuvenation" project that I was part of, was an anacrusis for a period of change and renewal throughout Myanmar following the 2015 elections.

[160] See for example: https://www.bbc.co.uk/news/world-asia-59649006

Throughout its history, YGH's buildings were added to, subtracted from, changed, stretched, and remade. Ann Stoler's analytical notion of ruination, her focus on the political and daily life of imperial debris, her material and infrastructural approach, what people *do*, and her refusal to gloss over contemporary realities of what she calls imperial formations with terms such as "colonial legacies", is useful in thinking with YGH's colonial structures (Stoler 2008). "Writing with buildings" accepts this challenge and provides a way to navigate the task by writing-out the realities of colonial legacies. Through materials and spaces written on the page, imperial formations come to life; sometimes in the simple observation of a nun's hand on a worn wooden handrail, as in the opening vignette of Chapter 1 where colonial atmospheres meet contemporary rhythms in the main building's stairwell.

Colonial administrators', hygiene experts', architects' and engineers' actions and decisions linger in the buildings' corridors, wards, and bathrooms; for good or for bad. At the same time, the encaustic tiles did stand the test of time, and so did the masonry walls. Nonetheless, their formation, organised by atmospheric conditions, was based on *decisions* on how to use wind, sun, and temperature, founded on ideologies rooted in imperial ideas. Stoler's notion of ruin as the state of a thing and a process (ibid) allows this heritage to be alive, an agent in the history and future of the hospital, rather than an inanimate category, driven by preservationist ideas of heritage conservation. Within this it is important to define YGH not as ruin, despite building on Stoler's notion of ruins.

Here, a reading of the hospital as a living, social, and affective archive might be useful. Inspired by Stoler's reading of Dutch archives on Indonesia (Stoler 2009), I suggest that a productive engagement with the "ruins" might be an archival approach. Rather than "reading" buildings (Forty 2000), I suggest to understand and approach buildings as places ("place" as discussed in Part I, where time and space converge). The hospital campus as a social affective archive can tell us much about its past and, by logical extension, its future. Like Stoler, rather than reading and analysing what is written in the pages of her archives, it is the spaces in between, what is not said, that is

interesting; the anxieties and unspoken hierarchies embodied in the buildings' walls, teasing out the trapped airs that linger.

At YGH, colonial and post-colonial times meet and layer with more recent ideas of what a hospital is and should be. The hospital's corridors and spaces, *especially* the colonial area ones, are far from ruinated. People used and adapted them; verandas became wards, offices, and again walkways; bathrooms are renovated and made accessible for wheelchair users; the well-planned ventilation of yore is appreciated and reinstated again where it was lost by adaptation, interpretation, and reconfiguration, in a continuous cycle. The boundary between past and present has been blurred, following Hanna Le Roux's metaphor of the façade boundary that blurs environments and ideologies (le Roux 2004). And the boundaries continue blurring; today's decisions are tomorrow's consequences.

At the same time as challenging YGH's buildings ruination/dilapidation narrative, especially international planners (including my past self) like to evoke for their purposes, I acknowledge them to be *ruins of a past*, that in themselves became seeds; seedlings for the hospital to grow into what it is today. New buildings, with their own future ideological debris, layer alongside, into, and across the old. YGH is alive. Therefore, I am using Stoler's useful call for specificity and careful analysis of imperial debris and formations, to notice, as Anna Tsing did with her Matsutake mushrooms (Tsing 2015), the regenerative attributes of these specific colonial buildings. Stoler's ruins, analytically, allow for a tangible, material engagement with the "colonial debris"; the things that "weave their way back through racialized hierarchies and the concreted aphasias on which privileges depend" (Stoler 2008: 209). However, building on this, I think with the notion of renewal from within the imperial debris. This leads us to Anna Tsing and life in capitalist ruins (Tsing 2015).

The colonial project in Burma was rooted in economic interests and capitalist ideologies, as we saw in Chapter 4 when we explored the hospital's history. The, from labour, ruinated bodies that washed-up in the "Pauper Ward" were symptoms of the region's capitalist exploitation. If you

remember the "Pauper Ward" was a "special" nursing block for "a class of patients not met with in any other similar institution in India", a "floating population" of native Indians, brought to work. These, today demolished, buildings are symbolic of the capitalist exploitation of colonial Burma, which continues under a different flag (the one of the Myanmar military) until today.

Life at YGH is life *from* the capitalist colonial debris. Like deforested wasteland became fertile ground for Tsing's Matsutake mushrooms (ibid), the colonial hospital buildings, the empire's (capitalist) ruins, are fertile ground for the hospital's renewal. While not the natural more-than-human ground of the Matsutake, the colonial buildings lend the hospital prestige and sententiousness, as well as favourable thermal properties and lasting materials.

The point I am making here is one of growth and renewal from what looks like wasteland on a first glance, with trees growing from eves, leaking pipes, and moss and salts blooming on brickwork. However, like the Matsutake mushrooms, notwithstanding more human agency in the case of buildings, new continues to grow from the existing. For example, the shiny new cardiac operating suite inside the colonial building with banyans growing from its eaves, or the 2014 built Modular Operating Theatre Complex wedged between the main buildings, the cancer wards, and the Ghost tree that persevered over time. These new structures are different to the Matsutake, they are man-made, but like the mushroom grow from the debris left behind by capitalist exploitation; colonial or otherwise.

Leaning again on Mol's notion of bodies/objects manipulated in practices (Mol 2002), I notice and acknowledge the practices that made the Victorian style buildings on campus, the colonial ruins with their imperial formations, and the dilapidated infrastructure, neglected by the military regime; (wilful) neglect is also something "done to" buildings. Here the hospital is multiple: An imperial formation and a seed of renewal; this multiplicity sits uneasy together. Nevertheless, this hospital multiple, these two "versions" if you like, depend on each other, standing in edifying tension.

While I discuss the ruins of the empire in regenerative terms, I am sure that the hard to grasp and every growing "rot" (Stoler 2008: 200) from within the imperial formations is everywhere. I have shown some of it in the way departments are spatially organised by specialties, the old faculty model of care as discussed in the introduction and in Chapter 3. In the following chapter (Chapter 8), we will encounter mould in high corners of one of the newest buildings on campus, pointing to the rot of (neo-)colonialism that haunts the hospital today in building practices and designs. This is the rot Stoler talks about: the extension of colonial exploitation seen in expat experts (Kunz 2023), international aid, and building regulations. Another type of "rot" generated from the time of the military regime is very much alive in people's and institutions' habitus: a reluctance to plan and invest in the future. Rhythms of material decay were, and still after a transition to a hybrid democratic government sharing power with the military, addressed in an *ad hoc* manner, rather than through careful long-term planning; the rot of eroded trust in a future.[161]

I see "rot" not only in the mistrust in a future. Continued export of buildings and technologies from centres of knowledge to the periphery is part of this as well. While working with European teams on international projects, I have often witnessed puzzlement and irritation so to why a "solution" that worked in Europe/USA/Australia or even Singapore did not work in Yangon, pinning it on local incompetence, and neglecting local specificities. Similarly, processes that work in Yangon do not necessarily work in Myanmar's rural areas or smaller cities; one clinician pointed to the knowledge and facility gap between YGH (the centre) and district hospitals (the periphery). Ultimately, at YGH, I can only see the rot, point it out, be specific in my writing and language, but leave judgement thereof to today's inhabitants of the spaces. They have a desire for "modern" hospitals that look and feel, smell, and work like the ones many of the foreign trained doctors know from their education in Edinburgh, London, Sidney, and Singapore.[162] The problem I *can* identify as a building professional

[161] A mistrust that the 2021 Military Coup confirmed once more.
[162] These are the cities I heard more often about as destinations for doctors to receive foreign training.

and social anthropologist is that the way we build our hospitals today is often not in line with the atmospheres they must operate within.

Global Atmospheres

Throughout the thesis, I show in detail how "there is no hospital in general". However, I cannot fail to notice that hospitals have *airs* in general: The ICUs' and operating theatres' globally homogenised atmospheres.

Whenever I would ask a surgeon or an anaesthetist about the difference between patient care in an operating theatre or ICU in Yangon, a tropical climate, and a temperate European climate, the answer was always: "There is none". This answer is symptomatic for the discrepancy of what a hospital should be (a space of international best practice), *versus* what it is (a localised place with people, needs, climates); and is also not entirely true on the ground, practices differ in an ICU in Yangon to an ICU in London.

Coming back to temperature and by extension humidity, when the air temperature in a theatre is too high it is unsafe for the patient. Microorganisms grow in warm environments, increasing the risk of infections. When the humidity is too high, condensation can develop on the ceilings and equipment, resulting in non-sterile indoor "rain" on patients or instruments. Furthermore, if either the temperature or the humidity is too high, surgeons might start sweating which is distracting and drops of sweat might fall into a patient's open incision; cold is bad as hypothermic patients are more likely to get wound infections. Therefore, machines maintain room temperature and humidity within a range[163] and filter the air. Air in YGH's operating theatre is controlled to the same coordinates as everywhere else; anaesthetists work in globalised environments.

[163] In the UK between 18°C to 25°C and 35% to 60% humidity; see: "Health Technical Memorandum 03-01 Specialised ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems" p.44ff (at: https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM0301-PartA-accessible-F6.pdf)

Here I would like to take a moment and pick-up Ghertner's "prosthetic atmospheres" (Ghertner 2020). While in Ghertner's discussion these atmospheres are pockets of clean air, linked to privilege and ultimate survival in a polluted world, prosthetic atmospheres at the hospital are acute. They keep the patient alive. Machines tightly control air filtration, humidity, and temperature, in operating theatres and ICUs. At the same time, they are contingent on electricity. This "air" is the same regardless of geographic location, standardising procedures and protocols, keeping bodies to certain temperatures, and air clean. Air quality is key for infection control. In very dry (dusty) or humid weather infections are likely; flies carry disease and are the biggest issue. While these tightly controlled airs hold immense potential, meaning surgeons from anywhere can operate everywhere and surgical advancements can travel, the airs' contingency on electricity makes them, and by extension the human body, immensely vulnerable. International guidelines collide with local needs when electricity cannot be readily provided. In Yangon power cuts are common, especially since the military coup of 2021, and their frequency tied to the seasons. During the hot season when the growing numbers of air-conditioning units in the city overload the fragile grid, power outages are more common than during the cold months.

The last time I discussed the issue of electricity with someone from the hospital was in the summer of 2020, at the end of the hot season when the air became so muggy that everyone was hoping for the rains to start. All rooms in the modular operating theatre suite have UPS[164] battery back-up for 15 minutes. Anaesthesia machines and oxygen have one hour UPS battery back-up, but after 15 minutes lights go out and the room ventilation stops; the surgery teams get their mobile phone torches out if necessary. Only the cardiac room and two other operating theatres (three of ten in total), alongside the corridor lights, have diesel generator backup. When the power cuts, nurses rush to the electric theatre doors to keep them open to avoid getting trapped; surgery teams inquire with the hospital's electrical maintenance department how long the power will be out, to be able to plan

[164] Uninterruptible Power Supply

for the patient on the table. Often the length of power cuts is predictable by the source of the cut. YGH has priority and gets power back more quickly than rest of Yangon, using more than one power source. Usually, power cuts do not last as long as they used to. Today, the surgical teams just wait in the dark, for up to one hour, until power comes back. If electricity remains cut for longer, the team must hand-ventilate and finish with torches. YGH's modular operating suite has not had a case like this since about 2015. Only recently, in late spring of 2020, Yangon suffered a longer power cut. It lasted for three hours in the early morning. The time of the power cut meant that the surgical teams were able to wait and start the scheduled surgeries later in the day.

The point I want to make here about homogenised atmospheres, is that while they hold immense potential, they are contingent on electricity. This makes the human body on the operating table vulnerable. YGH's operating theatres do not have electricity issues as they used to have when I first started working on campus in 2015, or other, less acute, departments continue to have, for example the forensic department as we noted in the previous chapter. Nevertheless, if the power goes out for longer than one hour the prosthetic atmospheres fail. I do not want to advertise solely mechanically ventilated, lit, and air-conditioned hospitals, something possible as shown by projects such as the Nyala Paediatric Centre in South Darfur[165], but it is important to question and discuss the (over) reliance on electricity that creates the atmospheres that keep us alive. If the power goes, the lights go out, and life with it. In this sense, power cuts are an anti-rhythm, disruptive of "natural" rhythms. However, another reading is possible. Given the state of the world, and fact of electricity's existence, it might be more productive to think of electricity as a meta rhythm, and plan hospitals accordingly.

[165] For details of the project see the architects' website: https://www.tamassociati.org/portfolio/nyala-paediatric-centre/

Nightingale Wards

In the case of prosthetic atmospheres, brute force, artificial air and light contingent on electricity, provide the environment that chimes with patients' bodies. However, many environments across campus are more or less in tune with the local natural and the social environment, the two often overlapping.

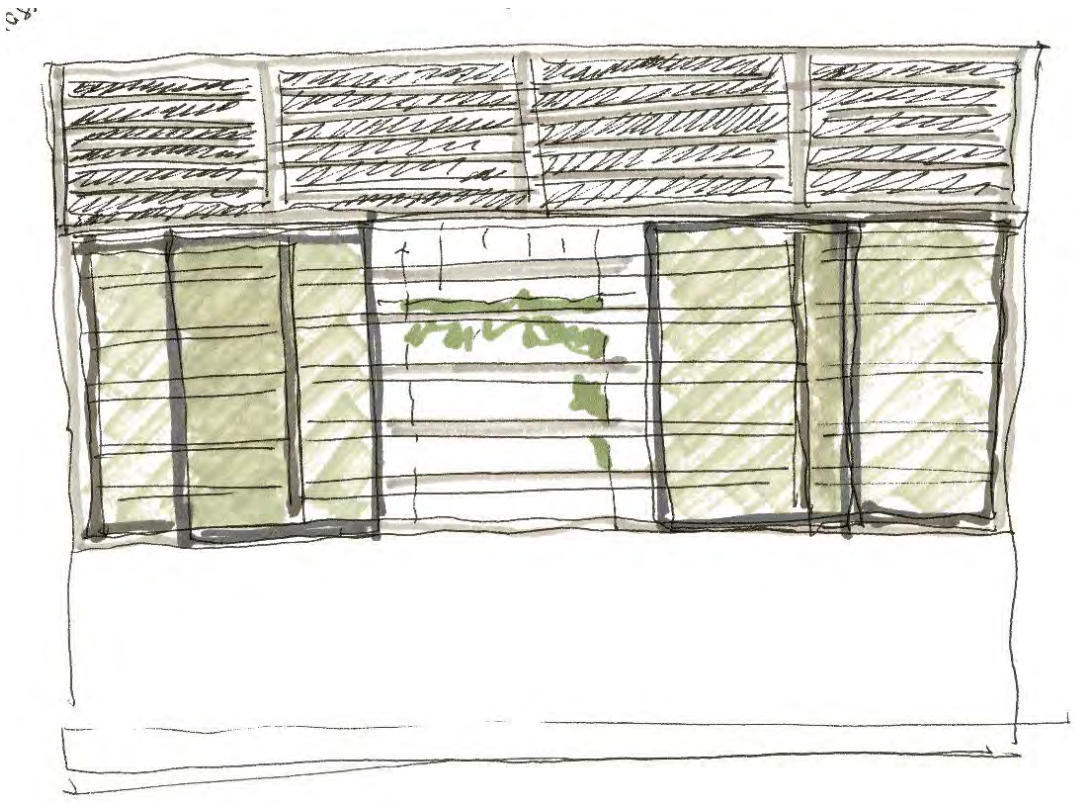
As we saw, much of the hospital's overall layout, buildings' positions on the site and their floor plans, elevations and sections, are rooted in Eurocentric ideas of biomedicine and comfort, class, race and gender ideologies, often grounded in atmospheric conditions; the local natural environment layered with the (foreign) social environment of comfort. These roots are still visible today and continue to influence how more buildings are designed and where they are placed.

A general lack in family spaces continues to pose moral as well as infrastructural problems, as noted in the previous chapter. The theme will emerge again in the next chapter, when "our" attendants' (in the words of an administrator) fill gaps in the system by occupying "spaces of responsibility", finding literal expression in the spaces the attendants occupy. While clinical staff has always been overstretched, starting as early as the hospital's inception, as documented in the India Office Records at the British Library, at the time it was nurses who did much of the care that attendants do today. Therefore, the colonial planners saw no need for dedicated family areas, nor was there a will to accommodate family; to them biomedicine was done by experts, separate from social and individual relationships. A belief rooted in what healthcare should be, rather than what it is.

Anthropologists know well, that the care of patients is inherently social and local, and with it the spaces of care (Mol 2002; Van der Geest & Finkler 2004). Yangon General Hospital lives this every day, even if biomedical discourses are upheld in obvious contradiction to visible realities as also briefly noted above; nurses, patients, the family, and the buildings become entangled in different temporal, spatial, and environmental rhythms, and with global biopolitics through the bedside care

arrangements. I will come back to this in the thesis conclusion with the discussion “No General Hospital”.

Now we turn our attention to the entanglement between bodies, buildings, and the environment. While the colonial design needs to be questioned, it was not all bad; favourable orientation of buildings lead to well-ventilated wards, thick brick walls continue to keep the buildings cool and are durable, high ceilings and intricate joinery allow air flow and views outside. The reason these buildings still function today is tribute to the insidious colonial project of researching the local context in manic detail for exploitative means. We saw in chapter three how colonial town planning was a well-oiled machine. Building-designs often borrowed vernacular techniques, and administrators used planning regulations, for example construction materials and distance between buildings, for political means (Turner 2021). Grown from within this colonial project, the Rangoon General Hospital was suited to the environment – good ventilation does not only cool the building, but also prevents mould in humid climate – and provided a “comfortable environment” for healing. But comfort for whose body?



Beside (body)political issues, the idea of *comfort* is based on European feelings on temperature in the tropics (le Roux 2020). These ideas are alive in the bricks of Yangon General Hospital today. In a society like Myanmar, comfort is grounded in care, caring, and showing up for each other, rather than cool air. Family spaces are dearly missing, as several interlocutors bemoaned. Or, as one said, the entire hospital is social (family) space today; spaces, between clinical areas and buildings, the corridors, parking areas, sheltered nooks and crannies are flooded with bodies. In the buildings from the turn of the last century, built structure and bodily rhythms overlap rather than collide, as is the case in some of the newer structures.

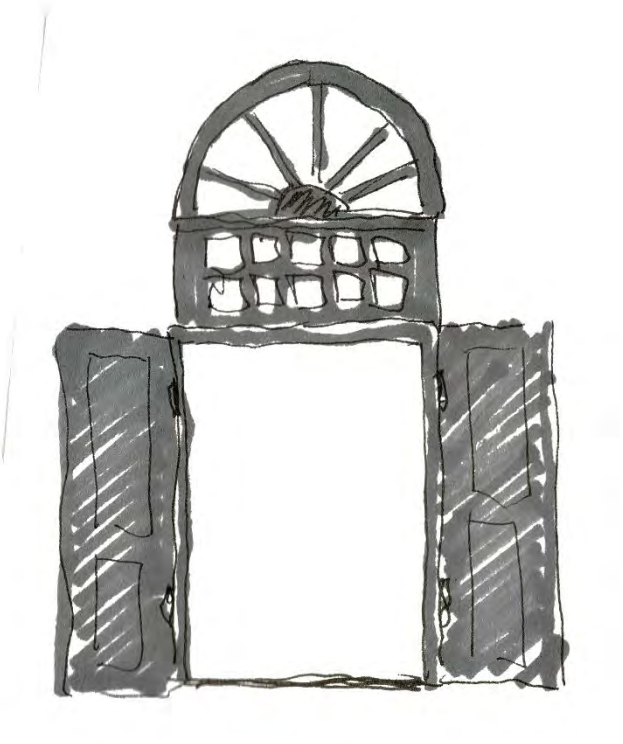
The clinical colonial buildings on campus constitute of model Nightingale Wards.[166] The famous 19th Century Nurse revolutionised nursing and in particular healthcare architecture. In 1860 she wrote about the importance of environmental factors on patient health and nursing (Nightingale 2010); in *Notes on Nursing* she details the positive physical effects of views, light and colour (Nightingale 2010: 84); three years later in *Notes on Hospitals* she describes the need for fresh air and ventilation as well as lighting of wards for healing, and the negative effects if these are neglected, such as spread of disease (Nightingale 1863). Her writings, often grounded in meticulously analysed quantitative data (Sinha 2017), became the basis for hospital design, first in Britain and the empire, later throughout the world, until the 1950s when new medical knowledge heralded the high-rise as a viable typology for hospitals (Williams 2020).

In the 1860s Nightingale integrated environmental and bodily needs, and their rhythms in her tracts on hospital architecture, discussing health benefits of natural light, ventilation, and views of the

[166] Principles developed by Florence Nightingale are still today a reference for good hospital design, especially when thinking in terms of environmental sustainability with an emphasis on natural ventilation and light.

outside. Today building regulations pick-up body rhythms and room ventilation in guidelines addressing the heat certain number of bodies produce in a space and humidity exhaled by lungs.[167]

At the New Rangoon General Hospital, understandings of the relationship between bodies and buildings translated into generous external corridors with high ceilings, set-back, equally vertically generous, wards (think "ball room"), to protect its occupants from the tropical climate. The external corridors give shade from the relentless sun and shelter from the seasonal rains, while allowing for a well-ventilated space through generous openings to the wards. All the joinery of windows and doors is carefully crafted for maximum ventilation; the ward doors with openable leaves, have a swingable fanlight, and a vertically twisting porthole above, made from teak or pyinkado.[168] The spatial organisation with nurse and doctor rooms placed between wards keeps walking distances manageable. The design, highly functional at the time with European bodies in mind, is still an efficient space for basic healthcare at YGH[169], safe for its over occupation. The wards in the main building are an attempt and exemplar of overlapping structure and bodily rhythms; perspiring bodies are cooled, and spaces are ventilated by the Andaman Sea's winds captured in the buildings; natural light floods the wards and minds of patients through large openings,



[167] In the UK see for example Health Building Note 00-09 by the Department of Health (at: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-09_infection_control.pdf) which addresses infection control, and Health Technical Memorandum which deals with ventilation specifically (at: https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM0301-PartA-accessible-F6.pdf). Guidelines here are based on bodily rhythms.
[168] Pyinkado is a hard wood, harder than teak, with a resinous quality, and with similar resistance to termites as teak.
[169] Personal conversations with working nurses and a healthcare space planner.

protected by external walkways; physical exhaustion of nurses, workers, and doctors is countered by floor plan layouts.

While the ward design works for the individual body, the overall spatial design was not for Burmese bodies. Communal spaces were left out, the comfort of individual bodies trumped the social body and the comfort from care by loved ones. Today, the new Modular Operating Theatre Complex, despite its many environmental issues which we will encounter in the next chapter, seems to attempt a compromise. While the wards themselves still focus on the patient, ante space in front of the wards is plenty; at night, this corridor space transforms into a dormitory.

In the first part of this chapter, I showed by way of the hospital's atmospheres how past decisions are today's consequential realities for the hospital's bodies and buildings. Colonial, and other oppressive regimes' colonial formations linger, while rhythms of renewal chime in consonance or discord with echoes of the past. Going forward we will remain in the present. While keeping the atmospheric conditions in mind, we will see in detail how rhythms of bodies and buildings collide, collapse, and/or constitute each other, bringing the relational as well as disruptive energy of infrastructure into focus.

AIR, BLOOD, BUILDINGS

Air

A patient is breathing rhythmically on an upper floor of the colonial main building. Through a mask on their face, oxygen moves into their lungs, carbon dioxide moves out.

A daughter or a husband is by their bedside, tired and worried for their kin, there to attend to the patient's needs day and night: feeding them, cleaning their body and clothes, administering

medicines, and providing pastoral care; a kind word and reiterations of encouragement, as much for the patient's benefit as their own.

Via hundreds of metres of thin metal pipes, oxygen floods the patient's lungs. The pipes climb along white ward walls, around and over cornices, down red bricks that have been in place since the turn of the last century, into the ground-level basement where the manifold is located.

Here, large oxygen bottles feed the system. They are delivered by young men on flatbed trucks, every day, weekends and holidays included the truck trudges through the Yangon traffic from the factory a few miles north. The pipes' lengths vary with the patient's exact location. They are longer if they are on one of the two upper floors, shorter on the elevated ground floor.

As air moves in and out of the patient's lungs, the bottles feeding the manifold empty. The metal warms up and the cold damp from the thermodynamic processes dissipates as the oxygen escapes into the manifold feeding the patients' breaths on floors above.

As the tanks gradually empty, Hain Thura Kan, a worker from the oxygen department, or one of his colleagues, sets off to check the manifolds in his care. The patients' breath is his days' metronome.

With spanner in hand, Hein Thura Kan visits the different manifolds three times a day, at four-to-five-hour intervals, and in sync with the hospital's breath.

Clinging the spanner on the shoulder-high gas bottles he checks their charge. If they are empty, loosening the bolt from the dry bottles, he changes them for new cylinders, cold and damp from the condensed water on their surface. The thermodynamic process is his visceral cue. The clinging and

banging, the touch of a hand sensing the temperature of the metal, a counting of empty and full cylinders, is a routinised intimacy, making sure everything is in order. Only the careful affective diligence with which Hein Thura Kan conducts his task betrays the awareness of its importance. Hein Thura Kan will never meet the patient, and the patient and their attendant would not pay any attention to the tall man with his spanner, hurrying from manifold to manifold in flip-flops, a t-shirt, and tied high longji.

Patients' breath organises maintenance rounds and delivery routines. Breath synchronises Hein Thura Kan's and the other oxygen department workers' journeys to the manifolds, and the flatbed

trucks' navigation through the gruesome Yangon traffic, while patients' paths and the keeper of their breaths are unlikely to ever cross. Infrastructure mediates this relationship.

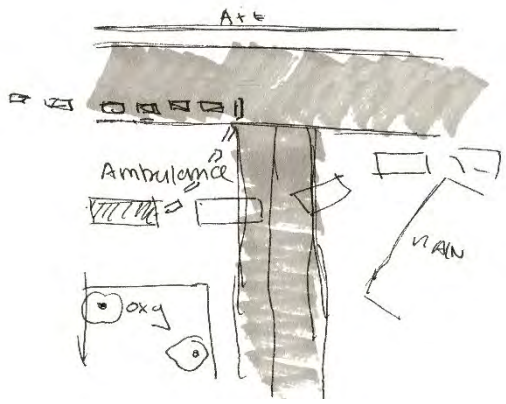
While rhythms and routines at times overlap (sun, laundry, and morning rounds), sometimes collide and butt up against each other (bus schedules and waiting times), here they give rise to each other. Bodily rhythms (breathing) determine mechanical rhythms (emptying of the oxygen bottles), which shape human routines (oxygen rounds). The rhythmic breathing of patients dictates the oxygen flow in the manifolds. This bodily rhythm sets the frequency of the maintenance rounds that Hein Thura

Kan and the other workers from the oxygen department must make, with spanner in hand, to the manifolds around the main campus; breath keeps time for the institutional routine.

Blood

Where in the case of oxygen the mediation through infrastructure is relational, in other instances they stand in a tension of relationship and rupture.

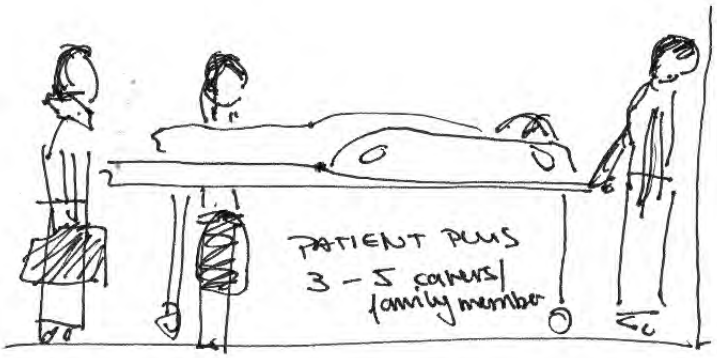
An ambulance is waiting at the back of the A&E, just outside the Oxygen Store, between the main building's west wing and the Radiology and Laboratory building. A team of A&E



workers, a nurse in tow, arrive with a patient on a gurney, their flustered but calmly cooperating family members follow alongside with bags of necessities for a hospital-stay. Sometimes the patient is unconscious, other times a moan can be heard, most likely a traffic accident victim.

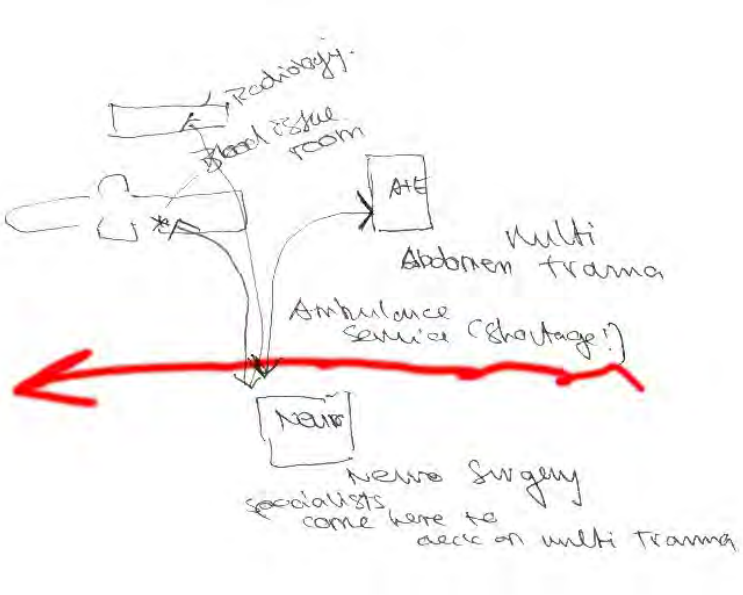
They might have multiple traumas and already had surgery at the operating theatre in the A&E. It is likely that they have been under anaesthesia and came up for this transfer in order to go under again once arrived at the Neurosurgery operating theatre. Neurosurgeons told me that other specialties are afraid of head injuries, so it is them who get-in last and will keep the patient for recovery. The few times you will see a child on campus, it is most likely here, with head trauma or a brain tumour.

For some reason, which neither I nor one of the hospital's anaesthetists have understood, the Neurosurgery team refuses to operate in the A&E's operating theatres. They insist on transferring patients, making them go in and out of aesthesia. In contrast, cardiac surgeons do operate in the A&E's theatres if necessary; but they are also just next door as opposed to a 10-minute walk across a hazardous road, as is the case with the Neurosurgery Department. The question arises, if it is necessary to uphold antiquated understandings of specialities translated into the hospital spaces. As explained in the introduction, the model of care is "by institute". Buildings on campus are organised along specialties, akin to medical textbooks or university departments, rather than along the lines of patient flows, surgical, and clinical needs such as critical or high dependency care, specialist expertise in relation to care, or the rhythms of bacteria and viruses (infection control). This structure (physical and figurative) sculptures and corsets the hospital's daily life.



The ambulance with the patient makes its way across the busy, and unforgivingly hot or wet (depending on season), four-lane one-way road that divides the main and the extension campus where Neurosurgery is located with its two operating theatres and 150-bedded wards.

If the ambulance was available when called by the A&E team, it now might get stuck in traffic while travelling the 50 metres it must cover on one of the city's busiest east-west arteries. On arrival, the patient is going into operating theatre two, allocated for emergency cases; the gurney goes one level up, accessible with a lift at the other end of the building from the main entrance and the operating suite. The lift was installed in the last 15 years only. Before the early 2000's, patients on stretchers were caried up and down the stairs.



The Neurosurgical team has only two operating theatres, too few for their case load, I am told. This lack of space puts pressure on the speed at which surgeons operate. The patient is operated on much faster than usual in less pressured settings. Lack of space leads to shorter surgery times which means more bleeding, and more bleeding than in turn requires more blood transfusions. Transfusions come from the Blood Issue Room in the main building, on the main campus, across the afore mentioned hazardous road.

The surgery team usually orders enough blood for any given surgery, however in case of unforeseen circumstances, a worker is sent to fetch transfusions during surgery. This can take up-to 45 minutes, while the anaesthetised patient and the surgery team wait.

Should the patient need a CT scan or other imaging services, they must track back to the main campus. The department's CT broke recently and remained un-replaced or repaired in anticipation of the new JICA built Cardiac and Neuro hospital,[170] which, according to my interlocutors, was due for

[170] https://www.jica.go.jp/myanmar/english/office/topics/press180720.html

completion in 2021. The new specialist hospital's current fate after Covid-19 and the Military Coup of 2021 is unknown to me, as is the CT scanner situation.

Once again, an ambulance is called to take the patient to the imaging department. This time, from the extension site to the main campus, the ambulance must circle the entire city block due to the one-way system around the hospital. Traffic jams are common.

The pathway infrastructure and spatial configurations, stretched over two sites, have a direct effect on clinical services and patient care, as does the context of the hospital within the city. Embedded in the rhythms of the urban environment, the ebb and flow of cars and buses,[171] and the timing of traffic lights compete with bodily rhythms of life and death. Roads, ambulances, and hands carrying blood, relate and rupture at the same time.

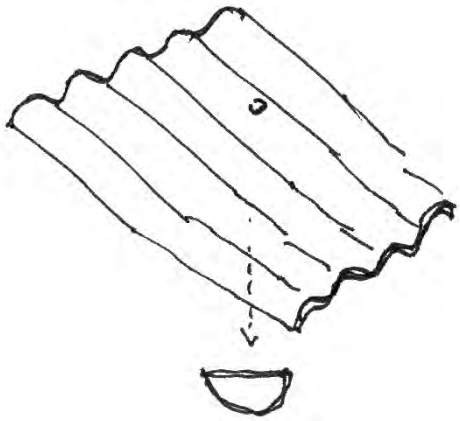
Collision of structures and rhythms, intangible in form of institutional organisation, are tangible in form of buildings and movements across campus, shedding light on the entanglement of bodies, buildings, and the city. Rhythms of breath and blood are related and ruptured by infrastructure.

Buildings

Throughout rainy season, when U Than Thein Gyi, the head of the building maintenance department, arrives at his office at 9 a.m., ward sisters filled his desk with new reports of leaks, and requesting repair. Behind the desk hangs a large A0 vinyl print of my former team's masterplan; a symbol of planning, hope, and a reminder of the "bigger picture" so easily lost in the nitty gritty of individual

[171] The government banned motorcycles and mopeds in Yangon. Urban myths as to why, range from superstitious generals to public health efforts to reduce accidents.

repairs and general maintenance of the 69 odd buildings on campus. Every time we meet in his office he points at the plan with a smile.



Daily, U Than Thein Gyi's team ventures out to mark the reported leaks so they can be fixed when roofs are dry and safe to climb. Nurses know this process. They place buckets strategically to avoid flooding of operating theatres floors, ward beds, and corridors. Most of the team's time is spent fixing leaking roofs as soon as the rains stop, checking for the reasons of leaks; often a seedling that took root in the gutter, or slid its hairs in the crevices between bricks, cracking the building hull, roof sheets loosened by wind, or general material decay. It is the younger members of the team, their nimble and athletic bodies, who climb around the roofs during the dry season.

Another major part of this team's job is the maintenance of doors and windows; heavily used hinges given into wear and tear. A door can only be opened that many times, but is essential for control of fire and infection, but also of privacy, hierarchies, and knowledge.

Mould, comfortable in air conditioning units, needs to be removed and leaking pipes fixed. Mosses love the humid environment around leaking pipes. They bloom in bight greens and climb walls alongside the pipes, leaving the façade damaged in their wake and

making it prone to breach. One might ask, why all this leaking? The poorer the materials, the more fixing is necessary. The poorer the construction method, the more leaking.[172]

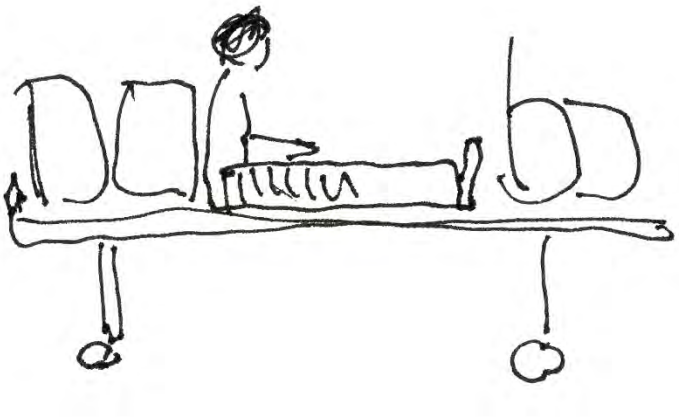
While craftmanship is an issue in Myanmar, materials everywhere decay. Seasons cycle through the year, nature slides its fingers into every crevice possible if not held at bay, and material metabolisms dictate maintenance patterns and daily routines.

Repair here at YGH is the daily reality; Grant's reading of repair through "broken world thinking" normalises repair as part of ideas of modernity (Grant 2020). Repair, here physical repair on campus, is ongoing, highlighting by extension that any system needs repair, and is always undergoing repair; breakdown is ongoing, not an event (ibid:19). This is something that also Vernooij et. al. discuss with regard to Sierra Leone's wider healthcare system (2022). While repair work has often been framed in moral terms, and as virtuous, Grant (2020:20), like Vernooij et. al. (2022: 20), remind us that repair work is not always optional and/or voluntary and should not be romanticised; nor is it a geographic condition, as shown by for example by Mol's conceptualisation of "tinkering" where repair and maintenance are part of well-resourced systems (Mol in Vernooij et al. 2022: 2). Repair suggests that something was in a perfectly functional state; I would, as do Vernooij et al. as well as Grant, suggest that this perfectly functional state is a fiction. While Vernooij et. al. suggest "temporary patching up" (Vernooij et al. 2022: 7), I would like to propose, at least for thinking with physical infrastructure, the concept of constant "rehearsal" as discussed in the introduction; a concept that implies the possibility of renewal, and trial and error, embracing in a way Grant's (2020) broken world thinking. When Covid-19 arrived in Myanmar, U Than Thein Gyi's small, under resourced team, as we saw in the introduction, maintaining the infrastructure of the hospital, the hull for the prosthetic atmospheres, sprang into action. They put up light-partitions, modifying the spaces for improved infection control; they installed handwash basins at every entrance to buildings; they improvised foot-operated taps. It was the team with the highest job vacancy rate (to remind you: 70% in 2019),

[172] Based on conversations with contractor.

who were the first on the infectious battlefield, creating the infrastructure to hold the virus at bay, with, at times, unexpected resonance in patients' bodies.

One afternoon, I am sitting with my friends and interlocutors by the oxygen plant, I notice a new sound. Admits the cacophony of the oxygen machines' regularly hissing, the decompressing the of the A&E's autoclave, and the sudden onset of the generators head-numbing hum, I hear a rattle. At first it goes unnoticed until it becomes a regular sound, sometimes complemented with a moan. A broken body on a stretcher, yanked over a kink in the floor; broken tiles reverberating in broken bones.



The maintenance team had built a new PPE room to contain the virus in case of a severe outbreak, when YGH would become a frontline Covid-19 hospital, at point still a few months in the future. The new structure on the ICU bridge severed the most direct connection between the main building, especially the Orthopaedic Department and the MOT and Imagining department. Patients transiting between these departments, a common connection, must now take the longer route: with the lift to ground level, on a covered walkway along the back of the main building, past the Oxygen department, behind the A&E, up a ramp to the Imaging department or further onto the MOT. Kinks, changes in floor surfaces, and broken tiles, beset this path; each one finding an echo in the patients' bodies, creating a pathway of pain.

In the second part of the chapter, three ethnographic vignettes demonstrated the multiplicity of the hospital. The hospital multiple is a place where humans and non-humans, services and spaces, built- and natural environments, are in constant motion: walls breathe, blood and people shuttle back and forth across ruptures, while nature and time continuously encroach on the hospital's built

environment, and the maintenance team is on the forefront of infection control. Patients', pipes', and pathways' daily existence overlap, entangle, and form visible and invisible synergies. The hospital's buildings emplace all this. Writing *with* buildings allows us to witness the human/non-human entanglements, the practices done to and with the buildings, and the meaning of materials in all of this.

CONCLUSION

Buildings have material metabolism which synchronise with rhythms of day and night, work schedules and bus times, bodily functions, and wider political and social systems embedded in palimpsests of history. I am interested in the choreography of it all. Here, the boundaries between past and present, nature and society, blur; today's decisions are tomorrows consequences; infrastructures relate and rupture while constituting life on campus. The detailed discussion of buildings and infrastructure, through writing with buildings, highlights human agency and responsibility. The moss and betel nut stains come from humans; humans not turning off taps, or failure to build non-leaking pipes; betel juice spat on the floor; humans tending to buildings.

This chapter developed two arguments. One on a vertical axis which brings history and its debris into the present. The other along a horizontal axis of acute (situated in the present) human and non-human entanglements. Both take the practices of bodies and building, the hospital multiple generated through practices, as a point of departure. The hospital is a place with fungus and damp, mould and material decay, a place of structures and rhythms of daily life, and workings of a greater system.

Drawing on my own ethnography and leaning on scholarship by people such as Ann Stoler (2013), Anna Tsing (2015), and Asher Ghertner (2020), I propose that at the hospital the distinction between human and non-human life collapses. The hospital multiple, its buildings understood through Annemarie Mol's *Body Multiple*, in which a body/object is constituted by the practices done to it, is in

constant motion, in a repetitive rehearsal. Writing with buildings, with the hospital's places and infrastructure, puts realities of daily life into sharp focus; not as an abstract category, "the hospital" in its generic form, but the hospital as a place is lived and complicated. The multiple scales, from the specific detail to the hospital campus as a whole emerge: A campus with 27 specialty departments, spaces in-between, and a long history in a bustling southeast Asian metropolis; all of it emplaced and specific.

As much as "no one lives in the world in general" (Geertz 1996: 262), there is no hospital in general; however much ideas of best practice and standardised processes would like us to make believe. Much of the daily tactics making a hospital work originate in the exactness of place. A preoccupation with standardisation and best practice overlooks the realities of the hospital's daily life. At the same time, we (anthropologists at least) know that daily tactics and improvisation are the reality for many hospitals (see for example: Lichtenstein 2019; Livingston 2012). I would go as far as to say all hospitals. Therefore, ethnography is pertinent, beyond academic acrobatics.

Reading and understanding the hospital as a social affective archive can be productive here.

Infrastructures mediated the hospital's human relationships, services, and human-material interactions, emplaced in colonial and global atmospheres. This mediation can be relational, as in the case of breathing walls, or ruptured where a road severs the flow of people and blood, or indeed quite messy where nature continuously encroaches onto the built environment. We live in symbiotic relationship with our buildings, in which not only human, buildings, and infrastructures (from pipes to roads) are actors, but also animals, plants, rhizomes are part of the ecology.

When thinking of the hospital, a space for healthcare, I propose to think, and design and plan, with its multiplicity. With its human and non-human entanglements. With functionality mediated and related by infrastructure. Ultimately, thinking and making a hospital, the hospital multiple, through the category of *practice*, in a constant rehearsal full of potentiality (rather than a series of failed performances).

Finally, both chapters in this section show that the container and contained are indeed continuous (Carsten & Hugh-Jones 1995b). Chapter 6 and 7 bring Bourdieu's *fields* and Mol's *practices* into one plane by revealing the multiplicity of the hospital, collapsed through its practices, social and material, into one field.

"Part II: Rhythms" showed how infrastructure has a direct effect on healthcare. I started by rethinking infrastructure and the human at the hospital. One is dependent on the other. Walls breathe and blood flows between buildings. Buildings that individuals tend to; buildings that mediate. Writing with buildings, writing the mortar into the ethnography, is part of this.

Going forward, we will see why and how the hospital, emplaced through its (dilapidated) buildings and infrastructure, continues to function. Along the way, we will meet individuals in their "spaces of responsibility", telling us of their values and beliefs of what a hospital is (and is not).

IV Individual Encounters

How and why does the hospital function at all?

CHAPTER 8: SPACES OF RESPONSIBILITY

"BUT AT LEAST SOME CAN LIVE"

Wooden treads creak underfoot as I am ascending to the first floor of offices of the department. The buildings were repurposed at the end of the 2010s from offices occupied by the Department of Medical Sciences, which moved to Naypyidaw. I pass the "Prof Rai Mya Knowledge Transfer Room", on my way to meet the acting head of department, not really the head as he reiterates multiple times in our conversation – but what can he do but his best?

The knowledge transfer room is the library named after the Department's first head, an eminent figure who retired in 2010 after having founded the haematology department in the 1990s where the Dermatology department is today; along with his junior consultant, he brought furniture from home and repaired broken beds they found in storage. Prof Rai Mya is also responsible for the current buildings. Normally in Myanmar, professors have a three-month period of "preretirement" to prepare for the new stage in life, but Prof Rai Ma, I am told, came every day to YGH to oversee the renovations for which he raised much of the funds through private donors; he took the renovation of the department "from blueprint to finish".

When the department moved to its current location around 2008-2009, the government budget for turning the office building into a clinical department was limited. As a first, and most important, step Prof Rai Mya used the small funds to build a new toilet block. Safe sanitary facilities and clean water are a corner stone for infection control, and hygiene is the haematology department's main concern. A point stressed repeatedly throughout my conversation with its acting head.

On the way to showing me the toilet block, we pass workers installing fire exit signs. My host immediately checks where the signs are going (nowhere), explaining to the workers what they need to do. A senior consultant checks the fire exits for his department; he looks at me, what can he do?

The department treats 70-100 inpatients plus outpatients for chemotherapy and blood cleaning (plasma exchange). Outpatients have two days a week "assigned", on Monday and Thursday, but I am told clinics run pretty much daily. Patients come with acute fevers or anaemia; "emergency is everyday".

Haematology is dealing with very sick patients, some of the sickest at the hospital, but its buildings do not reflect this. They are adapted offices from an era bygone, lacking key facilities as I learn, such as positive and negative pressure rooms. The transplant area should have positive pressure, and the room for patients with infectious diseases, negative pressure. For example, Leukaemia patients should be treated in positive pressure rooms with HEPA filters[173]; but such a space does not exist. This means doctors and nurses carry a lot of responsibility in ensuring everything is clean, controlling comings and goings, and ensuring spaces are not overcrowded.

The team treats patients on an open ward. I am told this is not ideal, “but at least some can live”. Towards the end of our tour, the acting head asks me if he should not treat patients at all just because the care is “substandard”? It is the best possible care right now. I have no answer.

Currently they can only do Autologous Bone Marrow Transplant, which uses the patients’ own cells. Allogenic Bone Marrow Transplant, in which another person's bone marrow is being used, is not possible at YGH because of the department’s infrastructure. The acting head explains that in the 1960s hospitals in Europe and the US did Autologous Bone Marrow Transplant on specialist wards, in positive pressure rooms with HEPA filters. Today, in many countries, the treatment is done on normal wards, or ambulatory.

At YGH patients are always admitted for autologous procedures because “the general environment is not clean”. Here, my passionate interlocutor refers to the difficulties that patients face ensuring hygienic cleanliness after they have been discharged. This starts with clean water. Even if YGH was

[173] High-efficiency particulate air filters; an efficiency standard for air filters.

perfect, patients go out into a world where they have to contend with inadequate infrastructure; saltwater seeps into ground water wells, power cuts are frequent, and unsafe waste disposal causes toxic environments.[174] Furthermore, I am informed, many patients and their families, who are mainly responsible for an environment suitable for recovery when it comes to ambulatory procedures, do not know much about public health and general hygiene (he is not the last person we will be hearing this from); doctors are also public health educators, as we saw at the end of Chapter 5.

While autologous treatment can be done on open wards if everybody is careful and takes responsibility for their actions, the lack of a positive pressure room means allogenic bone marrow transplants are impossible, and mostly unavailable to patients in Myanmar. Additionally, the lack of space prevents YGH from training students in this procedure. Here, infrastructure, specifically the lack of clean air, impedes individual healthcare outcomes as well as medical training and research in the country.

North Okkalapa General Hospital's buildings (NOGH), Yangon's other major public hospital and Yangon Medical University 2 training hospital, allow for allogenic bone marrow transplant. However, the team at NOGH is facing other difficulties. HLA typing[175] needs to be sent abroad; money, drugs, sisters, and supportive care are missing. At present, NOGH cannot use its facilities most of the time, nor can they train students. While, as I am being told when I ask if YGH and NOGH are competing, "in Myanmar everybody is competing", it seems to me that rather than rivalling with each other, the hospitals are mostly contending with what Vernooij calls elsewhere "infrastructure instability"

[174] For news reports on Yangon's groundwater, electricity grit, and toxic waste, see:
https://www.frontiermyanmar.net/en/under-pressure-why-yangons-groundwater-is-slipping-out-of-reach/
https://www.frontiermyanmar.net/en/down-to-the-wires-fixing-yangons-broken-power-grid/
https://www.frontiermyanmar.net/en/myanmar-braces-for-further-power-disruptions-as-solar-initiative-stalls/
https://www.frontiermyanmar.net/en/plastic-and-the-pandemic/

[175] Human leukocyte antigen (HLA) typing is used to match patients and donors for bone marrow or cord blood transplants.

(2021).[176] Infrastructure instability is not a technical problem, it is political, institutional and relational (Vernooij 2021: 19). Here, at YGH, in Yangon, and Myanmar at large, infrastructure instability extends from questions of value and clinical practice, as discussed by Vernooij, to knowledge production and education. When clinicians cannot be trained in certain tests and procedures, infrastructure instability destabilises knowledge production and education.

The story of the department's buildings, and the speciality at large, the individuals' roles in the infrastructure's making, its use, maintenance, how it is thought of, and how the buildings' stories are told, reflect overarching patterns of improvisation, initiative, and personal responsibility.

The chapter's introductory vignette gave an insight of the level of personal responsibility and the role of infrastructure for healthcare and knowledge production. Following a brief introduction of a useful framework to think with, in the context of Myanmar, we explore what I call "spaces of responsibility" through administrators' experiences of "Managing the Campus' Daily Life",

[176] According to interlocutors, private hospitals in Myanmar don't have the required facilities, as Haematology is a costly discipline with relatively few patients, which is not lucrative for private providers.

"Attendants", and the nurses who are "Responsible for Everything", before turning our lens on the "Affective Routines" of workers. In the conclusion categories of responsibility will emerge from the chapter's spatial understanding of responsibility.

INTRODUCTION

In this chapter I show how and why the hospital works at all; a question you might have asked yourself after reading the previous chapters that described the tensions endured by the hospital. Individuals like the retired Professor Rai Mya, or the Haematology's acting head, take on what I call "spaces of responsibility" to ensure the continued functioning of the hospital.

In Chapter 5, I introduced Ardeth Maung Thawnghmunng, and her *Everyday Economic Survival in Myanmar* (2019). She provided us with a framework to understand individual ways of, and personal responsibility in, coping with a state like Myanmar, where state violence hangs a question mark onto much of the future. In her scholarship, Thawnghmunng identifies four strategies that individuals employ *vis-à-vis* the state to sustain in their daily life: "Loyalty / Accommodation", "Passive Resistance", "Voice", and "Exit". Thawnghmunng's discussion of economic survival in Myanmar demonstrates individuals' strategies with relation to a weak and hostile state. With spaces of responsibility, I built anthropologically on Thawnghmunng's economic framework "LPVE" (her abbreviation), to understand the hospital through its enacted practices and materialities.

Thawnghmung highlights multiple studies showing that ordinary people in authoritarian regimes prioritise short term and fragmentary responses to their economic survival over systematic change or political reform (Thawnghmung 2019: 7f.). Based on my observations at the hospital, I see this extending to the built environment where individuals often seek quick fixes over lasting system change. As one interlocutor in Chapter 5 said: "We fix it the Burmese way" At the same time as working the system, this interlocutor takes charge for a specific aspect of the hospital's existence; he occupies a space of responsibility. Without spaces of responsibility the hospital would not function.

Buildings need human allies. A building without humans, using and caring for it, becomes a ruin. YGH is far from being a ruin, as demonstrated in Chapter 7.

Drawing daily life on campus I saw a multitude of workers, technicians, engineers, cleaners, drivers, vendors, service provides, patient attendants, visitors, doctors, nurses, nurse aids, and homeless people[177] care for patients, each other, and the campus, with their individual sets of values, with more or less agency, occupying assumed, given, and sometimes coerced "spaces of responsibility".

Most individuals working on campus occupy multiple spaces of responsibility; chosen, given, mostly out of necessity, some with compassion. An administrator deals with the campus' animalistic life when dogs breach the confines of the compound; doctors ponder the benefits of lighting for patient wellbeing, they become interior designers, buy furniture, or learn about the intricacies of different air conditioning systems; ward sisters and nurses double up as janitors, pharmacists, and trainers for attendants doing the bedside care; an anaesthetist researches replacement parts for broken jet washers for the MOT's laundry; workers help patients and their families navigate hospital life, often against a much appreciated monetary reward; people act as living way-finding systems (the "side cars" we encountered in Chapter 3), guiding lost visitors to their destination; the ambulance driver transports goods across campus from the medical store to departments; a security guard becomes a logistical ward manager, the right hand to the sister; a patient's family member experienced at navigating cancer treatment advises other families on the process; attendants clean bathrooms. All these people assumed responsibilities whom they themselves say "should" be carried by someone else, but their personal values and beliefs about what a hospital is and "must" be, walked them right into their "spaces of responsibility".

[177] Homeless in Burmese: အိမ်ခြေမဲ့လူတွေ or အိမ်မရှိ ရာမရှိလူတွေ - literal translation: person lacking a home or person who as no home who has nothing / much.

As U Than Thein Gyi, one of the hospital's engineers, said: "Everybody is doing their bit; everybody at the hospital holds themselves accountable and tries to fulfil their responsibilities. That is what keeps the hospital going. If we start pointing fingers at each other, everything will just stop." This is a sentiment palpable on campus, even for the European researcher drawing its daily life, and repeated with similar words in many conversations.

Spaces of responsibilities are given or chosen, sometimes overlap each other, and can be congruent with buildings and physical places, most go beyond job descriptions on paper; [178] they require ingenuity, compassion, and sometimes empathy, at times they are personal choice, individual commitment, and a level of connectedness, to each other and the place where it all plays out.

Interesting are individual's or groups' acquired and assumed spaces of responsibility, what they reveal about their values *vis-à-vis* a hospital; the "shoulds" and "coulds", personal aspirations, expectations of a hospital, a job, a service, and the state.

Writing about individual encounters in the context of responding to the question of how to represent a hospital, a public institution, in text, means writing people *with* and *through* the places and the buildings, that contain, at best enable, at worst thwart, the daily life roaring within the built and figurative structure. In this chapter, I write individual encounters *with* the literal and figurative spaces they occupy: the materialities constituting the physical spaces of patient beds, offices, wards, corridors, workshops, courtyards, undefined storerooms, and the "spaces of responsibility", while paying particular attention to the moment where the physical space and spaces of responsibility interface.

The characters in this chapter are based on individuals I met on campus who generously shared their time and thoughts with me. Interlocutors have been split in two characters or several have been

[178] When I asked about job descriptions, I was told by an interlocutor that he did not have one; someone else told me they were in the making. To me it seems, based on my observations, job descriptions to not exist in the sense you might expect from, for example, the NHS.

amalgamated into one; I spoke with many administrators on campus, workers, nurses, attendants, and doctors than represented here in individual characters. I took ethnographic liberty in creating characters to anonymise individuals. Healthcare workers have been heavily targeted by the military since the 2021 coup.[179] While I do not see any direct threat, arbitrary accusations have led to unjust arrests; it is impossible to judge what might be a trigger.

MANAGING THE CAMPUS' DAILY LIFE

Dr Pwint Oo is one of many administrators on campus. We meet in her windowless office in one of the campus' more recent buildings, a reinforced concrete (RC) frame structure, it could also be a steel structure, with masonry infill and aluminium cladding. The new-build's thermal properties, its light levels, and ventilation are only faintly comparable to the campus' Victorian structures; there is light, it is cool, and there is air to breathe. Halogen lamps illuminate our faces; I would love to write about dust particles dancing in the air, but the harsh light from the chemical reaction does not allow for romantic theatrics, they are reserved for soft sunlight in naturally lit rooms. The air is cool from split air-conditioning units quietly whirring on, not the thermal properties of century old thick brick walls and large openings for natural cross ventilation. The faint smell of breakfast snacks recently consumed lingers in the still air.

Dr Pwint Oo's halogen-lit and well airconditioned, or more accurately "air-cooled",[180] office is getting chilly. In the stale air we discuss how she has perceived changes on campus over her years of duty at YGH. The hospital's organisational chart reads not unlike military organisation; there are officers and assistant officers. Administrators, doctors, and nurses rotate between hospitals. Exceptions are

[179] For context on the situation of healthcare workers in Myanmar since February 2021 see:
https://thediplomat.com/2021/05/medical-workers-targeted-in-myanmars-post-coup-crisis/
https://www.bbc.co.uk/news/world-asia-56827116

[180] Split aircons / AC do not do more than cooling the air, a different system is required for air to be "conditioned" i.e., filtered, humidity controlled etc.

highly specialised consultants, for example haematologists who have not many other places to go beyond YGH and NOGH. Workers stay put on campus, many over generations.

The atmosphere is jolly, nurses come and go, one brings Dr Pwint Oo a coffee. I learn about her daily routine, and main concerns.

Spatial Responsibility

Dr Pwint Oo's spaces of responsibility overlap with two buildings from two different eras bygone, each facing distinct challenges. The older building is in a constant battling with nature; trees taking root in eaves and decaying materials. While the younger building's MEP[181] services are stretched to their maximum; overload of the system would not be an overstatement.

Eight medical superintendents are responsible for twenty clinical buildings (depending how the buildings are counted, for example the Haematology department is a cluster of four connected buildings which I count as one here), some administrators have only one charge (A&E and the main building have one responsible person each) while some have as many as five buildings under their care. At YGH, the administrators who are responsible for certain buildings are referred to as the "responsible persons" for this building. Their space of responsibility is a literal place on campus.

If anything goes wrong from electricity to parking, door hinges to leaking pipes, fights between staff and attendants, they are the first port of call. Since clinical specialties and buildings are congruent at YGH, it is the buildings' respective clinical departments that come knocking. Quite literally, someone walks over and knocks on the responsible person's plywood door, to report the respective department's latest faults and shortcomings that cannot be fixed *in-situ* and necessitate some expert involvement: an electrician, a carpenter, or a mediator. Previously, I was still on campus as project architect, the knock would be at the maintenance engineers' workshop door. This system was

[181] Mechanical, Electrical, Plumbing

changed, and the administrators were put in place to direct requests to the correct team. This avoids overloading individuals who are prone to respond to problems they are not responsible for, or unable to adequately address, but non the less, in an effort to help, would take on; often spaces of responsibility are assumed out of compassion. Sometimes an engineer or a junior staff would not feel they can say "No" to a doctor, someone higher in rank; here, spaces of responsibility can also be coerced by hierarchies.

Today Dr Pwint Oo investigates the problem and asks the ward sister to write a report which is discussed at weekly Monday morning meetings, and the necessary steps are initiated. The issues I hear most about are so called "social issues"; flights that break out between security guards and attendants over parking, for example, disagreements between workers and doctors and nurses, clinical staff and patients and their families. Sometimes Dr Pwint Oo's spaces of responsibility are not a literal space, but spaces of authority.

Vendors, Waste management, Homelessness and "Our Attendants"

She speaks about how problems with vendors on campus not following rules became worse when some individuals from the administration left the hospital for a few years to continue their professional development; one left to do an MA in hospital administration, the other a diploma. Both had been active in organising and containing the campus. While both individuals had been tasked with waste management, security, and general organisation of the campus' public spaces, the deterioration of the situation when they left, and the immediate improvement upon their return, indicates their personal commitment; a space of responsibility they occupied personally. In conversations with administrators and workers, their names have become synonymous with waste management, campus organisation, and discipline, in positive and respectful tones.

I remember an unruly market and sprawling stalls, alongside issues with litter and virtually no waste management system in place, when I first arrived on campus in 2015. Medical waste was not segregated, and Yangon City Development Committee (YCDC) was responsible for waste management within the campus walls. The arrangement was that YGH was answerable for waste management *inside* buildings, YCDC organised waste management *outside* the buildings. Collection areas were unorganised and trash pickers could be seen around campus at dusk. The situation improved when YGH, under the two mentioned individuals, took over waste management everywhere on campus, inside and outside buildings, and systemised it.

Today, YCDC collect refuse from dedicated areas on campus, including a healthcare waste collection space where labelled bags are signed in and out.[182] Two markets, or what is called a canteen on the extension site, have are allocated space and vendors have assigned stalls. While these systems fell into some disarray during the two mentioned individuals' absence from campus, they never got back to their previous disastrous state.

[182] What happens to general and healthcare waste is another story. I refer here to journalistic investigations and official reports from recent years, which detail how healthcare waste becomes part of illegal recycling businesses and general waste management in the country is in its infancy:
https://myanmar-now.org/en/news/myanmars-illegal-trade-in-medical-waste-poses-coronavirus-risk
https://wedocs.unep.org/bitstream/handle/20.500.11822/30985/WMM.pdf?sequence=1&isAllowed=y

The main issue the administration has with vendors is that they are difficult to control: "We cannot apply the rules and regulations." Dr Pwint Oo contends that many things must be excused. She and her colleagues have no enforcement powers; it is “just hospital rules”, they cannot fine nor arrest anyone. Sometimes they will take an especially unruly vendor into an office and confine them for the day, but that is hardly a deterrent. As we saw in Chapter 5, vendors see it as a necessary performance. At the same time, even a senior administrator knows that someone needs to make a living somehow, which is hard in Myanmar as other authors discuss impactfully (see for example: Thant Myint-U 2020; Thawnghmung 2019).

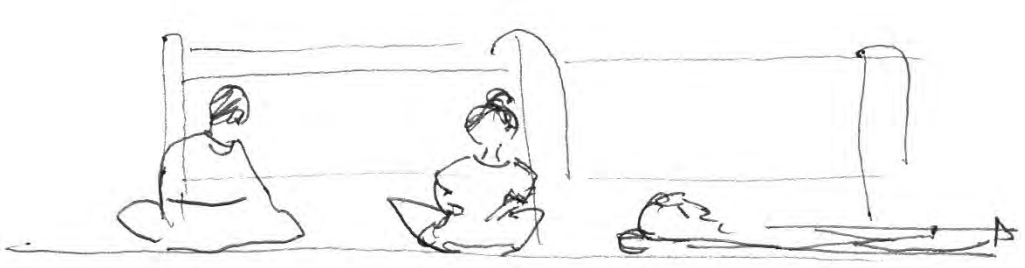
When talking to the people whose job it is to reinforce the hospital’s rules and regulations, I detect a grey zone of compassion. Vendors have hours when they can operate on campus, 6 a.m. to 6 p.m., then they clean and set-up for the next day. Many never go home, they just stay at the hospital, sleeping under awnings or inside their stalls. I learn of one “big” family, whom I know well from countless hours drawing around campus. According to Dr Pwint Oo, they are the biggest problem: most of the rubbish around campus is from them, and the father is getting more family members to join the business, while the kids are hawkers, peddling fruit, often harvested from trees around campus.

The grey zone of compassion also comes across as we discuss homeless people on campus. The administrators know who-is-who; a patient lying down while waiting for an appointment, a family member waiting on news of a loved one, or one of the many homeless who made the hospital their home. The problem the administration is facing is how to apply rules: “If we kick homeless people out who are lying down on the floor, we have to apply the rule to patients and their families too”, and that is an issue. Attendants can stay on campus, but they have no dedicated spaces; or as one interlocutor put it, in the absence of any dedicated family areas, “the entire campus is a social space”. In recent years, eating areas have been added in closed-off corridors or between buildings

under corrugated roofs, but they are unpopular, sometimes dirty, and inconveniently located for some wards.

In countless conversations with the ICU team, we discussed their need for family space. Attendants of ICU patients are responsible for vital tasks from oral hygiene to creaming and massaging the incapacitated bodies in the tired air of the ICU ward. The problem is that the patient’s bedside carers have nowhere to rest and sleep at night, so they make camp on the concrete bridges connecting the ICU, as we saw in Chapter 3. When night falls, deckchairs unfold, and blankets are spread onto tiles the colour of dried blood. When attendants are allowed to stay on campus, Dr Pwint Oo muses, how

can she enforce the rules against a homeless community camping out on campus, or the vendors staying overnight?



As we saw in previous chapters, the Covid-19 pandemic shifted support networks. With the disappearance of spaces that monks created in monasteries for patients' families to stay, and assumed responsibility for, attendants are stranded on campus. This leaves the administrators with little choice but to "pretend not to see them" when family of patients find shelter in places they are not supposed to. Afterall "they are also our attendants". Since the monasteries had to close their dorms, the responsibility for "our attendants" shifted its weight onto the hospital, turning into moral dilemmas for my interlocutors. They know what it means to live in Myanmar, contending with the realities of daily survival; they know the cost of healthcare and of the debt many of their patients accumulate over a hospital stay; they know of the comfort of a loved one at one's bedside. So much is happening between the "shoulds".

Support Services

Dr Pwint Oo, amongst everybody else I speak to, administrators, nurses, doctors, engineers, and general workers, recognises the vital importance of "our attendants". They wash patient bodies, fetch medicine, make sure the patient is comfortable, offer a familiarity in an utterly unfamiliar environment. Most patients travel six hours or a day to YGH from their home, for many their journey is longer, for all the journey is expensive; at times so expensive for families that attendants cannot afford to take trips home. The notion of a disproportionate high number of attendants per patient is

not only voiced by Dr Pwint Oo, but she is clear that most of what attendants do, *should* be done by the hospital: catering (food), laundry, laboratory tests, medication. If family members do not need to go out to fetch off-campus services, less attendants would be necessary. “We need to provide catering service, laundry service, all medical equipment and drugs... Private hospital(s) [are] providing all this - attendants are there only for the patients (their wellbeing and comfort)”. This is how it “should be”. She concludes, that in order to reduce attendant-numbers, the support services need to improve; but Dr Pwint Oo also contends, quality of patient care is dependent on allowing attendants.

The “lack” of support services, that Dr Pwint Oo speaks about, leads people like the ward sister, we meet later in the chapter, to take on a “space of responsibility” in which she tells patients what healthy eating looks like. An unpublished report from 2020 by Dr Thin Thin Hlaing and Dr Samantha Field, recommend kitchen facilities to be provided at Myanmar public hospitals for families to cook. The feeding of a sick family member or close friend at the hospital is yet another “space of responsibility”, this one occupied by attendants.

What hospital should this be?

While focusing on quite detailed issues from laundry to food, Dr Pwint Oo also speaks of the need to define closely what type of hospital YGH is and should be. A trauma centre? A tertiary care hospital?

A cancer care centre? The many issues the hospital faces, litter, overloaded sewage system, congestion, too many cars, and a general lack of space would be sorted if less people were coming.

On a normal (pre-pandemic and pre-coup) Thursday seven departments have outpatient clinics. This means over 700 patients, additionally to the 2000 inpatients and their attendants, mostly arriving in the morning or the night before, need spaces to wait, but also to eat, digest, and rest until their appointment; and most of the 700 patients bring someone for company. Fewer patients would mean less pressure on the infrastructure. In the previous sentence my initial instinct was to write "fragile infrastructure", but it seems important to point out that nothing about the hospital's infrastructure and buildings is fragile in the face of the sheer number of bodies they accommodate.

Confronted with rising patient numbers and finite space, MoHS, the Ministry of Health and Sports, is developing (or was until the 2021 coup) hospitals outside Yangon and Mandalay,[183] to relieve pressure on YGH, NOGH, and Mandalay General Hospital. This is a slow process that ties-in with patients trusting the state and its more "peripheral" hospitals. YGH has a reputation, which nowadays, with its "free of charge services" and renowned specialists and facilities, attracts patients,[184] while patients continue to mistrust local clinics and township hospitals. Here, YGH, as a public institution, has been coerced into a space of responsibility by the wider system. Macro and micro systems collide on campus; an attendant's digestive tract meets the wider healthcare environment of the country in the hospitals overloaded sewage system; which the hospital's engineers must tend to.

[183] Myanmar's second biggest city.
[184] See Céline Coderey's chapter "Health" in the *Routledge Handbook of Contemporary Myanmar,* where she describes how YGH did not used be a hospital of choice (Coderey 2017).

ATTENDING

A teenager is sitting near the drinking water tank, sheltered by an overhang, close to the side entrance of the Modular Operating Theatre Complex where the public toilets are. The branches of the Ghost Tree do not quite reach anymore. He is a tenth grader in high school, fifteen or sixteen years old, taking care of his mother, at home and here. They came to YGH via the referral of a doctor they know at the New Yangon General Hospital up the road from YGH. Anticipating that his diabetic mother would have to come to Yangon anyway, they skipped the local clinic in their village, four hours' drive from the metropole. In any case, he feels that YGH offers better services, the hospital's reputation is its lure.

His calm demeanour does not betray his inner turmoil of worrying for a mother. With a solemn smile he says he was worried to not be able to take care of his mother properly in the unfamiliar city. Now that he is here, and his mother is improving, he feels better. Bags strewn around him and his friend who accompanied him from the village are the belongings of fellow attendants. People waiting for a family member to get better are united in a communal plight of waiting. In these affective spaces, attendants share worries, reassurances, protection, and knowledge about the hospital and its

processes. They trade secrets where to find the cheapest pharmacy or do laundry undisturbed; some will continue to be friends after they leave YGH, others will never see each other again.

His daughterless mother is on a floor above, on a female ward with a woman from the village, a neighbour, by her side. He asked the neighbour to accompany his mother to the hospital; it is better for a woman to care of a woman, I am told. The son could not do what needs to be done. His and his friend's task is to wake up every morning at four or five and get breakfast for the patient and the bedside carer. The rest of the day, they spend waiting for instructions from inside the ward, demands for foods, running errands, and fetching medicines.

These are the numerous attendants Dr. Pwint Oo speaks about above, "ours". The number of accompanying family grows with the kilometres between their home and the hospital. At a minimum one is to be on the ward, twenty-four hours near the patient, one has to run errands, and one for guarding belongings when the other is on an errand. If they are from Yangon, or have family who can host them, the "tag team", the two "runners" outside the ward waiting for instructions from inside, can go home at night. If a patient is not from Yangon, or has no relatives living near YGH, it becomes difficult. The tag team need somewhere to sleep. This is often on the hospital grounds.

Attendants' spaces of responsibility translate into literal space on the hospital grounds in the spaces in-between. Attendants occupy the spaces between buildings and wards, doctor rounds and visiting times, between rules and regulations. Attendants fill the literal spaces in-between with their spaces of responsibility, they plug the gap that the system leaves behind, the

"should" and "could" of the hospital, by providing food, doing laundry, fetching drugs and tests, washing sick bodies, and doing bedside care.

RESPONSIBLE FOR EVERYTHING

The teenager is sitting outside the Modular Operating Theatre Complex, one of the busiest buildings on campus that supplies the hospital's wards, consultation rooms, theatres, waiting areas, and mortuaries with a steady flow of patients, dead or alive.

Patients go to and from the "Ortho" wards for planned surgery, less fortunate patients might be headed for the ICU, unlucky ones for the forensic department. Cardiac surgeons operate on the building's top floor, shuttling patients back and forth on concrete bridges between their building and the MOT. Admissions to all units come from the outpatient department (OPD)[185] on the building's ground floor, where departments also see their discharged follow-up patients in the afternoons. The multiple walk- and pathways, literal bridges, and figurative patient pathways visible only on paper, connect like tubes into a patient's body. The Modular Operating Theatre Complex pumps patient-bodies into the hospital's concrete arteries and cavities.

The five storey, RC frame structure was built in 2014/15, a mere five years ago at the time of my research. I had often visited the newly commissioned[186] building when I was project architect for the hospital's rejuvenation project. Its dull aluminium cladding and tinted blue windows look unwelcoming on a good day.

Three surgical units occupy one floor each between the OPD on the ground and the operating suit on the top floor. It is early afternoon, June 2020, the first Covid-19 wave is deemed over, when Nilar

[185] Patients are either admitted via the OPD, having been referred by other hospitals, or the Accident and Emergency Department (A&E).
[186] The term "commissioning" comes from shipbuilding. It means essentially that the building is ready for service and operating as intended by the owner.

shows me around one of the female wards. The morning bustle of doctor rounds has subsided; the ward lies in a susceptibly calm twilight, steeped blue by the UV protected unopenable outer windows.

I met Nilar and her ward by way of these back of house pathways, which, as discussed in Chapter 3, are often only distinct in speed or temporarily. For two months, I followed goods around campus, from the medical store to localised storerooms. Sketching its pathways and drawing the hospital's localised storage facilities has proven to be an invaluable introduction to departments, especially their frontliners: the ward sisters and nurses who unwaveringly keep the lights on, quite literally at times.

I allowed the logistics to guide me into the spatial reality of medicines, cleaning materials, syringes, drip bottles, and other medical equipment. This opened pathways into conversations I would otherwise not have had. Informal encounters, emplaced in the moment. My diligence following the goods, coming to draw the storerooms and people who care for them, a side typically hidden, unseen, and overlooked by most international visitors, served as proof of my commitment to the realities of the hospital's daily life.

Many ward sisters proudly show the systems they developed for smooth operation of their ward. They patiently explain the additional work they do as store managers, pharmacists, janitors, and trainers of patient attendants. As one interlocutor eloquently said, nurses "fill the gaps". Which gaps, she left open. To me these are the gaps where system and reality do not align; the gaps that spaces of responsibility fill up, also here, high above the teenager waiting for his mother to get better, operating between buildings and bailiwicks.

In the local store on Nilar's ward, nurses need step ladders to reach the upper levels of the shelves lining the walls. Nilar explains the system: one side of the room is storage; the other side are medicines to be issued. Take-in and inventory of medicines and everything else that arrived from the medical store is not "really" her job, "but she has to do it"; the unit has no pharmacist. The need for

ward/department pharmacists a common tenor with others in the hospital; I am told that each unit *should* have a pharmacist.

As we leave the unit's medical store, to my surprise, Nilar takes precious time out of her afternoon to show me her dimly lit ward. I am getting an overview of the floor plan as it is used on a daily basis. From my time as project architect for the masterplan development, I have access to the building plans. These show an open nurse station with unobstructed views of the ward's activities. In the built interaction of the plan, the nurse station is a room with two doors to the corridor and to the wards, which can be closed by privacy seeking nurses. The discrepancy of the design to "as built" [187] underlines the notion that buildings are constantly made, a process. Even a merely five-year-old building is not built as it was designed. High Dependency Units (HDU), a room each for very acute male and female patients (gender is inscribed in the building, a binary, always two HDUs, two bathrooms, two wards), are locate on either side of the nurse station, in closest proximity of the professionals; most HDU patients here should probably be in an ICU, but ICU beds are precious. Nurses are in short supply at the hospital, in the ICU and on wards.

Nilar speaks of an "imbalance between staff and patients"; a similar motif as raised by Dr Pwint Oo and colleagues. However, Nilar's story is less about overcrowding but workload.

Without attendants who do the bulk of the invaluable beside care, under her and her colleagues' supervision, the nurses' job would not be possible. While too many attendants can be challenging their importance is in no doubt; to the point that some nurses I speak to don't seem to understand my questions about attendants: "… of course they are here, we don't even need to mention their contribution, but let me tell you of them charging their phones illegally…".

Here I would like to note that literature on bedside care has shown that patients cared for by familiar faces and hands have a speedier recovery and run a lower risk of re-admission (Carr & Fogarty 1999). This literature however is geographically focused on the US and paediatric intensive

[187] A term used in architectural jargon; Architects often provide "as-built plans" following construction to document what has been built vs. what was planned.

care and emergency room settings (Carr 2014). Beyond the global north, some authors ethnographically discuss bed side care, but mostly in terms of a necessity to support clinical staff, rather than for its health benefits (Bhalla et al. 2014; Zaman 2013). However, as discussed earlier with Dr Pwint Oo, my ethnography indicates that family and friends have a role beyond mere physical care.

As Nilar and I walk and talk, we have a heartfelt conversation in the weakly lit and badly ventilated ward. She and her colleagues, rather than doing bedside care themselves, train and supervise family members or friends of patients to take care and look after their charges. They provide health education to patients and their attendants; according to Nilar, some patients are so poor "they don't know how to take care of themselves". Many do not know what is healthy to eat and how to wash themselves “properly” (in a hospital environment); patients are so poor and preoccupied with surviving on a day-to-day basis that taking care of their health has never been learned, nor is it a priority. As Nilar talks about this, she sounds judgemental, but not in a patronising or condescending way, she is compassionate. Her sense of duty is palpable. I heard similar sentiments from her colleagues across the hospital, and if you remember the public health talk from Chapter 5, you know of the educational responsibility the hospital takes on.

I notice most lamps have only one fluorescent tube, with the other missing; they are in short supply at the hospital. Not having enough fluorescent tubes is one issue, another is the difficult access. A ladder needs to be found for Nilar or a colleague to climb and change the luminant. The team tasked with changing light bulbs around the hospital is overstretched and understaffed, so it is the nurses changing light bulbs. While the wards are opposites of the Nightingale Wards discussed in the previous chapter, nurses here are true “ladies with the lamps”, a famous term coined by Florence Nightingale in her writing about the Crimean War in 1800s.

Nilar tells me how overcrowded the ward often is. Today seventy-five patients lie in beds on the male and female ward. Seventy-four beds are sanctioned; most days pre-Covid-19-pandemic one-

hundred to one-hundred-and-twenty patients occupied the space. If spaces are over occupied, holding more bodies than the space was designed for, the bodies produce more heat, sweat, and humidity than the ventilation system can circulate. In case of natural ventilation over occupation means the ward has not enough windows, or the openings are too small, to dissipate the stale air, which then heats-up and gets humid. In case of mechanical ventilation, the air ducts might be too small. This phenomenon can be experienced on one of the ballroom-high wards in the main building: when stepping into a ward with the number of beds as originally designed a century years ago the air is good and the space is light, while stepping into one with many more beds than originally intended the rancid smell of bodies is unpleasant.

We talk about the young building's already dilapidated condition. It is damp and mouldy in places; the air conditioning units are dripping. One of Nilar's tasks is the orchestration of drip buckets to avoid slippage and wet beds; another of her many acquired responsibilities, alongside keeping the lights on, instructing and organising the cleaning of the ward and its sanitary areas, and making sure that bins are emptied regularly and the new(ish) waste management system is adhered to. As the words tumble from her mouth, detailing her responsibilities, I get the impression that she is not being dramatic or overstating her duties. She truly is "responsible for *everything*", and knowledgeable of this "everything". She keeps apologising, she knows the ward "should be cleaner". Some years ago, a matron, the wife of an American surgeon visited and kept complaining that nothing is a clean as it "should" be, but Nilar and her colleagues are doing their best. According to YGH's 2019 numbers, the hospital has a 12% vacancy rate of general workers, the people doing the bulk of the cleaning. In absence of strong cleaning team, it is the nurses who feel responsible for cleanliness, they take on this space of responsibility by for example in the operating theatres cleaning machines themselves, not leaving the sensitive and crucial touchpoint for infection control to chance.

I mention the lack of windows to Nilar. Personally, I am thinking about natural *light*, but windows are a hot topic for Nilar. She immediately talks about the missing natural *ventilation.* A problem also noted by the building's "responsible person". The administrator's story is about expenditure. About exorbitant running costs for electricity, and maintenance budgets for the air handling units and air-conditioning; I am not even getting started about the environmental impact of the building that needs to be lit and cooled twenty-four hours a day.

Nilar's problems are visceral, at the intersection of bodies and infrastructure. She points out that when she opens a window it opens onto the service corridor, not to the outside. She demonstrates this by stepping into one of the female bays, opens a window, and, indeed, it is only the service corridor I poke my head into. Workers, cleaners, and security personnel shuttle goods, cleaning materials, and bags of waste back and forth. The ward's windows open onto these back-of-house corridors where the blue windows seen from the outside allow rain to seep in but remain firmly shut to prying hands.

The ward has no natural ventilation, only air-*conditioning*, no mechanical ventilation. Split air-con units (A/Cs) only circulate the air. They do not remove air and inject fresh air, as is the case with air handling units (AHUs) that circulate, purify, air-condition, and renew indoor air. The lack of fresh air/ventilation causes humidity from expanded breath. Mould creeps into high corners. Nilar and the clinical team have no chance of improving the situation, even with the knowledge that ventilation, natural or mechanical, *would* be necessary and *should* be there (let alone the awareness of the benefits of natural light and views for patients' health). I am thinking of the unseen conspicuous mass of mycelium (mould) being comfortable in the air-conditioning units. While the Haematology department in its re-purposed office buildings worries about a lack of air-conditioning units, here they are this new building's curse.

During the Covid-19 pandemic a key aspect of infection prevention was the opening of windows and social distancing: following the same principles like adequate bed spaces and ventilation in hospitals detailed by Florence Nightingale 150 years ago.

The Modular Operating Theatre Complex was only constructed in 2014/2015 and is already rotting away.[188] This shows that building context is critical; equipment might be universal, but the context is not. It does not work to construct buildings the way they would be built in, for example, cooler climates with more reliable electric and plumbing infrastructure (mechanical ventilation needs electricity and water). This is nothing ground-breaking for social anthropologists. We always understand that context is contextual. But for buildings, the many structures designed in one place and transplanted into another context, especially when it comes to buildings for biomedicine which many planners assume to be mostly independent from the environment (as can be seen in design guides for hospitals and laboratory spaces), this needs to be pointed out. Too many blueprints for hospitals get transplanted from one city to the next, from one continent to another without being properly thought out.

[188] In several conversations I was unable to figure out the liability in this case. No one seems responsible that this building has been badly (I would say faultily) designed and built, causing continuous problems not only for the building and staff, but for patients' health given the problems with mould.

The hand that cannot open a window needs to be seen, the patient with a drip bucket beside their bed must be made visible. Only then can we truly understand the impact inadequate buildings have on our lives and body-minds.

What my personal encounter with Nilar and her ward showed, is that such mismatches between environment, the building's context, and the built infrastructure are bridged by people like her. Coming back to the motif of the gap, it is in these gaps where the spaces of responsibility take root. Where "is" and "should" do not meet; where the drip bucket patches the dripping air conditioning or the leaking roof; where mobile torches light the windowless operating theatre when a power cut lasts longer than the back-up power.

AFFECTIVE ROUTINES

Rain is pounding on the workshop's tin roof, Hein Thura Kan raises his voice above the hypnotic drumming. The air is humid and hot. He tells wild stories from his childhood, of shootings at campus gates in the 1980s; of copper pipes that transported oxygen, which disappeared when the rope that covered the valuable metal rotted and exposed the treasure; he laments what a shame it is that the main building's roof is not tiled anymore, the metal sheets that replaced the old tiles make the top-floor hot and noisy when it rains; he questions who profits from the demolition and construction of new buildings.

Hein Thura Kan is a general worker who grew up on campus. He is full of stories that might seem trivial to some, but indicate his personal investment in the hospital, its buildings and places, its continued functioning; the campus is a protagonist in his life. His father and grandfather, who came from India with the British colonisers, had cooked at the hospital's now demolished kitchen until they passed away. Having left campus to work somewhere else, he spent time in prison, and was sent to a labour camp where he was one of the two hundred men who came out of four hundred

going in. Finally, he returned to YGH in his late twenties when his mother called on him. She needed someone to work at YGH to be able to keep her home after his father's death.

This is a story I hear often. People working on campus because their forebears and mothers, aunts and uncles did the same, because the family needs to keep their home. With work at Yangon General Hospital, a public institution, a general worker (this includes security guards) receives a monthly salary of around 150.000MMK[189] (I have heard varying numbers depending on position and department, but all in the same range) alongside a "room", an apartment to live in. In Myanmar, government workers get housing with the job; the pay is meagre, but the home is valuable. An anthropologist from Yangon University tells me of similar generational allegiances at her place of work; any public institution in Myanmar has its genealogy of general workers. They are families have been associated with the institution and its buildings for generations. Hein Thura Kan's wife also works at the hospital. She cleans wards, shuttles samples and blood across campus, runs errands for the nurses and ward sisters, helps with logistics, and assists patients and their families to navigate hospital life. Despite this long-standing relationship,

[189] Approximately $107 in March 2020 (1 US Dollar = 1,395.02 Myanmar Kyats on 3/31/2020). In October 2022, the same monthly salary amounts to $71.

they do not wish for their children to continue the tradition; the pay is not good, and Hein Thura Kan feels it is not good to be around suffering all day.

Doctors, nurses, and administrators rotate in and out of the hospital. The workers stay. Cleaners, general workers on wards, nurse aids, dressers, maintenance workers, oxygen workers, and the security guards, are the keepers of institutional knowledge, the many little stories and rumours of a hospital, their presence is continuity. Fathers and grandfathers, great-grandmothers and aunts have worked at YGH in the demolished kitchen, under tiled roofs, onwards, and in workshops. Why is an oxygen worker commenting on roof tiles, on stolen copper pipes, and pondering missing rubble? The workers care for the hospital; they observe its developments. Their home is contingent on the hospital, and the campus is an extension to their home where they wash after the day's work, get food from donations, and their children do homework under shading trees in the afternoon. At the same time, the hospital is equally dependent on them. Administration goes to lengths to keep workers happy by accommodating their wishes to switch departments, work certain hours, move them around if there are disputes. While I have never heard of industrial action, workers organising themselves, at YGH, Zaman shows in his ethnography about an orthopaedic ward in Bangladesh what happens when workers in a similar setting go on strike: the system collapses (Zaman 2005).

I am told that one needs to know someone to get a job here. It might be that money needs to change hands; Buddhists have it easier than Hindus getting a job; Muslims must hide their persuasion, a mirror of deep-seated racist attitudes in society. The workers' genealogical allegiances are well known across hospital's hierarchies. Towards the end of my fieldwork, the hospital was hiring staff. A young woman who applied said she had to hide that she has family working on campus, the administration is trying to make changes. I did not have a chance to discuss this with the person responsible for HR.

While Hein Thura Kan grew-up on campus in downtown, today he lives with his mother, his wife, and children in Dala. In the mid-1990s hospital moved the workers to the township across Yangon river

from their accommodation on campus. My interlocutors say the administration at the time did not like laundry hanging outside. Bama[190] believe that women's clothes must not hang above the head of men, otherwise men lose their power;[191] but "Indian's hang laundry out to dry". If the laundry was the actual reason, a compounding factor to lack of space on the ever-growing campus, or urban myth, racism towards non-Bama minorities, especially Hindus and Muslims (the “Indians”) is commonplace and systematic in Myanmar. In Dala, the workers were divided into separate Hindu and Buddhist housing areas. In the Hindu quarter all non-Buddhists live. The conversation that elucidated all this, was telling in itself. I asked two of my friends if they were neighbours. At first, they could not understand the question. How could they be neighbours? One was Hindu the other Buddhist.

Even though housing is provided, not much else is taken care of. As in many Yangon suburbs basic infrastructure is missing, roads are not paved, electricity is temperamental, and drinking water is not readily available. Since the housing was built over twenty-five years ago, residents saw no further maintenance. If something breaks, the occupant fixes it. Additionally, after the move, workers were faced with additional costs, such as transportation across the river by small barges, and food which was formerly obtained from the canteen. With the modest salary, even these small benefits made a big difference, but the home is the biggest factor in all of it.

YGH workers have right to staff housing. This is a major reason for workers to remain in employment at the hospital, or for the children of workers to join YGH’s unskilled workforce. Some of my interlocutors said they would prefer other careers but they need to the keep working at YGH, so their parents have a roof over their heads.

[190] Myanmar’s Buddhist ethnic majority.
[191] During the protests in 2021 against the military coup, a movement started in which protestors hung laundry across roads to stop the military from entering. Indeed, military was seen taking htamein down before move forward. https://www.vice.com/en/article/bvxej5/sarong-revolution-women-smash-gender-taboos-to-fight-myanmar-junta

With the modest salary, paraphrasing some of my interlocutors, workers like to work where money comes easily; tips for good work are appreciated. I have heard this view of workers by administrators and doctors alike, and similarly, but in more guarded tones, from workers themselves. Everyone knows government salaries are meagre, impossible to live on alone. In earlier chapters, I have mentioned that most doctors work in private practice after their day job at YGH, and specialisation is often dependant on how lucrative it is in the private sector; trauma surgeons are in high demand while for example haematology and nuclear medicine are specialities usually only found in government hospitals.

The A&E, with its stressful atmosphere and long night shifts, is the department for workers who want to make money, and incidentally get additional training. Many workers here learn basic clinical procedures to support the clinical staff when pressure is high. In the A&E, workers become companions to the patients and their families during a traumatic experience. They make sure patients get to go where they need to, arrive well on the ward, help them settle-in. Workers typically get tipped 10.000MMK per patient, taking care of seven to eight patients in a day, this means in two days, tips double their salary. Wards in contrast are less stressful environments and generally good places to earn decent tips. While many patients reported that bought special treatment, such as better beds or location in the ward used to be customary this has been outlawed in recent years, although tips for workers are still commonplace. I have heard a minimum single tip on a ward is 1000MMK, up to a total of 15.000MMK a day. Some wealthier families leave a large tip at the end of a patient's stay with the ward sisters, who distributes it (more or less fairly according to the workers) between the ward team consisting of sisters, nurses, aids, workers, and dressers.

At the same time, everybody I spoke about "money coming easily", qualifies their opinions immediately. Some workers do not care for the money, they want an easy job, without night shifts and stress. The elderly, chronically sick, or mothers might prefer the specialist outpatient department with its predictable day-time hours, and no emergencies. One worker became a campus

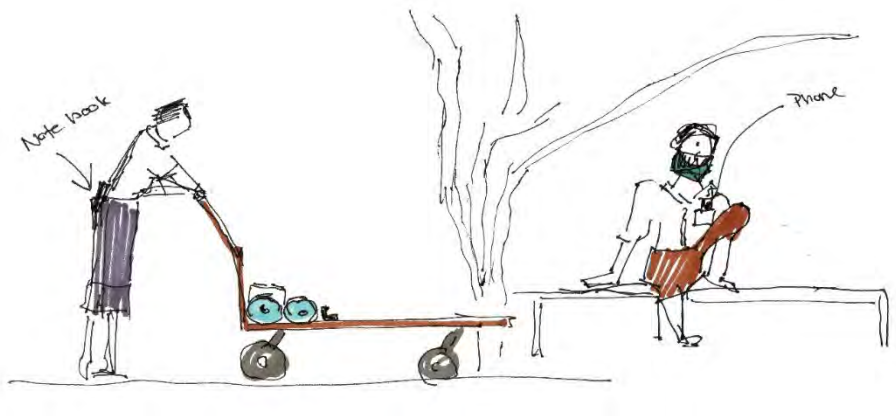
cleaner, working outdoors, avoiding wards with patients since she became pregnant, despite the additional money she can make on a ward. Others do not want to work in the operating suits where air condition blasts all day, for fear of sickness.

Hein Thura Kan's friends work at departments where they get more money than he can make in a non-patient facing department, but he says that patients are very poor and stressed. This money his friends make is not "pure"; it is more money but not honest money. There is always a pull between honest money and the low income. Hein Thura Kan would like to change job and work in a different department. He says he would like to work in a department where he can work hard, do good for patients, and then their family might give him some money.

I believe all this is more complicated than money. Workers' salaries are extremely low, beside the free housing the job is not the most attractive, there is no space for a "side hustle". The need to make money is often conflicted with empathy for patients, as Hein Thura Kan expressed above. He says, when he was working for a company, he would make money on the side by providing information about his bosses, what whisky they liked or what times they would be at the factory. He had no problem with this, everybody in this arrangement was wealthy, except for him. At YGH patients are not wealthy and they and their families are suffering. He feels conflicted about profiting off other's suffering. He is clearly touched. At the end of the day Hein Thura Kan wants to leave YGH. He says, working at YGH one is always surrounded by suffering and earning a living from suffering in whichever shape or form is not good.

In this conflicted space, workers take on spaces of responsibility. When, for example, the security guard becomes the ward sisters' right hand, or A&E workers help family members and attendants transferring from the A&E to a ward and settle-in, despite the financial "appreciation", they feel responsible and justify the reward by doing good. The oxygen workers take their job extremely seriously. They clearly occupy their allocated space of responsibility for the hospital's collective lung. They run when the electricity cuts and speak of the importance to do a diligent handover at the end

of the shift to avoid problems. While this has also much to do with a harmonious work environment, their space of responsibility is important to them. General workers are routinised and often calculated, at the same time their routine is affective, guided by compassion for the patients and their families, who could be them. They occupy multiple spaces of responsibility: towards patients which overlap with a literal space of responsibility, their home, and the need for economic survival.



CONCLUSION

In this chapter we saw administrators, family members and hospital staff occupying literal spaces of responsibility where buildings and spaces overlap with their responsibilities.

Vernooij, Koker, and Street (2022) delve into the intricate workings of hospital care through the lens of a patient's pathway, providing a detailed analysis of the breakdown and repair moments in patient care coordination. In this they shed light on the crucial role of small acts of intervention and improvisation by multiple individuals across the patient pathway. While this approach offers valuable insights, the authors content that patient pathways as ethnographic method are individualistic and might obfuscate wider structural inequalities (ibid:6f). While patient pathways by definition take place in in-between spaces (between institutions, departments, wards and laboratories), I extend this valuable approach by turning my attention to the spaces in-between and the practices within. It is in these spaces where I see what Vernooij, Konker, and Street identify as

repair work to the system. The article ties in with my argument of spaces of responsibility through the lens of what the authors' call individualisation of responsibility, conceptualised as acts of temporary repair and care for the health system itself (Vernooij et al. 2022: 1). I see something similar at YGH and I agree with Vernooij, Konker, and Street's analysis, while adding a spatial and material dimension to it. Spaces of responsibility, rather than just "responsibility" refer to *actual* space where responsibility manifests itself and becomes visible.

When it comes to waste management, and individuals' owning this this particular space of responsibility (the organisation of waste disposal points), reflects the expectation that a hospital campus should be orderly and clean; something also mirrored in the many signs around campus, reminding individuals not to litter, spit betel nut, or talk loudly. Here it is interesting who owns this space of responsibility. Despite the signs around campus, visitors do not seem to own this space of responsibility but rather complain when it is not clean, despite littering themselves. Administrators occupy often complicated spaces, when two spaces of responsibility overlap. For example, when orderliness of the campus collides with compassion for "our attendants", or indeed the hardships of daily economic survival in Myanmar. While attendants and monks take on spaces of responsibility around food, bedside care and shelter, the hospital as a whole is coerced into being a space of responsibility by the wider system.

Attendants' spaces of responsibility become the literal spaces in-between around campus, and the cracks in the public institution; what a hospital "should" and "could" do beyond the bare necessities is tamped by individuals like a loving son or empathetic neighbour.

Nurses occupy the gaps that the system leaves behind and bridge mismatches between local environment and globalised ideas of healthcare spaces. Their spaces of responsibility overlap with storerooms and bathrooms and become visceral through light and air. Here we see the clear expectation that a hospital should be clean, and it should be a space where patients learn about health, how to take care of bodies, one's body and others'.

Workers feel the hospital should be a place where they can make a decent living off their work. For many workers, their allocated spaces of responsibility overlap with literal space, for example the day-wage cleaner who collects litter around campus, or the A&E. All workers occupy a space of responsibility towards their family, which overlaps with their home, provided by the hospital. This in turn creates a dependency on the institution, in which they occupy a coerced and, as we have seen, value-led space of responsibility; the hospital's collective lung, or the wellbeing of sick and traumatised individuals. Empathy driven, this space of responsibility is complicated by beliefs in Karma and the need for economic survival.

A common tenor across the hospital spaces and hierarchies is that of patient care. Patients are the reason for the hospital's existence, its literal and figurative spaces of responsibility. Rules like "don't pay for jumping the line" indicate a two-way responsibility which also includes patients; one should not take bribes, at the same time, one should not bribe. Furthermore, it shows the expectation of a hospital: it "should" be efficient. Staff highlighted in conversations, while the hospital "should be" efficient, this is a two-way process in which patients and attendants must play their part as well.

Spaces of responsibility are tightly interwoven with the hospital's infrastructure. Inadequately planned spaces, as we have seen with the Orthopaedic Complex's ventilation issues or with hand washbasins and scrub rooms in the wrong location, means that an individual needs to take personal responsibility to seek out the basin, rather than being reminded to use it by its mere presence, demanding responsibility of the individual. Shortage of workforce is equally creating spaces of responsibility when individuals must take on "everything" and taking personal responsibility for cleanliness rather than following a check list.

I am not able to unravel every space of responsibility at the hospital, which is also not the purpose of qualitative research. In its detailed texture, my ethnography of practices showed how thinking with spaces of responsibility is productive. Spaces of responsibility get beyond ideas of "shoulds" and "coulds", into what is actually going on and connect to the literal hospital spaces. This illudes at why

the hospital keeps functioning at all: individuals occupy spaces of responsibility, for diverse reasons, some personal, others institutional.

When looking closer, inspired by Thawnghmung's categories of economic survival, we can identify multiple categories of responsibility that emerge through the individual practices and are brought together in spaces of responsibility. In the ethnography have seen caring, affectual, educational, infrastructural, and bridging responsibilities. Thinking with these categories help to understand the hospital multiple as an affective hospital, a hospital of care, the hospital as an educational space, as mediative infrastructure, and as a bridge between the state and its people, reminding the state of its responsibility.

While "spaces of responsibility" are a conceptual framework that emerged from my ethnographic fieldwork at a Yangon hospital by expanding on Ardeth Thawnghmung's "LPVE" to the hospital and its literal and figurative spaces, they are a useful framework beyond Myanmar, Southeast Asia, and the global south. Indeed, I propose spaces of responsibility as a useful concept to understand hospitals in general, regardless of geographic location, political systems, and available resources.

Hospital Echoes[192]

Nora Wuttke

Material:
Fabric paint on cotton,
Steel clips, wire

"Hospital Echoes" is an installation based on sketches made during Nora's ethnographic fieldwork at Myanmar's biggest public tertiary care teaching hospital in Yangon.

The installation is composed of ten near 1:1 reproductions of field sketches. The banners echo the hospital's rhythms and intensity, speaking to the spaces in-between the literal and figurative hospital structures.

In all of Nora's work drawing is the start and end point. Her Drawings are about relationships of bodies in space, between people, and to places.

If you would like to find out more about Nora's work, follow her on Instagram: nora.wuttke

[192] Exhibition text for *Hospital Echoes*; shown at SOAS's Lady David Gallery, London in April/May 2023

SPACES IN-BETWEEN, ZONES OF PRACTICE, NO GENERAL HOSPITAL, AND ARTFUL ETHNOGRAPHY

In this dissertation, architectural practice, ways of seeing, and the anthropological craft of ethnographic narrative come together to make a novel proposition: drawing and writing buildings.

The main question, and challenge, of this thesis was, how to capture a hospital, that, like so many anthropological subjects, is complex and difficult to grasp whole and represent it in text; what strategies allow public institutions to be represented in ethnographic writing? My proposal is an ethnography with the (built) environment.

While the bulk of the thesis presents an ethnography of the daily life of Yangon General Hospital in Myanmar, it also offers a methodological and epistemological proposition for a novel multi-modal ethnographic practice, speaking to, and at the same time broadening the potential of, visual anthropology with "artful ethnographies". Here, the ethnography serves as a proof of concept. The epistemological and methodological proposition is reliant on the ethnography of the daily life of Yangon General Hospital, and *vice versa;* both developed in tandem.

Parts II, III, and IV draw on and add to hospital ethnographies, with a distinctly material and spatial contribution; a mostly overlooked orientation in hospital ethnographies as well as in medical anthropology, while hospitals as public institutions have not featured much in anthropology of infrastructure, buildings, and architecture. With the proposition of, and experimentation with, drawing and writing buildings, I situate this thesis in the growing body of sensory and arts-based ethnographies.

I started by reconceptualising how to think about buildings, through drawing and writing *with* them. By mobilising Annamarie Mol's concept of the *Body Multiple* (2002), repurposing her theory of how to think about bodies and objects to understand buildings, I was able to shift from "perspective" onto "process", re-conceptualising buildings as process as well as *practice*s: the things we do

in/around/with the built environment. This founded the basis for how this thesis thinks about buildings: as "multiples" where one building/campus/hospital is many in one, not as objects we look at from different angles, through a series of eyes. The hospital multiple emerged. Where Mol de-singularise a specific disease in *The Body Multiple* (2002), I de-singularise the hospital.

In her scholarship, Mol theorises care as entangled with (medical) technologies, rather than in contested opposition. In a similar move, I complicate human and non-human relations on campus, showing how (health)care, bodies, and buildings, are entangled with infrastructures, pipes, wires, bricks, and concrete. I mobilise a distinctly material understanding as social anthropologist, architectural designer, and artist; stopping where medical anthropology starts.

I engage literature from anthropology of infrastructure, buildings, and architecture, which have a strong focus on either infrastructure such as roads, pipes, and wires, or house/homes, to understand a public tertiary care teaching hospital. Furthermore, the hospital multiple has affective agency. By reaching for Gell's *Art and Agency* to understanding indexes/art objects, and in my case buildings, as secondary agents, and art as a category of action (1998), buildings become pivots of social relations.

Here, Bourdieu's tangible concepts, especially habitus and fields, have been instrumental in conceptualising spaces of responsibility from which, following Mol, zones of practice emerge. As noted in the introduction, Mols' specific philosophy of bodies/objects in practice, is akin to Bourdieu's theory of practice. Both have an ambiguous relationship to objective knowledge, both reach for practices, and are interested in specificity.

Bourdieu is concerned about bodies in space, and the materiality thereof, as we see in his work on the Kabyle house (Bourdieu 2000a), where materials feature especially heavily, and in *An Outline of a Theory of Practice* (1977: 87). Mol is interested in bodies in practice, conceptualising *The Body Multiple* (2002); however, her handling of bodies/objects does not fully enmesh space and materiality. By bringing Bourdieu and Mol together, materiality and space come into conversation with the multiplicity, and agency, of bodies/objects. This allows for a departure of perspectivism,

following Mol, moving towards a material and spatial (and symbolic) understanding of multiples, in which the (spatial and material) hospital multiple, and by extension the building multiple, emerges. Reading Mol and Bourdieu together allows me to bring bodies, building, space and materiality into one frame.

At the same time, atmospheres, moods and agency allow me to push concepts beyond a nature-culture-dichotomy, through my drawing methodology that engages the visceral and ephemeral, a world beyond words. In this, I unsteady the categories “building” and “hospital”.

At the start, I was interested in seeing if biopolitical ideas of institution, as developed by Foucault, and the idea of continuity between container and contained, as discussed by Carsten and Hugh-Jones, Buchli, Yaneva, and Bourdieu, can come together. As mentioned, Bourdieu’s tangible concepts proved to be valuable here, while I also reached for more contemporary approaches such as affect, atmospheres and moods.

Moods are non-verbal registers of experience (Gammeltoft 2018). In Gammeltoft’s work, domestic worlds are integral parts of individuals. Similarly, at the hospital, institutional worlds become an integral part of the individual, patient, attendant, and staff alike, and their experience; hospital atmospheres can permeate its inhabitants very being.

In this, the lines between build and natural environment, human and non-human/more-than-human start to blur. The Oxygen workers’ daily routine is guided by patients’ breath, during Covid-19 their daily life completely changed, from a twelve-hour shift pattern to a twenty-four-hour pattern; Maintenance staffs’ daily tasks change with the seasons, plant growth, and viruses; The patients’ and attendants’ circadian rhythms are directed by doctor rounds, nights with fluorescent lights, food donations, traffic patterns, and seasons, rainy, hot, or cold.

In this thesis, I come at the hospital from an in-between space, a dialogue between architecture and anthropology, drawing and anthropological narrative, buildings and bailiwicks, a place where nature

and culture are one, albeit not always harmonious. Rather than approaching the institution from a particular *perspective* or *function*, I understand it at the hand of *practices* and visceral *experiences* of the campus, its buildings and atmospheres. Through my art practice/artful ethnography and emplaced writing (with buildings), new ways of understanding the hospital multiple emerge. Writing with buildings shifts between scales and environmental registers, providing a novel ethnography of the daily life of a hospital through "Place", "Rhythms", and "Individual Encounters" (Parts II, III, and IV in this thesis).

By engaging the hospital through my drawing practice, an artful, as in mindful, field encounter, I was able to note the manifold oscillations, connections, scales, and relationships of bodies in space, human and more-than/non-human, through a visceral encounter. Artist Zheng Bo draws plants stretching through concrete cracks of urban environments to *be* with them, to *sense* them;[193] I drew daily life on campus for the same purpose, to *sense* its oscillations. Through analysis, the process of writing with buildings and their materials, I brought these visceral, non-textual observations, into the context of anthropological literature. In contrast, the artist brings his observations through the artwork (or the index as Gell would say) into the art-world, where their frame of reference is art-history. Two distinct practices materialise: the artful ethnographer and the ethnographic artist.

Four key arguments result from the thesis: "Spaces in-between or "The In-between Hospital"" a conversation with hospital ethnography; "Zones of Practice", a discussion of the implications of the ethnography; "No General Hospital", a deeply ethnographic argument for makers of hospitals around environmental and cultural specificity of hospitals; and "Artful Ethnographies" which develops the methodological and epistemological proposal I am making. I am ending the thesis with a look ahead, by discussing the potential avenues for "Going forward" from here.

[193] For an interview with Zheng Bo on his show 'Wanwu Council 萬物社.' That explores the question, "How can humans sense the way plants practice politics?" see: https://www.berlinartlink.com/2021/08/10/zheng-bo-interview-gropius-bau-2020-artist-in-residence/

SPACES IN-BETWEEN OR "THE IN-BETWEEN HOSPITAL"[194]

From a position of in-betweenness (anthropology, architecture, art practice), guided by experimental methodology between art practice/drawing and classic ethnographic enquiry (participant/observant participant observations, archival research and interviews), my ethnography turns its attention to the hospital's interstitial spaces; the in-between spaces where care and healing is negotiated, and in-betweenness becomes institutionalised at Yangon's biggest public tertiary-care teaching hospital. We saw across the chapters how individual attendants, nurses, and others patch the holes that the institution/state leaves behind, and in turn become a system of their own (on which the healthcare system heavily relies). This idea chimes with Vernooij, Koker and Street's conceptualisation on "responsibility, repair and care in Sierra Leone's health system" (2022), where the repair and care work done by family members, administrators and clinical staff in the hospital becomes repair and care for and of the system.

Drawing, as all art-making, toys with liminality and is attuned to the non-verbal and visceral, was essential to lead me into the spaces in-between. Hospital ethnographers, as seen in the literature review, discussed the importance of the intersection of biomedicine with familiar care (Brown 2012), hauntings and/or religion (Hannig 2017, 2022; Varley & Varma 2018), history with the present moment (Horwitz 2013; Mika 2021; Street 2012, 2014), environmental decline with healthcare (Hodges 2017), or the importance of repair and maintenance of the hospital's physical infrastructure (Grant 2020; Kehr 2018; Street 2012; Vernooij 2021; Vernooij et al. 2022); practices that I drew taking place in-between beds, job descriptions, wards, doctors' offices, and theatres (the biomedical purview). My ethnography attunes to these practices through its experimental methodology and locates them in literal physical spaces; "The In-between Hospital" emerges. Here these practices of (familiar) care, taking responsibility, repairing, maintaining, rehearsing, are located in actual physical

[194] I thank Alice Street for her comment in the *Viva Voce* for the thesis for coining this term.

spaces; such as the covered bridge in front of the ICU that throughout the day changes from a busy thoroughfare and waiting area to a dormitory for family members of ICU patients, its changed marked by the time of day and the practices performed (fetching diagnostic tests, eating, putting on pyjamas, massaging feet).

Maybe it is the interstitial space, the space of repair and care, in reference to Vernooij et.al. (2022), or the improvisation of medicine to draw onto Livingston (2012), that holds the hospital together.

Coming from an in-between space myself, between social anthropology, architecture and art practice, I was able to attune to this space, be comfortable between buildings and bailiwicks. My positionality and methodology affording me the ability to pay sustained attention to the relationships that evolve in these spaces. Adding to Vernooij et.al.'s (2022) call for repair to be part of health system planning, I would suggest that interstitial space has to become part of it as well, in terms of architectural design and the system.

Anthropologists are not alone in this call. In many conversations, as the ethnographic chapters showed, hospital administrators, doctors, nurses and family members, said as much in very practical terms when it comes to attendants on campus: we need more/better family spaces.

Hospital planning needs to pay attention to the spaces in-between, in architectural design terms, but also in terms of the system.

The in-between hospital is another one of the hospital multiple, the many hospitals that other scholars made visible through paying attention to well-known areas of clinical practice like the clinic, the ward, the laboratory, or the A&E and the ICU.

I demonstrate that the spaces in-between physical structures and clinical purviews are crucial to the biomedical work of the hospital and shape the "atmospheres" and "moods" defining hospital life for patients, attendants, and workers; when life rests under the holy tree, or in corridors-turned-waiting-rooms where family members await for instructions from the ward, or administrators

created spaces for understanding between vendors, who supply vital products from bedpans to lean foods, and clinical staff. My ethnography highlights the importance for hospital ethnographers to examine often overlooked spaces in hospitals that are essential to healthcare.

ZONES OF PRACTICE

This argument leads me to my second point: we need to think, design, plan, make, and re-make hospitals through an understanding of the zones of practice that emerge when sensing, being, seeing, engaging with the hospital's rhythms, uncovering spaces of responsibility and understanding.

When making, and explaining, *Hospital Echoes*, a spatial installation based on my fieldwork sketches from YGH, on show in Bloomsbury, London, in April/May 2023 (you find the exhibition text as prelude to this concluding chapter), I realised what the hospital is "really" about, the story I wanted to tell and felt was important to tell: as discussed above, the hospital is about the spaces in-between; between buildings and bailiwicks, where its rhythms of daily life roar with varying intensity. In this I am speaking to the spaces in-between the literal and figurative hospital structures. These are the productive spaces of action and cultural value that are accessible and laden with meaning for the ethnographic drawer/artful ethnographer.

"Are these the hospital's sheets?" A question that visitors to my installation asked me often. The answer is "No", Yangon General Hospital has no sheets for its patients. As we have seen in the ethnography, patients and their attendants bring sheets, blankets, and pillows themselves. The hospital neither has a kitchen. Again, attendants get food for patients from home, from donations, or from stalls around the campus. "Lack" is becoming a business opportunity and the wares on offer at stalls around campus can be read like an ethnography of the daily life of the hospital. You can find such hidden stories of daily life in the drawings: stories of the in-between. In-between physical structures, the buildings, waiting for doctors, getting to appointments, medicine shuttling back and forth between departments; and in-between structures of the system, getting food for patients,

chatting with a colleague, taking a break. It is in these spaces in-between, that often overlap with what I call here “spaces of responsibility”, where responsibility manifests in physical space, we see the hospital the clearest; in the practices with/to/around the hospital; the zones of practice.

Understanding buildings through practice, the things we do with/in them, leads me to propose to think, make, and re-make hospitals through rhythms and their frequencies that pulsate through the buildings. As we have seen in close observation, these are utterly contextual and visceral.

In my proposal for zones of practice I do not mean a formal built expression. My proposition is an epistemological one, how we think about and seek understanding of hospitals/public institutions.

When we are planning and building hospitals, zones of practice rather than functions should be the core of the design. As my ethnography showed, functions change, science moves on, and does so in a different pace than building-time. Practices remain. Therefore, I propose a different understanding of how to think with hospitals and public institutions. It is at the Ghost Tree’s trunk where the hospital’s daily life congregates and thickens. Essentially the hospital is made of spaces of responsibility, which come to light through the careful observation of practices and spaces in-between, giving rise to zones of practice, not through an analysis of functions. Before my ethnographic fieldwork I would not have recognised the trees as harbours of important to clinical practice.

Now, you might wonder what zones of practice are. To define or categories them would take another research project, moreover I want to suggest that rigid categories are not necessary, even counterproductive. Categories have the potential to get stuck and produce an illusion of universality, something I am distinctly writing against. Zones of practice are a mindset, a way of thinking when making hospitals.

Maybe a start is to take existing *functions* and rethink them into zones of practice. As I said this is more of an epistemological proposition. What happens? WCs are no longer just toilets, zones of

practice overlap here, laundry, dishes, and bodies are emptied and washed here; the toilet as a zone of practice extends onto the ward, includes the pathway and the shimmying in bed, the careful and slow movement of a body with casts, the steps, and the kinks in the floor surface that make movement painful for broken bones.

Finding, seeing and being with the practices leads to understanding hospitals (better). I am stopping with the epistemological proposition before I venture into an architectural and design discussion. Nonetheless, I believe by reordering space through zones of practice, we can reconfigure the hospital, for example by questioning hierarchies of current activities, making space for the practices on the ground. In this we part ways with a functionalist thinking towards a practice/zones of practice based thinking. In this I do not discard functions, after all we understand functions very well and many disciplines can contribute research. We need to take existing functions and re-think them into zones of practice. In this, I propose an epistemological shift in how we think about and with the built environment.

NO GENERAL HOSPITAL

Daily life on Yangon General Hospital Campus showed many things, but throughout all ethnographic chapters echoed that there is no hospital in general. This observation challenges the universality of healthcare materially through its buildings and infrastructure. Social anthropologists know that not only experts "do" biomedicine separate from the individuals and social relationships, and most architects also understand that healthcare is not universal. Planners know this, and doctors. Even if they think such a thing as universal biomedicine exists, what they do on the ground tells us otherwise. Nonetheless, when hospitals are built, experts come in, people with ideas, ideologies, and beliefs, as we saw so clearly with the inception of Yangon General Hospital in Chapter 4.

Anthropologists know that biomedicine is not neutral, nor the same everywhere (see for example discussions in Berg & Mol 1998a; Mol 2002; Van der Geest & Finkler 2004); to quote Mold and Berg

from a quarter of a century ago (1998b: 3): "[…] Medicine is a heterogenous coalition of ways of handling bodies, studying pictures, making numbers, conducting conversations. Wherever you look, in hospitals, in clinics, in laboratories, in general partitioners' offices - there is multiplicity." In this thesis I showed that this multiplicity translates into the spaces of biomedicine. Something medical anthropologists have done before me, and makers (planners, architects, policy makers, administrators and so on) need to pay attention to.

Doctors, nurses and other health practitioners know "how medicine is done on the ground", as my ethnography clearly shows. However, I encountered a tension between what *the hospital* "should be", "We know this is not best practise, but what can we do?", *vis a vis* the reality; power cuts mean that digital patient records are more of a curse than a blessing, Haematology has no positive pressure rooms, and air-condition units drip in the MOT while Nilar cannot open her ward's windows.

Simultaneously, most architects and planners I know talk about context sensitive design and the importance of the environment, yet I also hear about what I call "universal air", air-conditioned operating theatres, and "international best practice". I have seen too many new buildings on campus not fit for their context, which overtime translates into unfit for purpose, which is the medicine done on the ground. How could it be different when *Architects' Data* [195] (Neufert et al. 2019) is one of the most popular reference books for budding architects the world over? The hefty volume, organised by building typology, offers data on everything from standard room and kitchen-counter heights to number of toilets in public buildings. At the same time, building codes are copied from one country to another.

[195] From the publisher's website (emphasis added): "Architects' Data starts with the basics of designing for a new building project, before moving on to covering *everything* an architect needs to know. It also looks at the design styles and specifications for creating different types of structures, such as those made for residential, religious, cultural, sports, medical, and other types of occupation." https://www.wiley.com/en-us/Architects%27+Data%2C+5th+Edition-p-9781119284352

At one point during my time as project architect on campus, I encountered the issue of distance between utility access holes in Yangon. For cleaning purposes, municipal workers had to go into the system to clean utility access holes because the distance between them was too long for the available tools. However, they had been built "to code", a code copied from Singapore where different equipment was available, without considering the kit available in Myanmar. A problem that keeps resonating in my interlocutors "doing it the Burmese way".

Not only building codes are, at times poorly, translated from one country/context to another. Ideas of best practise travel too when experts transcend environments. Digital patient records might be the best practice for patient safety in the UK's NHS, but in Yangon with its many power cuts, a different system might be safer. An interlocutor relayed a conversation of a time she visited the central sterile services department (CSSD) with an international hospital space planning expert. The expert was horrified that YGH was not using single-use plastic bags[196]; all items should be placed in such clear bags, ideally with an indicator strip on each pouch confirming the sterility of the instrument inside by changing colour during the process, and scanned with bar codes for autoclaving,[197] but YGH does not have this system; nor the resources to buy the bags reliably or dispose of them safely. As Hodges notes, this "prepacked modernity" relies on (unavailable) supply chains (2017: 326), is embedded in a hygiene discourse that spread from high income countries across the world (ibid: 324), and is not necessarily rooted in science (ibid:325). At YGH, they use reusable linen bags and metal boxes. Plastic bags are only used for specialist items, that are, for example, very small and at risk to get lost. Nurses from each surgery team (cardiac, orthopaedics, and general surgery) clean and pack the items. This takes up back to spaces of responsibility. The nurses know what they have to do, the system is reliant on individuals' knowledge; individuals

[196] Typically made from high-density polyethylene (HDPE), polypropylene (PP), or polyamide.
[197] Autoclaving sterilizes material using saturated steam under pressure ("moist heat").

occupying a particular space of reasonability, entangling hygiene, risk, and responsibility. Nevertheless, the system works and is *appropriate* for the context.

While materiality and technical details are contingent on wider systems, spaces are too. Given Yangon General Hospital's position within the wider healthcare system and its economic context, the hospital has spatial needs, for example for attendants.

What my ethnography showed is that the hospital, its built environment, is inherently relational. Buildings mediate relationships, as we saw in Chapter 7 "Bodies and Buildings", and he hospital itself as an institution relies on its relationship with its patients. Something not surprising to anthropologists, but important to point out to and remind planners, designers, and administrators, the makers and maintainers of hospitals; the build environment has direct effects on healthcare. I showed this through infrastructural examples, such as the distance between the A&E and Neurosurgery operating theatres, and the (lack of) air pressure in areas of the Haematology department.

My ethnography has shown that hospitals are culturally contingent (Van der Geest & Finkler 2004), as well as materially and spatially dependant. With a detailed study of the latter, I am adding and furthering to the existing literature. Medical anthropology has shown over and again that biomedicine is not universal, even the people who buy into this shared fantasy do not act accordingly. My distinctive methodology, drawing and writing buildings, complicates infrastructure(s) and shows that biomedicine interacts with the material reality on the ground (also) through materials and space. This means, there is no hospital in general; and by extension institutions are not universal.

The making of the hospital is about knowledge and how we come to know what we know; again hospital ethnographers understood this for while (as for example Mika 2021; Street 2014 show). I propose to pay attention to practices and experiences of bodies and buildings in and *with* hospitals. I do not say that expertise does not exist, but it is often technical knowledge divorced from the

places, history, cities, rhythms, and individuals on the ground. This thesis proposes a way through the messiness by using buildings as guides, infrastructures that are intimately interwoven with daily life, practices, and experiences of the hospital's inhabitants. What we see is, how hospitals really work through zones of practice. An argument not new for hospital ethnographers and medical anthropologists but pivotal for architects, administrators, planners and all the other makers of hospitals.

ARTFUL ETHNOGRAPHY

Writing with buildings is a humanistic more-than-human proposition for writing ethnography, and by extension writing with the (built) environment. This approach does not relief the humans who made, and are responsible for, the the state of this world, fully acknowledging that not all humanity is equally responsible, from their responsibilities. This approach responds to current calls to re-think how we write anthropologically, as for example Kiik does on the Myanmar context (2018), in a more-than-human world by writing experiences, practices, and more then human agency into the text; the humidity, the wooden handrail, the stairwell where rhythms and atmospheres run into each other and at times mingle. Colonial atmospheres of ideas about disease, air flow, and race overlap and at times collide with contemporary medical practice and sealed environments for surgery, or back and front of house speeds run into each other in the main staircase and overlap with the hospital's mood of waiting.

My last point comes together in my installation *Hospital Echoes*.

The ladies carrying tiffin containers wear their longjis short, as they get food for their charge. Doctors, their hip bags indicative of their profession, wear their htameins long to the floor, one has their hair open. Workers and attendants around campus tend to wear their longjis short, while doctors and nurses, and some visitors, wear them long, betraying their profession, and the ins and outs of their daily lives; the doctors might have a car, they do not need to use public transport and

move around as much and as quickly as the workers. A colleague, years ago when I was project architect for the hospital's rejuvenation project, told me how difficult it is as a Burmese woman to wear a long htamein on site-visits. Today I can see this discussion reflected in my sketches through my artistic engagement.

I came back to London in September 2020 with eleven sketchbooks and scans thereof that I organised in my digital notebook chronologically. Today, I might use this step of digitalisation as part of the analysis and organise the sketch pages differently; or not, who knows. At one point writing my thesis, I was stuck with the concept of "Rhythms". I started to think through my sketches, the number of them and the stories they tell. Using a projector, I reproduced them by hand on white cotton with black fabric pen and fabric colours. A process akin to the ink pen and colour markers of the original. In this process I had several touchpoints of engaging with the drawings: making them, scanning them, organising them, analysing them, and making a spatial installation that echoes the hospital in its rhythms and density. Drawing went from being a method, to a methodology, to an epistemology.

All these moments were essential for my thinking. The process here is more important than the object, and the medium is part of it. Doing all this with a tablet would be a very different process; not better or worse, different. I am curious to explore this going forward.

The question of which medium we as artists use is interesting, especially the question of digital *versus* analogue. Both are equally valid but have such different processes that influence how we think as practitioners. Having a sketchbook with pages that have boundaries, one page after the other, is very different to an infinite white board on a tablet. Different connections are made, and engagements with the material are different.

All this is making an argument for "artful ethnographies": ethnographies that sustain engagement, are visceral, and make us vulnerable. In a conversation with an artist who frequently collaborates with anthropologists, she told me: "You make. Your art practice, your installation makes you

vulnerable; the anthropologists I collaborate with are like curators. They never make themselves, they never become vulnerable." It is in the making that I understand. Art is a way to be with the world, and that is, to me, the ultimate purpose of artful ethnography. With this I am embedded in an existing tradition extending from visual anthropology, connecting to exciting current approaches at the intersection of art and ethnography, with a distinct connection to the anthropological literature, rather than seeing myself in the art world, with a different heritage in art history. My kinship lies within anthropology, a mindfully artful ethnography, and sensual ecologies.

GOING FORWARD

The world has seen many apocalypses, as Maynard and Simpson point out in their collaborative indigenous scholarship (2021; 2022). Places like Yangon have lived through many catastrophes and extinctions, colonial extraction, economic hardship, and environmental collapse. Learning from Yangon General Hospital means learning to run and make hospitals in a world that needs to re-make itself. As we have seen throughout the ethnography, change, collapse, and renewal are inevitable. As Maynard and Simpson argue, we need to be okay with that, the world has ended many times for large parts of humanity, and the world as it is today might not be worth saving; renewal rather than salvage might be the answer (ibid). Rehearsal rather than performance is the way forward. What is happening to the world today, is not new, not as extraordinary as some might like to believe; another iteration will follow as it has before. If this new world needs hospitals remains to be seen. For now, I think, hospitals are important places for knowledge exchange and production, for training, and for care; public hospitals are important spaces. However, we need to understand them differently; less as a universal typology, more like a multitude, emplaced spaces of responsibility, and zones of practice, alive in a series of rehearsals.

In order to look ahead, it is productive to turn back to some of the initial questions of the thesis.

What is a building? The ethnography showed, buildings carry affect and neglect; they carry hopes and aspirations. They accommodate a multitude of hospitals; it is a collective lung, pathways of pain, infrastructure of death, colonial airs, a series of spaces of responsibility, and so on. Place is a function of time, and buildings are places of function of time. Artist James Benning copied artworks of famous artists to be with them, showing that it takes time to understand places and by extension its people (Prince 2021). Art is a way to understand place, and it is it important to understand place, to understand people. Consider for example the artist Bill Taylor, a slave and later working farmer. The art world considered him "untrained" (ibid). What his critics did not understand was that he was trained in the places he painted (ibid). His paintings show an ultra-precision in the landscape (ibid). Had Benning not paid close attention to the *places* Taylor painted, he would not have understood him as an artist. To quote artist Damian Ortega: The artist is the scientist of our times. Understanding this allows us to make better places by giving us time and "space to understand" each other, to reach back into my ethnography.

A question that is always on my mind, "how do we live with our buildings and they with us", is best answered with the utmost brevity: through rehearsal; through failure, trial and error, improvisation, and getting up the next day to do it a bit better (Maynard & Simpson 2022). What we are left with is a choreography of rehearsals, not a series of failed performances. Lastly, why does it work at all against the backdrop of rehearsals, failed and otherwise? It is individuals who occupy spaces of responsibility that ensure YGH keeps going. Knowing this, we can make better buildings. As Boyer wrote, infrastructures have revolutionary potential (Boyer 2018); and so do buildings.

Infrastructures are mediators and always "[…] enable something else to happen" (Boyer on Larkin in: Boyer 2018: 227). Buildings help and hinder knowledge and knowledge production, as we saw especially in Chapter 9 where the Haematology department cannot train the next generation because of inadequate buildings. Buildings mediate, but they also rupture. They save lives and take them.

With an ethnography with the (built) environment, writing and drawing buildings, I put forward an *experiential* engagement with buildings, shifting from form and function to *practice*, adding materiality into the discussion. Atmospheres and Rhythms run into each other in the hospital's staircases and corridors, spaces of responsibility occupy the literal gaps between buildings and systems.

What emerges is a humanistic more than human anthropology. Spatial arrangements lead to social arrangements that lead to emotional arrangements, to knowledge and practice.

This thesis presents a novel approach in which we look out from the buildings, the imperial debris, the infrastructure that contains daily life at Yangon General Hospital, into the faces, the practises, and the ideas that inhabit the build environment that is the hospital.

With this baseline established, new avenues for investigation open. In a way I find myself where I started, now equipped with new ways to understand, and think with the built environment. For example, the question begs what influence spaces and their materiality have on healthcare, medical practice and by extension knowledge. In Chapter 8, we saw how the facilities, the buildings themselves, tie in with clinical practice. I can see a collaborative project with medical anthropologists and engineers to explore this further, and in more detail, on the scale of individual "zones of practice".

I also see questions that concern the hospital's wider environment, infrastructurally, historically, and spatially.

What are the energy regimes, locally and globally, that govern the "global"/ "universal" and "colonial airs" that I detected on campus? Throughout the ethnography we encounter electricity as an enabling and hindering factor in the hospital's day to day. Electricity, alongside medical knowledge production, creates the "global atmospheres" I talk about in Chapter 7. Here I see a

natural extension into an anthropology of electricity emerging, by asking what are the wider energy regimes that govern global airs and local atmospheres, in healthcare and beyond?

In extension to the question on energy, intimately entwined with bodies as well as the environment and (colonial) extractivist practices, this thesis made me curious about the possibility of an anti-colonial architecture, and its place in today's sustainability discourses.

Lastly, we saw how the new Rangoon General Hospital was constructed, accidentally, as a beacon of biomedicine in a secondary province of the British Raj; how do notions of "periphery" and "core", historically and today, play out in hospital buildings and medical knowledge? A study of a hospital constructed at the same time, the late Victorian/early Edwardian period, in London, a "centre" for medical and architectural knowledge, a direction many look towards, would allow a comparison between "the centre" (of knowledge, medically and architecturally) *vis a vis* medical practice, research, and knowledge production today and historically in "peripheral" buildings and geographies.

Meanwhile, pipes continue to leak, roots inch into foundations and under eaves, materials metabolise; all undoing the stability of the hospital as portrayed in this thesis.

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